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The Open University and Oxford Brookes University

Milton Keynes Family-Nurse Partnership: Wave 2A

***‘Collaborative Working with Children’s Centres’; a service
evaluation project***

Final report on project findings

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December 2010

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Acknowledgements

We would like to acknowledge with thanks the contributions and cooperation so freely and generously given to this study by the following, without whom this work would not have been possible:

The Family Nurse Partnership Team Milton Keynes;

Christine Thompson, Professional Lead, Health Visiting/School Nursing, Community Health Services, Milton Keynes;

Elaine Jackson, Milton Keynes Sure Start Children's Centre Strategy Manager;

The participating Sure Start Children's Centres coordinators;

Practitioners in other associated services;

Charlotte Ritchie (interviewer);

The members of our project team;

and special thanks to;

The young mothers who participated in the study.

John Oates
Jane Appleton
December 2010

Executive summary

This document reports a qualitative study of experiences with and attitudes towards the Family Nurse Partnership pilot programme in Milton Keynes, focusing on the ways in which the programme has been operating in conjunction with other services for parents with young children, especially young mothers, and the role of the programme in developing client autonomy. The study was carried out in 2010.

Data were gathered through semi-structured interviews with the members of the Family Nurse team, with clients, with local Sure Start Children's Centre Coordinators and with practitioners in other services associated with the work of the Centres and the FNP team.

Respondents gave freely of their time and spoke frankly about their experiences and views. In all, 37 people were interviewed, including the 7 FNP team members, 15 clients, 5 Children's Centre coordinators and 10 practitioners in associated services.

Opinions about the conduct and efficacy of the FNP pilot scheme were consistently very favourable, with the members of the team, and the scheme materials and practices being held in high regard, both by clients and other services involved. The strengths-based approach was especially valued.

Some further development possibilities were identified, concerning the relatively low level of communication that was being achieved between the FNP and other services, and about the perceived inaccessibility to other practitioners of the specific programme-based activities used with FNP clients. These were widely seen as being of potentially great benefit to practitioners outside the scheme.

The necessity of understanding the complexity and depth of the needs of young parents also emerged as a core theme, linked with the need to tailor ways of working and offering services so as to avoid stigmatization and hence putting up barriers to client participation. Some concerns were expressed that the fact of being a teenage mother does not in itself always carry a high need association, especially where adequate family and community support is in place, and that needs may also be great in less-young parents where such support is lacking or other risk factors are present.

Clients were especially appreciative of the value to them of the close, sustained and supportive relationships that had been established with their Family Nurses. Availability, both practically and emotionally, also emerged as a key factor in client satisfaction and in the maintenance of clients in the programme.

Recommendations are made for development opportunities based on the findings of this study.

1. Introduction

Background

The Milton Keynes Community Health Services commissioned The Open University to carry out in collaboration with Oxford Brookes University a study of the Family-Nurse Partnership (FNP) pilot programme in Milton Keynes.

While the programme studied is based in Milton Keynes, the study findings can be viewed in the context of previous evaluations of the FNP programme conducted in different parts of the United Kingdom and the United States. These include a large-scale evaluation of the FNP by the Institute for the Study of Children, Families and Social Issues (Barnes et al., 2008; Barnes et al., 2009) and several randomised trials in the United States (for comprehensive summaries, see Gomby et al., 1999; Olds, 2006; Olds et al., 2007 and/or Olds et al., 2009).

Aims of the study

The study was funded by the Department of Health and its aims were to:

- systematically gather and analyse evidence from the primary participants and stakeholders in the FNP pilot programme;
- develop an understanding of the dynamics of the programme's links with other services;
- provide insights into the role of the FNP, in conjunction with other services, in enabling clients to become more autonomous in their access to and use of appropriate services once their programme participation ends;
- offer guidance on best practice in facilitating service integration and client uptake of services

2. Method

2.1 Setting

The study took place within the Milton Keynes Primary Care Trust area and commenced in January 2010. The main data collection period was April-August 2010. The study adopted a qualitative approach and in-depth interviews were conducted with a range of respondents to address the initial project aims.

2.2 Sample

Interviews were conducted with 37 respondents in total, as follows:

Family Nurse Partnership Staff Team: 7 respondents

Interviews with the Family Nurse team included four Family Nurses, the team supervisor (also a Family Nurse), the team administrator and the team psychologist. The purpose of the interviews was to gain an in-depth understanding of the role of the Family Nurse in providing support to young parents, including the barriers, challenges and facilitators, as well as the experiences of working alongside other community services.

Family Nurse Clients: 15 respondents

In-depth semi-structured interviews were conducted with 15 young mothers, who were clients of the FNP service. The purpose of the interviews was to explore with the young mothers their experiences of the Family Nurse Partnership programme, their views about other support services and about leaving the FNP programme when they reach the end of their enrolment in the programme.

The young mothers who participated in the study were aged between 15 and 20 years old at the time of interview; one was aged 15 years, two were aged 17, four aged 18, five were 19 and three were 20. None were married, while three were living with partners. Four were living with their parents, one with relatives, one in a specialist hostel and the remainder, six in all, were living alone with their infant.

Six of the young mothers had no educational qualifications; none had any 'A' levels. Two had some GCSEs and five others had GCSEs plus an NVQ or equivalent vocational qualification. Two had gained only a vocational qualification. Only three were in employment. Their children ranged in age at the time of interview from 11 to 65 weeks; the average age was 40 weeks.

Sure Start Children's Centre Coordinators: 5 respondents

Individual interviews were conducted with 5 Sure Start Children's Centre Coordinators. Interviews with the Coordinators covered the following areas: background information on the Centre catchment area and its specific needs profile, needs of and engagement with young mothers, issues in developing client autonomy, multi-professional working, interactions with and attitudes towards the FNP programme and other services, and ideas about potential positive future developments.

Associated Services Practitioners: 10 respondents

Interviews with the associated services practitioners covered the specific aims and roles of the associated service in relation to young mothers, and the topics that were covered in the interviews with the Children's Centre coordinators, adapted for the specific service concerned.

2.3 Recruitment

The Family Nurse team members were accessed and approached via the Professional Lead of Health Visiting services and through a team meeting where they were informed about the study and invited to ask further questions. All were invited to take part and agreed to do so.

FNP clients were recruited initially through an invitation letter and outline project information sheet distributed by the FNP nurses. This invitation included the number of a dedicated phone line to the interviewer and volunteers were asked a simple initial set of demographic questions, to assist with representative sampling, and then their consent was sought to participate in a face-to-face interview. No volunteers refused to participate in the full interview. Travel costs were reimbursed where necessary and a token payment in respect of their contribution was made after the full interview (an ASDA gift voucher for £20; the nature and value was not disclosed prior to interview). Responses to the recruitment invitation by this method were very slow and this substantially delayed the data collection schedule. Respondents were often unable or failed to keep appointments, necessitating repeated rescheduling of times and venues. A second round of recruitment via the FNP nurses eventually resulted in the full planned quota of interviews being achieved. To complete this, there was a small number of interviews which were carried out by telephone.

A representative selection of coordinators of Sure Start Children's Centres in Milton Keynes was agreed in discussion with the Children's Centre Strategy Manager and requests to participate were made by telephone, following email information sent by the Strategy Manager. All coordinators approached agreed to participate.

In the course of the interviews with the Centre Coordinators, additional potential respondents from services associated with the FNP were identified and recruited by telephone contact. These respondents included health visitors, family support workers, a community midwife and staff at a Milton Keynes teenage mothers' hostel.

Study information sheets and consent forms were used for all respondents.

2.4 Data collection

The study used a systematic qualitative approach, with the primary data sources being a set of interviews conducted on a one-to-one basis by members of the study team with the various respondents. The interviews were semi-structured, using predefined schedules of questions and topics. While most interviews were around one hour in length, some interviews with the FNP staff were longer and extended over two sessions.

Interviews were digitally recorded and transferred to secure digital storage with no identifying information in the file names. These primary data were all stored in compliance with the security protocol reviewed by the Open University research ethics committee. The recordings were then transformed into text files by professional transcribers.

2.5 Data analysis

The transcripts were analysed by members of the project team using the qualitative analysis software NVivo 8 to organise and manage the data. NVivo 8 supports a range of levels of analysis from the initial identification of emergent themes, through the more detailed content analysis of the themes, including an examination of the balance and interconnections of themes and sub-themes.

An initial report on emergent themes from the data analysis was provided to the Professional Lead and the Family Nurse Partnership team, and a meeting was held to receive views on the analysis. Comments made during this meeting and in a subsequent meeting with the Professional Lead have been taken account of in the preparation of this final report.

2.6 Ethics Issues

The study ethics protocol and associated information and consent documents were submitted to and given a favourable opinion by the Open University Human Participants and Materials Research Ethics committee. The project team gained confirmation from the Department of Health that as the project constituted a service evaluation it did not need to be reviewed by the National Research Ethics Service. The British Psychological Society Ethical Principles for Conducting Research with Human Participants (British Psychological Society, 2009) were adhered to throughout the study.

3. Findings

3.1 The Family Nurse team

The interviews held with the Family Nurse team included four Family Nurses, the team supervisor (also a Family Nurse), the team administrator and the team psychologist. All seven team members gave of their time freely and were very keen to talk about their role and work with the FNP programme. All interviewees spoke with great enthusiasm about the work and appeared highly engaged with and committed to the FNP and the young parents they worked with.

Key areas that emerged from the data analysis included: the process of becoming a family nurse including participants' initial attractions to the Family Nurse role, the national training to become a Family Nurse and the pressures involved in this new way of working, how the team had come together to work locally, the infrastructure and facilities within which the team worked, the local support network and supervision, how the programme was delivered locally to meet the needs of the young parents involved in the FNP, how the team worked with other local agencies and services and participants' views about the future.

The themes which address the initial project objectives will be focused on in more detail, concentrating on those which provide clear insights into the Family Nurses' work with children and their parents engaged with the programme and their links with other services.

Context

For the Family Nurses interviewed, having the opportunity to do something new was one of the main reasons that they had decided to apply for the post of Family Nurse. Respondents were particularly attracted to being involved in a new programme of work which was evidence based as well as the FNP programme being part of a national research project. One stated that "*I actually felt that at that point in my career I needed a challenge*", while others commented that the timing of the new job opportunity had fitted in with their personal lives and was at a time when they had more space and time to give to their work.

Those Family Nurses who had been health visitors saw it as an opportunity to undertake more intensive and long term work with families, which because of the constraints of large workloads in health visiting they rarely had the opportunity to do:

"...and this seemed to offer the opportunity to work alongside someone for a long period of time, to do some sort of intensive work and have some good tools to be able to do it with. And quite exciting to be a part of a new programme implementing it or researching it."

Others described the potential of the programme for improved outcomes for children, by building on the young mothers' strengths and motivating them:

"I kind of thought "well you know, this is something that will hopefully prevent children coming into care"

All were very excited about the goals of the project: to improve pregnancy outcomes, enhance children's health and development and to improve long term health, social and life course outcomes for young parents. Some Family Nurses commented on having been enthused and inspired by the presentation on the Family Nurse Partnership programme given by the FNP central team when they had attended Milton Keynes. While some regarded the new programme as "*a bit of a leap into the unknown*", all talked about the opportunity to be involved in a research study testing the Family Nurse Partnership in England was a really exciting opportunity.

Training to become a Family Nurse

The Family Nurses started in their new posts in Milton Keynes on 1st September 2008 and at the time of data collection for this local project they had been in post for about 20 months. All the Family Nurses and the Team Supervisor had been selected for their posts through a process of competitive interview. All are women. The Family Nurses were employed to work in full-time posts (each with a maximum caseload of 25 young mothers) and the Supervisor who also holds a small caseload of three young mothers is employed for 30 hours a week working over four days. The team administrator also works part-time from 9-1 pm throughout the week from Monday to Friday.

Each of the Family Nurses came to the role having worked in nursing and or health visiting/midwifery for a number of years. All the respondents had a wealth of nursing and/or health visiting/midwifery experience and they reported drawing on their previous nursing knowledge and skills in the Family Nurse role. The Family Nurses were clearly a very able and highly skilled group of nurses. Some had also completed additional training in their previous jobs for example, Community Practice Teacher Training, Family Planning, Baby Massage and Infant Resuscitation training. Four of the five Family Nurses had worked in the Milton Keynes locality prior to becoming a Family Nurse and therefore had considerable knowledge of the local community and existing service provision and contacts. They reported finding this local knowledge extremely useful and continually draw on it their current role. As one commented:

"I actually had a knowledge of local services and I had a network of people... It was there as a foundation"

At the beginning of the Family Nurse Pilot Project the Family Nurses received an intensive formal training course organised through and delivered by the National FNP team. This training was delivered centrally and the nurses had undertaken it jointly with other Family Nurses from the 2A pilot sites. Without exception all the Family Nurses had found this training and development work extremely valuable as it had addressed a number of different areas and was delivered by experts in the field. The Family Nurses had learned a great deal about the philosophy underpinning the FNP programme, its ethos, its content, how to deliver the programme, for example recruitment and engagement with parents, key issues around parenting, building and maintaining therapeutic relationships and interventions to promote self-efficacy, as well as strategies for behaviour change. The nurses had also been trained in the use of the programme resources and tools including motivational interviewing, NCAST tools and PIPE [Partners in Parent Education] protocol.

The training involved both residential weeks and single training days including master classes in London. For many of the nurses it was a very steep but valuable learning curve and all commented on the intensity of the training course at the beginning when they first came into post:

“It’s been a huge learning curve and the training that we did for the Family Nurse Partnership was so intense ...”

However, there were several comments about the encouragement and support given by the central FNP team. The Family Nurses also reported on the value of meeting up with Family Nurses from other 2A pilot sites throughout the country on the residential training courses and study days *“because you can feel quite isolated doing the job where there is just a few of us, in an area where there is no one else to talk to about it. But when you get together on these days, you feel you are part of something.”* Getting to know other Family Nurses working in different parts of the country was important in preparing for the new role and sharing learning about the implementation of the FNP programme.

During the interviews, all the Family Nurse Team members commented on the initial pressures and stress associated with the start up of the Family Nurse programme in Milton Keynes. One described it as *“an absolute rollercoaster ride”* and another as *“quite daunting”* and *“it was just like a tidal wave really. And when I look back you think “How the hell did we all survive?” but we have.”* Indeed the intensity of the initial programme training (as described above) was not without problems. Several of the participants commented on the sheer volume of work they had to undertake in addition to attendance at training, recruiting young mothers to the programme, all the new learning associated with the programme and organising and undertaking all the client visits. In many cases in the early days of the pilot study this had resulted in the team members doing additional hours and working a lot of over-time and this had clearly had an impact on their work-life balance. It had undoubtedly been a challenging period of time for the whole team.

One team member observed how there was:

“.. an awful lot of training at the beginning and it is all bunched together. And we have spoken about this, and they have talked about it with the national people, and trying to get the balance right is really hard. Because you have to be up and running. But at the same time, you have to be doing some things earlier than other things.”

While all the Family Nurses clearly enjoyed their new role, they described the initial pressures and stress associated with other peoples’ expectations of the FNP service, wanting to do a good job and not let the programme and team down. Others shared worries about not wanting to fail and wanting to meet the programme fidelity. This quote captures some of the concerns raised about the initial stresses associated with the new job:

“Very, very, very [stressful]. We were all working well over and above.... really attempting very hard to do it properly, to do it justice, because I think we all had incredibly huge expectations of ourselves because of the

nature of the programme, and because of not wanting to let the programme down.”

Another nurse said: *“you wanted to do your best.”*. While someone else commented:

“I think we put extreme pressure on ourselves to start off with. Because you feel like you have been selected to do this job and ...there is a part of you that doesn't want to fail with your previous work colleagues. And there's the pressure we put on ourselves to meet the fidelity of the programme....”

An on-going theme emerging from most of the interviews was the problem of initially trying to fit everything in at the beginning when the FNP pilot first started, particularly the training, visits and weekly one-to-one supervision with the FNP supervisor. Some of the team also described how they found the requirement of the FNP programme to develop their own self awareness particularly challenging and stressful initially:

“I mean the whole of the programme really looks at you as an individual as well as the programme, you know, you have to become totally self aware of all your sort of weaknesses as well as your strengths.”

However, 20 months into the programme at the time of the interviews, team members were feeling more confident in their new roles and clearly enjoying the work. Being involved in the new pilot FNP programme and attending the nationally organised training sessions had undoubtedly helped to build a cohesive relationship among team members and forge effective working partnerships. Nonetheless, contextualising the work of the new Family Nurses is important in helping to understand the key themes emerging from the project.

The intensity of the initial training reveals the high skill level required of the Family Nurses to work with the programme's target population group. The commitment of all the Family Nurse team members to the programme was incredibly high. However it had been difficult to fit all the training in at the beginning of the project when the nurses needed it, when they were learning about many different things, when they were building new relationship amongst themselves as a team and when they were also recruiting young people to the programme. Feedback had been provided by some of the pilot sites to the central FNP team on the intensive nature of the training and as a result some of the training around infancy and toddlerhood has now been brought forward to better address the demands of the programme.

Infrastructure and facilities

Unlike traditional health visiting and universal services the Family Nurses working in Milton Keynes deliver a service throughout the entire geographical area of the City. Initially when the FNP commenced in Milton Keynes all four Family Nurses, the Family Nurse Supervisor and administrator were based together, working out of one local Children's Centre. The team were all initially (and all still were at the time of the study – except the FNP Supervisor) based in one small room at the Children's

Centre. During interviews with the Family Nurse Team mention was frequently made of the cramped working conditions and lack of storage space.

To ease the problems of lack of space the Family Nurse Supervisor had moved out of the Family Nurse Office and into a shared office in another health centre in Milton Keynes. This was regarded as *“the best solution we could come up with to what were a range of issues that caused immense frustration and difficulty”*. However it was generally felt that a better solution would have been for the supervisor to have an office in the same building as the other Family Nurses.

From the outset it was evident that IT, telephones, lack of space to store FNP programme materials and other infrastructure issues were a real challenge for the team:

“when we first started, it took us a while to get a telephone. We had mobile phones that had no reception in the office. We had no office phones, we had no IT... We had an office that did not have enough chairs.....and initially, we were all in the office together. You couldn't move one chair without knocking someone else's chair, and it is still far from ideal, I think. The IT is still a continual bugbear at times....”

“We have had problems with not being able to get on-line, and now we have to input all our data to Exeter, so we have quite a lot of questionnaires that we have to do with the girls at different times. We have our daily home visit sheets that we have to put in for each visit, which takes time. And then the frustrating thing is, recently, when it keeps logging us out or it says there is an error, and you look for it and there is no error. And I think a lot of it has been to do with Exeter andthey did a big migration ...because we were working on two different systems at one point. They migrated everything across and there was loads and loads of hiccups and stuff. So people appeared on our system as part of our caseload who weren't part of our caseload or, people that were, disappeared. Very irritating.”

“and for me personally the IT has been a complete nightmare and I don't shy away from computers...but I have found that incredibly difficult, the office not all having a computer, some of us being able to log in sometimes... there's never everything all working at the same time, you know, it's always an ongoing struggle.”

“that many people in a small office is not easy so you can't concentrate on writing your notes, you can't all use a computer at the same time. Computers break down and people get cross. I tend to fling open windows, and then everybody else is cold! ... Some people are loud on the phone.....but even if they whispered on the phone, in that space, you wouldn't be able to have another conversation, or keep your concentration.”

“If one of you goes into the filing room it's very difficult for somebody else to go in as well because it's small. It's just not a place to store stuff...”

Unfortunately for the team, problems with IT facilities were still on-going at the time of the interviews for this project and this was one of the main areas of dissatisfaction felt by the Family Nurse Team members:

“The computers are a complete nightmare and I haven’t been able to input data for a month now because the computer keeps locking me out and shutting down, ... they think it’s because we’re in a Social Services building, we have to log in to social care, use Citrix keys to log in to the PCT and then, so it’s just a complex system and they with all the Citrix, what they do is if you’ve been idle for 20 minutes then they just knock you off the system. They can’t see that we are actually working on Exeter so it’s usually when you’ve done the longest ... and we’ve got to redo it all again.”

“I mean to a certain extent we’re still feeling the aftermath because we’ve still got IT problems and we need to be rehoused somewhere.”

“...at this point in time we’re still having problems with IT, with connections, with stability of the, you know, our connections and so on. We have an office which is way too small, we haven’t got enough storage space, we haven’t got any internal post.”

The IT problems meant that in reality the team sometimes felt they had fallen behind with the important task of data input for the programme. Clearly teams require organisational structures and infrastructures that are supportive and functioning efficiently in order to deliver such a challenging evidence-based pilot programme.

Professional Team working

There are clearly different levels of team working which are important to the successful delivery of the FNP programme, including delivering the programme with fidelity, the interrelationships within the team and how the wider team fits in as a whole with other agencies and services.

Coming together

Being involved in the new pilot FNP programme and attending the nationally organised training sessions had undoubtedly helped to build a cohesive relationship among team members and forge effective working partnerships. Some Family Nurses described how team working took time to develop, as *“it’s taken time to get to know each other”* and has gradually improved over the months as early difficulties were resolved. One commented:

“I think the dynamics of the team were affected by the pressure that we were all under to start off with. We were like ships in the night. We weren’t seeing each other a lot of the time. ... You start off really positive and then we went through a little [difficulty] I thought we did anywayand I suppose that is part and parcel of teams normalising, isn’t it? But you go through that... and now I feel we work really well as a team. I feel we have come through all of that, and we are actually working, and we generally see each other in the office in the mornings, which is great. And

that was something that we had to work at. The importance of seeing each other and being able to support each other a little bit... we are a small team working within an area. There is nowhere else to get that support from so it is really, really important."

Family Nurses described how the team members had got to know each other well on the national training events, some of which were residential:

"We have all got very close going up to Durham together, going off to Yarnfield together....So we have learned together, we have grown together. The ideal is to learn from each other, and we do, we do talk."

Others observed how very positively the team members work together:

"Some teams, you know they don't gel, but this team has got a perfect balance of character and personality. They bounce off one another and as a team feel comfortable telling each other "you should have done it like this" and asking for advice. The majority of them come from a health visiting background, one comes from mental health so they've got a variety of experience so they can ask each other what they think. It's the perfect balance of personalities..."

"Looking back ... they have always been constructive... But if they hadn't been, it would have been challenged. They listen to each other. You can tell when they come in, they have developed a lot of support for each other, peer support, and you can tell that from the comments. I think....they don't always challenge as much as they might. They have never been a very challengey group.....just occasionally. So they have moved quite rapidly into a working-together group. ...They have learnt to work together well and quite quickly."

All interviewees described how relationships in the team are good, with colleagues being extremely supportive of one another. This is important given the challenging nature of the work and the intensity of the relationships which can develop between the nurses and their clients.

Supporting each other

All the Family Nurse Team members talked about the importance of the support they had received from their FNP team colleagues. Knowing that they could discuss concerns or difficult issues and also seek advice from the other Family Nurses was very much valued by all the team members:

"And if you have had a bad moment or there is something worrying you, you can always talk to each ... so there is that support – each other's knowledge. And if someone comes in and wants to moan, then we can act as a listening ear."

"I mean my colleagues have been amazing because I do, I get into my cases and I think "oh my God, what do I need to do here?" And I just text could somebody get back to me what, you know. And I'm quite, I'm okay"

with saying to my clients “oh I’m not too sure about that, I think I’ll get back to you on that”.”

“we chat amongst ourselves, we chat in the office, we chat at clinical supervision, we chat all the – you know, we can even sit outside a house and ring our colleagues and say – or text our colleagues, say “Look I’ve got this problem, any ideas?” You know, no, so it can be done anywhere, you know, it’s about communication at the end of the day.”

Each week the team has a regular two hour team meeting, with two meetings a month focussing on management issues and two which focus on peer support, one of which is with the Consultant Psychologist:

“Team meetings are about just very basic things that are happening in the office, computers and the likes. And there are team meetings where we can present cases. And then at the team meetings, once a month, the psychologist comes in. It is gradually developing because I love it when she comes to talk about something specific like the teenage brain, or self-harming. Just an insight from the professional about things that I haven’t really thought about. That helps me. And then she will also Chair ...where someone comes with an issue, and I like the way it happens. They present the issue and we don’t interrupt, we give them time to present. Then we can ask them questions to clarify things. Then the person who is presenting, keeps quiet and listens to us discussing the issue. And then from us discussing, the person that presented the case learns maybe, and then [name of psychologist] brings it to a close. That is really great. That is not something I have done before. I have really learned a lot from that. So from team times, we do learn from each other.”

The Family Nurses also reported that support from colleagues extended to covering each other for holiday cover and also a period of planned sick leave. The nurses also valued the tremendous support they had received from the central FNP team and the informal support they received from other nurses involved in the 2A pilot projects.

The role of supervision

The team talked about the importance of the weekly supervision they receive. The FNP programme requires that all Family Nurses receive both individual and group supervision as a fidelity measure (Rowe, 2009). In this PCT, the Family Nurses have individual supervision with the team supervisor once a week for an hour and a half, while the team supervisor has supervision once a month with the team’s psychologist and a managerial supervision session with the Local FNP lead:

“We have 1½ hours with each other. They bring cases, issues and we can share what has cropped up since last week. It’s mainly about what they bring. The stories they bring, part of the process is saying what does that say, how and what is the worker saying is the problem. A strategy I use in supervision is parallel processes, a nurse working with a young family has to find the ability to challenge and develop and work with them and enter uncomfortable areas to move their life forward. What do each of us have

to do to understand those we work with better and ourselves. It's vital we do this, it opens opportunities to us. It's worth being uncomfortable for a while if it moves us to a better place."

In addition the FNP Supervisor accompanies each Family Nurse on a home visit once every few months to observe the Family Nurse in practice.

The support that the team supervisor provides to each Family Nurse "aims to parallel the process employed by the nurses with the families" (Rowe, 2009: 122). The value of individual one-to-one supervision and having the opportunity to reflect on their practice and develop work plans and ideas was frequently mentioned by the Family Nurses:

"There is also the reflection that you do in Supervision, and I think that reflection in Supervision is far more productive because you have somebody there to bounce things off with, and give a different perspective. I always come away from it thinking, "Oh, I hadn't thought of it from that point of view before at all." So it can be really, really helpful."

"I quite like supervision...because I think it's an opportunity to talk ...an opportunity to reflect on things because we expect our clients to reflect as well and then by reflecting on things you see things slightly differently sometimes don't you? You get new ideas and new perspectives on things so I find that the weekly supervision really, really useful."

"[FNP Supervisor] is very good at helping you to see where you need to improve a little bit without making you feel you are being told. To be honest, I think most of us know where we need to improve. But she is incredibly sensitive and positive. She uses her motivational interviewing. I have learned a lot from her actually."

Alongside the one-to-one supervision, the team also meets weekly for team supervision. Each week the team has a regular two hour team meeting, with two meetings a month focussing on management issues and two which focus on peer support, one of which is with the Consultant Psychologist. There were some criticisms around the team supervision sessions (without the psychologist) because of a lack of structure and clear meeting agenda:

"I've found team supervision the one that's been least helpful and I think that's just because we've never really identified a real structure..."

Peer meetings for supervision are for the Family Nurses to present cases or discuss issues as a team. This is an opportunity for the Family Nurse team members to discuss some of their cases so that everyone has an idea of what each team member is doing:

"so we have a sense of what people are dealing with because that also gives you an opportunity perhaps to understand better what, why somebody might be stressed."

“and also when you talk within the team you just get such fantastic ideas you know, you go “oh my God, I never thought of doing it like that, that’s brilliant”.”

However, there was also a suggestion that these meetings could provide a very useful opportunity for the Family Nurses to talk more about and share with their colleagues how they had used the facilitators and other FNP resources in their practice. There was a view from some of the nurses that the team could make more opportunities to share their individual learning across the Family Nurse team.

The Family Nurses greatly valued their sessions with the team’s psychologist. During these sessions each team member is encouraged to present a case (two nurses on alternate months) and then the rest of the team discuss the case, hypothesise and talk about issues as they see them:

“I mean you get supervision once a month from our psychologist as well which is nice because sometimes you just don’t get it, you just, you know there might be another way to look at it or to understand, because you’ve always got to understand that they’re teenagers that you’re working with and they are the most important person in their life...”

“So it is a team effort and if we’ve got any problems we then have our consultant psychologist as well that we have team time with. So it’s not just you. And if you’ve got a problem it’s best to come out with it and say, you know. “How am I going to?” because at the end of the day we want positive results and there’s no point sitting on a problem that’s not going to be solved just because you think “Oh I’m not doing this well”. It’s about actually being honest and being self aware. “Well I don’t know how to take this, need to take it to the team, we need to have ideas”.

Having access to an experienced psychologist generated very positive feedback for all Family Nurses.

The needs of young parents

At the time of the study the age range of the babies of the young parents involved in the study was 5 months to 14 months. The Family Nurses described a range of needs of the young parents they were working with, but histories of self-harming, of overdose, sexual abuse, being involved with Social Services, safeguarding, deprivation, domestic violence, and being in care were described. Issues of homelessness and suicide attempts were also identified.

One Family Nurse described family needs in the following way:

“Vast, really. We have had quite a few with housing issues.....who have gone through homeless systems. A lot of family breakdown. A young person who is pregnant but they are parents. There are a fair few people whose partners have been in the care system. There have been quite a lot of mental health difficulties, depression, anxieties. There’s been domestic violence... childhood sexual abuse. Just the whole range, really.”

Others commented:

“...as you go further into these therapeutic relationships the Pandora’s Box opens.”

“So they range from like needing a lot more parent, basic parenting and basic parenting like how to bath a baby and how to change a nappy and how to hold the baby to needing educational support to needing support around anger management, support around managing the manipulative, controlling mother, how to be able to say “no, this is my child, I’m not doing it like that...””

The Family Nurses also talked about the challenges of working with teenage parents and recognising the developmental needs of this age group and their particular vulnerabilities.

“Teenagers are teenagers and they might be teenagers with babies but they are still teenagers. And, you know, you just have to remember that and ...they’re all at the end of the day vulnerable. All these teenagers are very vulnerable.”

Some Family Nurses also mentioned the need for social support, with some young parents being very isolated in their first pregnancy, lacking the confidence to identify peer or other group supports and often lacking input and support from their own parents or other close family. The lack of local services and facilities on some housing estates where young mothers were housed was also identified as an additional factor which can result in further isolation for some young mothers.

“The new housing they are being put into is [name of area].....and there aren’t many community services up there. So yet again you tend to be isolating them. Those kind of issues link with housing and the community, and that is really quite important, as well as other local services.”

The programme

All the FNP team participants were extremely enthusiastic about the Family Nurse Partnership programme and what it has to offer young parents. The criteria for young mothers to be enrolled on to the programme was for the mother to be nineteen years old or under at conception and for this to be their first pregnancy. A theme recurring throughout the interviews was the continual learning that goes on amongst both the nurses and the young parents. As one described:

“It’s great. It’s wonderful to have the programme. To be part of a research programme, which is very interesting. The clients are fantastic and the challenges that you have with the clients. But the things that you learn from them, and the involvement you have with the dads. I didn’t realise, but that has been great.”

All the Family Nurses discussed the strengths-based focus of the FNP programme and the importance of this empowering approach in developing client autonomy and

promoting self-efficacy. The programme focuses on individual's resources and opportunities rather than on deficits and problems (Rowe, 2009). Getting the clients to work out their own solutions to the issues they are facing, was recognised as an important and new way of working with young mothers:

“And we have been Health Visitors or midwives or whatever ... and we are very much into....sorting things out for people, sorting their problems, immediately “Oh, I have got to come up with an answer or solution!” Whereas, the other thing with the programme is “I’m here. But you are going to sort the problem out. You have to come up with the solution yourself.” So when you had 2 or 3 minutes in clinic, you were just fire-fighting, “Do this, do this, do this! Try this, try this, try this!” as opposed to saying “So it sounds like you don’t like the way he is eating now?” And they can say, “Yes, because he spits it out.” ... And you wouldn’t find the solution for them, they would find their answer themselves”

“It’s not me telling them they’ve done well, it’s about them understanding what they’ve achieved.”

Most of the Family Nurses commented on this strengths-based approach being a completely new way of working for them and in particular the value that motivational interviewing offered for their practice, in getting the young mothers to consider a range of different issues.

Developing a relationship

Having the opportunity to work with a small number of young mothers intensively over a period of two and a half years from early pregnancy provides the Family Nurse with an opportunity to build a strong therapeutic relationship with a mother and her baby. All the interviewees made reference to the importance of relationship building with the young mothers:

“Especially in the first few weeks of doing the programme, there is a lot of opportunity there to explore and get to know people in a much deeper way. And just to start to develop that relationship. And a lot of it is about.....you find out about the person and how they tick, and you work out what it is they can cope with, and what they can’t cope with at a particular time, or how they are functioning.”

“I think there is far more emphasis on the relationship that you have with the person you are working with.”

Visits are generally for about an hour and a half, with contacts being made mainly in young mother's own homes, their friends' homes or their parents' homes. Frequent mention was made of getting to know the young person and being sensitive to their particular needs and circumstances:

“There’s this huge amount of information that you find out about people. But do it in such a way that ... it’s about finding out about the positives, so you are not always harping back to all the negatives. So it is trying to find all the positives, you know. “Who were the positive people in your life?”

And “Why was that?” So there’s this thing about building the strengths of the person which is not about denying what has happened in their past, but about what happens now. “How can we move on from this”, kind of thing.”

The Family Nurses also talked about the trust that develops between the nurses and the young parents:

“It’s trusting these young women, and men. Believing in them, watching them grow, watching them become autonomous, watching their relationship with their babies, and their families.”

“I think, do you know what, I think they love it, I think they really enjoy it. I mean you know, some of my girls just say to me “it’s so nice just to have somebody that comes in, that really listens to me, that helps me, that doesn’t, that wants the best for me and my baby, that believes in me”. So I think they understand that we believe in them, that, you know we trust them, that we feel they can do it ...”

Indeed this concept of ‘trust’ was continually mentioned by the Family Nurse participants when they described building relationships with their clients:

“I think I’ve got a really good relationship with my clients and I think they feel that I trust in them, that I believe in them, that I’m dependable and that I’m a good resource for a number of things.”

Working with young parents in a programme that starts during pregnancy was regarded by the Family Nurses as one of the best aspects of the work:

“I think the fact that you have the potential to work with both parents so that the father can be involved in the programme. The fact that you start in early pregnancy because I do believe that if you form an attachment with your baby during your pregnancy it makes, I’m not saying it makes it easier because I think parenting is undoubtedly the hardest job in the world, but I think it gives them the opportunity to attach a lot better with their baby, have a much greater understanding of children’s needs because I think often we have unrealistic expectations and I think in order for people to change, they have to understand why they’re changing.”

Participants often compared the FNP role with health visiting, where there is not the same opportunity to spend time and develop such deep and intense relationships with clients because of the constraints of large caseloads.

“Well, having the programme is fantastic. So, as a Health Visitor, I would do a Baby Clinic, where up to 40 people could come in with an issue. And it was a problem-solving clinic, whereas this is more strength-based, it is affirmations and letting the client gradually develop their own autonomy, and that is just very different.”

The programme structure

For all Family Nurses, the structure of the FNP programme was regarded as one of its major strengths, along with the associated materials and resources, including a huge range of facilitators that are available for use with the young parents at each contact. A pack of materials with objectives and planned guidance is available for each contact with the young mother, with suggested activities including educational materials and facilitators for use at each visit, as well as suggestions for activities around goal setting for the client. A home visit report form is also completed at each visit, which notes the percentage of time spent on each of the five areas of the programme including personal health, environmental health, life issues, mother's role and relationships/support from family and friends.

The Family Nurses continually stressed the importance of the structured content, as well as the continuity and familiarity with the young mothers being an important part of helping to build the nurse/client relationship.

“It's good. It's great to work with it... I like the structure very much. I understand where it is coming from, and that hopefully it will reach the goals.”

However the Family Nurses also commented on the need to be flexible in delivering the programme to each young mother. One of the nurses commented:

“I think everybody I see, they may all get the same programme, but it is probably delivered in a different way.”

Another nurse observed:

“That was my big anxiety when I started the job was that's it's going to be very structured and it is a structured programme but how you deliver it, there's lots of flexibility around how you deliver it because you have take into consideration people's learning styles, people's ability to take in knowledge, you know, sometimes you could give endless amount of stuff and they just absorb it and just want more and more and others you can do three and a half minutes and that's it kind of thing, so you've got to be very choosey. And sometimes you just know that this is going to be a difficult day, they're just not going to cope with the situation at all and it's going to touch a raw nerve”

Working with the programme materials

Without exception the Family Nurses were extremely positive about the range of programme materials available for them to use with clients. *“Having something to offer”* was often raised by the Family Nurses and materials included a range of facilitators, educational materials and PIPE (Partners in Parent Education) tools, in addition to the motivational interviewing techniques and parallel processing learned by the Family Nurses. One team member described the *“excellent resources, really fabulous”*. Others commented specifically on the wide range of programme facilitators that they had available:

“I do like the facilitators because I think it has the potential to draw lots of stuff out...”

“so for example one of the facilitators in early infancy is something called love is a safe place so during that, the facilitators would go through things about “how do you feel about parenting, how does it make you feel when the baby cries, how do you work out what the baby needs?””

“There are so many of them. ‘Benefits and drawbacks’ is another one. When they are considering an issue, the benefits of doing it, the drawbacks of doing it. The benefits of staying the same, the drawbacks of staying the same. So they could really write down those and see more easily. There are just so many facilitators.”

Several of the nurses commented on the need to be quite creative when using some materials with the young mothers Each Family Nurse also had her own doll for modelling aspects of baby care for the young mothers. One nurse explained the importance of using the dolls for modelling rather than the mother’s own child:

“In case it makes them feel that they are inferior or they can’t manage, and to be respectful because this is their child. Also it encourages their autonomy.”

Another Family Nurse described her use of the doll:

“And it’s about showing them what to do with them... So, you have your doll and you say “Well [doll’s name] and I are going to show you what to do” because you never use their babies ever because, obviously if you get it right and they get it wrong their confidence and self esteem has gone down. So [doll’s name] comes out and ...so it’s about showing them what to do.”

Another Family Nurse commented on the use of cards and text messages with clients:

“And part of the programme, too, is the idea of sending them birthday cards, and the baby birthday cards, or “Good Luck in your new house!”

Communicating with clients through the use of text messages was a frequently used approach and discussed by the Family Nurses as an effective means of keeping in touch with the young mothers:

“I think having the mobile phone and the texting has just been so fab.”

Record keeping

Record keeping for the programme was a demanding part of the Family Nurse role, but was recognised by the nurses as important in ensuring that data collection for FNP pilot project took place. However the FNP pilot monitoring was not discussed in any great detail by the nurses. There were also requirements to maintain clinical records and family cards for the PCT and it was generally felt that that there is a lot of duplication:

“There is a lot of duplication even as far as the systems are concerned, you input info for FNP then for PCT purposes, then to child health and their system, it’s a long winded way.”

However, the team also talked about a new computer system being introduced into Milton Keynes which they hoped would help to avoid some duplication of the recording systems.

Building self-esteem, and personal growth

All Family Nurses firmly recognised the importance of enabling their young clients to develop their own autonomy as parents and the need to promote their self-efficacy and personal growth. The FNP programme is underpinned by a philosophy of self-efficacy and an expectation that clients will strengthen and change their behaviour (Rowe, 2009):

“So the outcomes of the programme are actually about self efficacy for one thing, building somebody’s ability to actually believe in themselves and their ability to cope and do things.”

Motivational interviewing was used by the Family Nurses to facilitate young mothers to consider a range of issues and options. The nurses described motivational interviewing helping them to identify change and to help guide their clients. One of the Family Nurses stated:

“We try to think about how we can develop the girls ready for when they leave the programme. It is not about creating dependency. It is very much about building their strengths and inner resources so that they have that ability to go out into the world a bit more and have a few more strings to their bow.”

Another Family Nurse described the potential of the programme in helping young mothers to set goals and to take steps to achieve those goals:

“It fits in with the motivational interviewing and encouraging them to take responsibility and to make a life goal or small goals at a time. And then they’ve got the self-efficacy which is about I suppose self-belief and if you’re told often enough you’re not going to do it, you won’t do it and if you start to believe in yourself you will start to succeed and if you are confident you can be confident with your child and it all helps around actually when your child starts saying “no” to you for you to be able to say “I’m the adult, I’m in charge and I am able to change or manage this situation”.”

All the Family Nurse team talked about the importance of building the self-confidence of young mothers. They described getting young mothers to look at issues in a different way by asking questions such as *“Why do you think this needs to be done?”* and *“How might this help you if you do it?”* Solution-focussed strategies and motivational interviewing were adopted by the nurses to build the young mothers

strength and confidence and to think about how they might change their behaviours and deal with similar situations in the future.

Some of the Family Nurse team members also talked about how when the mothers had reached a year in the programme that this had been a useful time to look back and reflect on the progress that the young mothers had made:

“Some of the girls have like come to the realisation that we’ve done a year ... and that’s a nice opportunity for us to think about all their strengths that they’ve gained and all that they’ve enhanced and how nice it’s going to be for them to be able to go out into the big wide world.”

The need to engage the young mothers with local services was discussed by all the Family Nurses and the team all reported working hard to engage the young mothers with other services (See *Working with other services and agencies*). The Family Nurses described the importance of the young mothers being able to access and use local services appropriately once their programme participation ended:

“We work hard to try and get the girls to go into the Children’s Centres because we want all these support networks to be there at the time when we do go away, and we don’t want that dependency on us.”

The Family Nurses talked about the transition for young mothers at the end of the programme and acknowledged that it would be an interesting time for both parties. In terms of enabling the clients to become more autonomous one commented:

“you want your clients to build up a relationship with you so that they can model that with their children so you want that but you also want to be able to make that break at some point. You know it’s like I suppose for a parent, you know, you want to have a really close and dependent relationship, or your child to have a dependent relationship with you but you want him to be independent and you also want them to be able to go out and succeed in life and I suppose we want that in a very short space of time with these young people. The difference is that you hopefully are always going to keep in contact with your child whereas that’s not going to happen with us, and it’s about how we do that.”

In preparation for ending the therapeutic relationship, the Family Nurses talked about developing the young mothers so that they are ready to leave the programme and for proper closure of the therapeutic relationship. The nurses described how the programme itself reflects a reduced pattern of visits, with contacts tailing off to monthly visits towards the end of second year, and a range of facilitators available to help them with this stage. Although at the time of the study the nurses had not yet encountered this phase of the programme, they felt confident that their training and the programme materials would prepare them to work towards ending the therapeutic relationship they had developed with their young clients. One commented:

“So the last few months is monthly visiting. And I think there is a lot of stuff in the paperwork that is about preparation for endings as well. So it is not as though you go one week and say, “Next week is our last week,

and then it is going to be goodbye.” So it is over four months or so that you are really starting to look at endings, and where the support is.”

Another nurse commented:

“One of the big helps we have is from the national unit, they encourage us to think ahead. There are bits of the programme that help deal with it. The idea of letting go, people moving on, them feeling loss and resistant to moving out. A parallel to that is a mother’s role, children grow up and the mother has to let go. Look at what you’ve done, you are pleased for them. There will be loss, you’ve been so committed and involved in their issues, a big part of each other lives. How do you view and deal with that? You visit less, talk more about next steps and how to facilitate that, celebrating achievement. It’s called the graduation programme, growth and having done something where you take the next step on... the work we’ve been doing has helped them develop to become independent.”

Working with other services and agencies

In the early days of the FNP pilot in Milton Keynes the team had been involved in making presentations about their role to other local provider services. Although this has continued there was a general feeling that if they had more time it would be beneficial to do more of these presentations to continue to raise people’s awareness about the FNP role and work. The Family Nurses reported having built up good working relationships in particular with local midwives, health visitors and social workers, although some reported still having difficult relationships with some local GPs and one participant was not sure that social care services fully understood the FNP role. All Family Nurses talked about the fact that they had had to initially work hard to sell their new FNP role to local colleagues:

“We’ve had to sell ourselves because it’s a new scheme, ... the community need to get it on board, understand it, otherwise they very much keep to their own pattern. It has been that we have projected ourselves, sold ourselves, contacted their doctors, health visitors, midwives so that’s been, we needed to do that, go to meetings so that people don’t think we are treading on their toes in their work and don’t know who we are etc. A lot of them have been old colleagues we’ve known for years and years anyway. They were great once we got to know them and the service, they were contacting us, both ante-natally and post-natally. The teenage pregnancy midwife we used to have meetings with all the time so that was really good.”

The Family Nurse team also discussed their role in encouraging girls to attend ante-natal sessions and midwifery appointments.

The Family Nurses reported some initial uncertainty about their role from some professionals but this was overcome once they began to get a better understanding of the FNP role:

“Initially, particularly with midwifery, we felt like there was a little bit of ... being wary about were we going to tread on their toes. And then, after

a period of time, there was this realisation that “no, we weren’t”. We were working separately, but what we were doing was actually enhancing what they were able to do with the girls, and it wasn’t about taking anything away from their relationship because it was a completely different one. I think there was a little bit of worry that, if we were involved, then they might feel they didn’t need their midwife.”

The need to continually attend meetings and talk to colleagues about their work was an important theme running across the Family Nurse team interviews. One nurse said:

“When we first started, when we first got it, it was all quite secretive. It felt quite secretive. We weren’t allowed to share any of the stuff we had with other people as it was all copyrighted to us. ...And we are based separately from them so we are quite isolated. That is why it is important to keep going into the Health Visitor meetings, and then they begin to get a bit of a better understanding... I think as far as GPs are concerned, we all still need to get in and speak to GPs about what the service is about a bit more. That’s become far more apparent as the girls have the babies and they have seen the GPs a lot more.”

The team also had to get round an early difficulty of the community midwives gatekeeping the FNP service, but this initial difficulty was soon overcome. One commented:

“The Community Midwives ... were a little bit handpicking and thinking “They would be suitable for you, they have loads of problems.” But, actually, the criteria was ‘Anybody nineteen and under’, and so we did a bit of negotiating and, in the end, the secretary on the Ward, photocopied every single booking that came into the hospital who was nineteen and under, and it was then available for us. So therefore, we were able to ring them up and say, “My name is ..., I am part of the Family Nurse programme, and I wonder if you would be interested in joining the programme?” And they did or they didn’t. And a lot of them were interested in it and we visited, and we told them more about it.”

The Family Nurse Team members also described working hard to engage young mothers with local services and in particular the local children’s centres. They were particularly aware of the need to develop young mothers’ independence from the FNP programme:

“We’re encouraging them to take part in anything and everything that’s in their neighbourhood and if they’d like to go but don’t feel comfortable we’ll happily go with them to things. If they just say no it’s not my cup of tea we’ll support it but would bring it up another time if they were ready to try a children’s centre or maybe go with their parents so anything yeah.”

However, Children’s Centres are not based everywhere in Milton Keynes and in a few cases engagement with some centres had not been easy as centres had not been quick

to pick up referrals to their services. Also because all the Family Nurses work across the whole of the Milton Keynes area and do not cover a defined geographical patch there was a strong feeling that it is difficult for such a small team to build strong local links with all local children's centres:

“The self-efficacy....the whole point about it is that they will help them see what is available locally. Now a lot of these young mothers....if you look at how they have supported them through pregnancy and having the child....quite a few of them have ended up in [Name of local mother and baby hostel], which is the mother and baby house because they have no housing or for various other reasons. A lot of them don't have any housing. So that means that as the young people, the young mothers have moved, the Family Nurses have been very aware that wherever they have moved to, they need to link them into the local services there. And there aren't Children's Centres everywhere. I mean there are practical issues with GPs. That's the first thing they are looking at. And it is encouraging to do all those kinds of things. So, yes, they do help them link into the Children's Centres. It depends whether they are there, if they are available. ... So, they are very well aware of the local facilities and what they might help them plug into.”

“We work hard to try and get the girls to go into the Children's Centres because we want all these support networks to be there at the time when we do go away, and we don't want that dependency on us. Some of them are more eager to go than others. Some girls you know if you can just get them through the door, then they will be fine. We have found that certain Children's Centres have been much more easier to get the girls into. And I have had certain Children's Centres where I have done a little referral form for them, and it has not been followed up. And when that happens, you know, you only get one chance a lot of the time with some of these girls, and if they haven't been contacted by them, it's like, “They can't be interested in me, so why should I want to go there?””

One participant also talked about the problem of some professionals not treating young mothers with respect:

“they come back again and again and say how disrespectful so many professionals are to that age group. And the way they talk down to them and things like this...”

Family Nurses reported that some services such as housing and paediatric liaison still “... send letters to health visitors no matter how many times you tell them it's FNP.” The Family Nurse Team acknowledged the extra work this caused their health visitor colleagues in redirecting communications to them and they really valued their health visitor colleagues' support in doing this additional work.

Thinking to the future

At the time of data collection there was considerable uncertainty about the future of the FNP programme locally and whether testing of the pilot FNP programme would lead to permanency of the service both locally and nationally:

“[Nationally] they’re planning on with their next waves, I think they feel they’ve got funding to carry on. It is a local thing and what Milton Keynes feels they can afford and whether they can benefit from it. That’s why we’re doing the research and coming up with statistics to hopefully prove that the aims and outcomes are valuable and worthwhile.”

Participants commented on the stress associated with such employment uncertainty in the near future:

“Yes it is difficult...You know you’ve got your mortgage to pay, you’re more ‘what’s happening next?’ ‘what am I doing next?’”

As no decisions had been made about whether the FNP programme would continue to run in Milton Keynes, participants were also unsure about whether they would have the opportunity to refine their new skills and knowledge by working with a new group of young mothers:

“We have said to [supervisor] we would love to do it all over again with 25 now we are familiar with the material. Yes, I would love to practice it all again.”

However several did acknowledge the considerable skills they had learned and developed through being a part of the FNP programme:

“If I go back to health visiting I’d feel like I’d be taking back an awful lot of skills as a family nurse from the programme but I’d like to just carry on being a family nurse.”

3.2 FNP clients

Fifteen interviews were conducted with FNP clients. One young woman's partner joined the end of her interview.

Clients valued the service; the education about pregnancy and parenting and the practical and emotional support it provides. The relationship that develops over time with the Family Nurse was highlighted as something that distinguishes FNP from other services and allows for more comfortable consultation and trust between client and practitioner. Many participants are not in contact with or using mainstream services and Family Nurses are actively encouraging clients into services and building their confidence to access them autonomously.

Accessing the Family Nurse Partnership

Most of the young women who were interviewed were introduced to the Family Nurse Partnership via a midwife ($n=6$) or GP ($n=3$). One participant had heard about the scheme via a friend who was already involved with the programme and one was unsure how she had been put in contact with her Family Nurse. Being the first cohort, all had found it relatively easy to access the scheme:

“The midwife contacted and it was really easy, I got a phone call within a week to arrange a meet up and fill out some forms and it went from there, so it was really quite easy.”

“Yes, ‘cos my midwife was very easy in getting into contact with them, so it was really easy in order to get a, get her to call me so, very quick and easy.”

“Yeah, ‘cos most of the time, some programmes like you have to... well, going to like call, call this, calling here, and then they say “Oh, maybe you’re not up to that” or “You’re too young” or something, you have to hold on, they’ll call you back and things, but this one wasn’t like that.”

While some young women were unclear about why they had been offered the service others understood and accepted that the service provided support specifically to young mothers:

“They said that ah, because, I don’t know, I can’t remember now, I think they said because I was young and obviously young mothers need more support or something, I don’t know.”

“Young mums, that’s all I really got told about... and I said I don’t mind, the more help the merrier, that’s what I said.”

“don’t know. I think it’s cos I was only 14 when I was pregnant, had her, and I was just a young mum so...”

Appeal of Family Nurse Partnership

For most of the young women who were interviewed, it was the offer of pregnancy and parenting education, and additional practical support, that attracted them to the scheme. Some indicated that they felt they were in need of the service due to their age and lack knowledge, or absence of other sources of support:

“Because she said that it could help me with anything, well if I don’t know anything about pregnancies, how to look after a child when you have a baby, and also if I need help with money or council and benefits, housing benefit and things like that. So when she said that, I said okay then, I’ll give it a go and see how it turns out.”

“Because it sounded like a good idea and then they come and help you all the way through the pregnancy telling you about the baby and stuff like that. So it just seemed like a good idea as I haven’t got any children before.”

“Just for giving me a little bit of support because obviously it wasn’t going to be easy and I knew it wasn’t so I needed all the support I could really.”

“Because I’m a first time mum, I didn’t really know what I was doing and she explained everything.”

“Because I was young and I didn’t really know much about it, and at that time I wasn’t talking to my parents so I needed a bit of extra support and she said they were really good. Yeah. I was worried because I was quite young so, yeah.”

Benefits of Family Nurse Partnership – improved knowledge

All of the young women who were interviewed were very enthusiastic and positive about the service in general and their Family Nurse in particular. Most felt that their knowledge about pregnancy, childbirth and childcare had greatly improved through their participation in the scheme and the worksheets, interactive and one-on-one methods of educating were felt to be both informative and engaging:

“Um, well it’s basically just going, the family nurse helps you through the pregnancy like teaches you different things about how your baby’s frame develops and what’s the best things for your nutrition and what to expect when the baby comes, um, and what to do expect when you’re going into labour, prepared you basically for everything, all good things and bad things that could happen before and after the baby is born and then also when the baby’s born she supports you with everything that you need to learn and do with the baby, you know, bathing, feeding, the best and... well not just the best stuff for it but the different options there are and what would suit you, well just basically that.”

“Yeah it did, it made a lot of difference, it helped me with everything because there was a lot of things that I do that I’d stop and think “if I

didn't know my family nurse I wouldn't really know about this or I wouldn't know how to do this".

"She told me like essential clothes that I need, well she done this game thing, like things that you need, things that you don't need and things like that I just wanted if you get what I mean...She played games with us like but it's like learning if you get what I mean."

"See, it says that 'mum, now that I'm ten months old, a lot of changes are happening to me'. It was every month through your pregnancy, it would be different things because obviously they're developing more. And it would tell you what it looks like, how it's doing, blah de blah, what nutrition it needs more and then every month, when he's born, it tells you what they do, the eyesight and the playing with toys and holding things. And it just explains so much cos like even my mum, some things in this, I'd talk to about my mum... with my mum, even, and she would like 'huh?' she wouldn't even really know, she's like... 'cos this has changed so much."

"Just all the support and help they've given me really, 'cos half of the stuff, I wouldn't have even known what to do and like whereas you get little baby books and things free and some Pampers thing, it's totally different to what you hear. Like if something's just written down by a person, it doesn't really mean a lot and you get someone talking to you about it, and then ways that you can keep your child entertained, like if he's crying for no reason, he's not tired or hungry or anything like that, she'll help you do something with your child. And it makes you less stressed out 'cos you don't what he's crying about and she just helps you do that and it's just 'oh, I could have done that like two weeks' ago' and he probably wouldn't have... but now, he's happy, he's doing something now."

Benefits of Family Nurse Partnership – practical support

As well as improving education and knowledge in terms of pregnancy, labour and parenting, the Family Nurse provided valuable advice and practical support in all areas of their clients' lives. Interviewees reported their Family Nurse helping with securing such things as housing, benefits, clothing, food and access to employment:

"Yeah like if I wanted, I did want to get a council house and she weren't quite sure like how to go about it so she asked like, I don't know, one of her colleagues or whatever you call them of what I could do and then they would tell her, then she'll come back to me and tell me what's the best option."

"I've done a lot of things and I've got help from a lot of people like my housing and my income support and benefit and everything. Even if I don't have food in the house, she always contacts people that can help me out all the time, so she's a help a lot."

"And she's given me insight onto things I'm allowed to get benefit-wise which I'd never have known about, even though, because my parents don't

agree with benefits and things like that, she's given me the help that I needed to understand it because my parents wouldn't, so she's always helped me along in that sort of sense."

"Oh well she did actually refer us to the doctor once because his head was actually growing at quite a fast rate so she did refer to the doctors which has been referred to the hospital so I guess if it wasn't for her we sort of wouldn't have had that."

"So she's got me in touch with solicitors and the job centre and child tax credits, everything I need to know she texts me or rings me to let me know once she's found out the information, so it's quite good."

Benefits of Family Nurse Partnership – relationship with Family Nurse

All of the young women who took part in the interviews valued the emotional support their Family Nurse provided and the strength of the personal relationship they had developed over time. Many spoke about a familiarity that had been formed through the continuity of contact, their comfort with their Family Nurse and their ability to trust and talk to her about *anything*. Some even described their Family Nurse as a 'friend' or 'mate':

"Well I can talk to her about anything, I think it's a really good relationship. Um, I don't know, she's just, she's really nice, she just sits down, chats with you, has a cup of tea or a glass of water or whatever she wanted and yeah, I just feel like I can trust her."

"We're quite close, yeah, I can talk to her about anything, even if it's something that's not even to do with the Family Nurse thing, but I can talk to her about anything and I know if wouldn't go any further."

"I think it's trust really, because I do trust her so it was hard before because I didn't really know her that much and then when she started helping me and like I actually trusted her, it's a lot easier to speak to her than it was before, but I trust her so that's what made it."

"No we get on really good actually, we're like, well I consider her as a friend and I think she does as well, she's just really supportive of everything even like personal issues like with my family and that, she just helps me with absolutely everything and any problems or worries that I've got with my daughter she'll help me with that even like the smallest things she'll help me with and she, it's really strong, because she's followed me through the pregnancy I've got like a really strong bond with her and she's only like... even before my mum I would call her first if I had any worries with my daughter because she's been there for me all the time it's like a really good support for me and I know that I can trust her even above my own mum because I know my mum's had children but she's not got like the experience and qualifications that my family nurse has and I

just grew such a strong bond with her because she supported me through the whole pregnancy.”

“I dunno, something different and I thought it would be a big help and it is a big help, still going on, and then I found out like because she would help me out with not only my pregnancy, the first year and the second year like until he’s two and that. And I’ve gained a friend out of it as well ‘cos she’s my friend now, that’s what I mean, I talk to her about like anything, I always talk to her about stuff, even though if she hasn’t come to like talk about that, I still manage to talk about something. But yeah, she’s really nice and her... I think it’s her sister or something, she’s got kids and I’ve got a couple of things off of them ‘cos they’re a bit old now.”

“Oh no, no, like I said earlier, like a friend really, a really good friend with loads of advice, it is actually, just basically like that. ‘Cos now that I’ve known her for ages, ‘cos I’ve known her for like a year and basically seven months, something like that, so she’s like a friend now.”

Several participants highlighted the flexible, relaxed, non-judgmental approach their Family Nurse took and appreciated their availability and demonstration of continued interest through ad-hoc contact or ‘checking up’:

“I guess the way she handles everything, you know, she’ll tell you, if you’re doing something wrong she won’t say you’re doing it wrong, she’ll like sort of say “let’s do it this way” or “why don’t you try this” and sort of give us advice like that.”

“She is and she’s the one that partly brings up the embarrassing stuff to her (laughs) but yeah she just like laughs, has a little laugh you know, we laugh together about it and she’ll just like get serious with it eventually, you know, she’ll say at the end.”

“Yeah, yeah, she’s made me feel a bit more confident like obviously she’s helped out a lot but she hasn’t made me feel bad or anything, she don’t make me rush to do anything, she just waits until I’m ready.”

“...because her phone’s always on so if I’ve got any problems I can ring her up at like five o’clock in the morning, it doesn’t really stop her if you know what I mean...”

“That they’re like really helpful and like you can ring them anytime whenever you need to ask them something. And like you can talk to them and they go through everything with you stage by stage, and they’re like really nice.”

The development of a personal bond over time distinguished Family Nurses from other services and professionals with whom participants felt less comfortable and who were thought to be less familiar with them as clients:

“They’re more informal and they’ve got more time to explain stuff, you know and spend with one person, apart from trying to get through like so many people, yeah.”

“I think it’s best cos like me and my family nurse like we’ve just, I feel comfortable to talk to her but with a midwife I wouldn’t, I don’t feel comfortable cos I wouldn’t know her. Cos like me and my family nurse I’ve been seeing her for quite a while and like we’ve just got to know each other. I don’t mind talking to her. I think the difference like is that like you only see the midwife until you give birth but the family nurses they stay there until the baby’s two. Like your baby has a bond with them as well and like it’s just they just know about you, d’you see what I mean?”

“They’re a lot more fun, sometimes you get worried ‘oh crap, I’m going to the doctor’s today’ or something, where I get excited when she comes round ‘cos there’s always something she’s gonna tell me that’s new and most of the time, I won’t know about it. And then other things is like I’d definitely, if I had to go and see her, I would, I wouldn’t make an excuse, I’d go, whereas the doctor’s, it’s like ‘oh, I don’t really want to talk to you about it, I don’t even know you’. Like when I first met her, I knew straightaway I could be open with her straightaway, she just like... I don’t know, she was there to help and she explained everything and then within two weeks, I was just pouring my heart out to her, I just told her everything. And she understands everything and... I don’t know, it’s weird.”

“More friendly. More friendly and we sit down and actually have a good chat with them and if there’s, if it’s not a healthcare worry, it’s just a general worry you can always speak to her, whereas you can’t just go to your GP about any random thing, it’s got to be obviously a reason which I’ve always managed to... But yeah.”

Though contact with partners and other family members was only mentioned when participants were prompted, all reported positive interaction with the Family Nurse. The father who joined the interview with his partner had also done work with the Family Nurse and reported many benefits for him, his partner and their son as a family:

“Actually, my mum thought it was a really good idea as well ‘cos I’ve spoke to my mum about it before I signed up, she said it would be a good help and she gets on with her, my mum used to always make her cups of tea and stuff. [Partner name] didn’t mind her coming round, [he] got involved and did things, [he] quite likes her as well, so yeah, we all get on with her, they all get on with her as well.”

Holistic service

For some participants it was the combination of learning, practical and emotional support that the Family Nurse provided that made the scheme so helpful for them:

“Well it’s the fact that she listens, she gives you advice, she helps you, it’s quite a lot ‘cos when you have a midwife they help you in the medical

department, but your family nurse actually helps you in all departments including helping you with groceries, so, and helping you both after your, after your little session with the family nurse she, she actually took me over to my mum's one day because my mum was planning for her wedding so... so she helped me out in all departments."

[Partner] "So like it's ... and like we're adults but like she sort of, she sort of says like, you know, she sort of comes in and says "oh are you sort of, you're up to date with your bills, your gas, your water, your electric?" And we're like yeah, yeah, we're up to date, you know so, yeah so she helps us out with our personal side and our family side and everything so it's good things."

Services currently accessed

Few of the clients interviewed were in contact with other services. One young woman had a social worker, but most others reported seeing only a midwife and their Family Nurse. Few provided specific reasons for not accessing mainstream services, though some suggested it was down to their personal characteristics or lack of confidence:

"I'm nervous but I want my daughter to like mix with other babies and things like that so..."

"I don't like going to places on my own and like different loads of people around but I want to start taking him."

"I'm sort of a person... if I don't know anyone, I don't like to associate with people outside except the family."

"No 'cos I'm not a person that likes to go in front of groups, go to groups, but I might end up going to like one of the baby places that my family nurse has said that to go..."

"Yeah, she has basically, she has actually told me to sort of associate with people, so like I can get friends and help from outside but I'm not the sort of person that likes having friends outside, I'd rather stay inside just stay home, not have people come in. Because in the past, I have had friends, when I wasn't pregnant, they seems to come around me when I had the money and we can just go outside and spend it. But now that I have my son, they seems not coming around anymore, so in that sort of a way, I'm sort of a bit scared having a friend that come around me 'cos I always thinking that if I have a friend that's coming, say she wants to be my friend, they are probably just coming because they just want money or they want me to spend my money on them and things like that. So I haven't got the confidence sort of to be with friends outside, I'd rather stay home."

One young woman indicated that she felt uncomfortable going to groups with older mothers:

“Yeah, it’s a mother and toddler group, most mums that go to it are like in their 30s, so I’ll probably be the youngest mother there, but when I lived closer to the city centre, there’s quite a lot of young mums there. But the further out you get, the more older the women get, so it’s actually quite weird a bit, yeah.”

As indicated above, the impersonal service associated with other professionals may also discourage participants from using them.

Accessing mainstream services

The young mothers who were interviewed were being actively encouraged into mainstream services like Sure Start Children’s Centres by their Family Nurse and were developing the confidence to be able to attend on their own:

“Yeah, Sure Start, yeah, she lets me know if there’s anything new that comes up and she knows what I’m into really, so she’ll say about things and I’ll say yeah or no or whatever and she brings me leaflets sometimes about things that are going on, so she’s pretty helpful with things like that. There’s things like... ‘cos I don’t really like staying in the house a lot, but when I’ve got money, I’ll go out and then half the time it’s to something she said or my mum or someone, but yeah, she’s pretty good with things like that.”

“No, I didn’t know anything like that, I didn’t know there was so much stuff like that all, I knew there was things obviously you go... to be quite honest, I thought they were just crèches that you just go to and you can join up with them and stuff. I didn’t know there was things that you could go and play and then activities and stuff like that, I didn’t know there was things like that until she said and give me leaflets and that about it and then I started going to them. And then she actually got me on a cooking course as well.”

“No (laughs). I haven’t really got the confidence to go down to somewhere like that but she came down with me, well she’s still coming down with me because it’s a bit hard to... I find it hard to like go into a room where I don’t know anybody.”

Few, however, were currently continuing to attend groups alone though many suggested they intended to in the future:

“When she comes over or she’ll... well if something comes up that I’m interested in she’ll like give me a call or give me a text and let me know or if it’s something for my daughter she can give me leaflets. I mean she has kind of told me like a million times to come down different places but I just find it hard to just get the confidence and go.”

“Yeah when she’s walking I’ll start to go so probably in the next couple of months I’m going to start taking her.”

Leaving the Family Nurse Partnership

All of the clients interviewed reported that they would be sad to finish the programme many would miss the support and friendship the Family Nurse provided. Many felt, however, the FNP programme covered the most important or difficult period of pregnancy and infancy and that it would be easier to cope in the future. Some were keen to maintain some kind of contact with their family nurse after leaving the programme and indicated that they would hold onto her phone number or meet socially in the future. Most were unsure of the kind of support they might need after being in the FNP programme:

“But I think in the long run like when she’s already gone and my daughter’s old enough I think I’ve already passed that like really difficult bit and it’s two years of me being a mother and I would have like adapted to it a lot better and I’m not being as worried as much about everything and I think because she would have given me so much information about the other outreach services I think I will still have other people to go and see if I needed any help with like anything once she’d gone.”

“ sounds really weird cos like I think she won’t be around and like she’s been throughout the pregnancy and stuff but I don’t think I would... I would want someone to keep an eye on his weight and that’s about it really.”

“I think that it will be okay. I think there’s gonna be like, it’s gonna be different, it’s gonna feel different but I’m looking forward to it. I just want some like independence, like on my own. But I will like miss it.”

“I think I’d feel confident but I’ll probably always have her number in, and to like say hello and find out how she’s doing and everything. I’d always keep in contact.”

Improvements to FNP

Few interviewees had anything negative to say about FNP. A couple, however, suggested that they would benefit from meeting some of the other young women who were also on the programme:

“To be quite honest, I think they could do more with getting all the girls together. Yeah, they’ve done it a couple of times and it’s really nice ‘cos then you meet new people. Because the first time they did it, I knew so many people there in the Family Nurse Partnership thing, I was like ‘oh my god’ I was actually pretty amazed by it actually, I wouldn’t have thought they’d join up either. Because some people, it was like I didn’t talk to them until I met back up with them and now I talk to them again now, so I’d like more bigger activities.”

3.3 Sure Start Children's Centre Coordinators

All five coordinators who were interviewed were pleased to talk freely about teenage mothers and their needs, and about the FNP programme and how it related to the work of their centres.

There was a high degree of agreement regarding the issues facing teenage mothers, while there was significant variation between coordinators in their reports on the extent to which young mothers are taking up services within the centres, and in their amount of knowledge of and contact with the FNP team.

Catchment characteristics

All of the centres were described as having catchment areas with varied populations, from families with high need levels, because of poverty, language or cultural differences, mental health issues or chaotic lifestyles, through to more settled, less needy families. For example, one spoke of:

“you have got people who have degrees who live on the estate, so there are people who are more affluent than others but, primarily, people are struggling.”

“We're defined as a mixed centre in the way that we have pockets of deprivation, but also have some more affluent areas.”

While the 30%/70% deprivation index split between centres was talked about by all coordinators as affecting resource allocation, all of them talked about the level of need not being fully met by their provision.

Problems around domestic violence, marital conflict and conflict between families were most commonly put forward as major issues affecting children's lives:

“domestic violence is really massive, and that affects children as well as adults. So we see a lot of children with emotional issues, social problems, parents not getting on with each other.....that's another big issue that we have to deal with.”

“And ... the children, they might have friends of the same age, and then they can't play out with their friends because their parents have fallen out, and that happens on a regular basis.”

There was also reference to 'mobile' families and fragility in community relations:

“we see people who make friendships very quickly, they are not sustainable. An issue arises because someone wants to borrow money from somebody....that happens quite a lot it does impact on the children because they form friendships here, and then they can be broken quite quickly because the parents won't allow them to play together.”

None of the coordinators spoke of teenage mothers as a special group, but rather talked about single parenthood as a serious problem, and about 'young mothers' more generally.

However all noted that just being young as a mother was not necessarily a problem, for example citing the example of young Asian mothers with strong family and community social support networks:

"I don't see a lot of teenage mums....well it varies. In the Bengali community, they are slightly younger. They are likely to be under 20 when they have their first child.... The mother and father in law will come and see us before they allow the parents and mums to come in with the child. We do have grandparents that attend as well."

Accessing services

All spoke about some parents being reluctant to access Centre services, for two main reasons; low self-esteem being related to a general lack of motivation, and a sense of stigmatisation being related to a wish to keep away from places where negative evaluations might be experienced:

"Lack of confidence and self-esteem, and being constantly told that you live on an estate that is regarded as being the worst in Milton Keynes. And how people have to cope with that.....it is quite hard."

"We very rarely get teenage mums in here which is quite a surprise but actually I think part of it is because this is a particularly big building and some of the things they could come to are universal services, it's very difficult for young mothers who are and feel inexperienced maybe feel intimidated to come into a building like this."

"there are some people from this estate who feel unable to come because they see it as open to people who are different [to them]."

Some talked about mothers who are less in need of the Centre services actually being more proactive in taking up services, and this being a matter of some concern since although the Centres offer a universal service, it is inevitably selective and may not be delivering to the more needy:

"[we call them] the 'yummy mummies' who go to a lot of different sessions which are open to everybody at lots of the different Sure Start centres."

There was some reference to opportunities specifically for teenage mothers being attractive at the Christian Foundation:

"We commission somebody from the library service to go into the Christian Foundation with the teenage mums to do stories, songs and rhymes so they don't feel intimidated because they feel, for whatever reason unable to come here but able to go into the Christian Foundation"

because that is more set up. The whole set up there is for teenage mothers.”

However, one coordinator reported recent improvements in encouraging young parents to take up the centre’s services by focusing on their particular needs:

“they are the groups you need to spend more time in engaging with in order to get them through the door. But they are getting busier and more popular, particularly the young parents’ group now which is really flourishing, and I think that is partly to do with X’s support because her background as family support worker here, is young parents, and she has spent a lot of time trying to engage with them, and working with them, and providing a service that meets their needs which is getting very successful.”

Centre aims

Coordinators talked about helping young parents to develop positive relationships with their children as part of preparing them for learning and for school:

“...children that we work with do not have a high degree of parental involvement, and that’s a lot about what we do. Trying to get the parents to engage with the children to give them real quality of educational experiences.”

Other aims that were described included encouraging young parents to access services such as housing, other benefits and support with finding employment.

Here again, working on improving self-esteem and confidence was seen as a core element of the work with young parents:

“it is about providing a facility where they can come and meet their peers and build relationships with other young parents and support each other. Having someone else who can understand their issues. So that is one thing that we are helping them to do, and the fact that some of our young parents who have come along to the session, how they have found out about us, through various methods, have then built relationships and friendships with other young parents within the group which has been very beneficial.”

Outreach

For all centre coordinators, outreach work is seen as an essential element of delivering services to young mothers. Because of the inhibitions noted above, where young parents are seen as reluctant to visit services and settings that they do not see as specifically intended for them, or where criticism and negative reactions are feared, visiting young mothers in their homes or in other settings where they can be found is seen as a valuable activity. All the centres seem to be putting a priority on this:

“We don’t always see the young parents. I think they would see that the Centre, perhaps, is more for older parents. If young parents come in, and obviously that has happened through the family nurse project.....we do

get some come in, but usually in dribs and drabs. We do have a Young Parents' group that isn't well attended, but they will come for things like cooking, and they will come to baby clinic. So we have to target where it is best to meet young mums. We are considering actually going to somewhere like Asda, and a coffee morning there, where it is not so formal or like an institution."

"We also do outreach at [name] house which is a residential unit for young mums over on [estate] and that is again the same sort of thing. We do talk to the young mums if they want and we try to deliver the activities over there."

However, there was concern expressed about the resource implications of outreach work and that financial constraints mean that less is being done than is seen to be needed:

"We can't do a lot of outreach to individual families, accompanying midwives, because we don't have the staff for that and in some cases that's what the family need."

"For here, [we would like to do] more outreach, to be able to work with the other health visitor teams in a lot more depth, be involved in a lot more of their case load in supporting the family a lot more and being able to attend more community events to raise our profile."

Needs of young parents

Centre coordinators described a range of needs that they feel young parents, or at least, some young parents have. It was highlighted by one coordinator that it is not so much age as circumstance that determines need:

"just because they are young parents, I wouldn't say they necessarily have particular issues or problems, because some of our parents are very capable."

A need often mentioned is the need for social support, with young parents tending to become somewhat isolated, lacking strong peer group support and often lacking support from their own parents:

"sometimes we have found that parents whether they are in a relationship or not, can be quite isolated, particularly if they are in a group of friends, where their friends aren't quite at that stage of having children like they are, so they can not have a peer group around them that are like-minded with children who are dealing with the same issues."

As well as the general value of helping parents develop supportive relationships with their children, it was noted by one that:

"the feedback we got from the session we did last month was actually that some young parents felt that sometimes they would like to come along and have some time away from the children to do things more orientated

towards their needs. Or giving them a bit of a boost, or boosting their skills, or having some relaxation time, or whatever it may be.”

Within this theme again occurred reference to self-esteem and stigma, seen as limiting initiative and willingness to participate in unfamiliar settings. An explicitly accepting, positive-evaluating attitude was described as being important:

“The whole stigma issue, it’s about valuing children and parenthood. We all do the best we can, none of us are perfect. There’s no book to tell you what to do. It’s about valuing what they are doing with their children and helping them to see the stages of development too, that really helps.”

Positive role models

A theme through the interviews was the importance of young parents having exposure to examples of good parenting and positive lifestyle attitudes, either through participation in Centre-based activities, or through outreach, or with other people in the community:

“At the moment we do have very many positive role models within the group, who are coming into the Centre with young parents and being very positive role models. And where possible, we try to use those positive role models to then support other parents who are then going to come into the Centre and support them in that way.”

And one coordinator saw a task for her centre as being to bring on young people who can then provide good examples for others:

“if we can engage with young parents early on, as early as possible, and support them in whatever way we feel is appropriate and they feel they need then, hopefully, they can go on and maybe provide role models for other young parents that are coming through the system, which is something we are really keen on.”

Developing autonomy

This was a strong theme in the interviews, talked about by every respondent, as a primary and crucial trait to nurture in parents. The ways in which this nurture can be provided were described, and the importance of individual tailoring of support in this area was stressed:

“to me it is about relationships. I think we offer, like, a triage system when people come in. We see where they are, measure what they need, signpost accordingly, perhaps do home visits, all the time raising confidence in a very positive, natural way. Could be ‘Don’t you look lovely today’, ‘Isn’t that fantastic what you do with your child’, ‘Aren’t they good at this?’ And we see this grows and develops their self esteem. Things like, somebody might want to make a phone call. We might, the first time, make the phone call for them. The next time, I might dial the number, and the third time, I might give them the phone book.”

“I think it varies depending on the young person but, for some people, it is about building peer relationships because that boosts their self-confidence and helps deal with any issues of isolation, or can help with depression, and that kind of thing. it is supporting them to have more independence, particularly if they are a lone parent, so thinking about access to appropriate benefits, returning to work, or starting work if they haven't yet been in the working arena, or access to training. So really getting them to think longer-term, how they will financially support their children.”

It was also said that there may be resistance, and that sometimes there is a need to be a bit tough with encouraging parents to take more responsibility:

“We have expressions here that, ‘We never look after children independently, parents are always responsible’. And we may ask them to buddy up with a friend, if they want to use the loo, or something like that, which can seem a bit harsh. It is about taking responsibility, and I think that's what we all do, we all work in harmony to do that, really. But that is going to be the ethos, and the vision that you have within your own team and your own Centre. You can't have something that is ad hoc.”

“We try to pick some of those barriers that stop them from becoming autonomous and let them know they've got choices. They don't have [to] let other people keep telling them what to do. You are an independent human being. and if you think it's the right thing to do, give it a try. It might not be the right thing but we all make mistakes.”

Integration into community

The importance of supporting young parents in building networks within the community was highlighted by several coordinators, and seen as a necessary element in the centre's service provision:

“I think you can get a lot from working one-to-one with parents. [but] I don't think that can be done in isolation. I think group work and bringing them into environments or taking them out into the community and integrating them, in their local community, has as much value as one-to-one work within the home would be.”

This was seen as a particularly acute need for young mothers who tend to become more isolated than those who are older, and also for people new to the area:

“There are a lot of parents that are very isolated in our reach and outside it because at the moment we can take anybody from anywhere. We won't turn anybody away. Even if they've come from far away, we would let them in. A lot of the issues may be due to isolation. If they are new to the area and have got no family or friends. They come along and we've got a few success stories of people coming along and making new friends.”

At the same time, building community integration was seen by one respondent as important for encouraging parents to access services within the centre, but that this is not always easy:

“They need to build their confidence within the community to bring them in here to a group scenario. We try to do that as much as we can but that is a continuous struggle.”

Views of FNP

In general, the work of the FNP programme is seen in a positive light, because of the in-depth and ongoing support for teenage mothers that the programme provides. At the same time, there is also a regret that such support cannot be given from existing services such as health visiting of the Sure Start centres themselves:

“from what I understand, it sounds like it is a very valuable project. It sounds like, for the hundred or however many parents there are in the pilot’s scheme, who are being targeted at the moment, I am sure, for those, it is probably a very useful resource to have and a very good support to have because I know how difficult it is, sometimes, for our Health Visitors to spend the time that they need with particular vulnerable parents so, having a dedicated team to support that particularly vulnerable group must be valuable.”

This was alluded to also in comments on the relatively small number of young people who can be helped by such an intensive and time-extended provision:

“I just wish there were more family nurses because we can think of families where we would like to signpost to them, and maybe one of our older parents, who has a daughter, who is 15 and is expecting a baby. And we know a lot of people have been turned away because there are not enough nurses, which is not their fault.”

The opportunity that this intensity of working gives to the Family Nurses to work with the whole family network was seen as a particular strength:

“it is really intensive work that you can see the output in some of their families. We have seen the work that they were doing and you can see the children and the young people already. I think their approach, they have...it is more holistic. I think they are more open-minded, I think because it is so intense, they have got fantastic relationships with the young people they work with. When they have met some of their young people here, you can just see the trust between the young person and between the family nurses. I think they break down barriers really well. They work with the partners as well, so it is not just the young female parent, it is the dad as well. And also the grandparents, they seem to have a really good relationship with the grandparents as well.”

Although the coordinator of the centre where the FNP programme was based was knowledgeable about the programme and how it operates, others expressed with some

regret a lack of information beyond what they had received at a briefing some months previously:

“initially when the service was being developed, we had some information that was sent through initially, but that was in the early stages when the nurses were being recruited and they were developing the project. So I had an awareness of it as it was being developed, and then we didn’t hear very much about the service. It, kind of, went very quiet, and then the next thing that came upbecause I know the Coordinator very well, I pop over for various reasons and see them, and know that they were there, because I would be in the Centre. But if I hadn’t been in the Centre, I wouldn’t have.....I don’t think their profile was particularly strong in other Children’s Centres.”

There was also what could be described as disappointment at not being able to access the techniques that the FNP uses. The brief exposures that some coordinators had had to the FNP manual contents had been tantalising because they had seemed so useful, and coordinators were then unable to use them;

“They did go through some of the methods they used, like the paper folding exercise and writing on each piece of the paper, the confidence building techniques with the mums I thought were amazing and how fantastic it would be if the support workers here could use them but they said we can’t let you have it.”

In general, again apart from the FNP centre base, coordinators felt rather out of touch with the FNP programme, and were unsure how much the FNs worked within their catchment areas. There were several expressions of a wish to have more liaison, joined-up working and shared practice with the FNP:

“the only thing.....just thinking about what would be helpfulis if we could know exactly which family nurses we are working with across this area. That’s not always been easy to share. ...Yes, that sort of information would be really useful.”

“I know they are working with a specific number of young women. I have no idea who those young women are. Maybe we should be proactive and meet them. It would be helpful if they are working with a young person in our reach area, that we work together. That’s something we need to think about.”

“I would see the family nurse partnership as a link for the family in the beginning and then integrating them into the children’s centre world to give them that second level of support.”

“I think working with Children’s Centres or other local community-based services is going to be a beneficial part of their work to complement what they do one-to-one wise.”

Communication with Family Nurses

Apart, again, from the coordinator of the centre where the FNP programme was based, a strong feeling came through the interviews of a disconnect and lack of communication between the programme and the other centres. This was evidenced, for example, by one centre coordinator believing that the scheme was finished and another who had had no communication beyond the initial briefing. These views were expressed with some regret, as the positive feelings about the programme were not supported by regular and informative communication, and by the FNs encouraging use of centres' provisions:

"I don't think we've had any communication with them to here. We've referred, speaking to the family support worker, two to them. They're not coming back here so I don't know how they are integrating back into different services. I don't have a problem with that because people do need that intensive support but how does that carry on when they leave? How does that enable them to access appropriate services here or elsewhere?"

"it would be good if they brought them along to services here, not just tell them to go but accompany them. I've not heard of any of that going on that would be good."

"we didn't have contact with them for quite a while, and I would say it has only really been.....I was checking these details with ... our family support worker, because she is our lead with our young parents. So she has had the main contact with the family nurse partnership, so my contact with them has been minimal, my personal contact."

However, where contacts are developing, this is seen as a positive thing:

"There was quite a big gap when we didn't have any contact with them and then, more recently, we have had a couple of young parents who have been on the caseload with the family nurses, and we have been working with them to do some joint visits, and also to support some of them to encourage them to come along to our group on a Wednesday afternoon. And in those cases, I believe it has been quite successful."

And there were suggestions made for ways to improve communication and joint working, for example:

"thinking about it, it would make sense if we had a dedicated link worker or someone who can maybe have a consistent approach to support parents in a particular area, or that maybe we could work more closely with in terms of a package of support for a young person that was developed in partnership rather than a package of support being developed by that team and us being a bit of a bolt-on to what they are doing, if that makes sense. It would be better for us to do it together like you would have a team meeting."

Provisions in Centre

It is abundantly clear from the interviews that centre coordinators are doing their best, in committed ways and with good staff buy-in, to provide as wide a range of services as possible within their Centres. These services are also structured and tailored differently in different centres to meet the needs of the catchment population, for example in the balance of outreach to in-centre provision or the availability of provisions that support speakers of English as a second language.

While, as noted above in Themes 1 and 5, the coordinators do not see teenage mothers as having unique needs, different from those of older (but still ‘young’) mothers, it is still recognised that certain types of provision are more attractive to younger mothers. Cookery was mentioned several times as one example:

“There are lots of different things to sign up to if you like to buy in. We have needlework, cookery going on. MK council has a framework where you can buy in services from them. We can also go out and commission directly like the needlework and cookery which we commission slightly differently.”

Locating provisions run by other agencies, notably health visiting, Connexions and SLT, in the centres, is seen by all respondents as an important part of the provision, more accessible because local, and also as an added incentive for parents to visit the centre:

“People come here for the two year check up because they can walk here from the estates. They don’t go to the local GP further away. Here it’s on their doorstep. They come in and sit in our link area, the children play, the parents go on the computer, we bring out toys if the children are charging around. It just seems to be a much more friendly place to bring your child [as] opposed to a doctor’s surgery.”

“We also have Connexions here, fortnightly, so young parents would come and talk to the Connexions advisers. They normally link into Connexions quite a lot as regards training or returning to work. So, in that sense, there are quite a few young people that would come in through that avenue, through Connexions.”

“We have our Saturday sessions with dads, Daddy Cool. That’s delivered through the voluntary sector. We contract with them, they’ve got an agreement to deliver 6 dad focussed sessions. They do things like den building and barbecuing, things like that. That’s been going for three years and is contracted through the voluntary sector.”

Linked provision elsewhere

This theme came through strongly in the interviews, and the concept of Sure Start Children’s Centres as ‘hubs’ for service delivery helps to encompass the main points made within this theme and Theme 13 below. As well as having linked provision within centres, as summarised in Theme 11 above, all centre coordinators described links of various forms with service provision, either immediately adjacent or located elsewhere in Milton Keynes:

“We also have, linked here a nursery. It’s not run by [us]... it’s run by MK council but they are interlinked in what we do and what they put on. They access our services, come to some of the groups and we access their services, e.g. crèche space if we’ve run out. There is .. working together to do what’s right for the children.”

“We work with Home Start who are a voluntary agency, PACT (parents and children together), those are our keys ones. Relate is voluntary sector but not a statutory body and they’re a charity.”

There was also enthusiasm to develop partnerships further:

“now that we are becoming more established, we need to be better about not necessarily providing a venue for people to come down and deliver things in isolation, but we look at more jointly funding and delivering the projects, so we work more in partnership. We are starting to look at how we really link our services together not doing things in isolation or alongside each other but really integrating what we do.”

Linking services

All coordinators were enthusiastic about their roles as a hub for referrals, both into and out from the centres, and for other less formal ways of serving as a link between the various services, both statutory and voluntary sector.

“if there is nothing we can do in-house, with the specialists within the team, [that] we could support through parenting support courses, or support groups... we would try and do that. But if we haven’t got the expertise within the team, we would always try and signpost to other agencies.”

This role is seen by all respondents in this group as a central and very important part of their work. The extent of this can be seen in the listing by one centre coordinator of just some of the services that are regularly linked with the centre in one way or another:

“I would say the most contact we have is with the health visiting team and community midwives, Job Centre Plus come and do a weekly service. Connexions; Children’s Social Care; Milton Keynes College; Ace; PCSO, Community Support Police Officers; local nurseries; schools; extended services, that’s for older children.”

And this positive attitude towards joining up with other services extended also to how in the future the FNP programme might with value be more involved with centres:

“thinking about it, it would make sense if we had.....and I know maybe this is hard for them to do.....have a dedicated link worker or someone who can maybe have a consistent approach to support parents in a particular area, or that maybe we could work more closely with in terms of a package of support for a young person that was developed in

partnership ... rather than a package of support being developed by that team and us being a bit of a bolt-on to what they are doing, if that makes sense. It would be better for us to do it together like you would have a team meeting.”

3.4 Associated Services Staff

Ten interviews with associated services staff were conducted. These comprised:

- Four Family Support Workers (FSWs) at Sure Start Children's Centres
- Two Health Visitors
- Two members of staff from a hostel for young mothers
- A community midwife with special responsibility for teenage mothers
- A personal adviser to teenage parents at Connexions

The interview protocol used with these respondents was an adapted version of that used with the Children's Centre co-ordinators.

Although there was a high level of agreement amongst the respondents regarding the issues facing young mothers and their needs, there was variation regarding knowledge of the FNP. Of the four FSWs interviewed at Children's Centres, two had significant contact with the FNP and two had had very little contact with, or personal knowledge of, the programme.

Catchment characteristics

While the FSWs and Health Visitors had specific areas to serve, the other respondents had a remit to work with young people across Milton Keynes as a whole. This meant that their defined target groups were slightly different, some based on geographical location and some on age range.

So, while a Health Visitor or FSW might speak of a mixed situation based on location:

“I think you would call it a glorious mixture....”

“all new, new housing, new flats really, and houses as well, so there you've got young people coming in, and some, now you can't build anything without there is some social housing in it, so you've got families buying their properties, young parents buying their properties... So we've got people buying but we also have the flats which were built in the late 60s/early 70s, one set of high rise before that became unfashionable and a lot of low rise, so three or four storeys high, some as many as six storeys high, that they have no lifts and they think... when they put families in, now obviously the selling off of properties that happened in the 1980s, a lot of the (what were council houses, public houses) are now being... have been bought by people but nobody has really wanted to buy the flats. So now you have the problem families are in blocks of flats, and you might have three or four children on the fourth floor, no lift, how do you manage that? It's really very difficult. So we've got those sort of problems, so we've got people who are out earning, people who are commuting to London, to work or other parents who are two incomes and the child going to a nursery, we've got old people, we've got families who have got family around the corner, families who have got family way across the

country and then also single parents or two parents together but neither of them working, living on benefits and poor....”

“...and I’d like to think that we see everybody on an individual basis, however we do have quite a high level of single parents that we support within our reach area so we’re looking at often quite young mothers who aren’t in employment or any education and so that’s mainly our reach area.”

“I mean there’s hard, there are hard to reach families definitely. Whether it’s because of domestic violence or you know alcohol abuse, drug abuse, cultural issues, lone parents. And then obviously you’ve got the extended families that are squashed into, housing conditions can be quite poor in X. You know in these three-storey houses where they try to cram as many people into one flat.”

For the more specialist workers, age range as well as need were the defining characteristics of their ‘catchment’:

For the young mothers’ hostel:

“Well they’re all young mums, aged sixteen to twenty-four. They come from various backgrounds, it can be from Children’s Services, they can be care leavers, they’re homeless, either through over-crowding or through, you know, they’re sofa-surfing or family break-up. We have such a wide group you can’t, you can’t sort of put them all in one group.”

For the teenage pregnancy midwife:

“The client group that I’m involved with are all nineteen year olds who are pregnant and so at their booking appointment they need to be nineteen or under at their last menstrual period. And I work as an additional support person for those young women and their families and their partners.”

For Connexions:

“We work from 14 to 20. 25 if they’ve got learning difficulties.”

“Basically a lot of my young mums are lone single teenage parents, a lot of them live in poor housing, a lot of them estranged from families. So in theory, they’re quite what we call the target support, they have need of a lot of intensive support.”

Issues faced by young mothers

Respondents were unanimous in citing a range of issues that were faced by young mothers, some of them practical, such as need of help with housing, benefits and education; and others that were more attitudinal, such as lack of self esteem and a sense of being adversely judged by others. Many of the young mothers encountered

by these services had also suffered from a lack of good parenting themselves and consequently had no models of parenting to guide them:

“When you’ve got girls coming from broken families, where maybe their families aren’t really supportive and what I mean by supportive, supportive gets misinterpreted. You get mums saying, “Yes well she can stay at home with me”. And that’s viewed as supportive. But actually if she’s not, it’ll either go the way that she does all the care for the baby and actually takes away the responsibility, so in the long run you’re not actually helping this young mum at all. Or they ignore them completely and let them get on with it. So a supportive family really needs to work together....”

“A lot of them have, a lot of them still have contact with the family but it’s very chaotic contact and it’s very chaotic the lifestyle they’ve led before they’ve come here. A lot of them, I’m not trying to put them in a box but if you were to, yeah, you’re asking me the question and I’m saying that that’s probably, social reasons is high...”

“Well, from their point of view, quite often these pregnancies are not planned. So it’s about getting them to understand what’s going to happen, the implications of continuing with the pregnancy, how their family is going to cope, practical things like where are you going to live, how are you going to survive money wise. Do you want to continue your education, do you want to get a job, all these sort of things that are really important. And not all of them need an awful lot of input regarding parenting, but a fair number do.”

Besides benefits and housing, getting the housing sorted, lack of education, so it’s getting them into their basic training, parenting skills and obviously the childcare issues are the big thing as well for them, and funding, for that funding for their education:

“And confidence with them and aspirations, it’s a big thing with them cos a lot of them are very lacking in confidence sort of thing. And we’ve got quite a few that are coming up now with really sort of basic education so we need to get their English and maths built up before we can even send them into college.”

Young fathers’ lack of support or actual abuse could also be an issue:

“And particularly with the dads. I mean the dads quite often aren’t, they’re even more difficult to engage, the young dads. And quite often I say to these young ones, it’s often they’re not interested in pregnancy, they can’t see a role, they can’t kind of identify I suppose with the mum.”

“She came here with very, very low self-esteem, she was pregnant when she arrived, she had a boyfriend, there was abuse, he was abusing her financially and physically as well, and she didn’t feel strong enough to get away from him.”

“The main problems are social problems, family issues and boyfriend issues, controlling behaviour, domestic violence etc. yeah. Those are the main reasons.”

“Sometimes you have to choose between your baby and your lifestyle, or your baby and your abusive partner.”

Barriers to accessing services

The factors that act against young mothers' accessing services are also a mix of practical and attitudinal barriers. Many young mothers, having suffered from poor parenting themselves, have no concept of what might be involved in becoming a parent and no sense of having to separate their own needs from those of their child:

“quite often I find that mums, dads definitely, mums to be often don't understand, don't get having a baby until they're actually in labour. (Laughing)... Or this baby's in front of them! And that sounds a bit ridiculous but sometimes they just don't really fully comprehend that this massive life event...”

“When we've got to a point where we have a mum who is not looking after herself. She's not engaging with her, she's not going to see her midwife, she's not seeing me [community teenage midwife], she's not going to classes, she's not doing anything to help her and her baby....”

“Of course we lose babies in pregnancy, which can be linked to lack of antenatal care and again lack of positive lifestyles...”

Many young mothers are reluctant to join in group activities at Children's Centres from a fear of being judged:

“we talked about the difficulties that they can have, so maybe it's how, whether they feel comfortable in walking into a setting like this. How comfortable they feel around professionals. Whether they feel they're being judged.”

“Yes, I think they will always, whenever I talk to a young mum about how they feel about being a young mother, they, they often say they feel quite judged. Maybe not by health professionals, which is good, but other people, that they feel there is definitely still a stigma...”

This reluctance to access services can also affect home visiting, such as the Health Visitor service:

“I think some think that we're going to lay down the law and preach a bit, so that's difficult. Not so much the getting, and I think some of my colleagues possibly could do, look at bit judgemental or a bit preachy. So I think mainly that they maybe don't see the point or they don't understand. For some, the old adage of the health visitors coming to see how clean the place is and how you're doing and make sort of assessments

and judgements perhaps, very much pertains, and so for some they pick up the antipathy or fear or whatever that their parents have got, you know..."

"Feeling confident, feeling able to go in to settings without feeling that they're going to be judged, I think that that's a real problem for some young girls you know."

"A lot of our mums do suffer with sort of feeling isolated, feeling that people are looking at them, don't feel that in the first instance that they can just come to a session because people might pre-judge them, and that's their, that's generally what they would say how they feel beforehand."

Time management and 'apathy' are other issues that affect access to services, whether in terms of young mothers attending external groups or keeping to set appointments at home:

"I think maybe sometimes because they're so young, they don't have the experience of being able to manage a diary or appointments or, it's quite easy to get frustrated with them if they don't do as they say they will."

"well I can think of one mum who I went to go and see last week and we prepared, she knew I was coming to see her. I always phone and text these young mums the day before and on the day to remind them, because sometimes they still forget. ...Yeah and she was in bed you know. And I had to ring her mum who was at work, who said "oh well knock on the door, try and get her out of bed". And she wouldn't answer her phone and wouldn't get out of bed to me and it's, it's very frustrating."

"But it's the group that just don't do anything. They don't, they're not in college, they're not working, they are doing nothing. And it seems to be those ones that we, are really lethargic, (Laughs) and very difficult to engage."

"Because they are teenagers. They are hormonal, they are tired. They don't really want to be doing what they want to be doing and it just all compounds the problem."

Several respondents also mentioned the sense of isolation and being cut off from peers experienced by young mothers:

"Not being able to access education maybe or that being affected by being a young mum... Yeah and I would say, maybe feeling isolated from their own peer group."

"I think probably isolation, there doesn't seem to be much of a community spirit sometimes, people are very much on their own."

There are also practical issues, such as money and transport:

“I think transport would be one and I think that’s probably quite a massive one actually in that even if something’s just across an estate, that can be like the other end of the world for causing anxiety, I’ve got to walk somewhere I don’t know, I don’t know how to get there, I can’t afford the bus you know, all of those things, so I would say transport is quite a big one.”

“Money. You know to be able to get transport to go.”

Overcoming barriers

When trying to work with young mothers who often display a lack of engagement, the respondents used patience and perseverance:

“Just by persistence, I think, to be honest with you. And if all else fails I’ll do one-to-one. But I will do everything I can to avoid having to do that.”

“It’s persisting and that’s really it really. At the end of the day you can’t, if they really don’t want to engage, they don’t want to engage.”

“this girl coming into clinic, a young mum with a child who she was desperate about his sleeping and I was sort of just saying to her, you know, he’s... ‘This is what you’ve got to do,’ you know, and I kept on saying, you know, giving her the same advice, and she’d come back a few weeks later and she’d be giving me the same story and I’d be saying ‘Have you tried this?’ and then she came in, she’d been perhaps... this was perhaps about three months it had been going on for, and then she came in one day and said to me... I said ‘How is such-and-such?’ and she said ‘Oh, it’s not a problem any more, what I did was this. My friend told me,’ and her friend told her exactly what I’d told her, but she was ready to hear it by then. So in listening to... well not listening to me, but in that sort of drip-feed, then when her friend said to her ‘What you ought to do is this,’ and I said ‘Oh that was a good idea,’ (laughs), ‘What a good idea, I’m so glad that’s sorted your problem.’”

Other factors included building up trust and not being judgmental or using intimidating terminology:

“I do have to be careful sometimes with, obviously with my language, that it doesn’t put people off, and it is about taking the time, if you can, to get to know people a bit, to gauge where their levels of understanding and such like are..”

“we had immense difficulty getting in to see her, really really hard to get in to see her and one of the reasons that she gave for that because I now get it and she rings me a lot and we do... there’s nothing magic about me, but you know, we now have a good relationship with her, I don’t think I’ll get her into any groups yet, but we have a good relationship now, but one of the things that she told me is that she feared I would do, is to... you know, is to try and lay down the law, and to tell her what she had to do

and get sort of cross with her when she didn't do it, and that's what had happened ...So she had a difficult, a stormy and difficult relationship with health visitors and I think felt quite judged by them and so I put my judgmental hat away! ...To be accepting, yeah, yes, and now we've begun to unpack some of the difficulties that she's got from her childhood herself, so we're hopefully moving forward..."

In terms of helping young clients remember appointments or groups, many professionals used mobile phones to keep in touch. Using text messages could also have the advantage of being cost- free for the recipients to receive:

"one innovation that we've had recently is the mobile telephone. We've been given a work mobile and the work mobile, that's great with the young mums, because if you ring their mobile phones and leave a message, they never pick up the messages because it costs, but if you send them a text they can read that without cost."

"And you have to keep reminding yourself that these are fifteen, sixteen year olds, seventeen year olds who are used to having an adult as a teacher. So sometimes they, they worry about contacting. They text, however, texting is the way forward! (Laughs)"

Children's Centres often used 'carrots' to overcome clients' reluctance to attend sessions and tried to provide activities that specially appealed to them:

"then we try to do a different activity running alongside each week. So whether it's sensory stuff or we've done a SALT day with handprints and footprints and sometimes we do a bit of painting, handprints. One week we did decorating photo frames, so we really try to, they seem to like the memorabilia stuff and that they can, the keepsakes and stuff."

"We have a group for young mums and they actually make, well we do lots of consultation with them about what they want about their, what they want from their group."

"...at the home visit we talk about how they might access the centre and how they feel comfortable about doing that, and the sorts of things that we do, you know, within the groups, particularly in the young parents, because they're doing scrap books and things so they take prints of their babies feet and things like that and they take photos of them doing messy play so they can make up a scrap book of their child's development. So that's quite a good pull, and the lunches is another one."

"we've done fashion shows with them, recently at [name] House they've done a CD and a DVD on songs which is quite good, and that all helps build their confidence so, yeah.."

Young mothers are also encouraged by the Centres to act as a positive role model to other mothers there and this can be used to boost self-esteem:

“the ones who come to this group engage really well and I often will ask them to come to stay and play on a Monday where we struggle to get parents to do the messy play with their children. This week the young mums had got their babies stripped off and they were mark making with paint on big rolls of white paper, the babies were crawling in it and walking in it, but on a Monday we struggle to get the parents to do that, so they will actually come and role model to the other mums.....”

“For actually, you know, bigger groups, and there are older, more mature, parents who maybe don’t see the value in messy play so much, which maybe because they are younger and they love that fun aspect, they don’t find difficult. It’s, I think they feel quite, you know, proud of themselves, and they should do, for feeling, you know, important, so.”

Ways of accessing services

Respondents were asked how clients gain access to the services they offer, and this varied across services.

For Connexions:

“They are, originally they are referred to us from Helen who is a teenage pregnancy midwife. She gets a referral, she’ll ask them if they need to see us and she always gives me a list of all her newly pregnant ones. So I get my referrals mainly through Helen but I’ll also get them through the college, I’ll get them through the children centres, I’ll even get them through the nurseries sometimes, and obviously the nursing practitioners will come into me as well and give referrals. And occasionally we get them from Social Services as well.”

Having had an initial referral, the Connexions adviser then often visits her clients at their homes:

“Having the money to travel is difficult. That’s why it’s quite good for me ‘cos I can go out to see them because to expect them to come into the centre they’ve got to find the bus fare and obviously if the baby’s unwell so that’s quite hard, so I actually go, either meet them out somewhere close to their home or I’ll go to their home to meet them.”

The Children’s Centre staff all make great efforts to engage with and encourage young mothers to come along to their sessions. As well as doing their own publicity, they work alongside other services staff:

“A lot from our own publicising, obviously Health Visitors do a lot of informing about Sure Start as do the Family Nurses, we’re fortunate to have the baby weighing clinic here as well each week so through that, and then publicising through the school so you know, the information is going out as it would to anybody, it’s just not being targeted.”

“Well usually it’s word of mouth and they just come in with friends or sometimes they attend a six week check with the Health Visitor and that

way, you know, they say “oh come and have a look at what services are available”. And baby weigh in as well, we do baby weigh in clinic on a Friday morning and we get lots of parents in and sometimes we tell them, we always tell them about our services, we always give them the family information leaflet/booklet and then it’s up to them whether they want to access anything else. Some parents just want to come in, get weighed, go home and they don’t want anything to do with any other services and some are very receptive.”

“Yeah, other ways we’ve done it is actually gone out and done a home visit and then gradually built up a bit of a relationship within the home and then transferred that in to the Centre, and if that means meeting her at the shops and then walking in together then you know, it’s really...”

However, even with a great deal of outreach effort, staff cannot always engage the potential clients:

“Yeah, I mean we do provide the young parents groups but as I say, it hasn’t been well attended, and it’s an area that we’re struggling to get through in to the Centre...in our reach area from using the Connexions database we established that there was five parents that were under 20 and we actually went out door knocking to those parents and we weren’t able to make contact with any of them really, two of the ones that we did just showed no interest in attending the Centre... As it is currently the group is running without anybody coming each week.”

Some young mothers are very wary of attending group activities because of their sense of being judged, as has been mentioned above. Outreach work and home visiting to introduce themselves and the Children’s Centre services is typical, and they frequently link up with other agencies, such as Connexions or the Family Nurse, to visit young clients and to accompany them to the Centre for the first few visits:

“Sometimes if we do joint visit with the family nurse we then walk them, meet them the next time and we walk down with them. Some of them will just come on their own, or they might bring a friend. So we sort of, at the home visit we talk about how they might access the centre and how they feel comfortable about doing that, and the sorts of things that we do, you know, within the groups, particularly in the young parents.”

The Connexions adviser is also willing to encourage clients along to sessions at the Centres:

“Cos like at the moment I’m trying to get them into the Children’s Centres, so we’re working with Children’s Centres to do special young mums’ groups because they do feel they’re very much judged by society and if they go into the older group of women, and I actually have seen it done, they do get looks and comments made at them so, but yes that’s their biggest fear of how they’re perceived in, sort of thing. And quite often if they’re nervous anyway I will agree to meet them and take them to the first one or two sessions so they sort of get to know the people in there”

Benefits of engaging with services

All respondents mentioned a range of benefits that accrue from young mothers' contact with the services on offer. Some stress the social and emotional benefits, and the knowledge and confidence that clients develop with respect to their parenting skills:

“Yeah, the socialising with other parents would be the main thing. There was one particular parent who came here, I wouldn't say she was necessarily a very young mother but she'd come from [another town] and she was very isolated, she had postnatal depression for the new baby she'd had and she had a one year old son as well and she knew nobody at all but since coming to the centre she's made some solid friendships, she's accessed computer courses, parenting courses, she's now on our parent forum, her older child is at nursery school and she's a real trusted, highly regarded member of the community and with lots and lots of, a big social circle of friends now and we've been able to support her with many, many kind of issues that she's had be it financial or social or depression or just seeing a young parent come in and enjoy the activities with their child, that is a success in itself you know, and we've got young parents that have gone on lots of different training groups you know, courses with the OU, and just developing in to the parent that they want to be...”

“Good outcomes? With the... well with all mothers but particularly thinking sort of the young mothers, is to see them when they do engage and they get the appropriate advice and sort of go... really being very confident in their ability to parent, and being able to do that independently and I think that's the biggie.”

The access to a range of services and being signposted to other agencies is also very important:

“I do think information is the key really and yeah, for me I just think as long as I'm providing that information and saying, “Did you know that this person, you can go there for this support and you can go there to find that out”, then they can make informed choices, and I think a lot of reasons why people you know, often feel like they're stuck in a situation is not knowing where they can go to utilise other support networks really.”

“... the Connexions Education Advisor, she comes in every week... She works really close with them and we've had a lot of girls go on to education. We've had hairdressers come out, we've had the young lady who's gone on to do law. We've got another young lady who's currently studying to go and do law again actually and she's just finishing her first year. She'll be applying to Uni next year. A lot of, a lot of the mums who thought they actually couldn't achieve, they didn't finish their school, they thought they were rubbish, they couldn't do anything, they're put on small taster courses, six week courses, access courses and they now believe they can actually achieve anything they put their mind to.”

Developing autonomy

Developing clients' independence and autonomy was a major aim for all respondents. They were conscious of the fine line between giving support and encouraging dependence on them:

“I think you have to be careful they don't become too reliant on you, cos what I tend to do is I sort of really sort of hold their hand to a certain amount and then I sort of start empowering them, so by the time I move away they're quite capable of doing that, but there is the odd one or two that will have sort of, people become dependent on you, get dependency, so that's what you have to watch out for.”

“I think it is about trying to move people on, because they can become very dependent almost on the group, so there's that element of yes, offering long term, as long as they continue to grow, I think that it's fine, but they need to move on, because if, you know, not growing and not making changes isn't good for them, really, so, life can't, doesn't stay like that.”

It is also a matter of tailoring the support to the needs of each individual, being responsive to the specific needs of each one:

“I think for me it's in stages, when you initially start working with somebody and you put in that high level of support, be responsive to what they're saying their needs are without the judgement of just thinking, “Oh, they're a young parent, they're going to need this level of support”, you know, they may not, but I think it really has to be on an individual basis and really inclusive of positive disengagement so that we're holding hands for a little while and going on a journey but we really want to be empowering people to be feeling good enough to go out and do these things for themselves really, so I just think that's really crucial, that positive disengagement.”

Continuity and trust

A major theme in engaging successfully with young mothers was their need to develop a secure and trusting relationship with the professionals who were working with them. Whilst the community midwife might only be with them for a few months and they might not get to see the same Health Visitor consistently, the Family Nurses were able to offer a consistency of care throughout pregnancy and the first 24 months of the child's life, and this long-term commitment allowed them to build up a strong bond with the young mothers that was key to a successful engagement:

“I think the work that they do is fantastic and I speak as a professional but also as the fact that I was that teenage parent you know, without that support and that sort of consistency with somebody so I really value the work they do, and you can see the relationships actually between a Family Nurse and their parent they're supporting, it's a very warm, positive relationship.”

“You know, they see the same person and everything, and they get the baby weighed by the same person, because if you come to a baby clinic you could see one of any four health visitors and if that’s not the health visitor you know or get along with then you don’t ask those very important questions, and I think that gives the young mums particularly that continuity and that opportunity to express what might seem the most silly concern but they have, you know, they feel confident enough in that relationship to do that, and I think that’s what’s vital, really.”

“I think the role of Health Visitor is obviously vital to us all but it’s not always something that you could have direct contact with, probably for our families being supported by a Family Nurse they would have that one contact, and I think that that probably alleviates a lot of their worry, they’ve just got that somebody there...”

“Over the last five years there’s been a lot of changes ... And people stop trusting. Why would you seek somebody out that you don’t know? I wouldn’t go and see somebody I didn’t know.... And if you are young and you’ve found somebody that you like to talk to, it’s really really hard, it’s really hard to find yourself coming to the point of changes.”

As well as the Family Nurses, the other support worker who was able to have a continuity of relationship with young clients was the Connexions adviser, who also felt that developing a trusting relationship was essential:

“But I think the most important thing is their relationship, their trust in me because I have a lot of sort of, a lot of clout. I have a lot of involvement in their life and their baby’s life so I think that is where they’ve got to trust me to be able to do that.”

Views of FNP

Two of the Sure Start FSWs had not had direct contact with the FNP, but all the other respondents had, and they were overwhelmingly positive about the scheme and about the nurses themselves. One of the major benefits of the Programme was the continuity of care it offered, as mentioned above:

“The support for the mums I think is the particular strength and the continuity of it sort of thing. Knowing, and they’ve got them for a long length of time as well so they know they’ve got that one person that’s quite stable sort of thing, I would say that is, it’s the support they’re actually giving to those mums.”

The other benefits were in terms of the developing confidence and sense of empowerment it gave the young mothers:

“But they are armed with information that really helps and support them in being good mums, and I think that’s imperative, really, really important. They engage really well with the girls and the girls really like them, and they don’t see it as, I can’t tell you of one that sees it as “oh

she's coming again, I don't like her" or "I don't like her being here because I feel she's intrusive", not had any of that..."

"The mums, they just, they were a little bit unsure at first, but once they really got going they really enjoyed it and they felt very special, because obviously they had only a set number that they could recruit. And it was like oh I've got a Family Nurse you know and you haven't. So seeing them enjoy the course and have a bit of a focus was fantastic! And seeing, just seeing the support and watching them grow and it was just brilliant and it just, you could see the difference between girls who were on the programme and girls who weren't. They were much more clued up. They did a lot more preparations, so particularly from the baby side of things and the parenting side... so the positives were they were more focussed, they got really good support and they, they just seemed to do really well."

"I just hope it continues really, I think that they've got it really right in terms of the support timescales, I think that that's you know, very well thought about really you know, I've certainly seen young parents who haven't had that input after having their first child certainly are becoming pregnant within two years after you now, within a year in actual fact in what I've experienced with families, so I think that the Family Nurse Partnership is probably reducing some of that by better education and contraception and things like that, and it is a preventative format."

"The positives have been being able to meet that, their age groups, and support them to access the services and that definitely does work."

With regard to the downside of the FNP, a frequent comment was that there were not enough FNs and also that some of the mothers initially recruited to the scheme were older (18/19 years old) and possibly less in need of the intensive FNP support than younger and/or more vulnerable teenage mothers:

"Not enough nurses, that's all there is really I would say. There's just not enough of them."

"We'd have more. That we would have a lot more of them assigned to young mums, yeah. It makes such a difference."

"Before it was like the 18, 19 year olds who have to come but now we're getting 14, 15 year olds and I think they're the ones that need nursing practitioner, but more often than not they're quite full. I've got a couple I'm looking at referring and I just need to find out whether they've got any spaces."

"Well I suppose what a weakness of the programme is that when they were recruiting, they maybe weren't recruiting the ones that really needed it. They recruited some very lovely young ladies, who were fabulous. But very well motivated in themselves, so maybe they didn't, they didn't need it as much as some of the other mums out there could do. The mums that really don't engage with normal services.... The mums that really need

that additional support. And I know that after talking to the nurse, the Family Nurses, you know that they did often say, "You know we do wonder if we've, sometimes we've recruited one or two that maybe are not really needing it". You know it's just, it was for more needy individuals."

A disappointment for some of the respondents was a sense of perceived secrecy, that the FNs were not able to share their techniques and materials with other professionals:

"I think the only thing is that there was this perceived kind of secrecy about what the programme was about. And I felt, I felt I could, didn't have the information to support the mums, if that makes sense.. We health professionals weren't allowed to know what they were teaching them.... And in fact I felt that it was a bit of a barrier, in the beginning, because they were very clear on that. And from the midwives in the hospital I found that they were quite cross about it, because they want, you know like well you know we'd want to know, you know we're interested."

"And they will come into the office and tell us things that I didn't know, you know, about you know to say "well we've got, we've got this paper of paper, the piece of paper" she said "and you have to fold it up and you're doing this with it and when we're happy we do this" and I'm like "oh that's a really good idea". She said "oh that was, that was the Family Nurse's idea". She said "I've been thinking about..." you know and it makes them think about things in a way that we just you know, many, many of the staff here have maybe done the childcare course, you know child minding in the past and sort of general things, well you know worked in a nursery etc, etc. But the way the Family Nurses are dealing with problems is totally new and you know I said to them "Can you share with us?" And they've said "No". (Laughs)"

FNP compared with universal services

Respondents cited various advantages of the FNP compared to universal services, such as the continuity, the method of training clients in parenting skills, the amount of time the FNs could give to their clients and the fact that the programme was able to be delivered in a way that met the individual needs of each client:

"Oh it's a million times better! It's what Health Visiting should, I'm not a Health Visitor, but it's what Health Visiting should be. You know you can't expect a new mum of any age really, just to have a baby and then say, "I'll see you in six weeks" you know. I think that's awful! It fills me with horror that these women out there are struggling to cope and not having the skills, the expertise, the maturity to be able to go I'll go to the Children's Centre, you know or things like, so it's filled a huge gap. It really, really has."

"...the parenting that's coming out now is so much better and so much more informed. Because if you're not told, you don't know. And being told so intensely on a one-to-one basis and actually getting it in a way that we, we couldn't possibly deliver it, you know because we're not trained and

the limited time that the Health Visitors had, I think that the life experience that child is going to have now, it's going to be so much, so much better because mum's informed and she knows, she knows what and why we do things."

"Well I don't think you can compare them really, I think as we know the key is looking at the families on a individual basis and I'm not sure that Health Visiting would give the capacity to do that on such a scale, obviously with the Family Nurses they're doing direct work with each family to their exact need..."

"I think they do better because they build a better relationship than your normal Health Visitor because as I say they've been there literally through the pregnancy and onwards so they've got to know this young person as well as the child. So I think they get to know them better than what you would as a normal Health Visitor, so I know there's a shortage of Health Visitors as well so..."

Specific resources for young parents

Most of the Sure Start staff interviewed said that they either had a specialist group for young parents to attend, or that they had tried or were trying to establish one:

"We have a group for young mums and they actually make, well we do lots of consultation with them about what they want about their, what they want from their group. They're absolutely brilliant at hands on, messy playing with their children, we've got some beautiful photos, and they actually set their own, they've set their own guidance as to, you know, no swearing and things like that because we've got toddlers within the group. Their age range is actually 17 to 25, obviously we take 16 year olds, but their actual current range is 17 to 25. And I was concerned about that because I thought actually maybe after sort of 22, maybe that's not, and we should think about a separate group, but because of other issues that have come out that have meant referrals from the 22 pluses to children's social care, we felt that we would have missed those ladies so we felt that maybe they needed a separate group, but consulting the group, that's not what they want. They feel that the older ladies within the group are good peer support."

"I think that they've got an awareness of it here but actually whether it, does it need to be that there's a specialist support group now because it's almost like a contradiction in some respects because we're saying you know, empower young parents to be a parent and allow them to feel that they can go on to be the best mum they can be on reflection of a 25 year old but then I think that they do pick and chose the thing, so if we provided a trip or something like that then that would be attended... ...so they're making that choice, maybe it's about them feeling I don't need to be fitting in to a specialist group, I'll just attend the Centre as I want to, because we have young parents attend the services within the children's Centre but not the specialised ..."

One of the Sure Start centres did do outreach work at [name] House, but found it hard to persuade the young mothers there to venture out to the Children's centre:

“On our last calendar we tried to do a young parents group and it just, it just didn't take off. It was really, really difficult to engage and obviously we were working with [the hostel], but it's a real challenge to get them to come into the centre.”

However, the same centre had had some success in engaging with young parents together:

“On an everyday basis we run courses like cooking on a budget and things like that, and we have our parents come in, and that's a group actually where I've seen both young mums and dads doing that together so that's been really, really good, I think young parents, young fathers kind of don't feel, with their street cred sort of thing, to come in and do the play but they can come in and cook and things like that, so that's been really, really useful, and just out of doing that you know, more confidence to be cooking more nutritious healthy meals on a budget at home...”

Multi agency working

The Sure Start Centres provided a 'hub' where many services could come on a regular basis so that clients had the convenience of accessing a range of support services under one roof:

“We have Relate here as well weekly, we have CAB here, so obviously we're trying to offer an umbrella service I mean in that regard so yeah, we could have ten appointments and still fill them each week for those services, both CAB and Relate, we work very closely with you know, the Health Visitors, we work very closely with Children's Services, Housing is another area where we are quite often in daily contact with you know, the needs of the families that we support do appear to be centred around those sort of support areas really.”

There was evidence of widespread co-operation and shared work across the services:

“Definitely the Children's' Centre, social services a lot, and the family support workers. And, actually, housing as well. We do, although we have no sway over housing, we can pick up the phone and just query different things and they are very good. If there's a specific problem they sort of will look into it, but Children's' Centre, they sort of link in to Citizens' Advice and all that sort of thing, and any other referrals by the hospital, say, like dermatology I can, it's all those usual things we would.”

A key factor in multi agency working was good communication between different services:

“I think it has to be multi-professional working because sometimes they’ll see something, or the client will say something to them that they’ve not said to you, and I think if you work in a cohesive manner you can offer a better support to the family, no matter what it is. And communication is kingpin, really, isn’t it? It has to be top of the pile and so not only communicating with the family but with the other professionals and, again, it takes the heat off you, and the pressure. If you’re the only one holding that and trying to sort out everything, gosh, that’s just too much, with too many cases, so it has to be shared and worked together. I think we do manage that most of the time.”

“Oh information sharing, absolutely. It’s so important and because the more that we share, the more we can help these young mums you know and it stops them from going round and round in circles. So definitely information sharing to help the mums.”

Different methods of recording and different terminologies used in services may cause problems. Knowing the individuals concerned and having ‘a face’ to connect to is seen as an important aspect of good multi-agency work and possibly a way of counteracting this:

“Probably a bit more, well I say sharing of information but we’ve gotta be careful what we share but certainly the information sharing should be easier. The Youth Service are a nightmare because they don’t keep records so they’ll quite often have a young mum that’s on there but they don’t make any records of it, so we don’t get to know about it unless we bump into them or it’s sort of passing in talking. So certainly with the Youth Service it would be more information sharing than anything.... As I say their information sharing’s quite hard to say the least. But the others, I find they run quite smoothly so I think it’s important you have a person and a face to talk to, and the same I always go there in person and I’ll talk to them, they all know my name, most of them have got my mobile number so, and I think that’s quite important.”

“With working across the agencies, it’s really good if you can get a good working relationship, a good working together and good communication and I would certainly say I’ve seen really excellent outcomes for families when we’ve managed to do that, to all sort of be talking. The difficulty is... the difficulties are the ones of language, the language that we speak, the shorthands that we speak and our thinking patterns, we think differently... And sometimes overcoming that to really understanding what we’re meaning. It is one of the difficulties. And then there’s the usual difficulty of playing telephone ping-pong with people. ‘Are you available when they’re available?’ and that’s a difficulty.”

“What would be lovely would be to have a proper multidisciplinary team that just works with teenagers. I think that would be fantastic! Because then you’ve got everybody on board at the same time. Because we all have our different notes and things it can, I suppose that is a downside actually,

we all have our different way of recording information.....and collecting stats. Now I think about it that's quite a big thing."

4. Discussion

4.1 Defining and identifying needs

A consistent view emerged that simply being a teenage mother is not an adequate or accurate indicator of the level of support need for mothers and their families. In some cases, especially where there is extensive and positive support from partners and extended families, the level of additional support need may be very low, even for a teenage mother. In particular, the existence of a supportive mother to the mother herself can be a protective factor. This can be supportive both from the point of view of experience and knowledge in childcare being readily available to the new mother, but also in emotional support and understanding of the changes and challenges of becoming a mother. The realignments of a mother's relationships with partners, parents and others that of necessity happen with the birth of a new child will often provide this protective support, but may also be a source of stress in the postpartum and hence worthy of monitoring.

In addition, respondents distinguished between those young mothers who came from what they termed 'chaotic' family backgrounds where they could not expect support or practical assistance from their families and where there were no helpful role models of parenting available, and those who had good levels of support throughout their pregnancy and beyond. However, some service providers commented that often slightly older (18/19 year old) teenage mothers had been assigned a Family Nurse who could have managed adequately without one, whereas there were many younger mothers (e.g. 14/15 years old) who were not assigned to a family nurse who would have really benefitted from the level of support offered by the FNP programme. As the FN service can only be offered to a limited number of young mothers it is important that it should be offered to those who have the greatest level of need.

Peer relationships were mentioned as a significant factor, either as being potentially supportive or as adding risk. The significance of positive role modelling was indicated, but systematic means of building on this potentially valuable approach could be thought about and developed further. There would seem to be opportunities here for more linking with other agencies, where young mothers are concerned.

Domestic violence and conflictual tensions with neighbours were frequently mentioned as further risk factors affecting new mothers, so being alert to the presence of such factors is an additional issue in determining need.

It was also stressed by the interviewees that the material and social environment of the mother's local area is a potent factor in heightening or moderating risk, so an holistic approach to assessing the care needs of a new mother is necessary. Given increasing ethnic diversity, the different cultural expectations of the age of first pregnancy, the support needs of new mothers, the role of extended families and the attitudes to accessing services need to be known, understood and adapted to.

Finally, isolation, physically, socially and psychologically, is identified as a serious risk factor and worthy of special attention. Other research indicates that mothers who experience social isolation are more likely to use negative parenting practices

(Bornstein et al., 2006; Daro, 2009; Repucci et al., 1997). Techniques for supporting community integration for new mothers would seem to be worthy of special attention.

4.2 Therapeutic relationships of Family Nurses with clients

Nurses and clients reported that the family-nurse relationship was central for promoting positive parenting practices and providing the mothers with the positive feedback, new knowledge, and the support they needed to achieve and sustain these changes. These findings are supported by previous research, which argue that developing the relationship between families and practitioners is crucial for promoting positive parenting practices (Korfmacher et al., 2007; Zeanah et al., 2006).

Without exception, FNP clients identified the relationship that developed over time with their Family Nurse as the key positive feature of the programme that distinguished it from other services. Trusted and strong personal relationships were formed through the continuity of contact and many participants spoke about the emotional support their Family Nurse provided, some even likening her to a friend or mate. Many participants described feeling able to talk about *anything* during meetings and valued the impartiality and confidentiality they were afforded by the Family Nurse. The service was often understood to provide an individualised service based on the familiarity of the Family Nurse with the client. Indeed Family Nurses were also thought to have particular skill and ability to connect with younger mothers.

Running through the data is a consistent emphasis on the need for relationships between providers and clients that are positive, warm, consistent and sustained. Clients respond well to the building of trust, the basis for close, confiding relations, which comes from reliability in appointments, good follow-up, taking the clients' perspective and being felt to be 'available'. A focus on supporting and developing the professional skills needed to build such relationships would seem to be warranted.

Continuity and trust

Many young mothers were felt to lack confidence and self esteem and so particularly valued being able to form a close and continuous relationship with their health care professionals. Also key to this relationship was a sense of not being adversely judged. A distinction between the FN service and the more universal one, such as that offered by Health Visitors and midwives, is that with the FNP young mothers knew that they would always see the same person, with whom they had been able to build up a relationship of trust over time. Several respondents commented that young mothers were more reluctant to make contact with or ask for help from, people they had never met before. It was also easier for young mothers to have one point of contact, who could assist them with health matters but also signpost them to other services, such as housing, education or benefits.

Another aspect of continuity was the care and education offered to the mothers both before and after the birth of their babies. The continuity of support offered to young mothers during the first months of parenthood was just as crucial as that offered before the birth.

Availability of Family Nurse

The availability of the Family Nurse was also a particularly valued aspect of the relationship. Many of the clients appreciated the flexibility of the Family Nurse and the ability to make contact when they felt like it. The Family Nurse was seen to provide a constant source of support and was described by some as ‘always being there’.

While the FNs made themselves readily available to their clients and this was an aspect of their service that seemed to be particularly valued, like other professionals they also found that using text messages was a good way of keeping in touch with young mothers, because they were more willing to text than to phone and ask for something, and also as a reminder of appointments, because young mothers could access text messages without cost, whereas a voicemail message would cost to access. Ease of contact and knowing whom to contact were important factors.

Reassuring, non-judgemental approach

Family Nurses were viewed as being relaxed in their approach which meant that clients felt comfortable and at ease with them. They were also thought to provide a non-judgemental and non-directive service, looking at various options, reassuring the action of clients and supporting their decisions. Some participants described how their confidence had been elevated by the support and encouragement their Family Nurse offered.

4.3 Strengths-based approaches

Of particular importance for this study is the concept of ‘strengths-based approaches’.¹ These are mentioned in past research as contributing towards positive outcomes for families (MacLeod and Nelson, 2000; Marsh, 2003) and play an important role in many programme models, including FNP (Rowe, 2009; Zeanah et al., 2006). All the Family Nurses discussed the strengths-based focus of the FNP programme and the importance of this empowering approach in developing a young parent’s self-esteem and resources.

Improved knowledge and support

The client group appreciated the education and practical support their Family Nurse was able to provide in relation to pregnancy, child birth and childcare. As first time mothers, many had initially been anxious about their lack of knowledge and experience, in some cases because of their age. Family Nurses were thought to provide valuable and reassuring help and information that the clients would otherwise have been unable to access. The progressive and informal methods of teaching were also enjoyed.

The additional information that Family Nurses were able to offer young parents about benefits, housing, education, employment and other available services was also highly valued and many clients appreciated and directly benefitted - financially and otherwise - from the more holistic approach the service took.

¹ Positively promoting parenting skills by focusing on what parents are doing right, rather than focusing on what parents are doing wrong, as in a deficits-based model (Davis, 2009; Einzig, 1999; Walsh, 2006).

Encouraging and fostering autonomy

This was highlighted as a crucial issue, and linked closely to relationship-building between service and client. Self-esteem was again seen as one of the core factors, and techniques for working directly on this area were seen by the coordinators as something that the FNP has, but is unable to share because of the copyright restrictions. There seems to be an important opportunity here, to consider what techniques for enhancing self-esteem, with the same efficacy as those used within the FNP programme, could be made widely available and shared among other professionals and services working with new mothers.

The interviews with associated service staff working outside the FNP programme add further weight to the importance of the strengths-based approach for engaging young mothers. While many of the associated service staff indicated that they used similar practices to the FNP nurses – including endeavouring to build positive relationships with service users, promoting acceptance and empowerment – they did not employ specific strengths-based models. The consequential outcome is evident in their descriptions of young mothers, which seem tainted with negativity and appear to indirectly suggest the use of deficit-based approaches.

This is particularly noteworthy when combined with the testimony of the young mothers that they feel restrained from engaging with other services as a result of perceived negative attitudes of service staff; a finding which is confirmed in other research (Barlow et al. 2005; Broadhurst, 2003; Prinz, 2009).

4.4 Integration into the community and multi-agency support

Previous research has highlighted the significant value of programmes operating with multi-agency support and community integration to achieve the best outcomes for families (Davis, 2009; McKay et al., 2006). This has been shown to be particularly important for the FNP programme (Barnes et al., 2008; Rowe, 2009).

Accessing services

Few clients were accessing other services on a regular basis. For some young women this was felt to be a result of their own personal characteristics, while others suggested that they lacked the confidence to access other services. Though rarely mentioned explicitly, given the reasons that participants preferred the Family Nurse Partnership, it is likely that many may also have been fearful of being judged by other practitioners or service users or may have thought other services too directive in their approach. Two participants indicated that they felt uncomfortable attending groups with older mothers and expressed a preference for services that catered for their age group specifically.

Family Nurses are actively encouraging participants into mainstream services by advising them about local initiatives and attempting to facilitate their autonomy by attending with them. Many participants were unaware of the activities and support available in their local areas and few clients had begun utilising services like Children's Centres on a regular basis, though some indicated that they would like to in the future. Several participants pointed out that the Family Nurse Partnership made accessing services much easier by visiting them at home.

Low self-esteem and negative attitudes to accessing services were seen as inhibiting factors. Outreach was seen as a particularly effective way of overcoming such barriers; simply expecting new mothers to come to Children's Centres or to contact services was seen as unrealistic. This suggests that an explicit approach to changing attitudes to service take-up and addressing self-esteem issues are crucial elements.

The outward-facing images of services need to be attractive to new mothers and seen as personally relevant to them. The triggers that lead to young mothers feeling stigmatised if they access services need to be identified and countered with positive messages.

Another of the factors dissuading young mothers from accessing services (such as those provided by their local Sure Start Centre) was a fear of being judged by others, whether service providers or other, older mothers that they might meet there. One effective way around this, found in some Centres, was to provide a group specifically targeted at these young mothers, and in others where activities provided (e.g. cooking lessons) encouraged young fathers to attend as well.

Another helpful approach was outreach by the Children's Centres, making home visits with the FN or Connexions adviser first, to build up trust and familiarity, and then by meeting the young mothers to accompany them to the Children's Centres for the first few visits. Some young mothers also faced practical barriers, such as ease of access to services, lack of transport or lack of money for transport, so support in overcoming some of these practical obstacles was also an issue. In the light of the refocusing of Sure Start on those most in need, the development of outreach would seem to be a high priority focus. This must be considered though in relation to the provision of existing universal services such as health visiting.

A further important finding of this study was that the young mothers interviewed reported generally positive attitudes towards receiving assistance from services. This contrasts with other research which has suggested that young mothers are often apathetic or even hostile to the idea of accessing support (Barlow et al., 2005; Broadhurst, 2003; Dale, 2004; Pearson and Thurston, 2006).

Social support

There was widespread agreement among all of the groups interviewed that social support is very important for helping young mothers. This concurs with several previous studies which suggest that social networks are vital to mothers' and children's positive outcomes (Pevalin et al., 2003; Zubrick et al., 2005).

In this study, the FNP stakeholders believed that social support is one important way in which FNP could more fully assist families. In particular, some Children's Centre coordinators and associated service staff questioned why nurses did not attend Children's Centres with mothers. Yet it is important to note that the Family Nurses and some of their clients did describe occasions when the nurses had accompanied the young mothers to Children's Centres. Several previous evaluations suggest that when practitioners physically go with mothers to group meetings, mothers are more likely to attend and participate over time (Moran et al., 2004; Pearson and Thurston, 2006; Repucci et al., 1997).

4.5 Multi-agency working

Communication and discussion

It was stressed how service providers value highly both formal and informal opportunities to share information amongst themselves, not just about clients and techniques, but also about how best to join up their services. Frequent contact was universally valued, and co-location of services was clearly a key factor in this.

The concept of ‘support packages’, tailored to the needs of individual clients, seemed to underlie much of the talk about service integration. Such an approach would seem to mesh well with a focus on an holistic needs identification and analysis element in working with clients.

Good communication and information sharing between the different services was seen as conducive to good practice. Different methods of working or recording information were possible barriers to this, but a way of counteracting difficulties was if the individuals concerned were able to form an ongoing working relationship; having a ‘face’ to connect to was seen as a vital aspect of successful multi agency working and having a knowledge of the role of other professionals and services. One respondent suggested that a multi disciplinary team dedicated specifically to young mothers would be an effective way of overcoming current barriers to effective communication.

The findings of this study suggest that multi-agency support and community integration may not be occurring as fully for the Milton Keynes FNP programme as could be desired. One factor that could be inhibiting this support is suggested by two sets of responses: those from the associated service staff and Children’s Centres coordinators. Both groups reported that they perceived the materials developed and used by FNP as being highly efficacious, but that access to these was barred. The evaluators suggest that this was a further frustration to the groups because when they asked the nurses for further details about using FNP activities in their everyday practices, no additional information was forthcoming. It is recognised that there are clear copyright and contractual reasons for this, but this fact did not always seem to be understood by the respondents outside the FNP team.

This finding is crucial because the lack of access to FNP ‘techniques’ seems to be putting distance between associated service staff, Children’s Centres coordinators, and the nurses. This study indicates that any misunderstandings that exist between FNP, the Children’s Centres, associated service staff, and other stakeholders must be addressed for effective multi-agency working and community integration to achieve the best outcomes for families. The Family Nurse team had worked hard to inform other local services about their role with young mothers and more generally about the FNP programme. In addition, it must be acknowledged that because all the Family Nurses work across the whole of Milton Keynes and do not cover a defined geographical patch it is difficult for such a small team to build strong links with every local Children’s Centre. The need to continually attend meetings and talk with other services was an important theme running across the Family Nurse team interviews. Yet responsibility for raising awareness about the FNP programme lies not only with the Family Nurse team but also with the wider organisational structure of the PCT.

5. Conclusions and recommendations

5.1 Conclusions

This study indicates widely-held views of a well-delivered, well-received and highly regarded Family Nurse Partnership pilot programme, seen by respondents as successfully meeting many of the needs of the teenage mothers in Milton Keynes enrolled in the scheme.

The Family Nurses were all found to be highly committed to their work, very positive about the programme and the effectiveness of their practice, and appreciative of the value of the supervision and support provision.

The clients all spoke positively about the great value to them of the sustained, supportive and meaningful relationships that had been built between them and their Family Nurses. Client concerns about stigmatization, and perceptions that services are 'not for them', have clearly been successfully overcome by the FNP team, and to some extent in relation to accessing other services.

The programme techniques, insofar as they are known about by practitioners in other services, were seen as potentially of value in enhancing provision by universal services, in particular those provided by health visitors in association with Sure Start Children's Centres.

The Children's Centres in Milton Keynes are clearly the major 'hubs' for inter-professional working and the diversity of contacts with other services, both statutory and third-sector, was found to be extremely wide-ranging and important for joined-up casework.

The extent of linkage and collaborative working between the FNP programme and the Children's Centres was found to vary significantly by locality. Where the services were co-located, interactions were frequent and seen as of mutual benefit. Where this was not the case, there appeared to be much less joint working, and the Centres concerned felt this to be an area for positive future development.

In general, the high levels of inter-professional collaboration that have been built up in recent years by the Children's Centres are an established mode of working with which the FNP is seen as potentially and beneficially becoming more closely integrated.

5.2 Recommendations

That:

- a) Priority is given to assuring the continuation of specialised services to teenage mothers of the type that the FNP provides;
- b) Means are explored for enhancing communication and collaborative working among the FNP programme and other specialised support for mothers via the networks established around Sure Start Children's Centres;
- c) Attention is given to the best methods for identifying risk and priority needs for enrolment in the FNP programme and other specialised support services, and ensuring that less-young high-need mothers also have appropriate ongoing care available through tailored support;
- d) Means are explored for making more widely understood and available for other practitioners, especially health visitors and family support workers, the range of techniques, such as those used within the FNP programme, that are available for supporting high-need parents.

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