

# **The “Family - Nurse Partnership”: developing an instrument for identification, assessment and recruitment of clients.**

*David Hall & Susan Hall*

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developing an instrument for identification,  
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October 2007.

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***Terminology:***

***Abbreviations:*** HLPP = health-led parenting programme. FNP = Family-Nurse Partnership. FNP-HV = the FNP home visitor. FNP-S = the FNP supervisor. FNP-team = the FNP home visitor *or* supervisor. RHV = routine health visitor (a “health visitor” is assumed to be a nurse working in the typical UK model of health visiting). MW – midwife. CHR = client- held record. AN = antenatal. PN = postnatal. NEET = Not in Education, Employment or Training. DO = (Professor) David Olds, who developed the Nurse-Family Partnership programme in the USA. NFP = Nurse-Family Partnership. NSF = National Service Framework for Children, Young People and Maternity Services.

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## Disclaimer

The views and opinions expressed in this report are those of the authors and do not necessarily represent the views and policies of any Government Department.

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Text quoted in paragraph 20 onwards: [22]	“ <i>Consequences of Teenage Parenthood</i> ” by Berrington A., & Ingham R. Commissioned by Teenage Pregnancy Unit; published by University of Southampton and available at <a href="http://www.socstats.soton.ac.uk/cshr">http://www.socstats.soton.ac.uk/cshr</a>
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Figure 5: [29]	From Jefferis B, Power C, Hertzman C. <i>British Medical Journal</i> – BMJ Publishing Group Ltd.
Figures 11 and 11A: [37]	Professor Richard Webber
Figure 12: [44]	Wassermann et al: Available on the WorldWide Web at <a href="http://www.ojjdp.ncjrs.org">www.ojjdp.ncjrs.org</a>
Figure 13: [45]	Dr Candice Odgers
Figure 14: [47]	From Findings “ <i>Fathers' involvement with their secondary-school-aged children</i> ” 2004: Joseph Rowntree Foundation. Available on the Worldwide Web at <a href="http://www.jrf.org.uk">www.jrf.org.uk</a>
Table 1: [79]	This version was published in the <i>Journal of the American Medical Association</i> , but was based on other sources including original questions published in the same journal and in the <i>Journal of Family Practice</i> .
Table 2: [83]	<i>Pediatrics</i> – American Academy of Pediatrics.
Box 7: [90]	From “ <i>Early Prediction and Prevention of Child Abuse: a Handbook</i> ”: John Wiley and Sons.
Table 3: [92]	Fischer et al in <i>Journal of Family Practice</i> , Dowden Health Media.
Table 4: [95]	This version of the questions in “5P” and “TWEAK” is available at <a href="http://www.rcp.gov.bc.ca">www.rcp.gov.bc.ca</a> and was derived from material published by Boston, MA, Institute of Health and Recovery and in <i>Alcohol health and research world</i> .
Table 5: [101]	West R. in <i>British Medical Journal</i> – BMJ Publishing Group Ltd. – derived from article in <i>British Journal of Addiction</i> .
Figure 25:	Bowns et al – SchARR, University of Sheffield.
Box 10:	Health Visiting Team, Huddersfield.
Appendix 2:	A draft copy of the National Maternity Dataset was supplied by Judith Myhill, National Datasets Service

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## **Additional appendices**

In our original report, prepared during the development of the project plan, we included in the appendix a number of questionnaires that we thought might be useful. These are listed below. However, we could not guarantee that they were the most suitable or the best available, as in many cases the original publications were in obscure journals or books and we were unable to review them all. Very few had been validated on a population of pregnant women in England. The readability scores were hardly ever included with the questionnaires but we thought that many of them assume a reading age of perhaps 14 or even 16 and would not be readily accessible to many individuals, and this would particularly be the case with those likely to be recruited to the FNP.

On reviewing these again in the light of the experience gained to date, we doubted that these instruments would prove to be useful and accordingly have decided not to include them in the definitive version of this report.

**Copyright issues** An additional issue is that of copyright. In our original report, we requested that these questionnaires should not be circulated outside the project team and staff. Subsequently, we have sought the necessary permissions but in some cases the copyright issues were uncertain. Of those publishers we have been able to contact, all have granted permission for publication in report form but one, Cambridge University Press, wished to make a charge (Appendix 14). If and when there is evidence and consensus that staff wish to make use of any of these instruments in the FNP, we will need to seek the appropriate permissions.

### **List of instruments included in the original report:**

- Appendix 3. Income and benefits
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# **Assessment and engagement in the Health-Led Parenting Programme: EXECUTIVE SUMMARY**

## **Aims and scope of this report.**

1. This work was commissioned in support of a proposal to pilot in the UK a model of intensive home visiting, involving a programme targeted to selected women and their partners having their first baby, beginning with recruitment at the booking clinic and continuing during pregnancy and up to the 2<sup>nd</sup> birthday. The programme aims to reduce adverse outcomes and social exclusion for the children of these families.
2. The UK programme has been designated the Health-Led Parenting Programme (HLPP).
3. The HLPP is based on the “Nurse-Family Partnership” (NFP) Programme of intensive home visiting by nurses, developed by Professor David Olds in the USA. This involves identification of young women pregnant with their first child, living in poverty, with few or no qualifications. The NFP has been shown to be effective in three separate randomised controlled trials (RCTs).
4. We were asked to advise on assessment of women pregnant with their first child, to identify those whose child may be at increased risk of long term adverse outcomes.
5. However good the assessment process might be, the success of the HLPP will depend on recruiting women to participate and we therefore included in our brief a review of recruitment, engagement and retention.
6. The end product of the work was to be an “Instrument” that could be used to identify women eligible for the HLPP – we interpreted this term to mean the whole process of identification, recruitment and engagement.

## **Approach and methods**

7. We first reviewed the literature to identify risk and protective factors that predict an increased risk of adverse outcomes for the child, with particular reference to those accessible during pregnancy with the first child. We also examined the literature relevant to recruitment and engagement. We then considered the demographic issues to determine the likely numbers of women who might be recruited using a range of different assumptions.
8. We consulted a number of colleagues in various disciplines and visited several sites for observation and discussion.
9. Using this material we constructed a list of risk factors with observations on their practicality and value, and devised a series of flow charts to illustrate various alternative “client journeys”.

## **Results of the literature review**

10. The adverse outcomes for the child include: few or no qualifications; poor employment opportunities; mental health problems and an increased risk of offending behaviour.

11. Prediction is limited by the intention to start the programme during pregnancy with the first child; this means that parent(s)' "track record" of child rearing, and the temperamental characteristics, cognitive ability and sometimes the gender of the child are unknown, yet these are often as powerful, or more powerful, predictors of outcome than factors identifiable during a first pregnancy.

12. Predictors useful in pregnancy include: young parenthood; educational problems - learning difficulties, dropping out of school, excluded from school, few or no educational qualifications; not being in education, employment or training ("NEET"); poverty; unsatisfactory accommodation (poor quality, frequent moves, homelessness); mental health problems; unstable partner relationship; intimate partner abuse; personal or partner history of antisocial or offending behaviour; low "social capital"<sup>i</sup>; ambivalence about the pregnancy or the prospect of parenthood; stress in pregnancy; low self-esteem and low resilience.

13. Mother's own family background factors: history of abuse; herself being the child of a young mother; poor relationship with her own mother; negative attitude of her parents to education; criminality, mental illness and alcoholism in the family.

14. Cultural, ethnic and language issues are also important in predicting educational outcomes; they are complex and generalisations are hazardous but in many areas of the UK there will be many families whose first language is not English and this will have implications for the HLPP. (We noted however that the NFP has as yet not been shown to be effective when delivered through an interpreter).

15. Specific issues applying to smaller numbers of women include: being Looked After; substance or alcohol abuse; traveller, asylum seeker or refugee status.

16. Smoking has multiple adverse effects on the fetus and the child. (Reducing the number of cigarettes smoked is of limited value – smoking *cessation* is vital to reduce risks for the pregnancy and the child).

17. Young parenthood is a major risk factor and is by far the easiest to quantify, but the risk is probably linked mainly to the socio-economic and educational circumstances associated with young motherhood rather than age per se. It follows that although age will inevitably be an important criterion for eligibility, the associated factors should be regarded as eligibility criteria as well and identified wherever possible.

18. Qualitative data obtained by interviewing young mothers, including those who have been Looked After, warn against acceptance of common stereotypes of young mothers. These young women resent the patronising and sometimes judgmental and hostile attitudes that they say are often encountered when using services.

19. Neighbourhoods affect outcomes for children. Postcode mapping will be useful in evaluation and research and perhaps in resource allocation, but it is not accurate enough to be helpful with individual clients, so details of their socio-economic circumstances need to be requested.

20. It is easy to list risk factors and the probability of adverse outcomes rises with the number of risk factors, but it is difficult to place these risks in rank order and an

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<sup>i</sup> Defined in various ways but includes poor neighbourhood, social isolation, lack of trust and few social networks.

arbitrary allocation of the service on the basis of the number of risk factors cannot be justified by available objective evidence.

21. Demographic data show that the mean age of having a first child in the UK is now 27. Women who have their first child in their teens are therefore now very atypical. Because relatively few of these young mothers have a useful number of GCSEs and even fewer will have any post-secondary qualifications, they start life with a disadvantage in the modern economy. Across England, around 7% of women have a child in their teens though the figure varies widely between districts. Of these, the largest proportion are aged 18 or 19. Most of the babies born to women under 20 are first babies.

22. Because of the variability in demographic data between districts, eligibility criteria that work well in one area may result in over or under recruitment in others.

23. On the basis of the literature review we constructed a list of the key factors that would determine eligibility for the HLPP; however, the way in which this is used will depend on the recruitment method and client journey chosen in each area.

### **Recruitment**

24. The need to recruit clients quickly to build up a caseload during the pilot phase means that the criteria used to determine eligibility will probably need to be more inclusive than would be expected in a national roll-out.

25. UK experience of two early intervention projects similar to the HLPP suggests that the greatest weakness is at the recruitment stage, rather than attrition once women have been recruited. It follows that getting recruitment right is a priority issue.

26. The experience of Sure Start, Head Start (USA) and similar programmes is that the most needy parents are the least likely to participate – the “inverse care law”. The most needy are often also the youngest. The literature on recruitment and non-engagement reveals a wide variety of reasons why women may be reluctant to participate in such programmes.

27. Midwives will be the main agents for recruitment. In order to generate the numbers of eligible clients needed to make the programme viable, a large number of midwives will be involved, with varying availability of expertise and time. The recruitment stage therefore needs to involve as simple a process as possible.

28. Several models of recruitment are considered. They differ in two main ways – the extent to which a detailed and time consuming identification process is applied by midwives in the booking clinic and the role played by the regular health visiting (HV) service in identifying potential recruits for the HLPP programme.

29. We are aware that midwifery services vary widely and it will be important to keep the recruitment process as simple as possible, since it is unlikely that the HLPP would have another opportunity to recruit any client who refuses the offer of referral at the booking clinic. The simplest model is one in which the midwife refers every potentially eligible client to the HLPP as a matter of routine.

30. However, we consider other more complex models whose feasibility and benefits may only become clear as experience is gathered.

31. In one such model, the midwives would apply an age criterion plus a checklist of high risk factors and refer all women thus identified to the HLPP nurse or supervisor, but refer all other women with their first baby to the regular health visiting

service so that contact could be made and a Needs Assessment undertaken in pregnancy. By this means, clients would have a “second chance” to discuss problems that they were reluctant to raise in a busy booking clinic could be identified and a referral to the HLPP could be made.

32. A good case can also be made for a model in which the midwife is able to refer potential clients to a colleague for more detailed assessment and possible recruitment on the same day and in the same premises as the Booking Clinic; however, this may not be a practical proposition in many places.

33. Needs Assessment during pregnancy is not routine in all districts but has been successfully introduced in some (though usually later in pregnancy than is ideal for the HLPP) and greatly reduces the time taken for Needs Assessment after the baby is born. However, local constraints may make this difficult to deliver and alternative client pathways have also been mapped.

34. We were reluctant to specify just one model of recruitment, because there are likely to be major differences between pilot phase districts in existing staffing levels, structures and policies.

35. Nevertheless, all pilot districts should subscribe to and apply the Principles outlined in the report, particularly with regard to staff selection and to the recruitment of potential clients.

### **Progressive universalism and the role of the community child health service**

36. Community-based child health services (CCHS) vary widely across the UK. Professional leadership, the commitment of the relevant Trusts and the quality of inter-agency working explain much of the variability. In addition to health visiting and school health, most CCHS include care and assessment of children with disabilities, child protection and child and adolescent mental health (CAMHS).

37. Health visiting in the UK is a universal service and should remain as such but each family has its own needs, some much greater than others. The term “progressive universalism” is used to describe the policy that the HV service should be available to all but tailored to needs.

38. In order to maintain this policy, it is important that the HLPP programme be embedded in a universal service and seen as a positive benefit offered to those who are eligible rather than a stigmatising service.

39. There are ongoing discussions within the project team about a number of wider issues that will impact both on the HLPP and on community child health services as a whole. Local advertising and marketing need to be considered. Possible approaches might include; a leaflet about the service given to all mothers; a higher profile for promoting the child health programme and health visiting in general; attitudes among all midwifery and health visiting staff that make parents of whatever age and social background feel at home; deciding on a name for the programme and the home visitors.

40. It would be stigmatising and therefore disastrous for the programme if it were to be perceived as aimed at potentially “bad” mothers. The presentation of the offer must be in positive terms of the services and support involved in the programme – mothers are likely to value extra support in pregnancy but the outcome likely to be most valued in the longer term by potential beneficiaries of the programme is for their child to be “doing well in school”.

41. There is persuasive evidence that a first contact by the regular health visitor in pregnancy rather than after birth is an important factor in building a useful relationship. This has important implications not only for the HLPP but also for the core programme of community based child health.

#### **Professional skills, information and confidentiality**

42. Interviewing styles and communication skills will be crucial to success both at recruitment and in retaining the commitment of parents to the programme. Some staff will need to change their style of interaction, developing greater expertise in empathic listening and motivational interviewing.

43. A national core or minimum dataset for maternity services is being developed and the team working on this made a draft available. We mapped the data needed for the HLPP to the national dataset and found a very substantial overlap, though ideally a small number of additional items would be added.

44. Buy-in from a variety of professional groups and other stakeholders will be important to secure local and national support for the HLPP and to ensure that the Programme is integrated with existing high quality initiatives (for example, continuing work arising from the Teen Pregnancy programme).

45. Detailed record-keeping by all staff involved in the pilot will be crucial, so that audit can be undertaken. The evaluation of the pilot phase will need to determine how widely the eligibility criteria have been applied, the acceptance and take-up rates, and the extent of engagement and retention in the programme. It will be particularly important to know the characteristics of the women who were not offered the programme or who were offered it but were never successfully engaged. The HLPP supervisor will need to be involved in overseeing these quality issues as well as supervising the work of the HLPP nurses with their individual clients.

46. To achieve these goals, the consent of women to use their data for audit may be needed. As there is continuing uncertainty about data protection and confidentiality, clear guidance will be needed.

The views and opinions expressed in this summary are those of the authors and do not necessarily represent the views and policies of any Government Department.

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# (1) Introduction & background

1. In 2006, the Government's report "Reaching Out – an Action Plan on Social Exclusion"<sup>ii</sup> set out a series of initiatives for tackling social exclusion. Among these were proposals to a) develop and promote better prediction tools to identify those at risk and b) to pilot a specific model of health led parenting support, developed by Professor David Olds in the USA (the Nurse-Family Partnership (NFP)). The Pilot was to run on 10 sites in England from April 2007 to March 2008. The NFP involves intensive home visiting from pregnancy through to two years of age by qualified nurses who are supervised on a regular basis. Each NFP has a caseload of 25 families. Long term benefits are postulated to occur by changing the life course of the children, through improved child rearing, better parenting, fewer abusive and neglectful experiences, more commitment to school and higher educational achievements, and improved life chances for the mother (and the father, when he is involved).

2. The pilot project in England is currently designated the Family – Nurse Partnership (FNP) to distinguish it from the USA programme. It will be delivered by FNP Nurses – abbreviated in this document to FNP or Programme Nurse(s) and supervised by FNP Supervisors – referred to in the report as Supervisors (see paragraph 112.2 for further comment on an appropriate title for the Programme and Staff). A pilot project is necessary as the feasibility and challenges of establishing a national programme in the ENGLAND are not yet clear. One of the most important aspects of the evaluation of the pilot phase will be an audit of the extent to which the FNP has been implemented on the ground, in comparison to the actual specifications of the Project Plan (see also Paragraph 122). This will lay the foundations for a possible randomised controlled trial in the future.

3. The proposal to pilot an FNP in the ENGLAND is in line with the report on child health surveillance and health promotion, "Health for all children"<sup>1</sup> and with the National Service Framework (NSF) for Children, Young People and Maternity Services<sup>2</sup>. These reports recommended a greater emphasis on promoting health and development, by taking a broad view of the family and environmental factors affecting child outcomes and applying available knowledge of what works. The differences between current practice and the Programme are discussed in paragraph 8.

4. **The goal** The goal of the FNP is ultimately to reduce social exclusion, defined by the Prime Minister as follows<sup>3</sup>:

"... social exclusion is a shorthand label for what can happen when individuals or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown"

5. **The aims** – to reduce adverse outcomes and promote positive outcomes. The good outcomes that we want to promote for children include:

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<sup>ii</sup> [http://www.cabinetoffice.gov.uk/social\\_exclusion\\_task\\_force/publications/reaching\\_out/index.asp](http://www.cabinetoffice.gov.uk/social_exclusion_task_force/publications/reaching_out/index.asp)



- Improvements in the health and well-being of the child - e.g optimal uptake of immunisations, improved access to services, appropriate management of childhood illnesses, fewer accidents, reduction in problems related to feeding and sleeping.
- Educational success – improved qualifications and skills, needed for improved earning capacity, reduced unemployment, better housing, easier access to services
- Less crime and fewer convictions
- Better mental health – improved quality of life, more stable and fulfilling relationships, less family breakdown, less intimate partner violence, reduction in smoking, less substance and alcohol abuse, less mental illness
- Better physical health – reduced social gradient of adult ill health
- For parents, the aims include greater self-confidence, improved job and career opportunities, better mental health and optimal pregnancy spacing.

The *adverse outcomes* include educational failure leading to poor employment prospects, low income or dependence on benefits, mental health problems, relationship difficulties and offending or criminal behaviour.

5.1. Sure Start had similar long term goals although its immediate aim was to address these outcomes by “ensuring that children are ready to benefit from their education when they start school”.

5.2. Sure Start has had measurable but generally modest benefits. On average only 30% of eligible families actually used Sure Start services<sup>4</sup>. A significant section of the population who did not use the services not only failed to benefit but actually did worse than a comparison group in a non Sure Start area<sup>5</sup>. A similar observation was made in American Head Start programmes. Conversely, more articulate parents place higher demands on services – they ask more questions and expect comprehensive conversations and answers. The most needy families use services the least – the “inverse care law”. The precise reason is unclear but may be related to feeling intimidated by the presence of more socially competent parents and pressures to “join in” or to resources being shifted to the programme and away from other services.

6. **Non-engagement.** The UK and USA literature describes a number of reasons why women fail to engage with such programmes<sup>6 7 8 9 10 11</sup> – see **Box 1**

7. The implications of the findings summarised in Box 1 for this project are that (a) it cannot be assumed that all women will welcome the kind of service offered by the FNP and (b) the process of recruiting and engaging women is likely to be the most critical step in developing a successful Programme.

8. A combination of centre-based services and outreach or home visiting is most likely to be effective. The skills, personality and enthusiasm of the outreach staff are crucial in engaging hard to reach families. In view of the findings in Sure Start an investment in intensive home visiting may be the best way to engage families with the greatest needs when there is a new baby in the home and to enable such families eventually to make use of Sure Start Children’s Centre facilities<sup>12</sup>.

## Why do professionals have difficulty in reaching some families ?

### Factors in the families

- ✚ High mobility of young families – multiple changes of address.
- ✚ Parents overwhelmed by problems – debt, poverty, bad housing, difficult neighbours.
- ✚ Changes of address concealed to escape debts or a violent partner
- ✚ Parents returning to work, leaving their baby with a minder
- ✚ Lifestyles that don't fit within the hours of the professional working week -
- ✚ Parents working long or unsocial hours - too exhausted to contemplate any additional activities with their children or to meet health professionals unless the child is ill.
- ✚ Transport to children's facilities is expensive for those on low incomes.
- ✚ Low level of trust in, or respect for, the health professionals they know
- ✚ Previous conflicts with health professionals - arguments about smoking or weaning
- ✚ Perception of professionals as intrusive, unsympathetic, authoritarian and out of touch.
- ✚ Feelings of inadequacy about entering the territory of middle class health professionals;
- ✚ Phobia of social encounters at children's clinics or health centres.
- ✚ Fear of exposing poverty, poor quality child care, abuse or domestic violence to "prying eyes" of professionals
- ✚ Embarrassment over poor reading ability
- ✚ Parental mental illness, domestic violence or substance abuse
- ✚ Not seeing any need for professional advice about their children

### Factors in the professionals

- ✚ Social, ethnic, cultural and linguistic barriers (in both families and professionals)
- ✚ Shortages of well-trained staff with relevant skills.
- ✚ Professional ambivalence about how to allocate their time and how many "no-access" visits to make before giving up.
- ✚ Professional fear of being too intrusive or of uncovering problems that have no solution
- ✚ Inaccurate record systems – data entry errors, parents changing their or their baby's name,

### Box 1

## 9. Differences between the NFP and UK health visiting.

9.1. The NFP has many similarities to midwifery and health visiting services in the UK, but there are also a number of important differences<sup>13 14 15 16</sup> – these are summarised in Box 2.

9.2. The NFP has a robust evidence base<sup>17</sup>. The NFP has clearly specified, ambitious and wide-ranging aims. These are defined as follows - *“to improve the health and development of infants in low income families and the life trajectories of the infants and their mothers”*.

9.3. UK health visiting staff define their role as “search for and awareness of health needs” and has always had an ethos of health promotion; but resource constraints in recent years have forced many staff to focus more on assessment of and intervention for problems, deficits and needs that are identified jointly by the client and the midwife or health visitor. Public concern about child abuse has forced staff to concentrate on identifying children at risk, to the detriment of programmes with a more strongly preventive and health promoting focus.

9.4. Successive reviews of child health services<sup>18</sup> in England have, however, emphasised the potential benefits of a more targeted service and of applying what is known about supporting parents and children in the early years, so that children and parents benefit not only because the risk of abuse is reduced but also because of an increased understanding of child development and parental mental health. These reviews, although controversial at times, have been well received and widely adopted in the England and have been influential in other countries, for example in Australia.

9.5. A project that seeks to apply the lessons and concepts of the NFP in England is, therefore, very timely. It builds on the strengths of England’s universal services and is entirely in line with current opinion and research in England, while challenging us to raise the standards, clarify the objectives and focus the use of resources more precisely in our children’s community service. Parents who participate will receive what is in effect a distillate of the very best that English community nursing teams have offered and continue to offer, but with the added benefits that their visitor has a smaller caseload and more effective professional supervision. It is important to note that the Programme Nurses in this project will not have any other regular caseload and will be funded as additional posts; parents who are not eligible to receive the programme will still receive the service that would be standard for them in that district.

<b>The Nurse-Family Partnership (NFP)</b>	<b>Services in the UK</b>
The NFP is not universal - there is a focus on actively recruiting young mothers who are poor, have few or no qualifications and live in deprived areas.	The service provided in the UK is universal – it is offered to all families with children under five. However, most health visitors target their services and their time, using a variety of “risk factor” checklists (see for example HFAC-4r)*.
It is offered only to first time mothers on the grounds that they are likely to gain the most benefit from the intervention.	A universal service, though staff do devote more time to first time mothers
Visiting begins in pregnancy.	Increasingly, Health Visitors do establish contact with mothers in pregnancy rather than waiting till the baby is born though this is not universal practice. However, visiting usually begins somewhat later in pregnancy than in the NFP.
Visiting is intensive throughout pregnancy and until the child is two years old	The NFP is more intensive (i.e. more frequent visiting) than the great majority of UK midwifery contacts or health visiting, though in some districts HVs devote at least 10 times the number of visits to the most needy clients as to those needing only a routine service.
The programme is based on an explicit philosophy and an evidence base that is regularly updated.	The evidence base for what is delivered in the UK is increasingly robust and is summarised in HFAC-4r and in the NSF†.
The programme is structured; its delivery is guided by a manual and includes a number of standardised materials.	The NFP is more clearly structured than most UK services, though some UK programmes provide a formal structure and materials, e.g., the Walter Barker programme.
The parent (usually the mother) is expected to be an active participant.	This is implicit in the best UK health visiting work, for example the approach taught by Professor Hilton Davis, but is explicit in the NFP.
The HVNs are supervised regularly (“supervision” is used in the sense understood by social workers and psychotherapists).	Managerial support is stressed for UK staff but supervision in the sense used in the NFP is less common except in cases where child protection is an issue.
An ethos of enthusiasm and commitment is emphasised as much as professional skills and qualifications.	This is emphasised in the NFP – however, well managed teams in the UK show a similar high degree of commitment.
The NFP has been subjected to three RCTs and the benefits can be quantified socially and financially.	There is no RCT of UK midwifery or health visiting as a single package with long term benefits for the child as the primary outcome measure. However, several trials examine specific aims and objectives of the programme – for example, injury prevention and depression.

\* HFAC-4r = “*Health for all children*” (Eds. Hall D, Elliman D): 4<sup>th</sup> edition revised. Oxford: OUP, 2006.

† NSF = National Service Framework for Children, Young People and Maternity Services. London: DfES and DH, 2004.

## (2) Defining the task

10. We were commissioned to devise a method of assessment and engagement for mothers, and their partners, as the first step in recruiting a cohort of parents to be offered an intensive home visiting programme (modelled on NFP), with the aim of identifying those most at risk of not having good outcomes for their children.

11. **Assessment** in this context could have three meanings, each with different implications for the type and complexity of the methods required:

11.1. Initial assessment of all mothers to determine which of them should be offered the FNP intervention.

11.2. Assessment during or immediately after the recruitment phase to identify their particular needs, problems and strengths, and their *perceptions* of their needs, in order to plan and inform the precise nature of the intervention offered.

11.3. Assessment to establish a detailed baseline for monitoring change, both at the individual level and as part of monitoring, evaluation and research.

12. The three are not mutually exclusive but we have focussed on the first two of these; assessment processes needed primarily or exclusively for research are outside the scope of this report. Any such assessment would need to form part of a submission to an Ethics Committee prior to its use, whereas assessment methods that (a) are already in use or have been shown to be valid and reliable and (b) contribute significantly and importantly to clinical and social care, can be regarded as routine practice.

13. **Our tasks** We defined our tasks as follows:

13.1. To consider how to *identify* those who (a) need the FNP the most AND / OR (b) would benefit the most – remembering that the most needy may have the greatest difficulty in engaging with, and benefiting from, the programme.

13.2. Having identified them, how to *engage* them into the programme and *maintain* their commitment.

13.3. To consider also how to identify those with little or no need for the programme.

13.4. To bring the findings together into an instrument / process / system that can be used by practitioners. For shorthand, we will use the term “**instrument**” to encompass all the various possible methods, steps and procedures that will be considered and, ultimately, suggested for pilot trials.

13.5. To present the finished product in such a way that it will be acceptable to managers, practitioners and the potential beneficiaries of the programme and as far as possible will be academically robust.

13.6. To relate any proposals for record keeping and data collection to existing and projected datasets and databases.

13.7. To ensure as far as possible that the project does not have unintended consequences and negative effects on families *not* offered this intensive programme (*cf* paragraph 5.2).

14. We recognised that a central theme of the task would be to apply a procedure that would have to be as simple as possible in order to separate those likely to benefit from those with little need for intensive support. A selection process of this kind has many parallels with **screening**.

15. **Screening** in this context involves using a simple procedure to divide up the population into (a) those women at high risk of having a child who may suffer “social exclusion” and who will therefore “qualify” for the intensive programme and (b) those at low risk, who do not need an intensive programme. This can be analysed in the same way as any other screening programme.

15.1. In other words, we can describe the task as a search for a method that will have a high proportion of “hits” – correct identification of the high-risk and low-risk populations – and a low proportion of “misses” – unnecessarily offering the programme to those who do not need it and not offering it to those who do. See Box 3. The economic implications are summarised in paragraph 15:8 and Box 3A

15.2. Screening programmes are most successful when the target is a specific biological disorder – a condition that a person either has or does not have. Conditions with a continuous distribution, like blood pressure, are more difficult<sup>19</sup> because one has to identify a cut-off, based on the best available information about the prognosis and the impact of treatment for different points on the distribution. In the present case, the task is much more difficult – the aim is to identify strengths and to balance these with needs and risk factors relevant to the prevention of a range of adverse social and educational outcomes many years in the future.

15.3. Screening is not meant to be diagnostic. An individual identified by a screening process is normally referred onwards for further evaluation. This may take several forms – in the present case, this is most likely to involve some form of psychosocial assessment. However, whatever approach is adopted, experience in other disciplines suggests that it is unlikely that very precise prediction of people at risk of adverse outcomes will be possible. It will therefore be necessary either to offer the FNP to many more parents than actually need it (in order to score as many “hits” as possible), or to offer it only to those deemed by our instrument to be at extremely high risk (in order to “waste” resources on as few “misses” as possible).

15.4. In reality, there will be many parents whose offspring are at increased risk of adverse outcomes compared to population norms, but who have a reasonable likelihood of spontaneous resolution or of responding to lesser interventions. They may have significant needs, of varying type and magnitude, but not need or benefit from the intensive intervention offered in the FNP; nevertheless, they may need (and currently receive) a service appropriate to their particular needs. We use the phrase “progressive universalism” to embrace the idea that a service can be universal but does not have to provide the same for everyone. See paragraph 93.2 for more details.

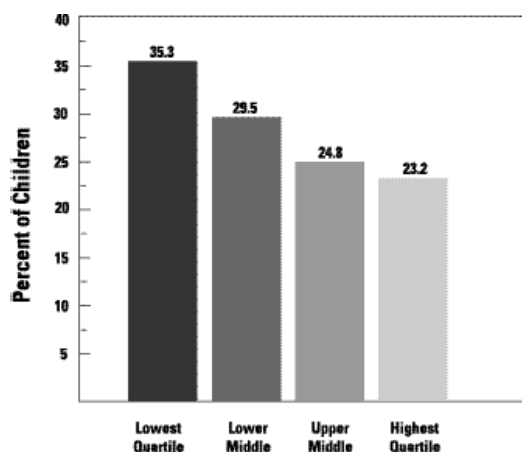
15.5. The issues are well illustrated by the findings of the Canadian Longitudinal Study<sup>20</sup> (see also paragraph 36.4). The authors stated:

“ .... a higher proportion of children in low-income families do not do well academically and socially, compared to children in families with higher incomes. But more children do well, despite unfavourable family economic circumstances, than those who do not. As you go up the scale of family income (or socio-economic circumstances) an increasing percentage of children show better development. However, there is still a number who do not do well, all the way up the scale. This relationship between early child development outcomes and socio-economic circumstances is usually referred to as a gradient (Figure 1). ..... the two tests (vocabulary and math) are a gradient when assessed against the socio-economic circumstances of the child's family. The proportion of children not doing well is higher near the bottom of the scale than it is at the top. But in all socio-economic groups there are some children who do not do well, and this is proportional to where families are on the socio-economic scale. For example, if 30% of the children in the bottom 20% do not do well, the figure is 25% for the next 20% and so on up the scale.

We found a gradient in behaviour similar to that for vocabulary tests for children at age four and five. These two measures of behaviour and vocabulary are estimates of brain development in the early years and are part of what is called a "readiness to learn" measure. These measures are predictive (in aggregate for populations) of subsequent learning success in school, mathematical performance, and rates of juvenile delinquency.

There are three implications:

1. There is no economic cut-off point above which all children do well.
2. Because of the size of the middle class, the number of children not doing as well as they might, is greater in the middle socio-economic group than in the bottom 20% of the scale.
3. Programs for quality early child development and parenting must apply to all sectors of society ... to decrease the steepness of the socio-economic gradient”.



The horizontal axis divides families into four groups or quartiles by income. The vertical axis represents the percentage of children age 0 to 11, who are identified as being in difficulty because of low achievement and/or behaviour problems. (from “*Reversing the Real Brain Drain*”<sup>20</sup>)  
**Figure 1**

### Box 3 - relationship between the precision of an Instrument and the Outcome

Instrument to identify eligibility	Adverse outcome likely if no intervention	Good outcome likely without intervention	Total
Positive = recruit	Hit (H)	Miss (M)	H + M
Negative = do not recruit	Miss (m)	Hit (h)	m + h
<b>TOTALS</b>	All adverse outcomes	All good outcomes	H+M+h+m

The **sensitivity** (H/H+m) is the ability to correctly identify women whose children will have adverse outcomes. The **specificity** (h/h+M) is the ability to correctly identify those with good outcomes.

**Scenario 1.** Assume that **10%** of 1000 children would have adverse outcomes without intervention and the sensitivity and specificity are each 80%. So 8 out of every ten children likely to have adverse outcomes are correctly identified but for every child correctly identified, **2** are wrongly labelled as being at high risk.

ELIGIBILITY INSTRUMENT	ADVERSE OUTCOME	GOOD OUTCOME	TOTAL
Positive	Hits - 80	Misses - 180	260
Negative	Misses - 20	Hits - 720	740
<b>TOTALS</b>	All adverse outcomes = 100	All good outcomes = 900	1000

**Scenario 2.** Assume that **5%** of 1000 children would have adverse outcomes without intervention and the sensitivity and specificity are each 80%. So 5 out of every ten children likely to have adverse outcomes are correctly identified but for every child correctly identified, **5** are wrongly labelled as being at high risk.

ELIGIBILITY INSTRUMENT	ADVERSE OUTCOME	GOOD OUTCOME	TOTAL
Positive	Hits - 40	Misses - 190	230
Negative	Misses - 10	Hits - 760	770
<b>TOTALS</b>	All adverse outcomes = 50	All good outcomes = 950	1000

**Interpretation:** as the proportion of clients with potentially bad outcomes goes down, the programme performs less well, even though the instrument has not changed. If 10% of clients would have bad outcomes, the Programme might “treat” only one client unnecessarily for every two who would benefit; but if only 5% of clients would have bad outcomes, the Programme would “treat” 5 clients unnecessarily for every one likely to benefit.

The number of “missed” children with adverse outcomes could be reduced by increasing sensitivity of the Instrument (for example, by widening the eligible age range and adding more risk factors); but at the price of making it less specific (more of the families recruited would have had good outcomes without intervention). **Scenario 3** shows the results when the sensitivity is increased to 90% and the specificity falls to 70%: 6 clients are now “treated” unnecessarily for every one who benefits.

ELIGIBILITY INSTRUMENT	ADVERSE OUTCOME	GOOD OUTCOME	TOTAL
Positive	Hits - 45	Misses - 285	330
Negative	Misses - 5	Hits - 665	670
<b>TOTALS</b>	All adverse outcomes = 50	All good outcomes = 950	1000

**Conclusions** (1) A Programme delivered to a small population with a high prevalence of adverse outcomes will score a better ratio of “hits” to “misses” than one delivered to a larger population with a smaller prevalence of adverse outcomes. (2) The result is that the cost of every “success” goes up as the prevalence of the target problem goes down. (3) There will always be a trade-off between sensitivity and specificity – in other words, if we want to identify a larger proportion of families who will have adverse child outcomes, it will be at the price of “treating” more families who would have good outcomes without any intervention. (4) The number of clients whom it is acceptable to “treat” unnecessarily depends primarily on the cost of the intervention (money, professional resources and clients’ time) and its potential to do harm.



15.6. It follows that the task of constructing an assessment method is not simply a matter of dividing the population into one group who should be offered the FNP and another who get only a basic routine service. This would have negative consequences for many families. Instead, our instrument must be capable of handling diverse needs and varying intensity of needs.

15.7. The FNP, like all intensive interventions, is expensive, and it is therefore important as far as possible to deliver the programme only to those families who have high levels of need and are likely to benefit. However, a caseload consisting entirely of very needy individuals would be extremely demanding on the staff. Furthermore, the programme may still be cost effective when the caseload includes a number of less needy women, as the following calculation shows:

15.8. In the Elmira study (the one for which Olds and the Rand Corporation carried out detailed economic analyses), Olds recruited 400 women but excluded 46 ethnic minority women, leaving 354. The aim was to recruit those who were under 19, unmarried and poor (social class IV or V). In fact, 61% of that 354 were poor. In the analyses these were compared with the remainder. The Rand Corporation analysis<sup>iii</sup> suggested that for those women benefiting from the programme the programme cost was roughly \$6000 per woman and the benefits over time were \$24000. For low-risk women the cost was also \$6000 but the benefits were only \$3000 – i.e., a net loss of \$3000. Of course, the benefit figures were only estimates and they may be optimistic. However, a rough calculation (Box 3A) shows that a programme can still be “profitable” or cost-effective if fewer than one fifth of women are actually high risk. Naturally, if the recruitment process fails to draw in a large proportion of those women who are most at risk and most likely to benefit, its cost effectiveness falls and eventually will reach a point where it is not worthwhile.

Box 3A: Cost and benefit depends on number of high risk women (case load of 25) –  
(in £000s).

Number high risk women	Number low risk	Gain due to high risk women who benefit	Loss due to low risk women who do not benefit	“profit or loss”
1	24	18	-72	-54
2	23	36	-69	-33
3	22	54	-66	-12
4	21	72	-63	9
5	20	90	-60	30
10	15	180	-45	135
15	10	270	-30	240
20	5	360	-15	345
25	0	450	0	450

15.9. In the next section we describe the approach we adopted and then examine the available evidence that could be used to identify parents at risk of adverse outcomes for their child.

<sup>iii</sup> [http://www.rand.org/pubs/monograph\\_reports/MR898/index.html](http://www.rand.org/pubs/monograph_reports/MR898/index.html)

### (3) Approach to the task – methods used

16. We have reviewed the literature but, as the subject matter is vast and covers many different topics and disciplines, it has not been possible in the time available to undertake comprehensive searches and *de novo* reviews. We have therefore relied extensively on existing expert reviews, systematic reviews, Cochrane Reviews and reports, both published and unpublished. We have also consulted a variety of experts, in academic departments and service provider units (health, education, social services, government departments and the voluntary sector), by telephone and e-mail and by personal contacts and have visited relevant establishments including Sure Start units and children's centres.

17. **Categories of evidence** The evidence available to inform the development of an instrument falls into two main categories. Firstly, retrospective cohort studies – these involve studying a cohort of young people, for whom good data are available, some of whom have one or more adverse outcomes as young adults, and asking the question “what distinguished them earlier in life from those with good outcomes?” Large longitudinal cohort studies in which very extensive data were collected over many years are a productive basis for such studies. These studies benefit from having a large number of subjects with and without the outcomes of interest but often suffer from the disadvantage that the initial data were collected without any specific hypothesis and therefore often are deficient both in quality and variety.

17.1. The second type of evidence is a prospective study – this involves identifying a sample of parents and / or infants with particular characteristics and ask the question “to what extent can adverse outcomes be predicted on the basis of those characteristics?” Often such studies are undertaken to test a particular hypothesis or assess the impact of a specific risk factor. They may involve designing an instrument that could identify families whose infant is thought to be at increased risk of adverse outcomes, to track their natural history to validate the identification process and then to test an intervention.

17.2. Cohort studies fall into two groups – those that focus on one particular issue and those that aim to address a wide variety of adverse outcomes.

17.3. A typical example of the first is the series of studies by Browne on predicting the risk of child abuse on the basis of characteristics identified early in the infant's life. Such studies have the advantage that data relevant to the hypothesis being tested are collected at the start but the disadvantage that very large numbers may be needed in order to generate sufficient individuals with the outcomes of interest.

17.4. Other examples include studies on sudden unexpected death in infancy (SUDI) or “cot death” (including sudden infant death syndrome and homicide), domestic violence, maternal depression, attachment, and self-efficacy.

17.5. The second type of study is exemplified by randomised trials of a comprehensive intervention in early childhood; the NFP is a prime example and there are a number of others<sup>21</sup>.

17.6. All studies that require the tracking of individuals over a long time period share the inherent disadvantage of being to some extent already out of date (see paragraph 50).

#### **(4) What predictive factors could be used in pregnancy to identify a high risk of social exclusion for the child?**

18. The literature on risk factors identifiable in pregnancy is somewhat sparse in comparison to that available on risk factors in the child. Not surprisingly, the predictive power of the latter appears to be greater since the child's characteristics and experiences are bound to influence the outcome. In the following section, we highlight IN SMALL CAPITALS the evidence that could be used in the present project, in which a decision about offering the FNP has to be made in pregnancy.

19. Research in a variety of disciplines contributes to our knowledge of what predicts adverse outcomes as defined previously (paragraph 5). Criminology and mental health studies have proved to be particularly powerful, but crime and mental health problems are often linked to educational failure, so research on the social factors that influence child development and learning is also important.

#### ***Young parenthood.***

20. Young parenthood is strongly associated with less good outcomes for children. The finding is robust but the reasons are complex. The most vulnerable young parents are those who have been "LOOKED AFTER" (In Care).

20.1. The significance of young motherhood changes as society changes. "We are witnessing an increased polarization of childbearing behaviour with one part of the population delaying childbearing to later ages and the other part not" <sup>22</sup> ..

20.2. Berrington defined young motherhood as being "below age 20 at first birth, and young fatherhood as being below age 23 at first birth, capturing one in ten men and one in ten women in the [research] sample. The circumstances of very young parents, for example, those under age 18 are likely to be different from slightly older parents.....

20.3. Previous authors have variously defined young fathers as those aged under 19, under 20, under 21, under 22, under 23 and under 24. For teenage mothers who had a jointly registered birth, only one quarter of the fathers were themselves aged under age 20. In almost half the cases the father was aged 20-24 and, for one in six teenage births, the father was aged 25-29. We focus on men aged less than 23 when they became a parent".

20.4. Moffitt <sup>23</sup> notes that:

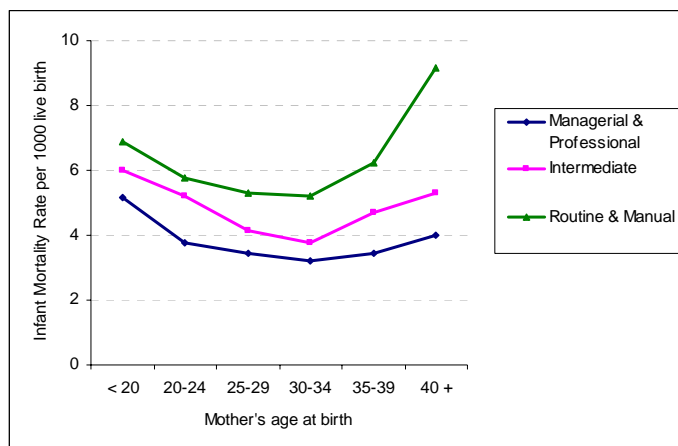
20.5. "Teen childbearers in the National Health and Development Study (NHDS), initiated in 1946, and the National Child Development Study (NCDS), initiated in 1958, made the transition to parenthood in the early to mid-sixties (NHDS) and early to mid-seventies (NCDS). The context of teen childbearing in the UK has changed dramatically since the 1970s and the costs are likely to have worsened for two reasons. First, contemporary teen childbearing is more likely to occur outside of marriage and, consequently, young mothers cannot rely on a partner's income for support. Today, nearly 90% of births to teens occur outside of wedlock compared to

40% twenty years ago. Second, State support has decreased, leaving young, single mothers especially vulnerable to poverty

20.6. Teen childbearing is a far more statistically deviant event today than it was in the 1970s. The risks formerly associated with teen motherhood (age 19 and under) in times past now affect young mothers who are older than 19, but whose childbearing is “offtime-early” (i.e., early when compared with the ages at which the majority of women have their babies) among contemporary cohorts of women who are delaying their first childbirth until their late twenties; the mean age of first birth in Britain is now 27. As a result, a woman who begins childbearing at age 20 or even later is disadvantaged today in comparison to her cohort peers. In the 1960s and 1970s secondary level education was often considered sufficient for many women entering the job market. In contrast, in the 21<sup>st</sup> century post-secondary education is increasingly necessary for entry to the modern labour market, so childbearing before age 21 reduces the likelihood of obtaining employment other than menial unskilled – and low-paid – jobs.

20.7. Moffitt reported that “Young mothers encountered more socio-economic deprivation, have significantly less human and social capital, and experience more mental health problems than mothers who gave birth in their twenties or thereafter. They tend to remain solo-parent families, Their partners were less reliable and supportive, both economically and emotionally, and were more abusive. Their children have more emotional and behavioural problems, higher rates of illnesses, accidents, and injuries, and their cognitive skills lag behind the children of older mothers. The 5-year-old children of young mothers were more likely to be disadvantaged by poor infant health, abusive harm, low IQ and problem behaviours”

21. The infant mortality rate is higher for young mothers and this is true across the social spectrum (Figure 2). The causes are complex but are likely to be significantly influenced by the behavioural traits associated with teenage motherhood as much as or perhaps more than purely biological factors: late booking for antenatal care, high rates of smoking and low breast-feeding rates may contribute.



Infant mortality rates by mother's age and socio-economic group, 2003-05 (Data from ONS 2006).

**Figure 2**

22. The problems associated with young motherhood are more to do with the social and educational background of these young women than their actual age<sup>24</sup>. Young mothers are more likely to have few or no basic educational qualifications (either no GCSEs or fewer than 5 GCSEs at grades A\* - C). An estimated 70% of

teenage mothers are not in education, training or employment (NEET), compared with 10% NEET among all young people aged 16-19; this situation is closely linked to low income, poverty, and poor accommodation, usually rented and therefore impermanent and often in neighbourhoods with low “social capital”. A significant number have had learning difficulties or other special educational needs – but these will be identified by their lack of GCSEs so it is not necessary to include special needs as a separate risk factor.

22.1. The term “NEET” may also be relevant to women aged 20-24; however, it is more difficult to interpret as women in this age group may have completed post-secondary school education and / or held a job, but have decided not to work or study while pregnant. The women most likely to benefit from the FNP are those who are not only NEET but also have no qualifications and no history of sustained employment or marketable work experience.

22.2. Berrington found that: “The majority of the differences in adult health are explained by the fact that teenage motherhood is itself associated with a higher risk of partnership dissolution, living in a non-work family, being dissatisfied with the neighbourhood, being emotionally distant from their mother and not having a confiding relationship”.

22.3. The same study found that “In general the children born to teenage mothers did not differ from the children of older mothers in their language development at 38 months, social development, gross or fine motor skills, or pro-social development at 42 months. They did fare worse in accidents and behaviour problems. This was mediated by the mothers’ mental state - teenage mothers are more likely to suffer from anxiety and depression, linked in turn lack of a co-residential partner and poorer housing quality”.

22.4. Similarly, Lopez Turley reported that: “the lower test scores and increased behaviour problems of the children of young mothers are due not to her age but to her family background”.<sup>25</sup> There were three lines of evidence:

- First, there was no evidence that subsequent children born to mothers starting child bearing in their teenage age years are faring better that the first born children.
- Second, maternal age disappears as a significant predictor of child outcome when social background factors are controlled statistically.
- Third, there was no evidence that maternal age was related to developmental changes as the child became older.

23. Young mothers are also more likely to smoke throughout pregnancy, and are less likely to stop smoking before or during their pregnancy<sup>26</sup> :

<i>Mother's age</i>	<i>% who smoked before or during pregnancy</i>	<i>% who smoked throughout pregnancy</i>	<i>% that gave up before or during pregnancy</i>
20 or under	68	45	34
All ages	32	17	49

24. “A number of factors predicted [in the ALSPAC cohort] who was more likely to become a teenage mother. At age 10 years, these included having a conduct disorder, having poor reading ability, being in a family in receipt of benefits, being in social housing and having parents who had low aspirations. The odds were higher for those young women whose own parents left school at 16, who lived in a lone parent family, whose father was in social classes IV and V, and whose own mother was a teenage mother. Teenage mothers are more likely to suffer disadvantage in adulthood, including being more likely to be in social housing, receiving benefits, to be dissatisfied with their neighbourhoods, to have suffered from partnership dissolution, to be in families where neither partner is in paid work. They are also more likely to be in poor physical and psychological health”.

25. In summary, the children of young mothers are at increased risk but this is primarily because of the circumstances associated with young motherhood, rather than because the mothers are young. While one might expect that very young mothers (under 17) may differ from those age 17-20 or 20-23, the data do not allow detailed distinctions to be made with respect to psychosocial outcomes; nevertheless, there are additional matters to be considered for young women under the age of 16, regarding both education and safeguarding issues.

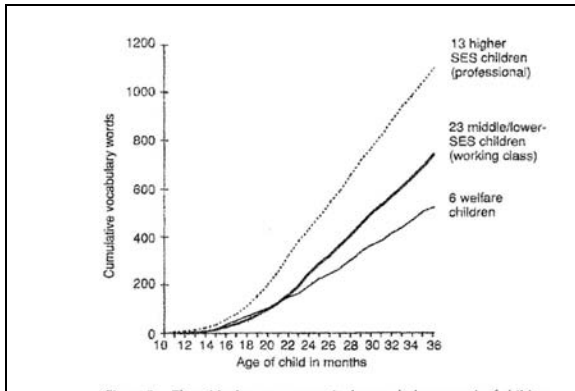
26. **“Looked After” women** Women who are currently or have been “Looked After” are a very high risk group (Box 4)<sup>27</sup>. Note however that in a district the number of pregnancies in Looked After young women will be very small at any one time.

- There were 320 mothers aged 12 and over who were looked after at 31 March 2005. The vast majority of these were aged 15 to 17 (97%). The percentage of females in care who were mothers increased with age from 2% among 15 year olds to 8% among 17 year olds. Overall, 4.1% of looked after females aged 15-17 were mothers (compared with 2.3% of all women aged 15-17).
- Between 25 and 50% of care leavers have a child before or within 24 months of leaving care (compared to 5% of all women under 20).
- Looked after young women are much less likely to have family support.
- Looked after young men are far more likely to become fathers than peers not in care.
- The children of Looked After young women are more likely to be taken into care; this results in some women avoiding involvement with services.
- 83% of young women who become mothers have no qualifications compared to 65% of care leavers without children.
- 8% of young people leaving care achieve 5 or more A\*-C grades at GCSE compared to half of all young people and only 1% go to university.
- Young people who are or have been looked after are 5 times more likely to have mental health problems.
- They have a 30-fold increase in the risk of becoming homeless.

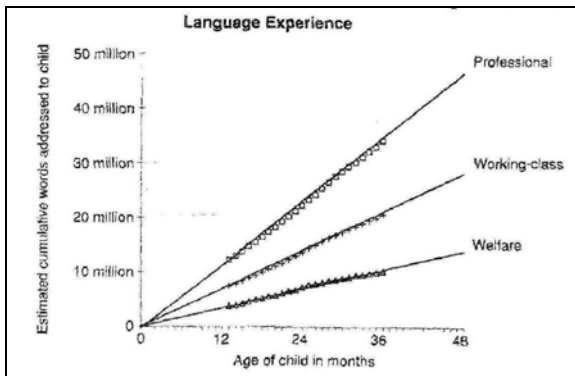
#### **Young women who have been Looked After**

#### **Box 4**

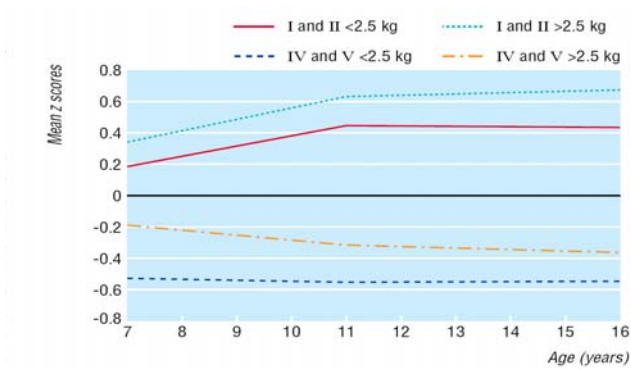
27. **Social background is related to educational outcomes** . For example, the rate of language acquisition and the use of language vary according to social circumstances<sup>28</sup> maths scores similarly relate to social class<sup>29</sup>. The difference increases with age. (Figure 3, Figure 4, Figure 5)



The widening gap with increasing age in the vocabulary growth of children from three different social backgrounds. (Reproduced from Hart and Risley<sup>28</sup> by permission of Paul H. Brookes Publishing Company, Baltimore & Dr Hart)  
**Figure 3**



This gap is related to differences in exposure to language in children from the three different backgrounds. (Reproduced from Hart and Risley<sup>28</sup> by permission of Paul H. Brookes Publishing Company, Baltimore & Dr Hart)  
**Figure 4**



Maths z scores from ages 7-16 years by birth weight and social class at birth (sexes combined). Class IV and V includes individuals with no male heads of household

Maths ability improves with age in upper social groups but declines in lower social groups (Reproduced from Jefferis B. et al<sup>29</sup> by permission of BMJ Publishing Group)  
**Figure 5**

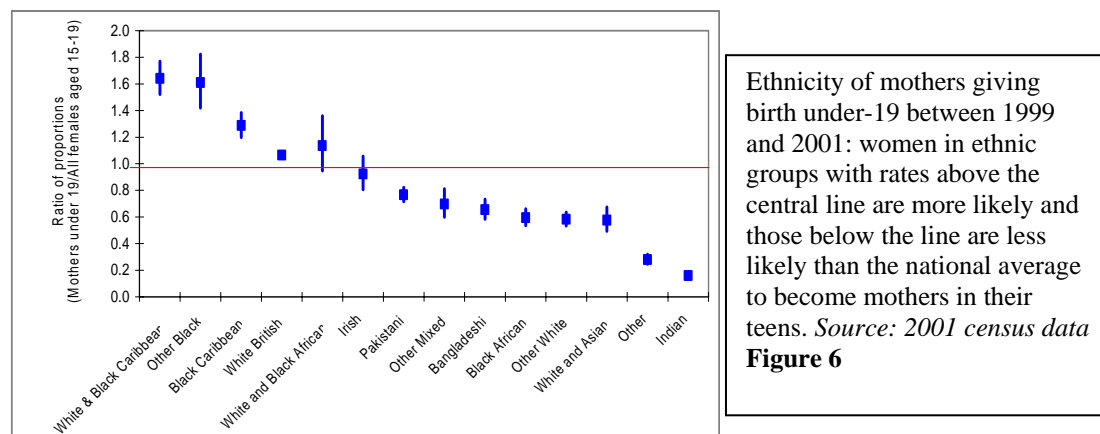
27.1. A review of the data from longitudinal birth cohort studies by Feinstein<sup>30</sup> indicated that by the age of five it is possible to predict with surprising accuracy which children are at risk of adverse outcomes. The predictive factors varied between cohorts but included SOCIO-ECONOMIC STATUS AND PARENTS' EDUCATION, though the steady rise in predictive power with increasing age of the child indicated the extent to which the child's experiences and progress through education shape his future:

27.2. "by age 5 it is possible to identify over one third of those who will experience multiple deprivation 25 years later in adulthood. By age 10, it is possible to identify between 44% and 87% of those who will experience multiple deprivation as adults, depending on assumptions about measurement and missing data".

## 28. ***Ethnicity, culture and language.***

28.1. England is a multi-cultural and multi-ethnic society and in some areas there are many families for whom the first language is not English. It is, therefore, important to examine the extent to which ethnicity, culture and language affect the risk of adverse outcomes for children.

28.2. Teenage motherhood is more common among some ethnic groups than others (Figure 6).



28.3. The issue of ethnic differences in intelligence has created controversy for over a century. American Black children on average score 15 points below American White children on measures of general intelligence (though this difference is shrinking) and Asian American children score about 3 points higher than Whites. The American psychologist Jensen in 1969 re-ignited this long-running “nature-nurture” debate by claiming that most of these differences are inherited, i.e. the result of genetic make-up. The consensus now is that a variety of social, cultural and economic factors are largely and perhaps entirely responsible for these differences <sup>31</sup>.

28.4. Whatever the explanations, however, educational data continue to show substantial differences between ethnic groups in England <sup>32</sup>. The charts illustrate this with data from a DfES report (Ethnicity and Education: The Evidence on Minority Ethnic Pupils aged 5–16. DfES 2006). They show, for example, that attainment in language scores at Foundation Stage is lowest in Pakistani and Bangladeshi children (Figure 7); exclusions from school <sup>33</sup> are highest in Black Caribbean and Black African children (Figure 8); there are wide variations in the educational background of parents from the various ethnic groups (Figure 9); the extent of poverty as measured by free school meals also varies widely by ethnic group (Figure 10).

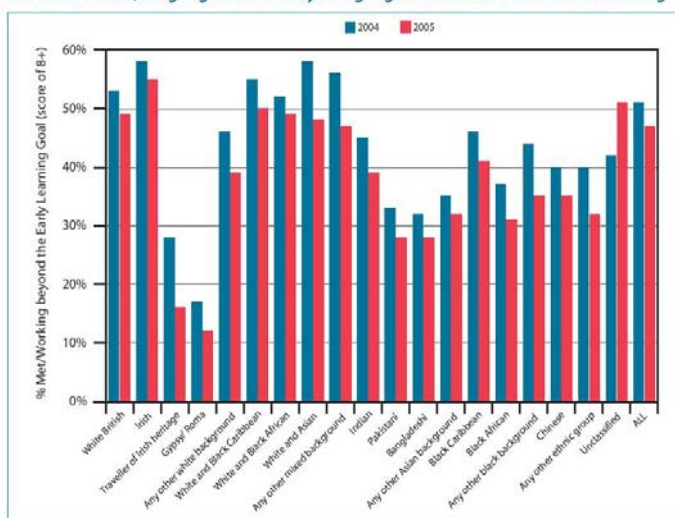
28.5. In families whose first language is not English and who use little or no English at home, a child may be disadvantaged by starting school without adequate knowledge of English, although many schools are expert in providing appropriate education for such children. Growing up in a bilingual household on the other hand can be an advantage. There is no evidence that bilingualism inhibits language acquisition or developmental progress and much evidence to the contrary <sup>34</sup>.



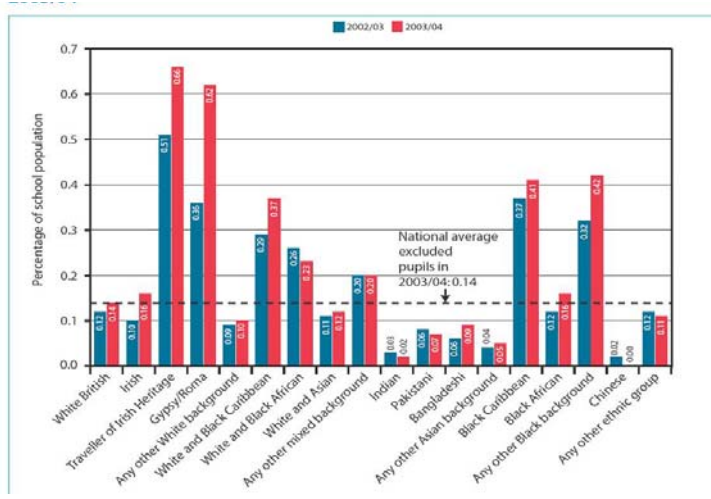
28.6. Working with families who speak little or no English often requires an interpreter. It is not sufficient merely to translate conversations literally – for the kind of work undertaken by the FNP an interpreter must be culturally sensitive and able to explain to the Programme Nurse how the parent is responding to and understanding the discussions<sup>35</sup>. Interpreters with this level of skill are not universally available and this may be a limiting factor in some districts.

28.7. For the FNP, these observations present a dilemma. The evidence suggests that MANY FAMILIES ARE AT INCREASED RISK AS A RESULT OF CULTURAL AND LINGUISTIC FACTORS, and might benefit from the programme; however, it is important to note that the *NFP has not been extensively tested or shown to be effective in settings with a wide diversity of ethnic and cultural groups where interpreters are essential*. This will be an important area of learning during the pilot phase.

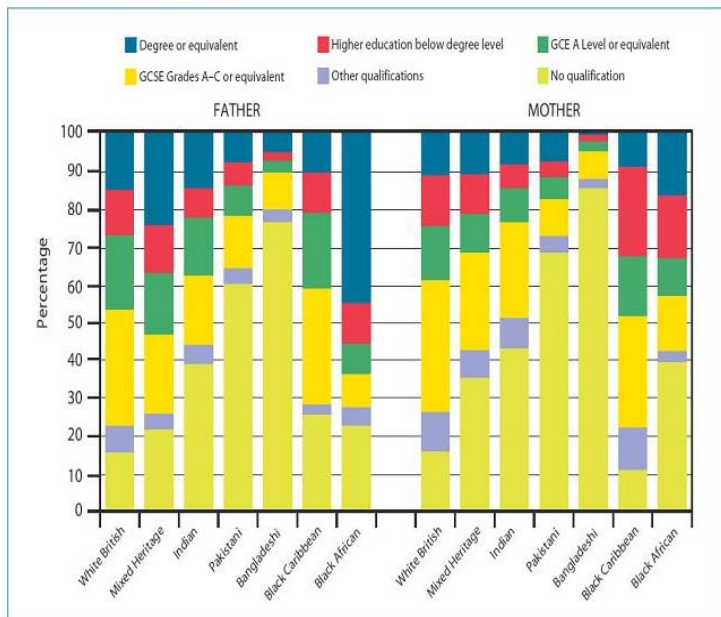
Communication, language and literacy: Language for communication and thinking



Attainment in Foundation Stage Profile (2004 and 2005). Communication, language and literacy, plotted against ethnic group (N.B.: Numbers are very small for Traveller and Gypsy Roma groups)  
**Figure 7**

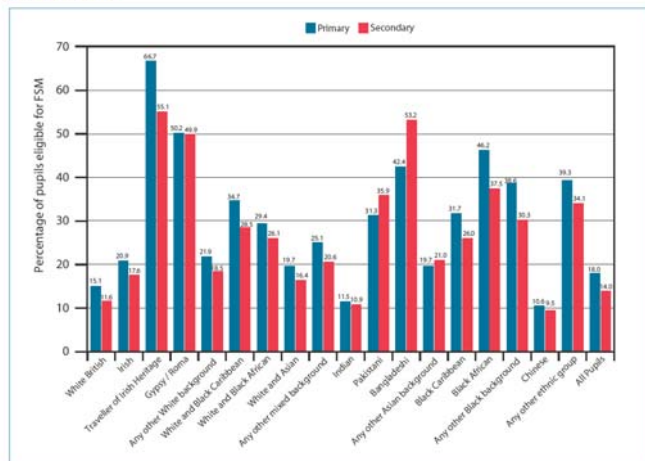


Permanent exclusions from school (2004 and 2005) -, plotted against ethnic group (N.B.: Numbers are very small for Traveller and Gypsy Roma groups)  
**Figure 8**



Highest qualification level of parents of young people plotted against ethnicity of the young person.  
**Figure 9**

**Figure 9: Percentage of pupils in maintained schools eligible for FSM by ethnic group (2005)**

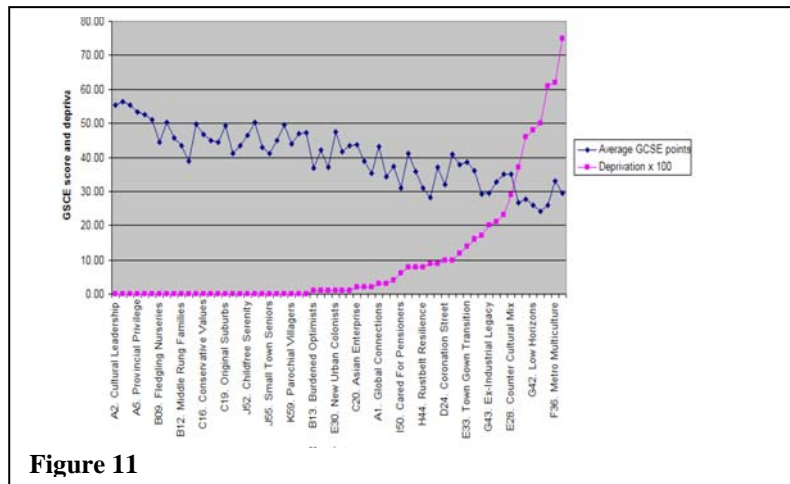


Percentage of pupils eligible for free school meals plotted against ethnic group.  
**Figure 10**

29. **Geography and neighbourhood.** Social geography and geographic information systems methodologies offer a powerful research tool, particularly in educational research. The Jarman or Townsend indices have been widely used as measures of social circumstances, but the Index of Multiple Deprivation is probably now the most relevant to the present work.

29.1. The influence of the neighbourhood, over and above that of individual families, is widely debated. One review suggested that neighbourhood effects are weak and several researchers have supported this view<sup>36</sup>. However, a review by Webber and Butler notes that:.... “other than the performance of the pupil at an earlier key stage test, the TYPE OF NEIGHBOURHOOD IN WHICH A PUPIL LIVES IS A MORE RELIABLE PREDICTOR OF A PUPIL’S GCSE PERFORMANCE than any other information held about that pupil on the PLASC (Pupil Level Annual School Census) database

(Figure 11 and 10A – next page). Analysis shows the extent to which the performance of pupils from any particular type of neighbourhood is also incrementally affected by the neighbourhoods from which the other pupils in the school they attend are drawn. Whilst a pupil’s exam performance is affected primarily by the social background of people he or she may encounter at home, the social background of fellow school pupils is of only marginally lower significance”.



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29.2. Webber argues<sup>37</sup> that using the MOSAIC system of allocating neighbourhood types to postcodes allows meaningful classification of households. It could be used to identify postcodes or types of neighbourhood where intensive intervention may be most useful.

29.3. Using this approach, 51% of teenage mothers live in highly disadvantaged areas, described as ‘struggling families’, ‘burdened singles’, and ‘inner city adversity’. In areas such as ‘high-rise hardship’ the prevalence of teenage motherhood is around five times higher than would be expected given the total number of mothers living in these areas. Teenage parents are six times as likely as other households to live in areas dominated by local authority housing. Over half of women conceiving under-18 rented from the council or from a housing association

29.4. In the future, detailed studies of local geographies may facilitate the optimal use of resources; however, we think that, at least in the early stages of piloting the Programme, pragmatic issues such as the location of services like Children’s Centres or the allocation of staff will take priority in deciding how to allocate FNP resources.

29.5. It is routine to record the postcode of all NHS service users. The postcode can be matched to any of the various indices of deprivation or neighbourhood type mentioned above, although there is a substantial degree of inaccuracy when mapping postcodes to census data. Furthermore, the majority of deprived families do not live in the most deprived areas<sup>38</sup>. Thus the collection of detailed information from each client about their own circumstances is always necessary.

### 30. **Social capital.**

30.1. Social capital” has been defined as “the glue that binds society together”. The social capital of the community resides in the functional community, the actual

Code	Mosaic type	Pupils	Ave GCSE	Deprivation
2	A2. Cultural Leadership	3648	55.44	0.00
3	A3. Corporate Chieftains	6226	56.29	0.00
4	A4. Golden Empty Nesters	6439	55.34	0.00
5	A5. Provincial Privilege	9075	53.32	0.00
6	A6. High Technologists	17173	52.61	0.00
7	A7. Semi-Rural Seclusion	12063	51.10	0.00
9	B09. Fledgling Nurseries	4877	44.51	0.00
10	B10. Upscale New Owners	10580	50.24	0.00
11	B11. Families Making Good	16577	45.68	0.00
12	B12. Middle Rung Families	25352	43.45	0.00
14	B14. In Military Quarters	879	38.98	0.00
15	C15. Close To Retirement	20667	49.73	0.00
16	C16. Conservative Values	13560	46.66	0.00
17	C17. Small Time Business	17777	44.85	0.00
18	C18. Sprawling Subtopia	23434	44.47	0.00
19	C19. Original Suburbs	16646	49.25	0.00
21	D21. Respectable Rows	13361	41.22	0.00
51	J51. Sepia Memories	437	43.48	0.00
52	J52. Childfree Serenity	3086	46.38	0.00
53	J53. High Spending Elders	5138	50.28	0.00
54	J54. Bungalow Retirement	2774	43.03	0.00
55	J55. Small Town Seniors	12051	41.26	0.00
57	K57. Summer Playgrounds	728	44.85	0.00
58	K58. Greenbelt Guardians	9027	49.56	0.00
59	K59. Parochial Villagers	7287	43.87	0.00
60	K60. Pastoral Symphony	5335	46.96	0.00
61	K61. Upland Hill Farmers	1412	47.33	0.00
13	B13. Burdened Optimists	10884	36.79	0.01
22	D22. Affluent Blue Collar	20524	42.05	0.01
23	D23. Industrial Grit	27637	37.02	0.01
30	E30. New Urban Colonists	3850	47.42	0.01

Code	Mosaic type	Pupils	Ave GCSE	Deprivation
31	E31. Caring Professionals	3943	41.55	0.01
56	J56 Tourist Attendants	878	43.44	0.01
20	C20. Asian Enterprise	11286	43.66	0.02
32	E32. Dinky Developments	2017	38.77	0.02
45	H45. Older Right To Buy	10627	35.38	0.02
1	A1. Global Connections	556	43.22	0.03
46	H46. White Van Culture	24009	34.26	0.03
49	I49. Low Income Elderly	6096	37.28	0.04
50	I50. Cared For Pensioners	1120	30.95	0.06
8	B08. Just Moving In	1870	41.20	0.08
25	D25. Town Centre Refuge	3613	35.72	0.08
44	H44. Rustbelt Resilience	18900	30.96	0.08
47	H47. New Town Materialism	25270	28.10	0.09
99	Unclassified	1477	37.14	0.09
24	D24. Coronation Street	16230	32.07	0.10
29	E29. City Adventurers	1162	40.89	0.10
34	E34. University Challenge	485	37.88	0.12
33	E33. Town Gown Transition	1796	38.52	0.14
27	D27. Settled Minorities	11444	36.07	0.16
48	I48. Old People In Flats	537	29.14	0.17
43	G43. Ex-Industrial Legacy	14528	29.39	0.20
35	F35. Bedsit Beneficiaries	559	32.80	0.21
26	D26. South Asian Industry	12832	34.99	0.23
28	E28. Counter Cultural Mix	4766	35.13	0.29
37	F37. Upper Floor Families	8555	26.67	0.37
39	F39. Dignified Dependency	2801	27.74	0.46
42	G42. Low Horizons	23617	25.81	0.46
41	G41. Families On Benefits	13560	24.15	0.50
38	F38. Tower Block Living	580	25.87	0.61
36	F36. Metro Multiculture	12074	32.98	0.62
40	F40. Sharing A Staircase	195	29.52	0.75

Figure 11A: Average GCSE points score by type of neighbourhood. (reproduced by permission of Professor Webber)

social relationships that exist among parents, in the closure exhibited by the structure of relations, and in the parent’s relations with the institutions of the community. Putnam<sup>39</sup> defines social capital as “a set of horizontal associations among those who have an affect on a community, and these can take the form of networks of civic engagement” and “features of social organizations such as networks, norms and truths that facilitate coordination and cooperation for mutual benefit”. According to Putnam these networks lay the groundwork for reciprocity, solidarity and participation, which in turn reinforce sentiments of trust in communities and the effectiveness of communications between individuals and organizations. Social capital is now regarded as a valuable concept for health professionals but direct reference to it is lacking in the longitudinal studies we have reviewed, perhaps because it has only been widely used in recent years.

31. **Predictors of offending and crime – lessons from criminology research** A number of studies report on young people who have been involved in antisocial behaviour, juvenile delinquency and crime, with the aim of identifying those factors in the family, childhood or environment that distinguished these young people from peers not involved in crime<sup>40</sup>. There is an overlap with the forensic psychiatry literature on antisocial personality, conduct disorder or externalising problems (stealing, lying, cheating, vandalism, substance abuse, truancy and running away) and offending by children and adolescents.

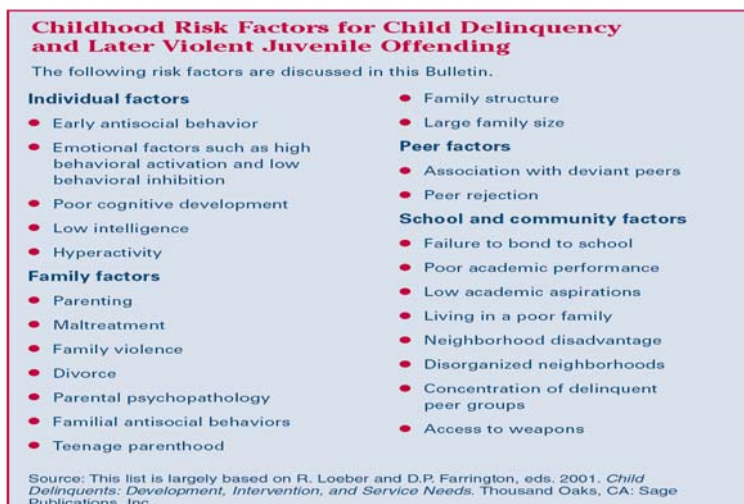


Figure 12

31.1. Prediction of adverse outcomes in general and offending in particular gets easier as children get older – not surprisingly, as patterns of behaviour, family and peer relationships and educational success or failure are important predictors of outcomes. Thus for example one study reported that:

31.1.1. “At age 8 the best predictors of subsequent offending are hyperactivity, impulsivity, and attention deficit; MARITAL DISCORD BETWEEN THE CHILD’S PARENTS; harsh or erratic parenting; and SOCIOECONOMIC DEPRIVATION. Separation from a parent for reasons other than death or illness is also important. Evidence from studies on vulnerability and resilience shows the importance of the cumulative effect of risk factors in the development of delinquency. Risk factors potentiate each other: children with two risk factors are four times as likely to become offenders as those with one or none, and with more risk factors the prevalence is greater still”<sup>41</sup>.

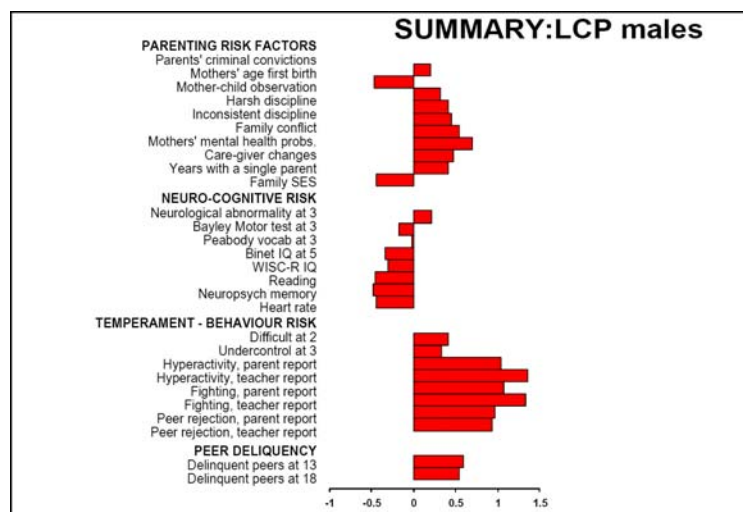
31.1.2. Family disruption is associated with offending and adverse outcomes; however, the nature, duration and cause of the disruption are important in determining the risk of these adverse outcomes.

31.1.3. “CRIMINALITY IS CONCENTRATED IN A SMALL NUMBER OF FAMILIES – in the Cambridge study, 5% of families accounted for about half of juvenile criminal convictions”.<sup>42</sup>

31.1.4. “..... childhood family factors (particularly number of parent changes, number of residence changes, and SINGLE PARENT STATUS) confer on participants a "generalized" risk for criminal conviction (i.e., these variables were associated with increased risk for violent and non-violent convictions).<sup>43</sup>

31.2. A North American review of delinquency<sup>44</sup> identified a number of predictive factors in the child. Many of these relate to the child but there are also factors in pregnancy that predict delinquency and offending: YOUNG MOTHERHOOD; YOUNG FATHERHOOD; DOMESTIC VIOLENCE; PARENTAL MENTAL ILLNESS AND ANTISOCIAL BEHAVIOUR; SUBSTANCE MISUSE; SMOKING; LOW BIRTHWEIGHT; PERINATAL COMPLICATIONS; UNSTABLE FAMILY SITUATIONS, LARGE FAMILIES; BEING “LOOKED AFTER” (Figure 12).

31.3. *The Dunedin study* is of particular value because (a) it separates various trajectories of adverse behaviour leading to offending and crime and (b) it quantifies the magnitude of the various antenatal and postnatal influences on children and the predictive power of measures taken in childhood. It is based on a longitudinal study in New Zealand and therefore generalisations to current circumstances in England must be made with caution. The size of the effects of the various factors varies according to the onset and duration of adverse behaviours and to gender; however, overall the findings suggest that factors identifiable in pregnancy are only weak predictors of adverse outcomes compared to those available in childhood (Figure 13<sup>45</sup>). The chart shows that SOCIO-ECONOMIC CIRCUMSTANCES, MOTHER’S AGE AT FIRST BIRTH, FAMILY CONFLICT, PARENTAL CRIMINALITY AND MENTAL HEALTH are the factors that would potentially be identifiable in pregnancy; however, neuro-cognitive, temperament and behavioural risks in the child together are more powerful influences.



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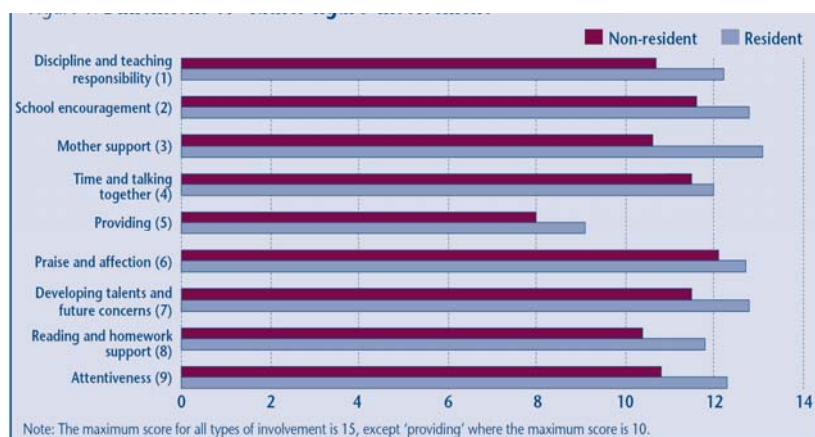
Figure 13

32. **Domestic violence and abuse** are common and are linked to adverse pregnancy outcomes (both emotional distress and physical trauma – the latter can have serious or even fatal consequences). VIOLENCE BY THE MALE PARTNER AGAINST THE MOTHER is strongly related to child abuse. A climate of violence and hostility has negative effects on the child’s emotional development and may be linked to aggressive behaviour.

33. **Aggression** in young children is a normal developmental phenomenon but most children learn at an early stage to manage and control their aggressive tendencies. Those who do not are at serious risk of later violent behaviours. The risk of this developmental trajectory is related to: HISTORY OF ANTISOCIAL BEHAVIOUR IN THE MOTHER; EARLY MOTHERHOOD; SMOKING IN PREGNANCY; POVERTY; PARENTS WHO HAVE PROBLEMS LIVING TOGETHER<sup>46</sup>. The odds ratio for an aggressive developmental course where a mother has multiple risk factors compared to none is 10.9:1. Early intervention programmes (including that of Olds) have had particular difficulty in demonstrating improvements in such families. Tremblay notes that a more specific focus on early aggressive behaviours and family functioning may be needed.

34. **Mental health, mental illness and learning difficulties.** These are identified in several longitudinal studies as risk factors. LEARNING DIFFICULTIES are associated with low educational achievement, itself an important predictor (paragraph 56). POSTNATAL DEPRESSION is an important factor for some adverse child outcomes, but it is difficult to predict, particularly in a first pregnancy.

35. **Non-involvement of fathers** There is a high rate of RELATIONSHIP BREAKDOWN between young parents, often followed by loss of contact. Fathers cite financial problems and conflict with the mother, and often also with his and her parents. Mothers are more likely to complain of fathers’ disinterest, antisocial behaviour, substance abuse etc as reasons for seeking to exclude him from involvement with the child.



**Dimensions of father figure involvement<sup>47</sup>**  
 Reproduced by permission of Joseph Rowntree Foundation .  
**Figure 14**

35.1. Fathers want to be involved and see their role as distinct from that of mothers. The views of teenagers on the role of fathers is shown in Figure 14<sup>47</sup>. The research on the benefits or disadvantages of father involvement is confusing and sometimes biased by covert or explicit political, religious, feminist or moral views. Having two parents is probably better than one, though it is not clear how much this is gender related and how much to increased financial, psychological and time resources.

FATHER INVOLVEMENT IS GENERALLY POSITIVE, SUPPORTIVE AND LINKED TO BETTER OUTCOMES – THE EXCEPTION IS WHEN THE FATHER IS VIOLENT, ABUSIVE AND HAS A HISTORY OF OFFENDING, RESULTING IN ADDED STRESS TO THE FAMILY. A CLOSE STABLE RELATIONSHIP WITH THE FATHER IS BENEFICIAL, WHETHER OR NOT HE RESIDES WITH THE FAMILY; conversely, occasional and erratic contact has little benefit.<sup>48</sup>

36. **Poor quality parental relationships** (whether parents are living together or not), especially those characterised by DYSFUNCTIONAL CONFLICT, are likely to be associated in turn with poor parenting and poor quality parent-child relationships<sup>49</sup>. Poor parenting (poor supervision, poor discipline, coldness and rejection, low parental involvement with the child) and disrupted families are risk factors for poorer social, emotional and educational outcomes for children and for offending and antisocial behaviour. In Life Course studies (paragraph 47), “a harmonious supportive relationship” has been shown to be a protective factor and such relationships have a substantial protective effect in individuals at high risk of anti-social behaviour and offending<sup>50</sup>.

36.1. In the Millennium Cohort Study about a quarter of unmarried mothers were “closely involved” with the baby’s father at birth and 9 months after birth a quarter of those fathers had moved in. Mothers are key mediators of fathers involvement. A closer mother-father relationship encourages involvement with young children among unmarried, urban African American fathers and there is a positive association between SUPPORTIVENESS IN THE MOTHER-FATHER RELATIONSHIP and father’s involvement around the time of a non-marital birth: “Supportiveness in the couple relationship – both the starting level and the change over time – has particularly notable consequences for the parental engagement of both mothers and fathers with their one year old children.” Fathers who were relatively satisfied with their relationships with their partners were likely to report more positive relationships with their children as well: “... being part of a strong emotionally satisfying partnership enables fathers to develop better quality relationships with their children”<sup>51</sup>.

36.2. In 2001, 61% of teenage mothers giving birth during the previous three years were lone parents, although this proportion varies from 26% to 86% and is higher in more deprived areas. Although 66% of births under-20 are jointly registered, for 46% of these births partners are usually resident at a different address at the time of birth. Young fathers (under 24 years) are around four times more likely *not* to be CO-RESIDENT WITH THEIR CHILD AT THE TIME OF BIRTH THAN OLDER FATHERS.

36.3. Only a third of mothers under-20 experience A STABLE RELATIONSHIP THROUGHOUT PREGNANCY and the three years after birth (compared to 88% for older mothers) and a further 49% will experience a change in their relationship status over this period, whilst 18% will remain a lone parent throughout; in comparison, among older mothers, 10% experience a change in relationship status, and 3% remain a lone parent during the three years after birth.

36.4. These data suggest that the quality and stability of the parental relationship may to some extent be predictive of the kind of parenting that the child will experience. The Canadian Longitudinal Study (see reference 20) noted that:



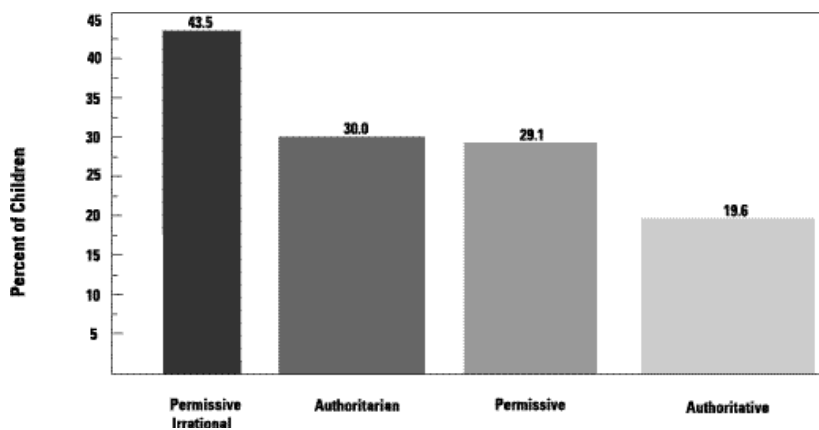
“ .... the impact of parenting on early child development is not a new concept, but there is increasing evidence of its importance. Four types of parenting can be recognised:

- i) Authoritative style - warm and nurturing, sets firm limits on children's behaviour; explains rules to children and lets them participate in family decisions;
- ii) Authoritarian style - highly controlling, lacks warmth and responsiveness; sets unbending rules;
- iii) Permissive - overly nurturing; provides few standards; has extreme tolerance for misbehaviour.
- iv) Permissive irrational.

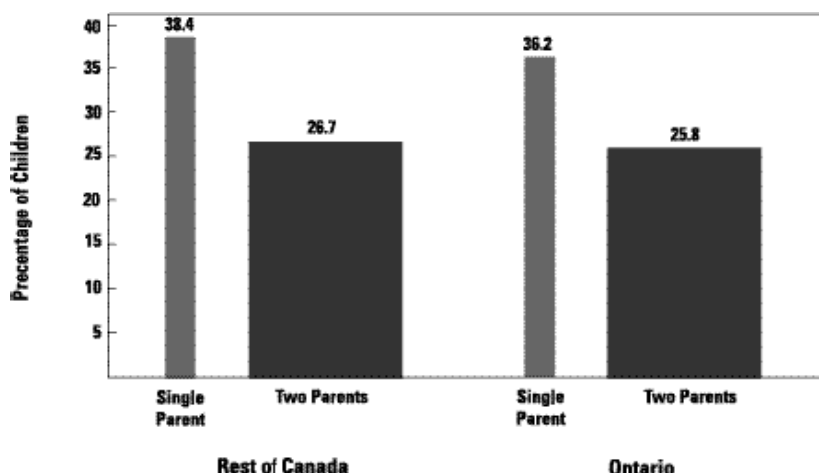
While there was a gradient in behaviour against socio-economic status, the biggest effect was not level of family income, but what was described as parenting style (Figure 15)”.

The authors found that children in one-parent families are at greater risk than those in two-parent families (Figure 16) but cautioned that:

“ ... the total number of children experiencing difficulties in two-parent families is much larger than in single-parent families.... positive parenting practices have important effects on childhood outcomes, but both positive and negative parenting practices are found in rich and poor families alike ... positive parenting practices are only weakly associated with SES (socioeconomic status)”.



Percentage of children with academic / behaviour problems related to parenting style – all socio-economic groups <sup>20</sup>  
**Figure 15**



Percentage of children with problems related to one / two parents family structure (width of bars represents numbers of children <sup>20</sup> .  
**Figure 16**

37. **Mother's Childhood.** A POOR RELATIONSHIP BETWEEN THE WOMAN, WHEN SHE WAS A CHILD, AND HER OWN MOTHER has been linked to poor mental health in adult life which in turn is linked to parenting difficulties and perhaps to attachment problems between the mother and her infant<sup>52</sup>. Whether these difficulties can be identified in pregnancy as part of routine clinical practice is a more difficult issue.

38. **Having an "External locus of control"** (believing that one's life is largely influenced by external events rather than being in control oneself), LOW SELF-ESTEEM AND SELF-CONFIDENCE AND LIMITED RESILIENCE in the face of adversity are related concepts that may be linked with parenting difficulties.

39. **Poverty, poor housing and lack of social support** are recurring themes in the literature on poor physical and mental health, social exclusion, offending behaviour and child abuse. It is often difficult to separate cause and effect but there is general agreement about their importance.

#### 40. **Smoking and alcohol and drug misuse**

40.1. There are specific risks linked to SMOKING AND TO ALCOHOL AND DRUG MISUSE. Smoking is linked to a variety of adverse pregnancy outcomes and in addition affects the physical and mental health of the child<sup>53</sup>. Nicotine and carbon monoxide affect the development of synaptic function and neurotransmitters in ways that appear to adversely affect behaviour. Excessive alcohol consumption in pregnancy carries a risk of fetal alcohol syndrome which affects brain development and has serious effects on intellectual function and behaviour. Substance abuse also has direct effects on the baby but in many cases it is the associated social problems that are more important for child safety and outcomes.

#### 41. **Stress.**

41.1. Maternal stress during pregnancy has been linked with raised corticosteroid levels and this in turn affects some aspects of brain development and physiological programming. Similar relationships have been reported between stress and abuse in infancy and adverse later effects on behaviour and personality<sup>54</sup>. These are generally viewed as negative and undesirable though an alternative view is that these behaviours are actually adaptive to a hostile environment<sup>55</sup>. Epigenetic imprinting is a mechanism whereby stressful experiences could be translated into behaviour, by modifying the expression of genes regulating behaviour patterns. Psychopathy appears to have a strong genetic component though adverse experiences probably also contribute<sup>56</sup>. This is a difficult area of research and it is important to interpret it with caution.

42. **Travellers** have an increased risk of poor health outcomes, mental illness and difficulties with schooling<sup>57</sup>.

43. **Other marginalised groups** such as recently arrived refugees, asylum seekers and illegal immigrants are also at increased risk<sup>58</sup>.

## **(5) Issues and Difficulties relevant to the Programme, arising from the literature review**

44. We have reviewed the evidence obtained from the literature about the main predictors of adverse outcomes that are likely to be related to social exclusion. The strength of the evidence varies considerably but all the factors listed have been suggested by one or more authorities to be relevant.

45. Our review shows that there are in theory many possible predictive factors that could be used to identify women who are at increased risk of their child suffering adverse outcomes and social exclusion. But it has also indicated a number of practical difficulties in creating a suitable instrument:

45.1. The concept of social exclusion incorporates a number of different adverse outcomes but there is no reason to expect that they would all be predicted by the same risk factors.

45.2. We found that the most helpful work on prediction was in the field of crime and offending. However, presenting the FNP in terms of reducing the risks of crime or of mental health problems would be both insulting to parents and disastrous for public relations.

45.3. Many of the factors that have been shown in various studies to predict adverse outcomes are based on observations made during childhood. For example, gender, cognitive ability, temperament and behaviour in early childhood are all important predictors; but as the FNP is offered only to first time parents and recruitment takes place during pregnancy, childhood data cannot be used. Prediction must be based solely on information available during the pregnancy, i.e. on information about the parent(s), not the child. Nevertheless, life course epidemiology studies show that interventions that address risk factors in pregnancy and infancy can change the trajectory of child development and impact on outcomes.

46. The pervasive influence of social class and background on educational outcomes, and the evidence that educational outcomes can be improved, together suggest that the main focus of the FNP programme should be about promoting educational success, rather than reducing the risk of offending and criminality. Educational success leading to recognised qualifications and prospects for employment is likely to be the best protection against the adverse outcomes listed previously. This approach parallels the original aim of Sure Start which was to “ensure that children are ready to thrive in school and to benefit from their education”.

46.1. This is an aim that the vast majority of parents will share and the approach should be - “We all want our children to do well”.

47. **“Life course epidemiology”** is defined as “the study of long term effects on later health or disease risk of physical or social exposures during gestation, childhood, adolescence, young adulthood and later adult life”<sup>59</sup>. Its purpose is to study the contribution of these various factors to identify risk, protective processes and resilience factors across the life course. Life course exposures or insults gradually accumulate through episodes of illness, injury, adverse social, psychological or environmental conditions, and health damaging behaviours. One bad experience or

exposure tends to lead to another and then another - “chains of risk”. There are two types. In the additive type, each adverse experience increases the risk of unwanted outcomes in a cumulative fashion; in the “trigger effect” type, only the final link in the chain has a marked effect on disease risk.

47.1. Although life course epidemiology focused initially on physical illness, it is relevant to the whole range of adverse outcomes. For example, figure 2 illustrates how a child might be exposed to parental factors that interact with genetically determined behavioural traits – but the risk of adverse outcomes would be affected by the quality of schooling and the nature of peer friendships.

47.2. Thus, the concept of the “chain of risk” is important to the present exercise; on the one hand, it implies that what will happen to a child as yet unborn is to a considerable extent determined by events yet to come and therefore precise prediction of adverse outcomes is impossible; on the other hand, it also implies that interventions to change the early life course may have far-reaching benefits.

48. **Sensitive data** Some of the information that would increase the accuracy of prediction is personal and sensitive (for example, experience of domestic violence or a family history of criminality); it may not be disclosed until the woman trusts the professionals involved in her care and therefore may not be helpful in the initial identification of women who should be offered the FNP.

49. Our review of the extensive literature showed a large number of risk factors for adverse outcomes. It was, however, difficult to extract quantitative information on the *magnitude* of the risk presented by each risk factor, the relationship between the *severity or extent* of the risk factor (for example, mental health problems) and the outcomes, or the extent to which the various risk factors *interact*. Furthermore, some risk factors are much more pressing than others – for example, excessive alcohol consumption or domestic violence may need an urgent response, but this can interfere with attempts to address more long term issues such as a return to education.

50. We noted in paragraph 17.6 that any research investigating the links between pregnancy and early childhood on the one hand, and adult outcomes on the other, has an inescapable weakness – in the intervening years or decades between the initial data collection and the measurement of outcomes, society changes, often quite dramatically, so that the findings must be generalised with some caution. For example, the 1970 cohort has the merit of following children into mature adult life, but the social conditions, and therefore the significance of many social indicators, of 1970 were very different from those of 2006. (For an example, see the section on “young mothers”).

*Factors that could be used to predict in pregnancy which women are at higher risk of having a child who will grow up with one or more adverse outcomes.*

- Young age of mother at first pregnancy and first birth,
- Young age and low socio-economic status of father,
- Poor quality, unstable or transient relationship with father
- Poverty – no earned income
- Learning difficulties, low IQ, dropping out of school, excluded from school, few educational achievements, no qualifications
- Mental illness
- Poor mental health
- Chronic illness
- History of antisocial behaviour, juvenile offending, criminality,
- Intimate partner abuse (domestic violence)
- Smoking
- Substance abuse
- Alcohol abuse,
- Stress in pregnancy
- Accommodation problems (poor quality, frequent moves, homelessness),
- Lack of social support (“social capital”) - poor neighbourhood, social isolation; few social networks, low self-esteem.
- Ambivalence about the pregnancy or the prospect of parenthood

Mother’s own family background factors –

- History of abuse,
- Herself being the child of a young mother,
- Being Looked After or in care,
- Poor relationship with her own mother
- Negative attitude of her parents to education,
- Criminality, mental illness and alcoholism in the family

In addition, some circumstances and situations may expose individuals to an increased risk of adverse health and educational outcomes:

- Ethnic, cultural and linguistic barriers
- Traveller lifestyles
- Refugees
- Illegal immigrants
- Asylum seekers

**Box 5**

## **(6) Practical application of the risk factors identified in the literature review ( Box 5)**

51. In this section we will consider how to make use of the risk factor information identified in the review. There are several practical issues to be considered – the time taken to obtain the information from the parent; their readiness to disclose personal and sometimes very private or sensitive personal material; the reliability of the information given; the relative merits of informal interviewing versus more formal approaches such as standardised questionnaires. These issues are discussed in more detail in paragraphs 100.4 onwards.

### **52. Young motherhood.**

53. The definition of the age of a mother is important for deciding on eligibility and for audit. Mother's age could be defined by the age at conception – more practically identified by the date of the last menstrual period (LMP), which is routinely recorded - the age at which she gives birth, or the Expected Date of Delivery in the event of fetal loss. The preferred method for the FNP would be the LMP.

54. A number of qualitative studies involving interviews with young parents, including some who have been “Looked After”, have examined the commonly held stereotypes of teenage mothers and young fathers<sup>60</sup>. This extensive literature can be summarised as follows:

- Young women who fall pregnant while still of school age (under 16) have often had a history of educational failure, resentment at the lack of support by and the criticism from teachers, being victimised and bullied, and having generally negative attitudes to and experiences of education.
- In spite of this, the experience of Re-integration Officers and Connexions workers is that many of these young women do realise their need for education and it is often possible either to re-integrate them into mainstream school or establish them in a special teen mothers programme.
- These young women may be ambivalent about their pregnancy but the majority want to make a success of motherhood and want their child to have a better future and a more successful school experience than they have had.
- Most young mothers realise that a second child would present bigger problems than just having one – but some make a conscious decision that they would like a second child and decide that it is best to embark on a second pregnancy sooner rather than later and then return to education subsequently. (The “Care to Learn” programme of support for childcare has proved to be valuable, though we heard concerns from some women that it needs to continue beyond age 19).
- Many young women are suspicious of professionals in general and health visitors in particular – the latter are linked in their minds with child protection and the removal of children into care.

➤ Young men often want to be good fathers in spite of having had poor role models in their own fathers – provided that they do not have a strong pattern of antisocial behaviour, violence or crime, contact with the child’s father is generally beneficial for the child.

55. In view of the complexity of their situation and the fact that they want to make a success of being apparent, it is not surprising that many young women resent the patronising and sometimes overtly hostile attitudes of many health professionals regarding their pregnancy. Such attitudes are likely to have a very negative impact on recruitment to and engagement with the FNP Programme.

56. The implications of these findings are that the term “young” mothers must be interpreted flexibly – there is no justification from the literature for selecting an arbitrary age (e.g. under 20) for recruiting women to intensive intervention programmes. If an age limit is to be adopted, perhaps 23 would now be more appropriate than 20 (for young fathers as well as young mothers). However, it would make more sense to recognise a continuum of risk and need. Young women are likely to have more disadvantaged backgrounds and circumstances than older women; they are less likely to have completed their education to GCSE level or to have progressed to post-secondary education; they are more likely to have disrupted family backgrounds and poor accommodation.

57. In communities where early marriage is the norm, the significance of young motherhood is likely to be different from that seen in young White UK-born women. The needs are not necessarily less but are probably different and will need to be addressed in different ways. See also paragraphs 28.1 onwards.

58. Assessment of the continuum of need is clearly more difficult in the realities of a busy clinic setting than the use of a single straightforward measure such as age for the selection of women to be offered the FNP. We will return to the question of how this might work later in the report.

59. **Poverty – Measurement and mapping.** Low income emerges from a wide range of studies as a key factor in adverse outcomes. There are many ways of defining and measuring poverty<sup>61</sup>. A distinction is made between Relative Low Income and Absolute Low Income. Relative poverty refers to the gap between the wealth of an individual and the “norm” (itself variously defined) for a community. It is important because perceptions of relative poverty, and the extent of the inequality of wealth distribution, are significant predictors of adverse outcomes for the individual and of undesirable outcomes for the community. Absolute poverty is defined in terms of the actual minimum income needed for a family of a specified size. In 1998/9 this was £210 per week for a couple with one child. Material deprivation is described by the number of items a family is unable to afford but which most people would regard as essential. A list of such items was proposed in *Measuring Child Poverty* (DWP 2003).

59.1. Financial status and poverty can be assessed in various ways. Receipt of benefits is one obvious measure but has many pitfalls, especially with young women who may be eligible for benefits but have not claimed them.

59.2. The postcode can be used to obtain the Jarman or Townsend indices or the Index of Multiple Deprivation<sup>62</sup>. However, mapping to enumeration districts has significant errors<sup>63</sup> and can only give an approximate idea of the deprivation and poverty characteristics of the area where the individual lives – it does not give any insight into their own financial position. Using neighbourhood types (e.g. MOSAIC – paragraph 29.2) is a different approach that gives more information about the nature of a neighbourhood but again gives no information about an individual.

59.3. Geographic information systems (GIS) could be used to plan how best to use the available resources for the FNP Programme – for example, to identify the areas where there is the greatest concentration of potentially eligible families, so that FNP Nurses can minimise travelling time between visits. GIS could also be used to monitor and map the uptake of the FNP Programme and the extent to which there is a postcode or neighbourhood bias in engagement and retention in the FNP Programme. However, these approaches are of limited use in working with individuals.

59.4. It is nevertheless very important to gain some insight into each individual's financial and social situation as guidance on employment, benefits, debt etc will often be part of the work undertaken in the FNP Programme.

59.5. A series of questions as in the Osborn instrument<sup>64</sup> may be useful for clinical purposes. The Osborn was devised over 20 years ago but has the merit of simplicity and ease of administration. It utilised 8 questions that are quick and easy to answer and are not unduly intrusive. It could be combined with a benefits check list and questions drawn from the *Measuring Child Poverty* list.

## 60. **Deficient social capital**

60.1. Measures of social capital are complex (Box 6); although comprehensive formal measures of social capital could be used to predict which women might benefit most from intensive home visiting, the research is as yet scanty<sup>65</sup>. Concepts of social networks, trust and emotional support are clearly important, however, and are often assessed informally by health professionals – for example, midwives often enquire about such matters at a booking clinic. Knowledge of “social capital” may be valuable baseline information on those women recruited to the programme.

60.2. A review of Social Capital measures for England was undertaken on behalf of the ONS<sup>66</sup>. The definition used was that of the Organisation for Economic Co-operation and Development (OECD) definition: “networks together with shared norms, values and understandings that facilitate cooperation within or among groups”. The authors generated a question set that reflects the various components of social capital (appendices 9,10). This set is too complex and lengthy for routine clinic use but it may be helpful to extract some items from it and it could form part of the toolkit of the FNP Nurses for future research purposes.

60.3. A matrix of social capital measures illustrated the lack of agreement on how best to do this. The views and attitudes of young people differ in many respects from those of older adults and for this reason a modified ONS scale has been developed - see appendices 9,10.



60.4. A related concept is “social isolation”. This too is difficult to define and ascertain and it is unwise to make sweeping generalisations about support networks without careful appraisal<sup>67</sup>. Individuals differ in the extent to which they need social contact and support, and in the ways they obtain it; some social contacts may be frequent but harmful and stressful whereas others may be infrequent but very supportive. Various assessment methods have been described – for example, an Ecogram is a diagrammatic representation of an individual’s relatives, friends and others with whom they have social contact. A structured measure of social support is also available<sup>68</sup>.

#### **Social Capital Measurement - Examples of indicators**

##### *Social participation*

- Number of cultural, leisure, social groups belonged to and frequency and intensity of involvement
- Volunteering, frequency and intensity of involvement
- Religious activity

##### *Civic participation*

- Perceptions of ability to influence events
- How well informed about local/national affairs
- Contact with public officials or political representatives
- Involvement with local action groups
- Propensity to vote

##### *Social networks and social support*

- Frequency of seeing/speaking to relatives /friends/neighbours
- Extent of virtual networks and frequency of contact
- Number of close friends/relatives who live nearby
- Exchange of help
- Perceived control and satisfaction with life

##### *Reciprocity and trust*

- Trust in other people who are like you
- Trust in other people who are not like you
- Confidence in institutions at different levels
- Doing favours and vice versa
- Perception of shared values

##### *Views of the local area • Views on physical environment*

- Facilities in the area
- Enjoyment of living in the area
- Fear of crime

#### **Box 6**

61. **Anti-social behaviour, offending and crime.** Acquiring details of family history of criminality or of mental illness is difficult in any family but is likely to be particularly so in the more needy families who are likely to be the subject of the FNP project. In surveys, young men are quite reliable in self – reports of offending behaviour and young women are probably similarly reliable about the offending

record of their current male partner (to the extent that they know his history); but there is less evidence on the extent to which young women's self-reports of their own offending can be relied upon <sup>69</sup>.

62. This evidence has been gathered in ad hoc studies and tested by comparing reports against official records – there is little direct evidence as regards clinical settings. In some cases, the history of a young woman who has been Looked After or the subject of investigation for offending behaviour may be available, but checking this information in most cases will be difficult; efforts to do so would almost certainly need consent from the client and may be counter-productive.

62.1. It has been suggested that a single question about a family history of alcoholism might identify a significant proportion of *familial psychopathology*; Weisman devised a screening instrument for family history of psychiatric illness <sup>70</sup> but this is unlikely to be suitable for use in routine clinical circumstances.

63. **Mental illness** in young parents, particularly mothers, has been extensively studied <sup>71</sup>. Instruments that aim to identify women at risk are used primarily as research procedures. The CEMDE report “Why mothers die”<sup>72</sup> noted that, taking all mental health causes together, including drug abuse and domestic violence, mental illness now causes more maternal deaths than the classic obstetric causes of maternal mortality.

63.1. A Cochrane protocol notes that there is uncertainty about psychosocial screening in pregnancy. Of all the psychiatric screening instruments available, the General Health Questionnaire <sup>73</sup> is probably the most widely used. The Antenatal Risk Questionnaire (Austin 2003) is an Australian instrument that reviews support, history of psychiatric disorder, stress and abuse.

64. The incidence of postnatal depression is increased in young isolated mothers and in some groups may be as high as 40%. Depression in the first year of life is associated with impairments in child development, particularly affecting boys. Thus it is argued by some that it is logical to identify women at risk of depression in pregnancy.

64.1. The Postpartum Depression Predictive Inventory has been used in studies by Murray and Cooper. They advise <sup>74</sup> that the *prediction* of postnatal depression during pregnancy is very difficult and is not recommended; but that its identification *after* birth of the baby is much more reliable; they also stress that, since it is treatable and treatment has long term benefits, it would be wrong not to offer intervention to depressed women in the postnatal period, whatever their social background. Instruments such as the EPDS are validated for the post partum period but must be used sensitively, otherwise they give spurious results <sup>75</sup>.

64.2. A review by NICE (“Antenatal and postnatal mental health” in draft form as of writing) concluded that screening for mental health problems in pregnancy did not meet National Screening Committee criteria for screening. However, they reviewed methods of prediction and detection and made the following observations:

64.3. “Those factors consistently associated with the onset of depressive symptoms during the postnatal period include depressed mood and depression during pregnancy,

anxiety during pregnancy, poor social support, recent life events, and a history of depression or other psychiatric history. With psychiatric history, the level of increased risk appears to be related to the severity and duration of the previous depression. Social support can be defined in terms of sources of support, such as spouse, friends and relatives, or in terms of the type of support received - informational support, instrumental support (such as practical help), and emotional support.

65. Disorders other than depression and psychosis are much less well studied in pregnancy and the postnatal period. A previous history of severe mental illness including schizophrenia, bipolar disorder, previous puerperal psychosis or severe prolonged depression in the postnatal period can all increase the likelihood of further episodes of mental illness after this pregnancy.

65.1. Enquiry about a previous severe mental illness, perhaps using psychiatric admission or contact with a specialist mental health service as indicators of severity (although the reliability of this may depend on local services), is important to identify women with an increased risk of puerperal psychosis or relapse of severe mental illness.

65.2. The use of a standard questionnaire such as the General Health Questionnaire may be worthwhile in some circumstances as it may reveal previously unsuspected mental health problems. The Edinburgh Postnatal Depression Scale has not been validated for use in pregnancy. For very young mothers the Adolescent Wellbeing scale could be used though it was not designed specifically for use in pregnancy and does not appear to have been used for that purpose.

65.3. Two brief focused questions that address mood and interest are as likely to be effective as more elaborate methods for identifying current depression and more compatible with routine use in many primary and secondary care settings<sup>76</sup>. This two-question screen for depression has been recommended by NICE though it is not validated for pregnancy use:

*“During the past month have you often been bothered by feeling down, depressed or hopeless?”*

*During the past month have you often been bothered by little pleasure or interest in doing things?”*

An extension to these two questions is *“Is this something with which you would like help?”* with three possible responses: No; Yes, but not today; or Yes.”

66. **Poor quality parental relationships** Poor relationships may be suspected from the lack of communication or tension between parents, or the mother may deliberately exclude the father, whether or not he wishes to be involved. Even apparently good relationships may be short-lived, particularly in the case of very young parents. The Relationships Dynamics Scale<sup>77</sup> could be used to assess the parental relationship in more depth but is unlikely to be a practical proposition for assisting decisions about recruitment.

67. **Domestic violence (DV)** (intimate partner abuse) is now widely recognised as a serious issue and is associated with risks to the child as well as to the

mother. Factors associated with intimate partner violence include young age, low income status, pregnancy, mental health problems, alcohol or substance use by victims or perpetrators, separated or divorced status, and history of childhood sexual and/or physical abuse. Many women are reluctant to disclose DV but are more likely to do so if they feel that they are likely to receive a sympathetic hearing and useful advice and support. The presence of their male partner at health consultations can make this difficult.

67.1. Attempts to “screen” for DV have had varying success. A UK systematic review in 2002 found insufficient evidence to screen for DV and a subsequent study advised caution with routine enquiry in primary care settings – one fifth of women objected to being asked when they had attended about something else<sup>78</sup>. However, the higher risks associated with DV in pregnancy and in the 12 months after child birth make routine enquiry in midwifery and obstetric settings more acceptable.

67.2. Instruments to screen for intimate partner violence have been developed (Table 1), and although some have demonstrated good internal consistency (e.g., the HITS instrument, the Partner Abuse Interview, and the Women’s Experience with Battering [WEB] Scale), none have been validated against measurable outcomes. A study in the USA compared several methods and found that no single method was likely to identify more than 50% of cases<sup>79</sup>. Women in the USA study said they preferred the topic to be addressed in a questionnaire in the first instance, rather than face to face. Computer –based questionnaires were no more popular than paper based methods. In England, midwives are encouraged to ask about DV as a matter of routine. A more detailed instrument was developed in Scotland and is available at <http://www.achb.scot.nhs.uk/reports/Pilot%20Report%20domestic%20violence%20report.pdf>.

67.3. The US Preventive Services Task Force reported as follows<sup>80</sup>:

“The USPSTF found no direct evidence that screening for family and intimate partner violence leads to decreased disability or premature death. The USPSTF found no existing studies that determine the accuracy of screening tools for identifying family and intimate partner violence among children, women, or older adults in the general population. The USPSTF found fair to good evidence that interventions reduce harm to children when child abuse or neglect has been assessed. The USPSTF found limited evidence as to whether interventions reduce harm to women, and no studies that examined the effectiveness of interventions in older adults. No studies have directly addressed the harms of screening and interventions for family and intimate partner violence. As a result, the USPSTF could not determine the balance between the benefits and harms of screening for family and intimate partner violence among children, women, or older adults”.

<p><b>Partner Violence Screen (PVS)<sup>18†</sup></b></p> <p>1. Have you been hit, kicked, punched, or otherwise hurt by someone in the past year?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If so, by whom?</p> <p><input type="checkbox"/> Person in current relationship <input type="checkbox"/> Person from previous relationship <input type="checkbox"/> Someone else</p> <p>2. Do you feel safe in your current relationship?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Is there a partner from a previous relationship who is making you feel unsafe now?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Woman Abuse Screening Tool (WAST)<sup>19‡</sup></b></p> <p>1. In general how would you describe your relationship?</p> <p><input type="checkbox"/> A lot of tension    <input type="checkbox"/> Some tension    <input type="checkbox"/> No tension</p> <p>2. Do you and your partner work out arguments with:</p> <p><input type="checkbox"/> Great difficulty    <input type="checkbox"/> Some difficulty    <input type="checkbox"/> No difficulty</p> <p>3. Do arguments ever result in you feeling put down or bad about yourself?</p> <p><input type="checkbox"/> Often    <input type="checkbox"/> Sometimes    <input type="checkbox"/> Never</p> <p>4. Do arguments ever result in hitting, kicking, or pushing?</p> <p><input type="checkbox"/> Often    <input type="checkbox"/> Sometimes    <input type="checkbox"/> Never</p> <p>5. Do you ever feel frightened by what your partner says or does?</p> <p><input type="checkbox"/> Often    <input type="checkbox"/> Sometimes    <input type="checkbox"/> Never</p> <p>6. Has your partner ever abused you physically?</p> <p><input type="checkbox"/> Often    <input type="checkbox"/> Sometimes    <input type="checkbox"/> Never</p> <p>7. Has your partner ever abused you emotionally?</p> <p><input type="checkbox"/> Often    <input type="checkbox"/> Sometimes    <input type="checkbox"/> Never</p> <p>8. Has your partner ever abused you sexually?</p> <p><input type="checkbox"/> Often    <input type="checkbox"/> Sometimes    <input type="checkbox"/> Never</p> <p><small>*Both the PVS and the WAST had preambles that indicated the questions applied to the last 12 months. †Answering yes to question 1 (and indicating it was by a person in a current or previous relationship) or question 3, or no to question 2 met the criteria for intimate partner violence exposure. ‡Endorsing either question 1 ("a lot of tension") or question 2 ("great difficulty") met the criteria for intimate partner violence exposure; questions 3 to 8 were not used in this determination.</small></p>
--

**Table 1**

68. **Impaired attachment in mother’s own childhood.** Attachment theory describes the developing relationship between one or more carers (usually the mother in the first instance) and the baby <sup>81</sup>. Impaired attachment has a number of adverse effects on the child’s emotional development. Mothers who had poor relationships with their own mothers are at increased risk of attachment problems with their own babies. Some researchers have developed instruments to detect warning signs of poor attachment so that intervention could be offered. Trying to identify high-risk mothers in pregnancy, before the baby is born, is clearly more difficult. However, Holmes has speculated that low levels of trust in others (a topic addressed also under the heading

of “Social capital”) seems to be linked to attachment problems in general<sup>82</sup>. Holmes and Robin . No formal measures of childhood unhappiness or instruments for assessing childhood experiences of abuse and neglect have been identified in the literature but a series of questions used in one study is shown in Table 2<sup>83</sup>.

Questions	Defining Responses
Verbal abuse: Sometimes parents or other adults hurt children. While you were growing up, that is, in your first 18 years of life, how often did a parent, stepparent, or adult living in your home: 1) swear at you, insult you, or put you down? 2) threaten to hit you or throw something at you but didn't do it?	“often” or “very often” to either question
Physical abuse: Sometimes parents or other adults hurt children. While you were growing up, that is, in your first 18 years of life, how often did a parent, stepparent, or adult living in your home: 1) push, grab, slap, or throw something at you? or 2) hit you so hard that you had marks or were injured?	“often” or “very often” to question 1 or “sometimes,” “often,” or “very often” to question 2
Sexual abuse: Some people, while they are growing up in their first 18 years of life, had a sexual experience with an adult or someone at least 5 years older than themselves. These experiences may have involved a relative, family friend, or stranger. During the first 18 years of life, did an adult, relative, family friend, or stranger ever: 1) touch or fondle your body in a sexual way, 2) have you touch their body in a sexual way, 3) attempt to have any type of sexual intercourse with you (oral, anal, or vaginal), or 4) actually have any type of sexual intercourse with you (oral, anal, or vaginal)?	“yes” to any of the 4 questions
Intimate partner violence: Sometimes physical blows occur between parents. While you were growing up in your first 18 years of life, how often did your father (or stepfather) or mother's boyfriend do any of these things to your mother (or stepmother): 1) push, grab, slap, or throw something at her, 2) kick, bite, hit her with a fist, or hit her with something hard, 3) repeatedly hit her over at least a few minutes, or 4) threaten her with a knife or gun or use a knife or gun to hurt her?	“sometimes,” “often,” or “very often” to at least 1 of the first 2 questions or any response other than “never” to at least one of the third and fourth questions
Household substance abuse: During your first 18 years of life, did you live with anyone who was a problem drinker or alcoholic? During the first 18 years of life, did you live with anyone who used street drugs?	“yes” to either question
Mental illness in household: During your first 18 years of life, was anyone in your household depressed or mentally ill? During your first 18 years of life, did anyone in your household attempt to commit suicide?	“yes” to either question
Incarcerated household member: During your first 18 years of life, did anyone in your household go to prison?	“yes”
Parental separation or divorce: Were your parents ever separated or divorced?	“yes”

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**Questions about woman's childhood experiences**

**Table 2**

69. **Poor accommodation.** The type and tenure of the woman's home needs to be ascertained and recorded in various ways. Unsatisfactory housing can be described and classified in various ways – for example, overcrowding, basic amenities and structural defects. There is evidence that poor housing has adverse effects on health<sup>84</sup>. Dirty homes correlate with other measures of poor care and occasionally a formal checklist might be useful, perhaps as an educational tool, but is not recommended for routine use.

70. **“Locus of control”** The original “locus of control” formulation classified beliefs concerning who or what influences things along a bipolar dimension from internal to external control: "Internal control" describes a belief that control of future outcomes resides primarily in oneself – an individual's own experiences are controlled by their own skill or efforts. Often these individuals grew up in families that focused on effort, education, and responsibility. "External control" refers to the expectancy that control is outside of oneself, either in the hands of powerful other people or due to fate/chance. This view is more common among families of a low socioeconomic status where there is a lack of life control. Generally, the development of locus of control stems from family, culture, and past experiences leading to rewards.

71. **Low self – efficacy.** The concept of self efficacy was introduced by Bandura. It is related to “locus of control” but is distinct from it. An individual may

believe that in general their future is in their own hands, but nevertheless may doubt their capacity to do whatever is required to bring about specific changes in their prospects. The interest in self-efficacy in the present context is two-fold. First, Olds reported that a sense of self-efficacy was a predictive factor in the extent to which young women benefited from the FNP Programme. Second, it is, at least in principle, susceptible to change<sup>85</sup>. This is important because self-efficacy is mainly seen as situation and behaviour –specific<sup>86</sup> - it therefore presents challenges for intervention programmes to identify ways of applying these theoretical concepts to bring about behaviour change.

71.1. Schwarzer has however described measures of “general self-efficacy” and also of “proactive attitudes” which have been validated for use in a number of settings<sup>87</sup>.

71.2. There is a literature on self-efficacy studies in pregnancy with respect to specific issues such as smoking, but very little on the role of self efficacy in determining how young women might think about and seek to improve the future prospects for their unborn child. Qualitative evidence from studies with young women who have been looked after gives some insights (see paragraph 54).

71.3. Since self efficacy is not a fixed quantity but can be changed, a low sense of self efficacy might well be a *risk factor for less good outcomes* but could also be an *indication* for such women in particular to be offered the FNP Programme.

72. **Low resilience, self-esteem, self-efficacy and mastery beliefs.** – Studies of resilience ask – “why do some children turn out alright in spite of poor childhoods; how is that some adults cope much better than others in the face of adversity?”. The literature deals with adversity and resilience in families and in children, but is not so helpful in the specific issue of resilience in young pregnant women living in adverse circumstances.

72.1. A review of resilience<sup>88</sup> states:

➤ “The asset of autonomy concerns self-esteem, self-efficacy and mastery beliefs Rutter maintains that a positive outlook, optimism and a sense that one can accept challenges is important. He describes a sense of self-esteem and self-efficacy as:

➤ “... a feeling of your own worth, as well as a feeling that you can deal with things, that you can control what happens to you. One of the striking features of problem families is that they feel at the mercy of fate, which is always doing them an ill-turn. So one important quality is a feeling that you are in fact master of your own destiny”. (Rutter, 1984)

72.2. External assets or protective factors have been described in relation to three primary systems in the child's world-family, school and community. In relation to the family, key factors are the consistency and quality of care and support the child experiences during infancy, childhood and adolescence; adequate and consistent parental role models and harmony between the parents; parents who spend time with children in order to pass on verbal and social attainments; parents who provide for and take an interest in constructive use of leisure and who provide firm and consistent guidance without repressive or rejecting attitudes.

72.3. In relation to the family, key factors include family size (four or fewer children); the availability within the household of care-givers, apart from the mother, all of whom were prepared to provide substantial amounts of attention to the child in infancy; a manageable maternal workload; structure and rules during the child's adolescence; family cohesion; an informal and multigenerational network of kin and friends during adolescence and few chronic, stressful life events experienced during childhood and adolescence.

72.4. Resilient families have three particular characteristics in common<sup>89</sup>. First they have a system of celebrations and acknowledgments of key events in the life of the family that have a stabilising effect during times of crisis (e.g. celebrating birthdays). Secondly family members have strong, durable beliefs in their ability to control life and thirdly, the family establishes and maintains routines for a variety of activities (e.g. specific times for meals or for accomplishing particular household tasks)".

72.5. Measuring "resilience" in any formal way is likely to be very difficult \_ nevertheless FNP's will find the concept helpful and relevant and may be able to assess it informally using the points listed above.

73. **Child abuse risk factors** Prediction of families at risk of abusing their children has been studied by a number of researchers. While preventing child abuse must be one of the aims of any early intervention programme, abuse leading to child protection proceedings is only the tip of the iceberg of poor parenting.

- Complications during birth/separated from baby at birth (1)
- Mother or partner under 21 years of age (1)
- Mother or partner not biologically related to the child (1)
- Twins or less than 18 months between births (1)
- Child with physical or mental disabilities (1)
- Feelings of isolation (1)
- Serious financial problems (2)
- Mother or partner treated for mental illness or depression (2)
- Dependency for drugs or alcohol (2)
- Infant seriously ill, premature or weighed under 2.5kg at birth (2)
- Single parent (3)
- Adult in the household with violent tendencies (3)
- Mother or partner feeling indifferent about their baby (3)

Risk factors for child abuse and neglect identified by Browne.(figures in brackets indicate weight attached to each item). In use, these data are combined with observations about the infant and infant/ parent relationships. Reproduced by permission of John Wiley and Sons.

**Box 7**



74. In England the best known work is that of Browne<sup>90</sup>. Using a checklist (Index of Need - Box 7) he was able to identify a group of families who were at substantially higher risk of being involved in child protection proceedings.

75. The figures illustrate the difficulties of this approach. In a study of over 4000 families with infants, the Index could identify:

- 45% of child protection referrals with a 2.6% false alarm rate;
- 63% of child protection referrals with a 4% false alarm rate;
- 74% of child protection referrals with an 8.4% false alarm rate.

75.1. Thus, although many cases can be correctly identified, a substantial proportion of misclassifications is inevitable and many cases occurs in the low risk group. The performance of any such screening procedure will almost certainly be worse if applied before the baby is born, as child abuse, like many other adverse outcomes, is related to some extent on the gender, appearance, intelligence and personality of the baby and on life events yet to come. Note however that the risk factors that would be identifiable in pregnancy overlap to a considerable extent with those described in studies of other outcomes in other disciplines.

75.2. A UK systematic review of instruments designed to identify risks of child abuse concluded that none of the available methods was sufficiently robust and the authors advised that “screening” for high risk of abuse could not be recommended<sup>91</sup>. The USA Task Force came to a similar conclusion.

76. **Unwanted pregnancy.** An unwanted pregnancy is quoted by some authors as a risk factor for adverse outcomes. It is however a complex topic as many women (and their partners) are ambivalent about their pregnancy. Simplistic judgments based on just one or two questions, or statements by the mother, may be misleading.

77. If the topic is to be raised at all the interviewer should be familiar with the key concepts involved. One way of classifying women’s feelings about their pregnancy is shown in Table 3<sup>92</sup>.

78. **SUDI** Risk factors for sudden unexpected death in infancy (SUDI) – there are three risk factors for sudden unexplained death in infancy – young mothers (under 27 and having more than one child); poverty; smoking in the household<sup>93</sup>. These risk factors are of course too broad to be of much use in selecting women to be offered the FNP but they are a reminder about the continuing hazards of smoking after the baby is born and the potential benefits of the programme for the physical health of the baby - any early intervention programme might reasonably include reducing the risk of cot death among its objectives. Furthermore, there is continuing debate about the proportion of SUDI cases that might in fact be due to homicide.

Intended	Planned	Wanted
<ul style="list-style-type: none"> <li>•Attempting to become pregnant</li> <li>•Becoming pregnant on purpose</li> <li>•Willing to carry the pregnancy to term</li> <li>•Being emotionally and physically ready</li> <li>•Talking about it first</li> <li>•Having sex without using contraception</li> </ul>	<ul style="list-style-type: none"> <li>•Determining when ovulation occurs and consciously trying to conceive</li> <li>•Not using contraception</li> <li>•Being financially prepared</li> <li>•Having a secure job or making sure partner has a secure job</li> <li>•Talking about the pregnancy before it occurs with a partner</li> <li>•Having a stable relationship, particularly marriage</li> <li>•Physical readiness</li> </ul>	<ul style="list-style-type: none"> <li>•Desire for a baby</li> <li>•Desire for another baby</li> <li>•Desire to be a mother</li> <li>•Partner was excited about the pregnancy</li> <li>•Both partners willing to raise the child together</li> <li>•Physical readiness</li> <li>•Emotional readiness</li> <li>•Having a home</li> <li>•Being married</li> <li>•Starting a family</li> <li>•Cannot identify with having a child that is not wanted, despite adverse circumstances</li> </ul>
Unintended	Unplanned	Unwanted
<ul style="list-style-type: none"> <li>•Not discussed between partners</li> <li>•Did not plan or mean for pregnancy to occur</li> <li>•Not on purpose</li> <li>•Pregnancy occurs when active prevention was used, such as birth control</li> <li>•Pregnancy just happens</li> <li>•Did not plan to become pregnant again</li> <li>•Lack of responsibility</li> </ul>	<ul style="list-style-type: none"> <li>•Pregnancy just happened</li> <li>•Pregnancy was an accident</li> <li>•Timing not good</li> <li>•Becoming pregnant despite efforts to use birth control</li> <li>•Result of "stupidity" or "lack of responsibility"</li> <li>•Pregnancy was something that was not supposed to happen</li> <li>•Did not discuss with partner</li> <li>•Wanting birth spacing further apart</li> </ul>	<ul style="list-style-type: none"> <li>•Not financially stable or no financial support</li> <li>•Lack of other (nonfinancial) support from partner</li> <li>•Being unmarried</li> <li>•Impediment to finishing school or maintaining job</li> <li>•Diffidence to having another baby</li> <li>•Guilt over being dependent on others for support</li> <li>•Perceived inability to cope with the pressure of being a single mother</li> <li>•Anxiety over physical changes associated with pregnancy</li> <li>•Too young</li> <li>•Wanting father's support, but not sure he is the right person to commit to</li> <li>•Just not happy</li> </ul>

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**Table 3**

## 79. High risk behaviours

79.1. High risk behaviours in the parents and particularly the mother are clearly linked to adverse outcomes for the child, whether they occur in isolation or in association with one or more other risks.

79.2. Substance abusing mothers do not all conform to the stereotype of the "drug addict" – those who can support their habit sometimes maintain an outwardly normal lifestyle. However, as a group these women are at risk of a variety of adverse outcomes for the baby both in infancy and later in childhood<sup>94</sup>. Although local policies vary in detail, any woman known to be abusing drugs in pregnancy is likely to be the subject of a child protection conference. The Drug Abuse Screening Test (DAST) can be used for screening.

79.3. Similarly, women abusing alcohol, either on a regular basis or in binge drinking, are at risk of having a child with fetal alcohol syndrome (FAS) as well as exposing the child to the social and economic risks associated with alcoholism. The prevalence of FAS is estimated at 0.9 -4.8/1000 for the full syndrome and 9.1/1000 (almost 1 in one hundred) for FAS spectrum disorders. There is still uncertainty regarding the pattern(s) of alcohol consumption that are most likely linked to FAS. The safest advice to pregnant women is to avoid alcohol.

79.4. Many midwives ask routinely about the use of drugs and alcohol in pregnancy (Table 4)<sup>95</sup>. Widely used screening tests for alcohol abuse include the Michigan Alcohol Screening Test (MAST), the CAGE screen ( ), the T-ACE (Tolerance, Annoyed, Cut down, Eye-opener), the TWEAK. These were not designed specifically for use in pregnancy. Several studies examined alcohol use habits in pregnancy with a range of approaches including the Alcohol Use Disorder Inventory Test (AUDIT), the TimeLine Follow Back for drinking and contraception, a risk questionnaire, the OQ-45, and the NEO-Five Factor Inventory. The various methods of assessment yield diverse results<sup>96</sup> and there is no ideal method for use in pregnancy. Among young women likely to be offered the FNP, social trends suggest that binge drinking is likely to be a bigger issue than chronic alcoholism. This is thought to increase the risk of “cot death” (SIDS).<sup>97</sup>

79.5. Straightforward questions about substance use and being open about the routine practice of a urine screen for drugs can create an atmosphere in which women are prepared to discuss their habit<sup>98</sup>; but this depends on good links with social services, and the child protection and drug rehabilitation teams. Many more women are using drugs than is generally recognised and many of them function very well in spite of the habit, provided that they can afford the cost.

<b>Alcohol screening tests validated for use in pregnancy The 5P test</b>		
Did any of your parents have a problem with alcohol or other drug use?		
Do any of your friends (peers) have problems with alcohol or drug use?		
Does your partner have a problem with alcohol or drug use?		
<b>Past:: Before you knew you were pregnant, did you drink any beer, wine or liquor?</b>		
<b>Pregnancy: in the past month, have you drunk any beer, wine or liquor?</b>		
<b>TWEAK</b> The TWEAK is a tool validated with pregnant women,		
<b>T</b>	Tolerance: How many drinks does it take to make you feel high? (Or this can be modified to "how many drinks can you hold"?) Record number of drinks. . No. of drinks	<i>Score 2 points if she reports 3 or more drinks to feel the effects of alcohol</i>
<b>W</b>	Worry: Have close friends or relatives worried or complained about your drinking in the past year?	<i>Score 2 points for a positive "yes".</i>
<b>E</b>	Eye-Opener: Do you sometimes have a drink in the morning when you first get up? Yes No	<i>Score 1 point for a positive "yes".</i>
<b>A</b>	<b>Amnesia (Blackouts): Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember? Yes No</b>	<i>Score 1 point for a positive "yes".</i>
<b>K(C)</b>	Cut Down: Do you sometimes feel the need to cut down on your drinking? Yes No	<i>Score 1 point for a positive "yes".</i>

**Table 4**

80. **Smoking** The adverse effects of smoking in pregnancy are well known – there are adverse effects on the fetus, on the physical health of the child and probably on behaviour (an increased risk of hyperactivity attention deficit disorder has been reported) Furthermore, women who continue to smoke (or whose partners or households continue to smoke) in pregnancy will probably go on doing so after the child is born. There is strong evidence of a link between smoking and an increased risk of sudden infant death, respiratory illnesses and meningitis..

80.1. It is routine to ask pregnant women about smoking. The unreliability of self-report as a measure of smoking status in healthcare settings, especially in maternity care, was noted in the first pregnancy trial (though not found by others in the 1980s). The evidence is very strong in more recent trials. Up to a quarter or a third of women describing themselves as non-smokers have levels of salivary or urinary cotinine (biomarker) incompatible with that self-description.

80.2. As the biochemical measures have a relatively poor correlation with the number of cigarettes smoked it is not possible to use, for example, cotinine levels to assess smoking reduction. Furthermore, people who do cut down and smoke fewer cigarettes often inhale more deeply in order to maintain their blood nicotine at high enough levels to avoid withdrawal symptoms<sup>99</sup>. A very high proportion of pregnant women describe themselves as having “cut down” but only biochemically validated smoking *cessation* can be regarded as a reliable outcome measure. For a heavy smoker a halving of the cotinine level may still represent a level of tobacco consumption hazardous to the fetus. It has been suggested that reduction in smoking to fewer than eight cigarettes a day is necessary to avoid reduction in infant birthweight<sup>100</sup>.

80.3. It seems likely that the findings of research apply also in routine practice – women are well aware of the pressure to reduce smoking or quit and although they are unlikely to deny smoking completely, it cannot be assumed that they will give reliable responses to questions about how much they smoke or the extent to which they have cut down since they became pregnant. Taking this into account, the Cochrane review (op cit) calculated that smoking cessation programmes in pregnancy may result in 6 out of 100 women quitting, fewer low birthweight and pre-term babies and a modest increase in birthweight. The trials had insufficient power to detect changes in perinatal mortality or very low birthweight.

80.4. Women’s fears that smoking reduction will, by increasing fetal size, increase the probability of a difficult labour or an operative delivery have been taken into account very rarely in the design and implementation of smoking cessation programs. There are also concerns about adverse effects of quitting, or increased guilt over continued smoking, on women’s psychological well-being and capacity to cope with adverse circumstances, with flow-on effects to the well-being of other family members as possible adverse effects of smoking cessation interventions.

80.5. Smoking could be seen as a proxy for adverse social circumstances and this together with the adverse negative biological effects of smoking suggests that smoking on its own could be regarded as a criterion for offering the FNP . However, there are two reasons why we do not advocate this: first, there will be some women for whom smoking is the only or main risk factor and for these other more focused but less costly interventions may be more appropriate; second, smoking can be a difficult

subject to raise as professionals worry about antagonising young women who have no intention of stopping smoking.

80.6. The vast majority of young women know that smoking is bad for them and bad for their baby. A formal set of questions to emphasise the point and to assess the level of nicotine dependency may be useful <sup>101</sup> (see Table 5).

Q1. How many cigarettes per day do you usually smoke? (Write a number in the box and circle one response)	<input type="text"/> 10 or less 11 to 20 21 to 30 31 or more	0 1 2 3
Q2. How soon after you wake up do you smoke your first cigarette? (Circle one response)	Within 5 minutes 6-30 minutes 31 or more	3 2 0
Q3. Do you find it difficult to stop smoking in non-smoking areas? (Circle one response)	No Yes	0 1
Q4. Which cigarette would you most hate to give up? (Circle one response)	First of the morning Other	1 0
Q5. Do you smoke more frequently in the first hours after waking than the rest of the day? (Circle one response)	No Yes	0 1
Q4. Do you smoke if you are so ill that you are in bed most of the day? (Circle one response)	No Yes	0 1

The Fagerstrom test for nicotine dependence: a quantitative index of dependence. The numbers in the pink shaded column corresponding to the smoker's responses are added together to produce a single score on scale of 0 (low dependence) to 10 (high dependence). Adapted from Heatherton et al. *Br J Addict* 1991;86:1119-27

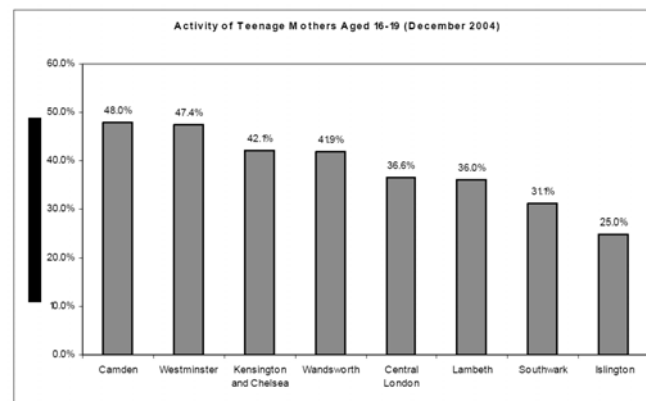
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**Table 5**

## (7) How common are the risk factors identified in the review? – Demographic data

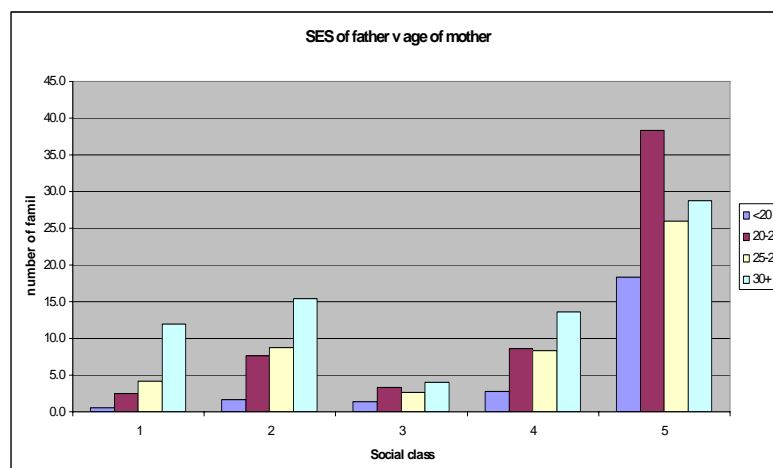
81. The FNP aims to target first-time parents focussing only those most likely to benefit. In order to plan the service and estimate resource requirements, estimates of how many potential clients might be identified are needed, using a range of assumptions<sup>102</sup>.

82. The most frequently identified factor in predicting adverse outcomes is young parenthood. This is linked to poor engagement with education and with poverty – on average, only 30% of mothers aged 16-19 are in “EET” – education, training or employment (see paragraph 21). However, this figure disguises wide variations – for example, Figure 17 shows that in London the highest figure is double the lowest.



**Figure 17 Teenage mothers in EET**

83. The fathers of children born to young mothers are also more likely than the fathers of children born to older mothers to be unemployed or in low paid jobs (Figure 18). The data are incomplete as details of the father are not always recorded when the birth is registered in the case of unmarried women.



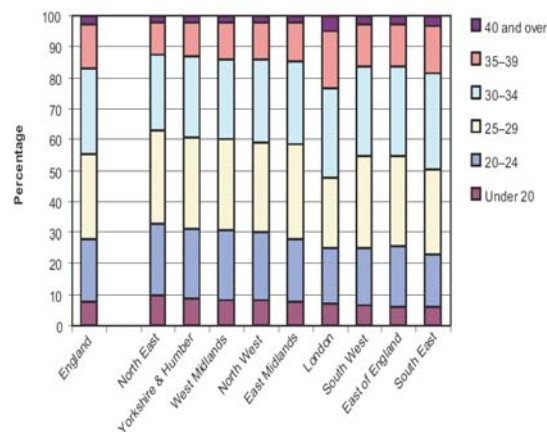
**Figure 18 SES of fathers by age of mother: the youngest mothers are the most likely to have partners of low SES**

84. The most powerful predictor that is also easy to ascertain is whether the mother has been “Looked After”. Data on Looked After young mothers are summarised in Box 4. Note that the numbers are very small and make up only a tiny proportion of all young mothers.

85. Although the other factors listed in Box 5 are important, they are in general more difficult to ascertain and to quantify. They are also likely to vary widely between and even within areas.

86. The numbers of births expected in the population is summarised in Figure 19. The average age of a mother for a first baby is now 27 years. On average, 7% of births are to mothers under 20 and 19% to mothers aged 20-24. 43% of all births are first babies.

*Figure 3.2.2 Percentage breakdown of age-specific live birth rates by age group of mother and region of residence, 2004*



Note: the rates for women of all ages, under 20, and 40 and over are based upon the population of women aged 15-44, 15-19 and 40-44 respectively.  
Source: ONS: Population Trends 122

**Figure 19 distribution of births by age and region – note wide variation.**

87. There are wide variations in total and age-specific conception and birth rates between areas. For example, in 2004 there were 42198 conceptions by women under 18 years old, of which 60% resulted in livebirths. However, the rate per 1000 women varied across the country from less than 20 to more than 80 – a fourfold difference. At the end of 2005, there were around 50,000 mothers under-20 in England (around 3.3% of all females aged 15-19); and a total of 64,000 children born to these mothers (around 2.7% of all children aged 0-4 years).<sup>103</sup>

87.1. Figure 20 summarises data for England. Figure 21 compares two areas, with high and low rates of births to young mothers.

88. Most long term outcome data combine all age groups under 20 years as “young mothers” but it is highly likely that there is a big difference between motherhood at 15 or 16 compared to 18 or 19<sup>104</sup>. The number of mothers under the age of 18 is a relatively small proportion of all “teenage” mothers – see Figure 22.



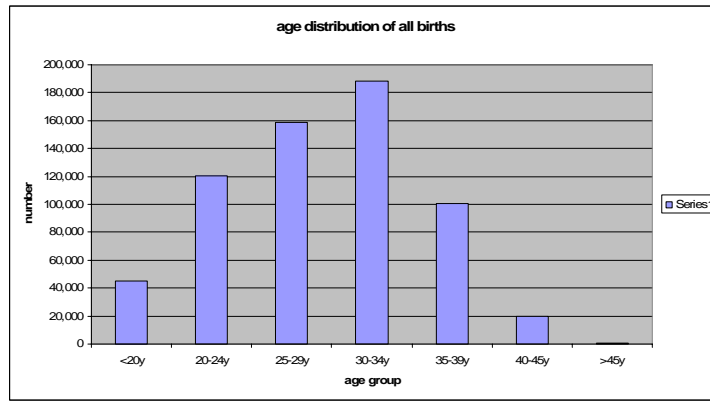


Figure 20

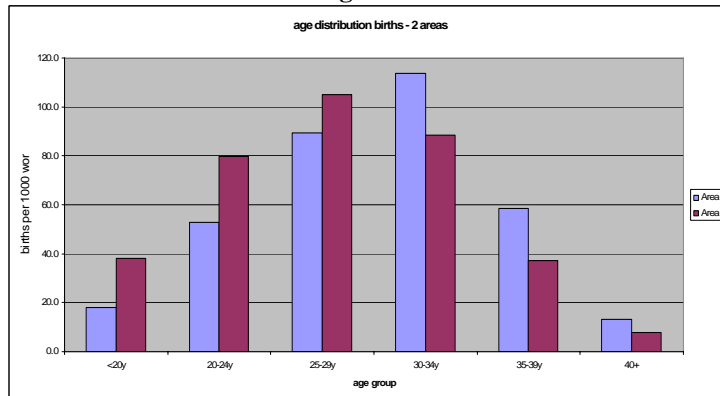


Figure 21

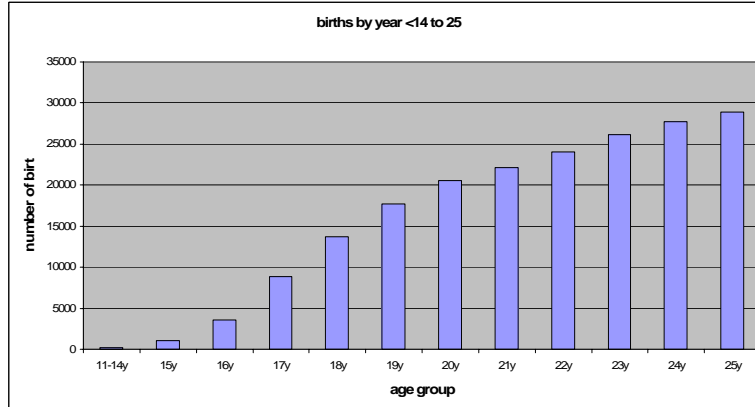


Figure 22

89. There are no comprehensive data on what proportion of births are first births by age group but a reasonable estimate is that among mothers under 20 no more than one quarter, and less in the younger mothers, are second or subsequent births (Figure 23). . The proportion does of course rise with each successive age cohort; thus around 55% of births to women age 20-24 are first births. . Among mothers under-20 at the end of 2005: around 20,000 (40%) had more than one child (Figure 24). Around 41,000 (82%) gave birth during 2005 (around 30,000 a first birth and 11,000 a subsequent birth). .<sup>105</sup>

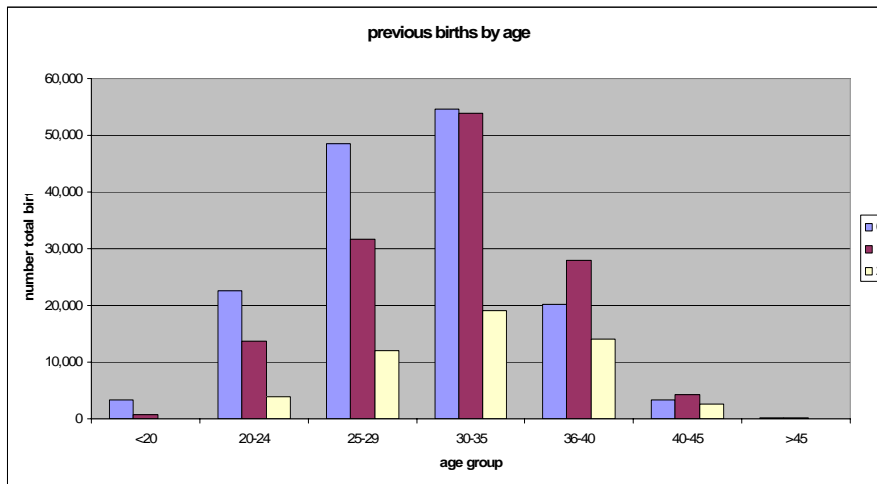


Figure 23

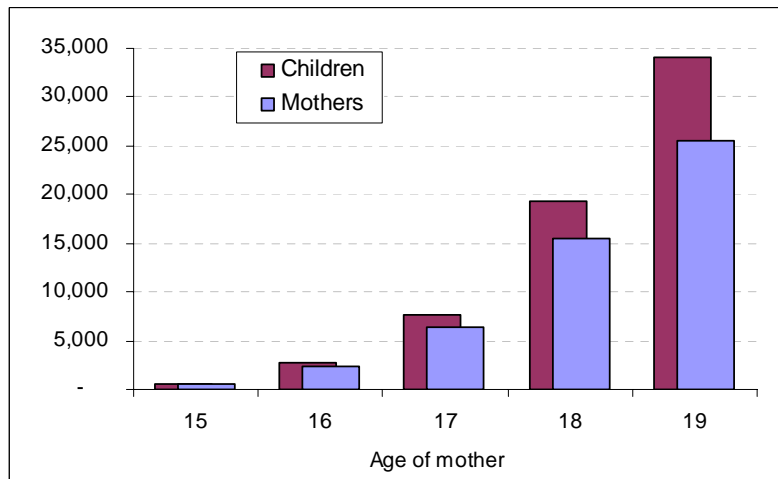


Figure 24

### (8) The Relevance of the demography to the planning of the pilot programme.

90. The FNP is labour intensive and expensive in money and in scarce personnel – the Programme Nurses have a caseload around one tenth of that carried by a HV in England. If the Programme is ever to be generalisable in England, it will be necessary to offer it only to the families with the greatest need and capacity to benefit. This means that it will be important to identify those families as accurately as possible – a difficult task.

91. For the pilot phase, however, the constraints placed on the project mean that it will be necessary to recruit subjects quickly and this in turn means that the criteria for entry to the programme during the pilot phase will need to be less stringent than would be the case for a national roll-out.

92. The demographic data summarised in the previous section illustrate the difficulties. By far the easiest eligibility criterion to operate is the age of the mother.

The youngest women are likely to be those who would benefit the most but the proportion of all births accounted for by women under 18 is quite small.

92.1. The figures in Box 8 illustrate how many women of varying ages are likely to fall pregnant and book in a 6 month period, for the population of Sheffield.

Depending on the assumptions made about acceptance and drop out rates, estimates can be made of the size of case load that could be accumulated in that time.

92.2. The figures in the table can be extrapolated for smaller populations; thus for a population much smaller than that of Sheffield, in order to build a case load quickly it is likely that the programme may be offered to some women who might not be considered eligible if the project is taken to a national scale.

<ul style="list-style-type: none"> <li>➤ City of Sheffield – population approximately 500,000, 6000 births per year.</li> <li>➤ 3000 births in 6 months (the expected recruitment period for the pilot study).</li> <li>➤ Sheffield has higher than average proportion of births to younger mothers – rate of 40 / 1000 for women aged &lt;20.</li> <li>➤ Population of women aged 15-19 is 18000</li> <li>➤ This = 720 births per year or 360 per 6 months.</li> <li>➤ Approximately 5/6 of births in this age group are first births, i.e. 300.</li> <li>➤ The population aged 20-24 is 24000 and the rate is 80/1000</li> <li>➤ This = 1920 births</li> <li>➤ In this age group about 55% of births are first births.</li> <li>➤ This = 1050 in a year or 525 in 6 months</li> <li>➤ The age distribution of potential clients is as follows:</li> </ul>														
<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <th style="width: 15%;">Age</th> <th style="width: 15%;">11-15</th> <th style="width: 15%;">16</th> <th style="width: 15%;">17</th> <th style="width: 15%;">18</th> <th style="width: 15%;">19</th> <th style="width: 15%;">20-24</th> </tr> <tr> <td>Number / 6 months</td> <td>6</td> <td>21</td> <td>57</td> <td>90</td> <td>126</td> <td>525</td> </tr> </table>	Age	11-15	16	17	18	19	20-24	Number / 6 months	6	21	57	90	126	525
Age	11-15	16	17	18	19	20-24								
Number / 6 months	6	21	57	90	126	525								
<p>If we assume 50% are successfully engaged, this provides 150 clients under 20 in 6 months – enough for 6 home visitors with case load of 25 each.</p>														
<p>For every 100,000 population, the figures would be:</p>														
<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <th style="width: 15%;">Age</th> <th style="width: 15%;">11-15</th> <th style="width: 15%;">16</th> <th style="width: 15%;">17</th> <th style="width: 15%;">18</th> <th style="width: 15%;">19</th> <th style="width: 15%;">20-24</th> </tr> <tr> <td>Number / 6 months</td> <td>1</td> <td>4</td> <td>11</td> <td>18</td> <td>25</td> <td>105</td> </tr> </table>	Age	11-15	16	17	18	19	20-24	Number / 6 months	1	4	11	18	25	105
Age	11-15	16	17	18	19	20-24								
Number / 6 months	1	4	11	18	25	105								
<p>If we assume 50% are successfully engaged, this provides 30 clients under 20 in 6 months – enough for 1 home visitor with case load of 25-30.</p>														
<p><b>Box 8</b></p>														

92.3. We will return to this issue later. We propose to turn this dilemma to advantage – we will suggest that the pilot phase should be used to study how potential recruits from a variety of backgrounds respond to the offer of the service and from this a clearer idea will be obtained of how best to narrow the criteria for entry. It may

be helpful for the pilot phase to engage some clients who, although not among the most needy, are keen to engage with and take part in the programme.

## **(9) Progressive universalism and targeted programmes**

93. Health visiting is widely regarded as a universal service, but this does not mean that it offers the same for everyone. The aim is to provide a basic or core service of health promotion and health surveillance for all families, but some families need more support for a short period of time, while others have complex long term needs. Some of the latter could be met by the FNP but many other families would need a very different service, tailored to their individual circumstances.

93.1. Successive editions of *Health for all children*, and the *National Service Framework for Children, Young People and Maternity Services (NSF)*, have supported these aims. Health visitors need to apportion their time carefully in order to make best use of their skills.

93.2. It is important to consider how the proposed FNP of intensive home visiting will relate to community child health services and mainstream health visiting. England is justifiably proud of the fact that health visiting is a universal programme and it would be tragic to allow this to disintegrate or to be eroded in order to support the financial and human resource demands of an intensive home visiting FNP. Nevertheless, the FNP will challenge the mainstream services to review and clarify their aims and their use of resources.

93.3. Most districts have some form of Health Needs Assessment protocol<sup>106</sup>. For example, in Sheffield, health visitors prioritise their caseload using three categories – low, medium and high priority<sup>16</sup> (see Figure 25). In Bristol, a checklist of family problems and stress factors was used<sup>107</sup>. Fenlands devised a method of Needs Assessment and undertook an in-depth evaluation of this<sup>108</sup>.

94. **Lessons from Health Needs Assessment** Several relevant lessons have emerged from reviews of Health Needs Assessment methods, health visiting practice and outcomes

94.1. Health visitors vary widely in the extent to which they prioritise case loads – some offer up to ten times more input to the highest need families compared to routine care, while for others the ratio is very much lower<sup>109</sup>.

94.2. Although health visitors recognise that the poorest families probably need their services the most, the take-up of routine reviews declines with the increasing age of the child more rapidly in the poorest families<sup>110</sup>.

94.3. Even when using a formal checklist system such as the one developed in Bristol, health visitors obtain substantially different results from those found by a researcher visiting those same families<sup>111</sup>. There are probably several reasons – pressures of time, varying ways of framing questions and interpreting answers, reluctance to open up painful topics when there is no time for discussion or no supporting service or intervention on offer, and reluctance of the client to disclose personal problems. Staff who work in both affluent and deprived areas are likely to have a different concept of what constitutes “good enough” parenting, and to elicit more needs, than those who work exclusively in deprived areas.

95. Appleton<sup>112</sup> found that there are at least 77 different Needs Assessment systems in use in England. She identified a wide range of instruments used by health visitors, the lack of evidence base for most of them, the variability, and the fact that in spite of requirements set out by managers many health visitors either do not use them or use them sporadically and grudgingly.

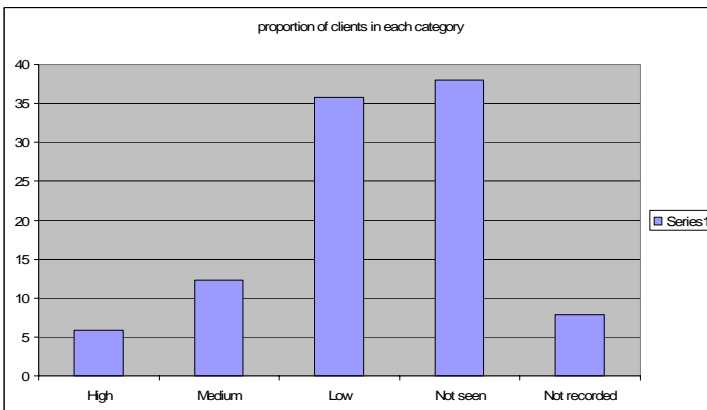
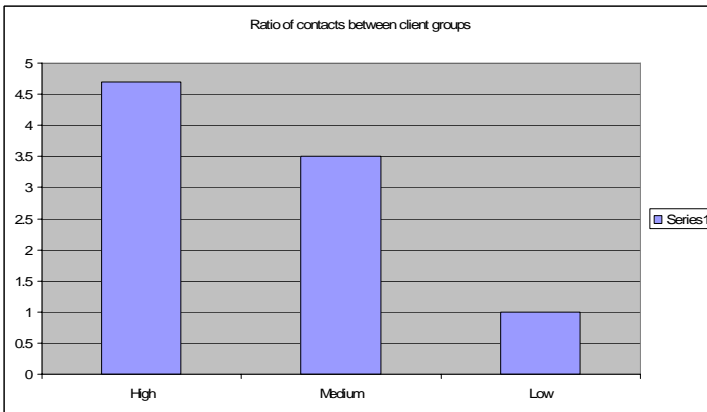
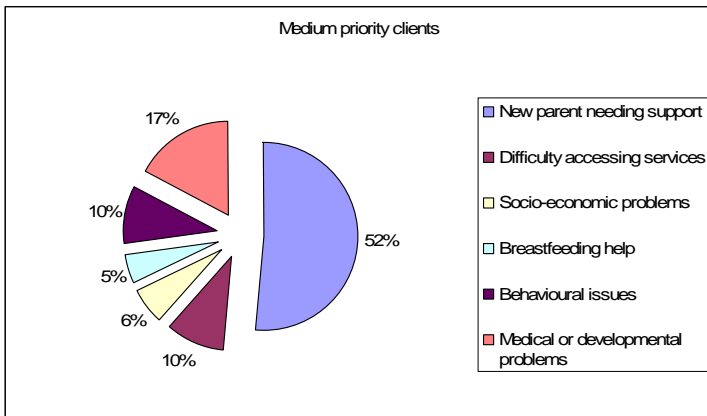
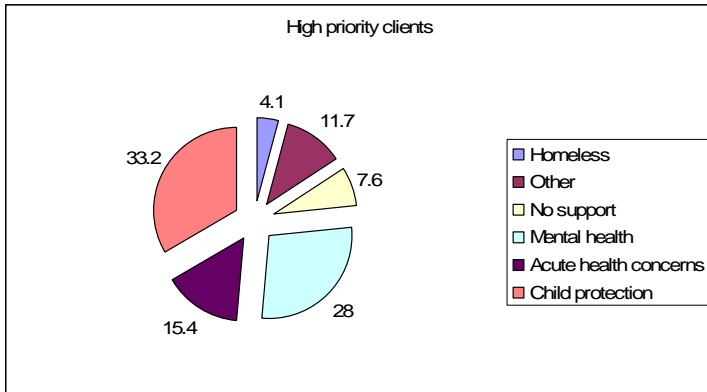
95.1. Cowley<sup>113</sup> reviewed the medicalisation of health visiting practice and noted that many health visitors ignore or pay only lip service to the requirements of local managers regarding Health Needs Assessments.

95.2. Time pressures and managerial demands often result in excessive attention being paid by the health visitor to getting through a list of topics instead of listening to the clients' real concerns<sup>114</sup>.

95.3. Clients designated as low risk and low priority (typically middle class mothers in stable families with a healthy first infant) still expect a quality health visiting service and value this, particularly in the early weeks of their first child's life. They object to poor service and resent the failure of staff to respond to phone calls and messages<sup>115</sup>. Furthermore, depression and domestic abuse cross all social boundaries.

95.4. Nursing practice recognises that "intuition" plays an important part in professional work with clients. It is based on a mixture of experience, astute observation, empathy and rapid mental processing<sup>116</sup>. Many nurses feel that too rigid an approach or structure makes them less effective in their work.

95.5. There is likely to be some tension between the requirements of the FNP to follow the protocol, and the widespread reluctance on the part of community nursing professionals in England to be tied into rigid structures. This suggests that at the recruitment stage it will not be easy to persuade the many community staff involved in pregnancy care to use either a nationally agreed interview schedule or any standardised instruments for identifying potential clients.



### The Sheffield Health Visiting Study.

The first chart shows how HVs spent their time with high priority clients; the second chart shows the time spent with medium priority clients; the third shows that HVs allocated their time according to priority; the fourth shows that high priority clients make up a small proportion of the “average” case load.

The study showed that although HVs provide a universal service, they allocate their time according to perceived need.

**Figure 25**

## **96. Lessons from other UK Home Visiting Programmes**

96.1. Olds has reported extensively on the NFP programme in the USA, but because the context is very different from that of England, it would be unwise to extrapolate his recruitment and attrition data to England.

96.2. In England, two studies are particularly relevant to the proposed FNP . The first was an evaluation of the First Parent Health Visitor Scheme (FPHVS) in Bristol <sup>117</sup>. The Scheme offers regular home visiting to first time parents, starting in pregnancy. In this study, 733 women were invited to take part and 475 agreed to participate. The refusers were less likely to be married, to have a supportive partner or to have a telephone. The attrition rate after enrolment was only 7% in the first year.

96.3. The second study was by Barlow et al <sup>118</sup>. This was a randomised trial of intensive home visiting. Midwives recruited at general practices on the basis of specified eligibility criteria and referred to the researcher who enrolled them to the study. Of 433 identified by the midwives, 120 declined to be involved, and 151 were excluded by the researcher, mainly on the grounds that they were not sufficiently high risk. A further 31 refused to be randomised. Thus 131 entered the study. As in the Bristol study, the attrition rate was low. The report does not specify how many possible clients were “missed” by the midwives and it is doubtful that such information could be obtained within this design.

96.4. These studies were presented to subjects as research that involved obtaining consent and some of the women who were reluctant to take part may have been more willing to accept the offer of the visiting programme if it had been presented as a regular service. Barlow’s cohort had an average age of 25 years and at least one third had one or more children, so one cannot extrapolate directly from her findings.

96.5. However, the two studies together suggest that in England the greatest threat to the success of an FNP will be at the initial recruitment phase – attrition was quite low in both studies once enrolment had been achieved. A considerable burden is placed on the professionals who must first identify possible risk factors and then persuade the woman to accept the programme offer – a task that may be time consuming and require considerable skill.

97. In England FNP , the first and sometimes the only opportunity to recruit women to the programme will rest with the midwives. We conclude that there are in principle two options: (1) midwives should have sufficient time, and appropriate training, to interview in depth all women having their first child, at the booking clinic, so that they can identify most of the suitable candidates for the FNP with reasonable accuracy and engage the client’s interest and commitment, prior to referral onwards to the FNP; OR (2) midwives are asked to apply only the simplest criteria and the need is accepted for a “second tier” of interviewing and assessment to be undertaken subsequently by other professionals, to determine eligibility and to enrol suitable clients.

97.1. In between these two options, a number of compromises are possible, but the experience of Barlow et al suggests that even when the midwives are presented with a detailed list of eligibility criteria, a second tier of assessment will result in a significant number of clients being deemed unsuitable. Conversely, there is a high probability that the midwives will “miss” many possible clients, due to pressure of time, non-disclosure of key information by the client or possibly, in some cases, lack of commitment to the programme as a whole by midwives. This appeared to be a significant issue in the study of Barlow et al:

*“.... Midwifery has a very ante-natal perspective of pregnancy and childbirth and the idea that there is a need for this service- I don't think they take that on board at all, they don't feel committed to that.....the midwifery manager in our patch was openly hostile to the home visiting service”.*

It is clearly crucial to ensure that midwives are fully involved in the planning and implementation of the programme so that they have a sense of shared ownership.



## (10) Recruitment

98. Our review of the risk factors for adverse outcomes resulted in a list of important issues that need to be considered. These were summarised in Box 5. Given that much of the predictive power for future outcomes is based on information to do with the young child, it is clear that prediction during the pregnancy with the first child can never be precise.

98.1. **The principles** Table 6 summarises the Principles which we suggest should be applied to the identification and selection of women who might be offered the FNP

**Table 6 is on the next page.**

99. **The key role played by midwives** We argued in paragraph 97 that the midwives will be key to recruitment so defining their task is crucial to success. However, there are important time constraints for many midwives.

99.1. The current trend to early booking in pregnancy is encouraged because of the screening and scanning requirements in modern obstetric and midwifery care. This means that the booking interview involves a substantial amount of explanation and discussion.

99.2. Pathways to the midwife vary – in some cases there are close links with GPs, in others midwives play a major role in pregnancy care right from when the woman thinks she may be pregnant. Some midwives undertake the Booking appointment at the woman's home. There are also variations in the roles played by other staff, for example midwives specialising in teenage pregnancy or substance misusing mothers.

99.3. After the booking interview, ideally at or around 12 weeks, most women will be seen again at 16 and then at 19-20 weeks. This means that if women are to be recruited as early as possible in pregnancy, as set out in the FNP guidance, the referral needs to be made whenever possible at the booking interview.

99.4. The booking visit is time consuming and opinions differ about whether it is realistic to ask midwives to undertake much additional interviewing beyond their normal routine as part of the identification process for the FNP. Similarly, we must assume that many midwives will not have time to undertake detailed explanations of what the FNP could offer (unless the booking clinic is also attended by a professional with more time to devote to women who need more discussion – this could for example be a specialist midwife for teen pregnancy, a specialist health visitor or a social worker.)

99.5. Several different models of recruitment are possible and we discuss these in detail in paragraphs 108. They differ primarily in the extent to which the midwife is asked to undertake any preliminary filtering. The ways in which the data on risk factors are applied will depend to some extent on which model is selected.

## **(11) Using risk factor data to create the instrument:**

100. There are several options:

100.1. The *purely geographic* approach – this involves identifying a set of post codes that are associated with high levels of deprivation and recruiting only those women who live in those areas. The midwife would simply refer every woman from these specified postcodes to the Programme.

100.2. While some degree of *geographic targeting* is essential, we suggest that at least in the pilot phase this will depend more on factors such as the location of Sure Start programmes and Children’s Centres, staffing patterns, and the need for home visiting FNP staff to spend as little time as possible travelling between clients. These decisions will have to be made by the local PCTs and Local Authorities who submit the successful bids for the pilot phase. At present, we regard the postcode as essential information for evaluation purposes but cannot make specific recommendations regarding its use in recruitment. However, in the future it may be feasible to design services in a way that takes more account of local geography, using for example the Index of Multiple Deprivation or the MOSAIC system.

100.3. Use *one simple criterion* to select those at increased risk. Of these, probably the only option is the mother’s age, notwithstanding the misgivings summarised earlier in this report. While we have no conclusive evidence that risk is proportional to age, in the absence of evidence to the contrary it is reasonable to suppose that the youngest women – those still of compulsory school age – are at the highest risk, followed by those between 16 and 19, while those aged 20-24 would have a lower risk. The age cut-off may need to be adjusted in the light of experience but we suggest that under 20 would be the ideal age to adopt for the first part of the pilot phase. Such an approach would however be likely to miss a significant number of clients who could potentially benefit.

(Recruitment is based on the mother’s age but the need to engage fathers must be remembered. In view of the varying ages used by researchers to define “young” fathers, and the absence of evidence as to which is best, we suggest that the cut-off of 23 for fathers is most in keeping with the literature; however, whether or not this has any practical relevance would depend largely on what services are offered for fathers, whether or not they are deemed to be “young” .

100.4. Use an *assessment interview* to identify risk factors and increase precision of recruitment. We have considered several possible ways of doing this:

- *Formal questionnaires* One important general issue is whether or not formal questionnaires should be used as well as, and sometimes instead of, informal history taking and interviewing. Formal questionnaires have the benefit of appearing to be objective psychometric instruments, but their validity varies according to circumstances, cultural factors and the ways in which they are presented to the client.
- Questionnaires can be self-administered, which has the advantage of saving time and allowing a degree of privacy while a woman thinks about her answers; or administered by the professional. The latter has the advantage that the way the questions are presented can be modified in line with the client’s situation and knowledge of English. Some professionals find it is easier to ask difficult or intrusive

questions when using a questionnaire – it can be presented as just a part of the routine assessment. There are some situations, for example domestic violence, where a questionnaire may reveal more information than an interview.

➤ We question the readability of many of the standard instruments we have reviewed in preparing this report, in the light of recent studies on adult literacy. It must be assumed that between 10 and 20% of potential clients for the FNP will have serious difficulties with reading at an equivalent age level of 11 years. In order to avoid embarrassing and alienating clients and to obtain reliable information, sensitive use of questionnaires would be vital, whether they are used at recruitment stage or later on, to profile clients.

➤ There is a perception among some professionals that the use of a questionnaire is tantamount to research and, as such, needs submission to an Ethics Committee. We would argue that (a) there is evidence that in some situations a clinical goal that is widely agreed may be better achieved by using a questionnaire (see for example the literature on domestic violence) and it is incumbent on professionals to use the method that is most appropriate (b) questionnaires that have been validated are simply an evidence based way of taking a history *but* (c) new questionnaires that have never been used or validated are new interventions and as such should be the subject of an Ethics Committee review. However, others may take a different view.

➤ Undoubtedly questionnaires should be used *after* recruitment when compiling a profile of the client (as used in the NFP), but we doubt that they should play a major role for our potential client group at the initial recruitment stage.

➤ *A checklist and scoring system for risk factors.* The experience of Health Care Needs Assessment by health visitors suggests that setting up a checklist of risk or stress factors, adding up the total number of factors and setting an arbitrary threshold for action is not likely to be a profitable approach<sup>119</sup>. While there is little doubt that overall risk and need is related to the number of stress or risk factors in the life of a family, there is no evidence base on which to decide what weight to place on each factor or how many factors are needed to cross the “threshold of need” for the FNP . Furthermore, such checklists are very poor at measuring resilience and protective factors such as having a network of loving supportive family relationships.

➤ *A scoring system that adds risk and protective factors* One possible approach is to add scores for need and risk factors to the score for protective factors such as social capital. Decisions based on such a score will still be pragmatic rather than evidence based; nevertheless, some health visitors find that compiling and discussing such a score does offer a useful way of opening up discussion with clients about what services might be useful for them.

➤ *Professional-led interviewing* Taking into account all these issues<sup>120</sup>, we suggest that the best approach to use for recruitment and in the early stages of the FNP is professional-led interviewing<sup>121</sup>. This is different from semi-structured interviewing, where one is exploring a whole range of questions with a client or research subject and is guided by their responses as to how the interview should be developed. Professional -led interviewing aims to obtain answers to a series of specific questions, but the interviewer is permitted to use a variety of approaches and tactics to gather the

information required, depending on the client's age, background and circumstances, and on whether she is accompanied by her partner.

- Good interviewing is based on a caring, respectful curiosity – the aim is want to find out what this woman's life is like, what makes her "tick"! The interviewer uses her judgment to decide which lines to pursue, in what order, and which are unlikely to be relevant. Questions can be asked of both parents if they are both present – this makes the interview longer but facilitates successful engagement of both parents.
- This approach means that all the professionals involved can contribute to the FNP Nurse's understanding of the client and to building the client profile. By providing definitions of the data items required, it is possible for staff to reduce a large amount of data to a simple code for computing purposes.

100.5. Appendix 2 sets out a proposed structure of professional – led interviewing and suggests how this might be coded; as far as possible this has been planned to be compatible with the draft maternity core dataset and with definitions used by other agencies in England. The appendix shows the degree to which the data proposed for the FNP map to the maternity dataset.

100.6. The process we recommend for the pilot phase of the FNP is set out in Table 7 (next page).

100.7. Some of the criteria listed in Table 7 would be easier to identify than others; for example, occupation and qualifications are unlikely to present any difficulty but domestic abuse may be a sensitive issue and lack of social support is hard to define.

100.8. The extent to which women matching these criteria could be identified by midwives as part of their routine booking interview is likely to vary between individuals and between services, depending on the available skills, time, staffing levels and policies.

100.9. Having identified one or more of the criteria listed under "Stage 3" in Table 7, in some cases the interviewer may judge that referral to another service might be appropriate as well as or instead of referral to the FNP .

## **101. Special circumstances**

101.1. *Interpreters* Women meeting the criteria whose first language is not English but who can communicate in English should be eligible. Women who need an interpreter, or a professional worker who speaks their language, should in principle also be included, but in reality this will depend on local resources; furthermore, it should be remembered that the NFP model has not yet been shown to be effective when delivered through an interpreter.

101.2. *Late booking:* An important issue arising from discussions about the FNP in the USA was that colleagues In England felt that while early booking and early referral into the FNP are highly desirable and probably relate to the degree of benefit obtained, women should be referred at any stage of pregnancy up to and including unbooked delivery, since many such women are likely to have high risk factors.

**Stage 1.** The first four steps in recruitment are:

- a) Determine if the woman lives in an area where the HLPP service is available.
- b) Find out if this will be the first child (see text for definition).
- c) Establish stage of pregnancy - the HLPP programme is offered to women booking at up to 28 weeks of pregnancy
- d) Establish the woman's age at LMP.

**Stage 2 (i)** . Any woman who *fulfils criteria* a), b) and c) and was *less than 20* years old at her LMP date is automatically offered the programme.

*Some pilot sites with large populations may well fill their caseloads solely with this age group. Others will also need to recruit women in the 20-24 age group in which case Stage 2 (ii) applies:*

**Stage 2 (ii)** Any woman who *fulfils criteria* a), b) and c) and will be *older than 20* but *less than 24* at the LMP date is eligible if *any one* of the following three rules apply:

- A. She is currently NEET *and* has never been in regular paid employment **OR**
- B. She is currently NEET and has no qualifications **OR**
- C. She does not have a stable supportive relationship either with the baby's father or with other supportive adults.

These Three Rules will “capture” a large proportion of the women aged 20-24 likely to benefit from the HLPP.

**Stage 3** A few women aged 20-24 might “pass” the Stage 1 criteria and have one of the following “risk factors” or extra needs, yet *not* be captured by the Three Rules.

- a) *Ever Looked After*
- b) *Status issues* – Refugee, asylum seeker
- c) *Traveller families*
- d) *Mental health problems:* history of self-harm, eating-disorder, other mental illness, victimisation of all kinds (domestic abuse, racial harassment etc.).
- e) *Housing issues:* mother not satisfied with accommodation – often linked with frequent changes of address; or serious problems such that accommodation is unsuitable for a baby (e.g., “homeless”, in a refuge, lodging with friends).
- f) *Poverty* – living on benefits with no other income; food insecurity.
- g) *Language and literacy:* difficulties in communicating in English **OR** literacy difficulties in English / other language. Consider availability of interpreters.
- h) *Smoking.* This should also identify young women who use illicit substances, as most users also smoke.
- i) *Alcohol and substance abuse.*

Table 7. (continued on next page)

## Frequently Asked Questions

*Should the following be included?:*

- a) Mothers who have no living child in their care – but have lost a previous child through stillbirth, infant death, or adoption or long term fostering (whether voluntary or as a result of care proceedings). *Professor David Olds advises that these should NOT be included as there are as yet no data on whether the programme is effective for these women.* Other interventions such as CONI or other forms of social support should be offered where available.
- b) Mothers who have previously had a miscarriage or termination of pregnancy.
- c) Mothers whose scan suggests an abnormal pregnancy, or who have a premature infant born before 28 weeks. (Among the 1000 infants in the ten pilot sites we would expect at least 70 infants who are premature or of low birth weight though only a few will be born before 28 weeks or be of extremely low birth weight).
- d) Mothers with multiple pregnancies.

Mothers in categories b, c and d *should* be included.

Table 7 (continued)

101.3. Women who are identified and referred into the FNP after 28 weeks of pregnancy could be included in descriptive accounts of the Programme; however, they would not be regarded as eligible subjects for the purposes of any future research as they will have had little or no benefit from getting to know their visitor during pregnancy.

101.4. *Women with complex, multiple or acute problems.* As we wish to support the concept of progressive universalism, it seems important to ensure that every woman is told about the health visiting service and reminded that every family is entitled to receive this universal service. It would seem illogical to set down rules that exclude women with severe or multiple problems and we suggest that as a matter of principle they should be considered for the FNP ; however, the supervisor (paragraph 111) should have discretion to decide that the woman is unlikely to engage effectively with it<sup>122</sup> or that the immediate intervention requires a different service. For the purposes of audit and evaluation, all such decisions and the reasons for them should be recorded.

101.5. *Self-referral* Some women who were not considered eligible for the FNP may self-refer or self-select because they perceive it as helpful. In the NFP programme in the USA, self-referring women may be accepted. This issue will need further discussion and perhaps should be re-considered in the light of experience. In some Sure Start Local Programmes, women from more privileged backgrounds sometimes attended the Sure Start centre, for example to obtain help with breast feeding – this may have been one of the factors that intimidated the clients for whom the service was designed (paragraph 6). Pending further discussion and practical experience, we suggest that self-referring women should be offered the same assessment as those referred by midwives.

101.6. *First pregnancy:* An additional issue will be the definition of a first pregnancy. For some women this will not be the first pregnancy as they will have had a previous miscarriage or termination. There will also be a few women who have lost a child through stillbirth or early infant death. For these women, their current pregnancy may for practical purposes be their first child:

a) Mothers who have no living child in their care – but have lost a previous child through stillbirth, infant death, or adoption or long term fostering (whether voluntary or as a result of care proceedings) should NOT be included as there are as yet no data on whether the programme is effective for these women. Other interventions such as CONI or other forms of social support should be offered where available.

Mothers who have previously had a miscarriage or termination of pregnancy; whose scan suggests an abnormal pregnancy, who have a premature infant born before 28 weeks, or who have multiple pregnancies *should* be included.

101.7. *Other problem births* It will also be important to consider how the FNP should respond in the event of a very low birth weight, disabled or chronically ill infant being delivered, or a stillbirth or neonatal death. This may depend partly on what other services are available. Again, the supervisor should have discretion as to whether these families receive the FNP service. Among the 1000 infants in the ten pilot sites we would expect at least 70 infants who are premature or of low birth

weight though only a few will be born before 28 weeks or be of extremely low birth weight.

## (12) Gathering and managing information

102. Midwives gather a core set of data about every first time mother at the booking clinic, in order to identify potential medical and psychosocial problems. This applies whether or not the mother is potentially an eligible recruit to the FNP , and whatever the outcome of an offer of referral

103. Data collected as part of the FNP should in the first instance be confined to what is needed for the highest quality clinical care, as defined by best professional practice. Review of various datasets<sup>123</sup> suggests that, if this is done conscientiously, the majority of the information referred to in our review as being potentially of predictive value, would be collected routinely as part of best practice.

104. We are aware that the NFP Programme documentation includes a number of instruments that will gather data about the client's background, views etc – however, most of these will be used during the course of the FNP rather than at entry to the FNP .

105. If more in-depth data collection is to be undertaken specifically for research purposes, a detailed proposal will need to be submitted for consideration by an Ethics Committee.

106. **Need for a minimum dataset** We have however found that there is no standardised approach to the interview undertaken by midwives when the woman first presents to the midwives' booking clinic, though it is claimed that most midwives would cover a similar range of topics.

106.1. While we anticipate that in the pilot phase, the midwives will probably simply refer most potentially eligible clients to the FNP staff, they may need to play a more active role in the future. There would be many benefits that go beyond this FNP in having a standardised minimum dataset for antenatal maternity services (and for obstetric, postnatal and child health services<sup>124</sup> as well).

106.2. We suggest that the relevant professions who are already working on the core dataset should also collaborate to standardise the booking interview (see also appendix 2 ).

106.3. It has been suggested that this interview should also follow the model of the Common Assessment Framework (CAF)<sup>125</sup> – in practice, we think that the topics covered in our review would map without difficulty to the CAF.

106.4. As it is likely that several professionals will be involved in the care of the young pregnant woman, and each will have their own approach to building a relationship, it is important to develop a method that is flexible between professionals but nevertheless gathers the data needed by the FNP Nurse to work effectively with the young woman and her partner.



106.5. One issue that must be considered in each pilot site will be the information transfer between the FNP team, the GP and existing specialist services (paragraph 117)

106.6. The information gathered at the woman's first visit to the booking clinic is likely to be incomplete and some aspects may be unreliable, perhaps owing to lack of trust or to pressures of time. Sensitive information may be given more readily in response to an informal friendly interviewing approach after the woman has got to know her midwife or her specialist FNP Nurse.

106.7. However, provided that there is agreement across the services about what information is needed, this need not be a significant problem for the FNP Nurse.

106.8. It does however represent a point of weakness in any evaluation. Deferring the collection of baseline information or collecting this over an extended period may mean that some of the responses change, either because of trust or because the woman genuinely feels different about a particular issue after getting to know and learning from the professionals she meets. This could be seen as an advantage as the information will be more meaningful but a disadvantage as some of the early benefits of the FNP might be under-estimated.

106.9. The baseline profile of those who refuse the offer of the FNP or never engage with it will be based on less comprehensive knowledge of the client than is the case with those who do engage. Furthermore, clients who engage with the programme are likely to be inherently different in many ways from those who do not, and this may relate not only to their life situation but also to their willingness to give *truthful* information *about* their situation.

107. The possibility has been raised that health data combined with data from social services, education authorities, youth offending teams etc., might be gathered systematically and used to generate more precise predictions about which families are most at risk of adverse outcomes. Such data could be processed on an anonymous basis and then fed back to the primary care team where it could be decoded in respect of the women for whom the team was responsible. This proposal is based on the concept of Predictive Risk Modelling<sup>126</sup>. Over a period of perhaps several years this could significantly enhance the targeting of the FNP, though it is clear that many practical and ethical difficulties would need to be addressed.

### **(13) Models of identification and referral to the FNP**

108. A number of possible models have been considered (see the Models of the Client Journey in Appendix 1); even within each of these models there is scope for variations.

108.1. Our review of the constraints on midwifery services, and the large number of midwives who will inevitably be involved in recruiting, suggests that a two-stage model will be needed. Appendix 1 illustrates a number of alternative models showing how the client's "journey" might be structured, together with the advantages and disadvantages of each. See also paragraph 113.2.

108.2. The options set out in Model 1A and Model 4 in the Appendix seemed to be the most promising. Model 1A was strongly supported by our advisory stakeholder group; but it remains to be seen whether it is deliverable in the pilot sites.

108.3. In discussions with pilot site staff, the paramount considerations were simplicity, the need to minimise the workload on busy midwives and the importance of ensuring that every potentially eligible woman has the chance to discuss the FNP with one of the programme staff, as this would be likely to reduce the risk of refusal.

108.4. There are several reasons why we are reluctant at this pilot stage of the project to make a firm recommendation as to which model will be “best”.

108.5. Each pilot site will have its own particular geography and demography. There is wide variation in the prevalence of risk factors between different areas of England (see for example Figure 17), so it is not possible precisely to calculate the numbers of potential clients that could be recruited in any one pilot site. Some may be able to recruit the desired numbers very easily while focussing on the highest risk groups, while others will struggle to reach the target numbers.

108.6. Each pilot site will be considering its own longer term solution to the issues of progressive universalism as set out previously in this report and will therefore have its own proposals as to the client’s journey.

108.7. The aim is for progressive universalism – every mother is entitled to a health visiting service, and it does not seem logical, at least during the pilot phase of this Programme, to *exclude* from the FNP those women who have the most challenging problems, whatever their age. This suggests that in the future it will be important to ensure that there is a second tier or second chance for those women whose problems are not identified by the midwife at booking. Some of the models set out in appendix 1 offer the option of a second tier”.

108.8. The pilot phase of the FNP is not a research study. Programme fidelity in *delivering* the Programme is important because it will lay the foundations for a formal evaluation and RCT in the future; furthermore, it is an expectation set out as part of the licence granted for use of the NFP materials. However, the details of the *eligibility criteria and recruitment procedures* are *not* part of that agreement. It may prove difficult – and is probably undesirable at this stage - to impose a single rigid recruitment structure on pilot sites.

109. We cannot produce concrete evidence that any one approach will be superior. We suggest, therefore, that in consultation with the pilot sites several models of recruitment and engagement are tested. Part of the evaluation will involve learning from the experiences of each site and comparing the actual benefits and difficulties in each approach. .

## 110. **Monitoring and adjusting the model.**

110.1. By continuously monitoring the uptake of the FNP and the success or otherwise of retention of the clients in the FNP , it will be possible to adjust the recruiting criteria up or down in order to stay on target for the desired numbers. The easiest criterion would be age – for example, all women under 17 might be recruited

from the start; adding all those under 18, then all those between 18 and 23 on the basis of at least one additional risk factor.

110.2. Whichever model is adopted, teamwork between midwives, health visitors, the FNP nurses and the supervisors will be crucial.

110.3. Staff involved in any stage of recruiting must be fully aware of the aims and philosophy of the programme. They must be enthusiastic in making the offer to potential clients, and present it in positive terms of promoting health and development – not as a programme for people with problems.

## **111. Role of the supervisor**

111.1. The supervisor plays an important role in the NFP. S/he will be responsible for monitoring referral patterns and processes, ensuring a balanced allocation of clients to the FNP nurses and perhaps adjudicating on difficult decisions about eligibility or withdrawal from the Programme.

111.2. The supervisor could also replace the FNP Nurse in undertaking the assessment of clients referred to the Programme. This would have the advantage of more consistency in decision making, and a fair allocation of clients based on their location and their degree of need; but the disadvantage of requiring the client to meet and talk to another “middleman”

111.3. The supervisor could not replace a routine health visitors’ “second tier” of assessment for all first-time pregnant women as suggested in some of the Models in the appendix: the numbers of clients would be much too large.

## **(14) What factors will affect recruitment, retention & attrition?**

112. Staff attitudes are crucial. Some studies have examined how young women feel when attending health facilities. In services that target teens, there is ample evidence that the attitudes of staff are crucial in encouraging appropriate use of the service. The “You’re Welcome” initiatives for sexual health services are a good example.

112.1. Consideration must be given as to how women should be invited to make use of the specialist home visiting FNP. In the interests of developing a policy of progressive universalism and avoiding stigma, we suggest that the offer should be presented in terms of being one component of a universal community child health service which also offers (for example) assessment and care of disabled children, a mental health service for children with emotional and behaviour problems, and so on. However, it will be obvious to parents that they are being offered a service that is not available to everyone and clearly it would be dishonest to pretend otherwise.

112.2. With regret, it must be acknowledged that health visitors are not universally popular (see also paragraph 6**Error! Reference source not found.**). A number of

reports describe disputes over various baby care issues, particularly weaning, and the widespread perception of the health visitor as the “child protection police”.

112.3. This suggests a clear need to present to the public a clearer and more positive account of what health visiting is about. In addition, it may be wise to find ways of describing the FNP Nurses in terms that clearly distinguish them from the routine health visiting service. “Home visitor” and “health visitor” sound rather similar to the layman.

112.4. Although it is expected that most staff working in the FNP will have a health visitor background, some midwives may also be involved and the title of the visitor must take account of the regulations regarding job titles and the professional sensitivities involved.

112.5. One solution might be to give the whole programme a memorable name so that the FNP nurse could be called the \*\*\*\* nurse. Alternatively, health visitors could be re-named – though that would undoubtedly be a controversial proposal. The obvious precedent for naming a programme is in New Zealand where the child health programme nurses are called the Plunket nurses<sup>127</sup>.

112.6. If, as we anticipate, the FNP is based in Sure Start Children’s Centres, the term “Sure Start Nurse” could be used as this label does not seem to have been adopted for any other purpose. This immediately places the FNP firmly in the wider context of 21<sup>st</sup> century children’s services.

112.7. Another option might be to name the nurse after the Local Children’s Centre from which she works – for example, the “Cornerstone Nurse” or the “Tinsley Nurse”.

112.8. It is also necessary to take into account the probability that some of the FNP staff will be midwives.

112.9. [Update note]. When this report was compiled there was no consensus on this issue but as of July 2007 the Pilot Project is known as the Family Nurse Partnership.

### **113. A policy of Progressive Universalism**

113.1. What does Progressive Universalism mean? As a minimum, there would be much benefit in telling every woman with her first pregnancy, and every woman new to the area, the name and phone number of her future health visitor (or of the health visiting service if it is a team approach) or, if that is not possible, how she can find out; this should be described in the context of the overall community child health service.

113.2. Ideally, we believe that meeting the health visitor or a member of the team at least once before the birth should become the norm at least for ALL first-time pregnancies. There is evidence that establishing this relationship in pregnancy is beneficial for future involvement and therefore good reason to see this as a priority - even for health visiting services that are under pressure because of staff reductions. A home visit soon after booking would quickly establish likely levels of need and, since

it would substantially reduce the time needed for Needs Assessment after the birth, it would not be an inefficient use of time<sup>128</sup>.

113.3. This is already the normal practice in many areas but in the majority of these the first visit is made too late in pregnancy to contribute to the FNP recruitment process.

113.4. [Update note]. An important review of Health Visiting has been published recently<sup>129</sup>.

#### 114. **Maximum recruitment and minimal attrition**

114.1. A key issue will be how to minimise attrition in the client journey between the midwife and the first visit to the specialist FNP Nurse (see Figure 26 “Attrition”). How best to achieve this will be part of the learning process and the evaluation of the pilot phase but we suggest that the following need to be considered:

*Children's Centres will be expected to provide the following services to children under 5 and their families:*

- early education integrated with full day care, including early identification of and provision for children with special educational needs and disabilities;
- parental outreach;
- family support, including support for parents with special needs;
- health services;
- a base for childminders, and a service hub within the community for parents and providers of childcare services;
- effective links with Jobcentre Plus, local training providers and further and higher education institutions;
- effective links with Children's Information Services, Neighbourhood Nurseries, Out of School Clubs and Extended Schools;
- management and workforce training

#### **Box 9**

114.2. All the professionals involved need to show that they are *proud* of what they can offer. The commitment and enthusiasm of the midwives, the other staff at the Booking Clinic and the managers will be crucial. They will need to “sell” the FNP, setting out the potential benefits of guidance, advice and support on a range of issues. The approach might be along the lines of “We all want our children to do well and to have chances that we never had”. Strong links with the Sure Start Children’s Centres will be very helpful and the services provided there could be described (Box 9)

114.3. We suggest that there should be a well-produced leaflet explaining about the community child health service, and health visiting, for all mothers, and how to contact the health visitor or the team; the intensive FNP should be presented as a desirable and valuable service for which some mothers may be eligible. In preparing this leaflet it will be important to find ways of presenting the service and the eligibility criteria honestly and in a constructive way.

## Attrition

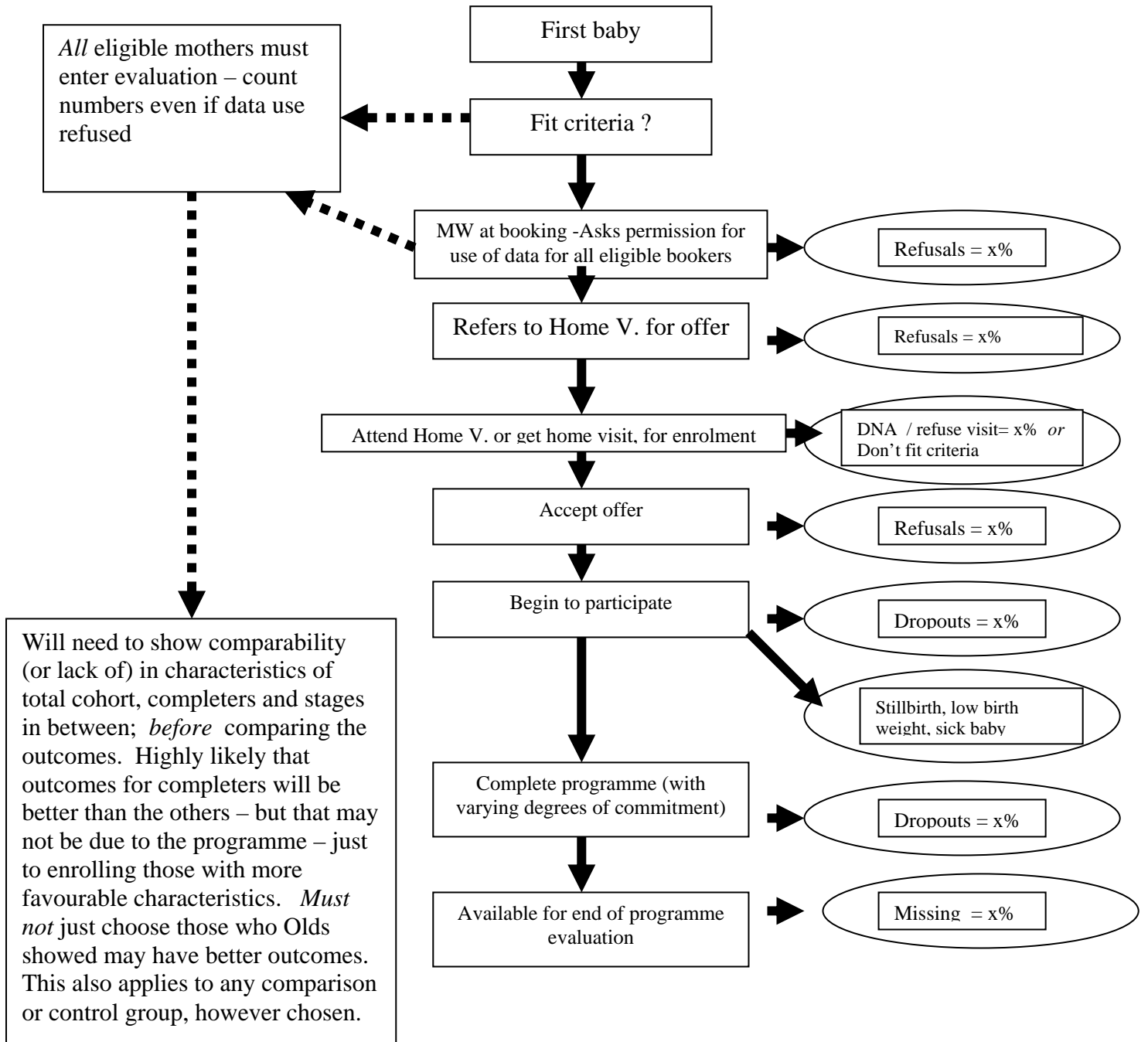


Figure 26.

114.4. If midwives are to be involved in any part of the selection process, they will need a well rehearsed script that is not coercive but explains why a particular woman is or is not being offered the FNP service. Conversely, FNP staff may need to explain to disappointed potential clients why they are considered unsuitable or ineligible for the service.

114.5. An infrastructure is needed to enable the booking clinic staff quickly to identify the location and contact details of the health visiting service for each woman.

**What confidentiality means to the Sure Start Team**

Anything we ask you and you want to tell us, we will treat with respect and we will keep it to ourselves.

We will not tell anyone anything you don't want them to know

The only thing we cannot keep secret is, if we find out that you, a child or another adult is being harmed or is likely to be harmed by someone

This kind of information will need to be talked through a bit more

We will decide together what we need to do with this information

*Courtesy of Denise Campbell, the Riddings HV geographical team and the SSCC team at Woodhouse, Huddersfield.*

**Box 10**

114.6. Arrangements must be in place to ensure that, after obtaining consent, details of each new client are passed promptly to the health visiting service and the nature of the arrangements suggested for each woman to contact, or be contacted by, the health visitor are clear.

115. **Consent** for information sharing and referral will be an important issue<sup>130</sup>. Many Sure Start programmes have already addressed the question of what parents should be told and what consent is needed for sharing important information<sup>131</sup>. The Sure Start model would need some modification – however, Box 10 shows one example of good practice.

116. **Social marketing** experts should be consulted<sup>132</sup> and local publicity should be undertaken to promote the health visiting service in general and the FNP in particular. Examples of possible strategies include local radio and newspaper stories, leaflets about the children's services given out by local pharmacists with every pregnancy test, DVDs about the Programme (perhaps featuring local mothers who have used Sure Start), and inviting local mothers to act as ambassadors for the Sure Start Children's Centre.

117. Buy-in from other professional groups will be important at both local and national levels. In particular, relationships with GPs, obstetricians and community

paediatricians will be important. There may sometimes be difficulties about the GP sharing information about the woman's previous history with a midwife, or vice versa though this should only rarely be a problem provided that proper consent is obtained. Questions from GPs about access to electronic information may be particularly sensitive in the light of current anxieties about "Connecting for Health". It may be necessary to review or clarify guidance from the GMC on these issues.

117.1. The midwife will need to consider how to transfer information to the specialist FNP Nurse. Suggestions include the antenatal care record held by the woman herself; one or more checklists if they are in use; any formal transfer of records must be supported where necessary by face-to-face or telephone conversation, when there are complex sensitive issues that staff do not wish immediately to commit to paper.

118. In general referral to the FNP should be undertaken at the booking clinic, but on occasion it may be triggered by information emerging as the woman gets to know her midwife. The midwife may need to use her judgement to defer referral until she feels the time is right, though this should be the exception.

118.1. The FNP must be offered to every woman who meets the criteria that have been agreed. The FNP Nurse will use her judgement and negotiate an agreement with those in whom criteria for referral are uncertain or equivocal.

118.2. A study by Barlow et al<sup>133</sup> found that in spite of carefully applied criteria for eligibility for the programme, the health visitors judged that some of their regular clients who had not been identified as eligible were more needy than those who had. Some form of feedback about the progress of the FNP work, and opportunities for community staff to influence the way the programme develops at local level, may be advisable in order to maintain a high level of commitment among *all* staff.

118.3. The initial contacts with individuals who are offered the programme will be crucial in building a relationship, and for this reason the pace of gathering information whether by informal conversation or the use of standardised instruments will need to be varied as discussed previously. However, some issues will need to be addressed at an earlier stage than others, for example smoking, substance abuse, excessive alcohol consumption and domestic violence have a direct impact on the outcome of pregnancy and the health of the fetus, whereas for example discussions involving the woman's future plans regarding education or the care of the child might be taken at a slower pace.

118.4. Fathers must also be involved whenever possible. See Box 11 for a summary of the lessons from Sure Start about services for fathers.



*Make Early identification of fathers a priority:*

- Programme-wide commitment to father involvement.
- A strategy for involving fathers.
- Provision of services specifically for fathers.
- Presence of a dedicated staff member (often a dads' worker) for encouraging father involvement

*Strategies used in Sure Start programmes:*

- Increasing the visibility of male workers at all levels to make the SureStart environment male friendly.
- Early programme focus on involving fathers where father involvement is deemed desirable.
- Collection of quantitative information on father attendance at Sure Start activities to provide a baseline and to monitor progress.
- Broadening programme 'office hours' opening to include evenings and weekends.
- Developing outreach Sure Start strategies to engage fathers pre-natally and around childbirth.
- Increasing provision of 'father-focused' services - building on men's interests (e.g., carpentry, sports or 'fathering').
- Guidance for programmes on strategies/approaches for encouraging father involvement in collaboration with specialist fathering practitioners and voluntary sector partners.
- Developing sensitivity to the needs of different groups within the community of fathers: lone fathers, sole carers, estranged or separated fathers, disabled fathers, fathers working shifts, fathers from minority ethnic and faith groups. Fathers with differing experiences and different
- requirements may respond best to services tailored for them.
- Utilization of mothers/female partners as potentially important facilitators of fathers' involvement in Sure Start activities.
- Use of mixed gender practitioner group leaders to model collaborative working between men and women.
- Carrying out local evaluations of the impact of father involvement in Sure Start on child, maternal and paternal well-being.

**Fathers – lessons from Sure Start (Fathers in Sure Start).**

<http://www.surestart.gov.uk/doc/P0001408.pdf>

## **(15) The skills required**

119. Both the midwives and the FNP Nurses will need to review their expertise with interviewing techniques. The approach taught by Professor Hilton Davis <sup>134</sup>, emphasising respectful empathic listening, and the concepts of motivational interviewing (MI) are likely to be useful <sup>135</sup>. The home visiting programme is likely to put demands on the parents who take part, to make significant changes in their lifestyle, ambitions etc. Rollnick <sup>136</sup> reports that a simplified structure of MI would be relevant to the current project. This approach helps professionals to understand the spectrum of communication with clients, ranging from non-directive empathic listening to the giving of information and directions; in the middle of the spectrum he uses the term “guiding” to emphasise the ways in which professionals can help clients to examine their motives, their desired goals and the obstacles to achieve those goals.

120. Barlow et al found that only half a local team of health visitors volunteered for training to undertake intensive home visiting with challenging clients and only half of those who volunteered were found to be suitable. One lesson from this project was that the requisite skills are by no means part of the repertoire of all health visitors or (by extension) midwives. Many nurses feel a burden of responsibility for their clients and find it hard to accept that their clients must ultimately take responsibility for their own decisions and lives – a counter-productive attitude that disempowers parents.

## **(16) The instrument**

121. This section brings together our proposals for the components of the Instrument.

121.1. There should be publicity at local level about community child health services in general, health visiting and the FNP .

121.2. The Programme should be marketed and reinforced with suitable literature available at the Booking Clinic and in other relevant settings, such as Sure Start Children’s Centres and Health Centres.

121.3. The weakest point in the FNP is likely to be the initial recruitment – if the offer of referral to the FNP is rejected at that time, it is unlikely that the client will ever be engaged.

121.4. The attitude of all professional staff to any woman attending the Booking Clinic must be warm and non-judgmental and the environment should be welcoming to women of any social background.

121.5. The identification process begins with determining if the woman lives in an area where the FNP is active.

121.6. The next step is to determine if this will be the first baby (noting the caveats about definition).

121.7. The criteria for eligibility to the programme will always include the age of the mother. This is based on her age at LMP (paragraph 53).

121.8. Experience and local demography may require some fine-tuning of the criteria but it is suggested that women under 20 should always be eligible; those aged 20-24 will be eligible if important needs and risk factors are identified. Midwives may use discretion in exceptional circumstances for women of any age. Women who have been Looked After on a long term basis will be eligible and high priority at any age.

121.9. Strengths, needs and risk factors should be identified by a process of professional-led interviewing that seeks to gather the necessary information in a way that is geared to the unique styles of both interviewer and client. The information should be summarised in a format that is compatible with computerised records and ideally with the proposed core dataset for maternity services.

121.10. Formal questionnaires may be used with discretion but do not form an obligatory part of the identification process – they are more likely to form a key part of the ongoing assessment and service planning *after* the client has accepted the offer of the Programme.

121.11. Women with challenging problems should not be excluded as a matter of policy, though they may be if it is judged that (a) services are available in the locality that are more appropriate to their needs and are likely to be taken up by the woman *and* (b) the woman is unlikely to be able to cope simultaneously with two professional services with different personnel, aims and style of working.

121.12. Two basic models are described for the client journey, each of which has several possible variations. One requires the midwife to make a very simple judgment about referral and to refer those who are eligible to the FNP Nurse (or the supervisor). The other requires the midwife to undertake a more detailed assessment and review of strengths and needs.

121.13. A case is made for a two-stage process in which the midwife undertakes the first “screen” but there is a second opportunity to identify women with less obvious needs.

121.14. No firm recommendation is made as to which model is more appropriate because this will depend on the demography, geography and resources available in the pilot sites.

121.15. Excellent inter-personal and communication skills, and interviewing styles that seek to empower parents, are a fundamental component of the instrument and without these the Programme is unlikely to retain clients or produce benefits.

## **(17) Matters needing further consideration**

122. *Audit.* The evaluation phase will take the form of a descriptive study and an audit. The classic audit trail will be followed<sup>137</sup>. Questions to be considered will include the extent to which the recruitment process has followed the agreed approach and the number of women who were identified, referred and engaged – and those who should have been identified but were not.

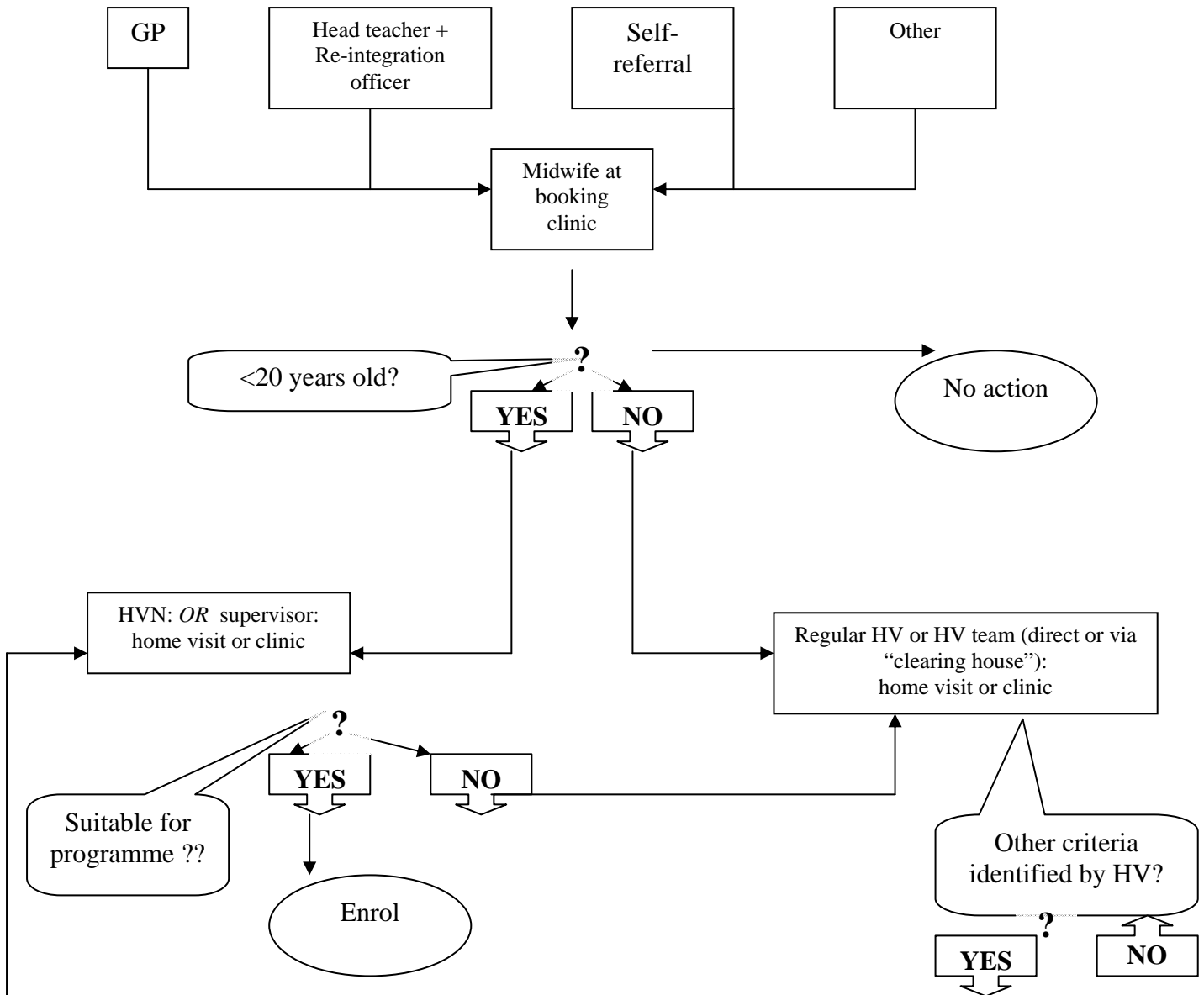
123. There are a number of other issues that will need to be considered, but it has not so far been possible to address these in the timescale of developing the pilot project. However, the important issues will include:

- *Data handling:* It will be necessary to review the process of gathering the data about every eligible client and entering it on a suitable database; consent for data sharing; relationship between proposed data requirements, the core maternity services dataset, and the database currently in use at each pilot site;
- Our understanding of the guidance on Data Protection, with respect to this project, is that data needed for clinical purposes may be held under conditions of confidentiality on all clients who attend the booking clinic and can be used on an amalgamated and anonymised basis for service monitoring without further permission. However, the client has the right to refuse consent for the data to be used for other purposes such as research that identifies them in any way. Such refusal must be recorded and the relevant data fields protected accordingly. This is a contentious area that gives rise to much concern on the part of professional staff, particularly if they are collaborating with non-professionals, and we think it will be advisable to get independent advice on this issue.
- How to define measures of child outcomes and how to obtain the data – the role of the Information Sharing initiative<sup>138</sup> and of paediatric and CAMHS databases in the context of Connecting for Health;
- The possible role of the Personal Child Health Record (the Red Book given to every parent) in obtaining consent and access to child outcome data. This is often issued only after the baby is born but there has been much interest in giving it to mothers during pregnancy<sup>139</sup>;
- The relationship in the context of this Programme between evaluation, audit and research, and the roles of Research Ethics Committees and Research Governance Committees.

## ***Appendix 1. Flow charts.***

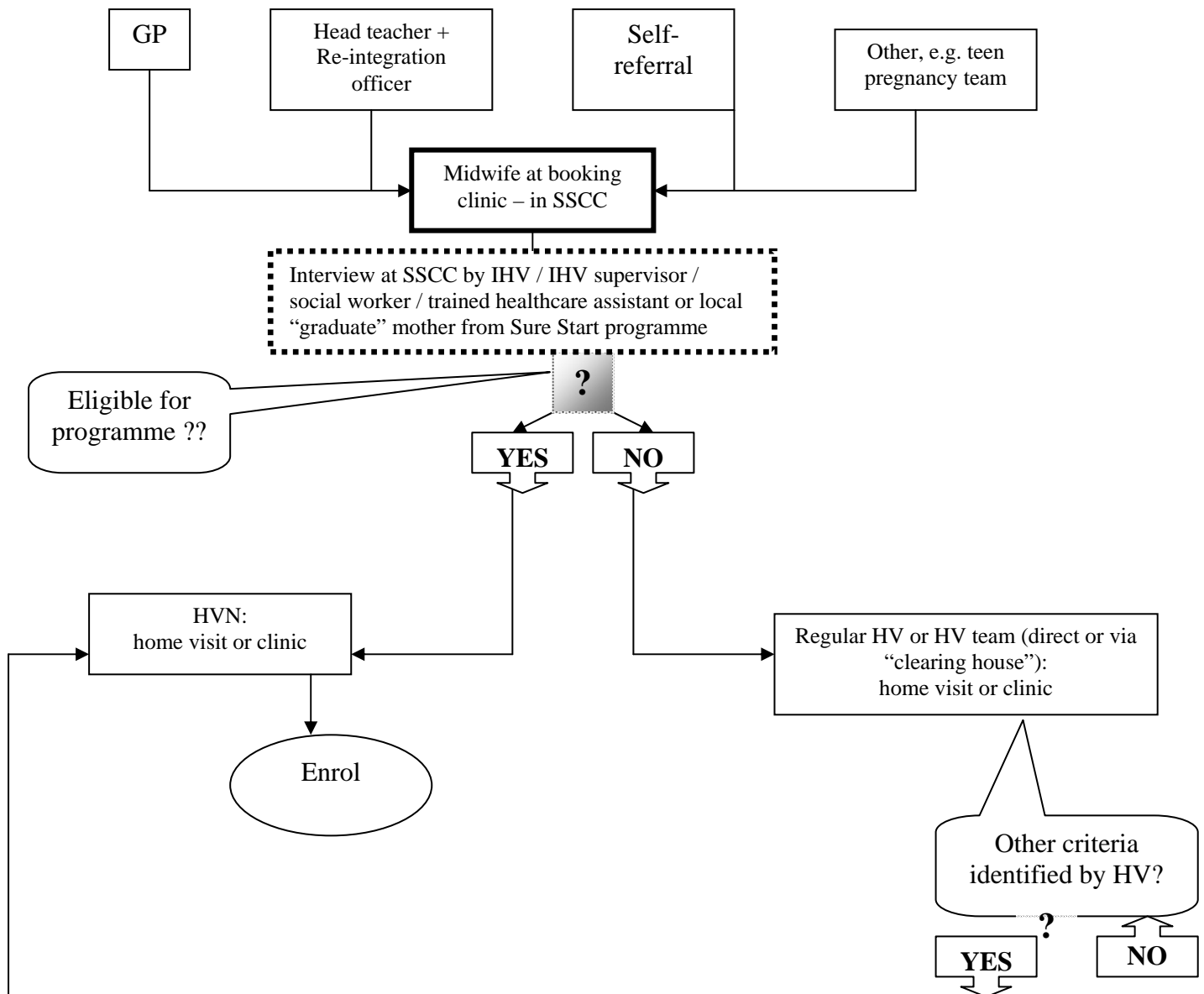
The flow charts on the following pages describe alternative “patient journeys” from the booking clinic to the FNP Programme. There are undoubtedly further variations but we think the examples are sufficient to illustrate the possibilities and the benefits and disadvantages of each.

**Model 1:** Midwife does simple sort: lives in IHV area, first baby, <28 weeks, + one easy criterion – e.g., refers <20 to HVN, >20 to regular HV team. **N.B.:** HVN = **home visiting nurse**



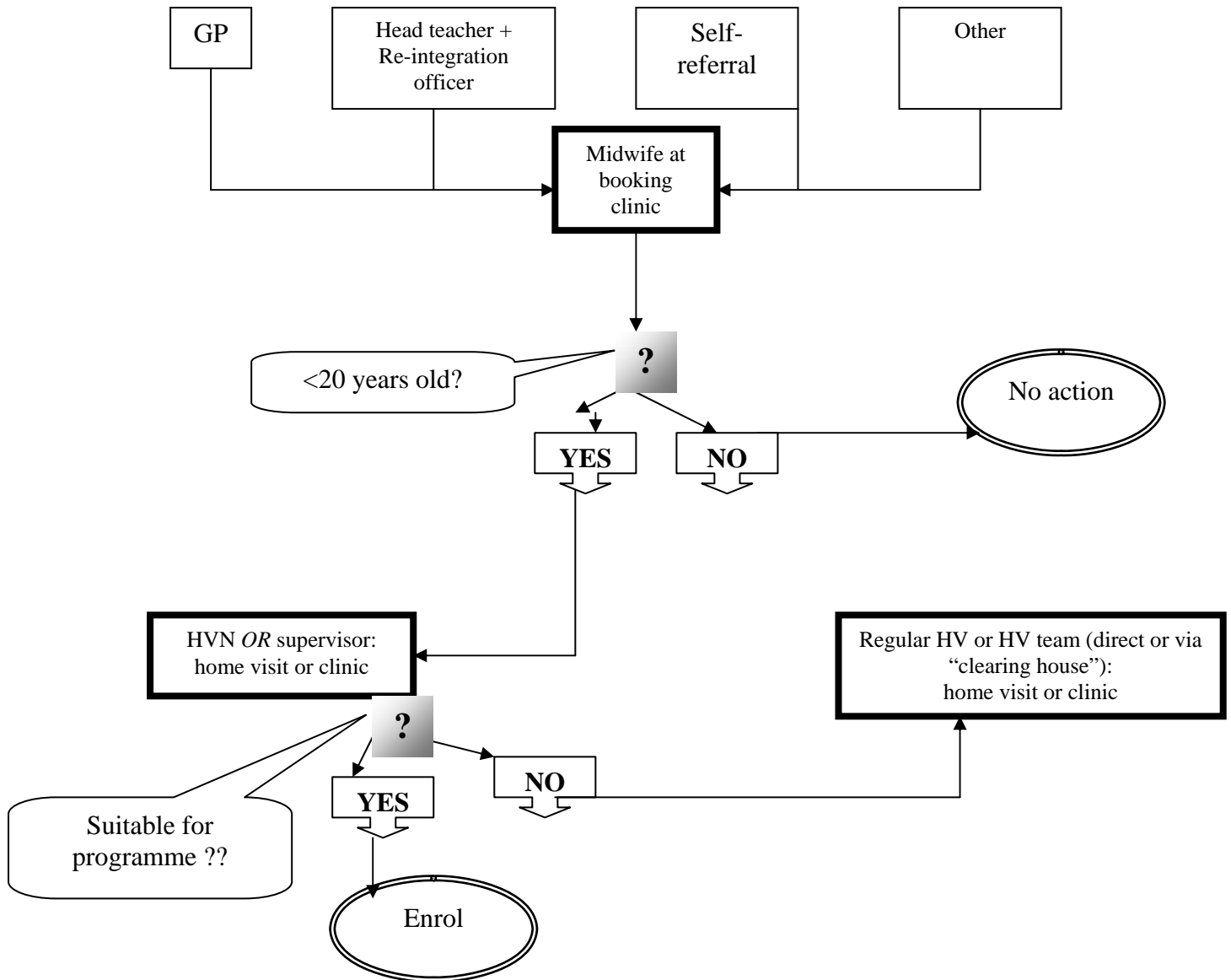
Advantages	Disadvantages
Simple to explain process to MW and simple for her to operate the selection	Simplistic referral rule excludes potentially needy clients >20 years old
Potential client goes direct to HVN – no middleman	Midwife has to explain & “sell” concept of HVN
Referral to HV team of mothers >20 in line with progressive universalism	Some stigma attached as young women treated differently from older
Generates reasonable number of clients fairly quickly: (though is still limited by number of pregnancies in under-20 age group).	Workload involved in referral of all women to HV or HV team
	May not be any structure or IT available to easily identify name / contacts of HV / HV team
	Clients (both <20 and >20) may get lost between referral and HV contact

**Model 1A:** Midwife works in SS Children's' Centre (SSCC): MW completes routine procedures, refers all first babies direct to colleague, same day & premises. **N.B.:** HVN = home visiting



Advantages	Disadvantages
Simple to explain process to MW	Significant workload for supervisor and / or other worker in SSCC
Potential client goes direct to programme from booking	May present difficult challenges for timetabling and organising as 1 SSCC unlikely to produce enough clients.
In line with progressive universalism	Expensive if professional staff used (cheaper if lay worker takes on the interviewing role)
Generates reasonable number of clients quickly:	Workload involved in referral of all women to HV or HV team
Minimal stigma	May not be any structure or IT available to easily identify name / contacts of HV / HV team
	Some stigma still attached as some women treated differently from others

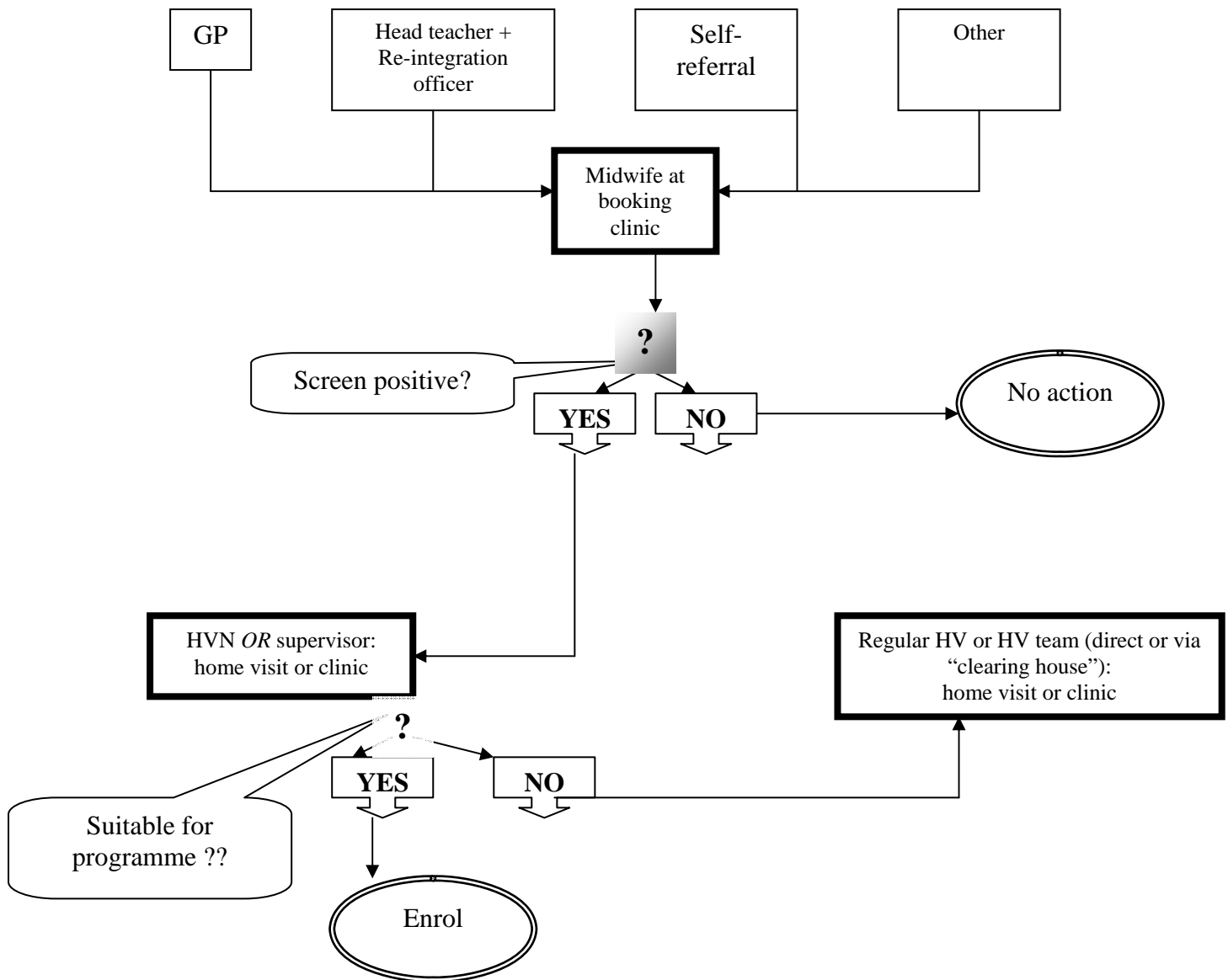
**Model 2:** Midwife does simple sort: lives in IHV area, first baby, <28 weeks, + one easy criterion – for example, refers <20 to HVN; no action for >20. **N.B.:** HVN = **home visiting nurse**



Advantages	Disadvantages
Simple to explain process to MW and very simple for her to operate the selection	Simplistic referral rule excludes potentially needy clients >20 years old
Potential client goes direct to HVN – no middleman	Midwife has to explain & “sell” concept of HVN
Minimal workload for midwife	Significant stigma attached as young women treated very differently from older; no commitment to progressive universalism
Generates reasonable number of clients fairly quickly: (though is still limited by number of pregnancies in under-20 age group).	Clients may get lost between referral and HVN contact

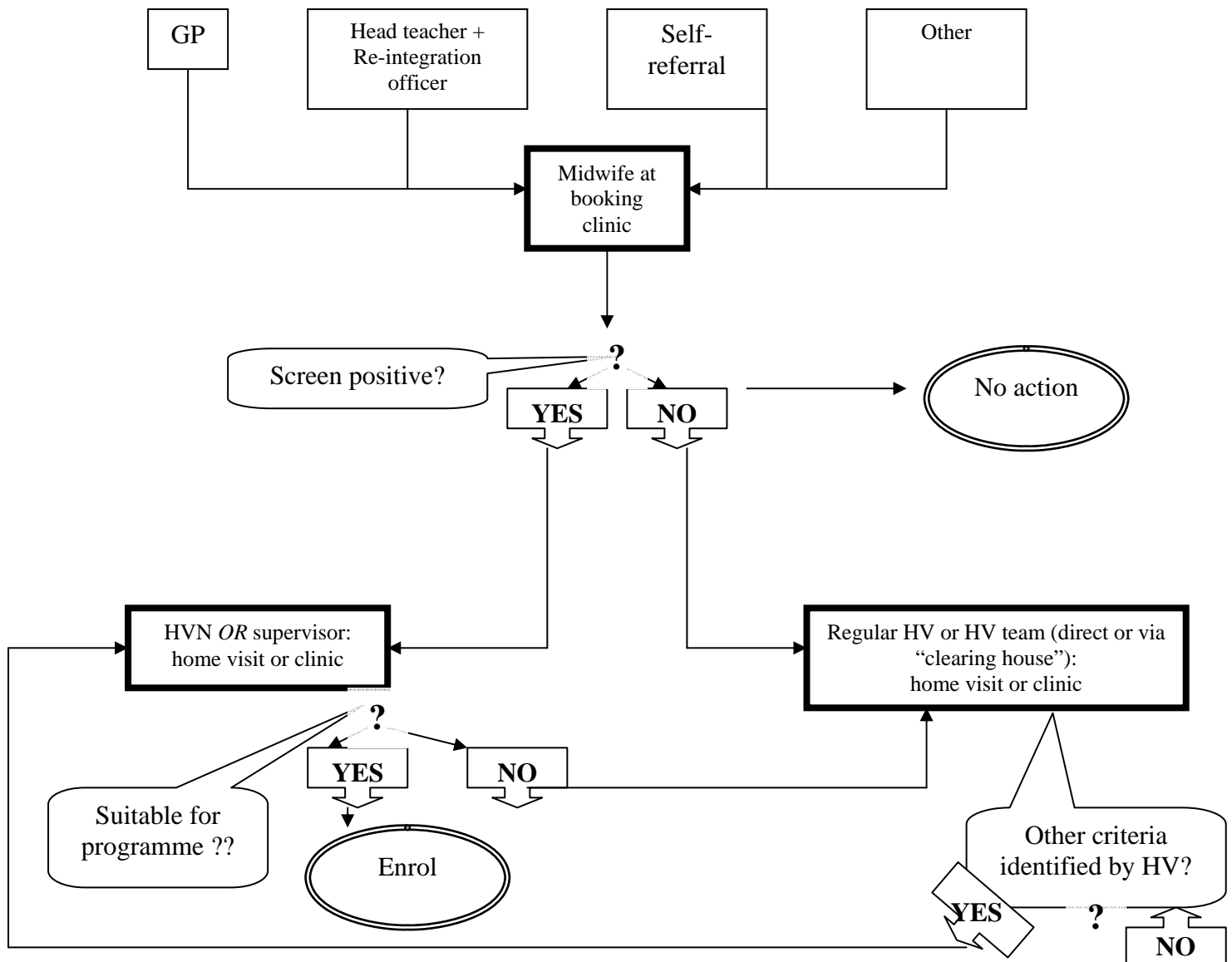


**Model 3:** Midwife checks: lives in IHV area, first baby, <28 weeks, refers all clients under specified age, and additional clients based on criteria – refers potential clients to HVN; no action for rest. **N.B.:** HVN = **home visiting nurse**



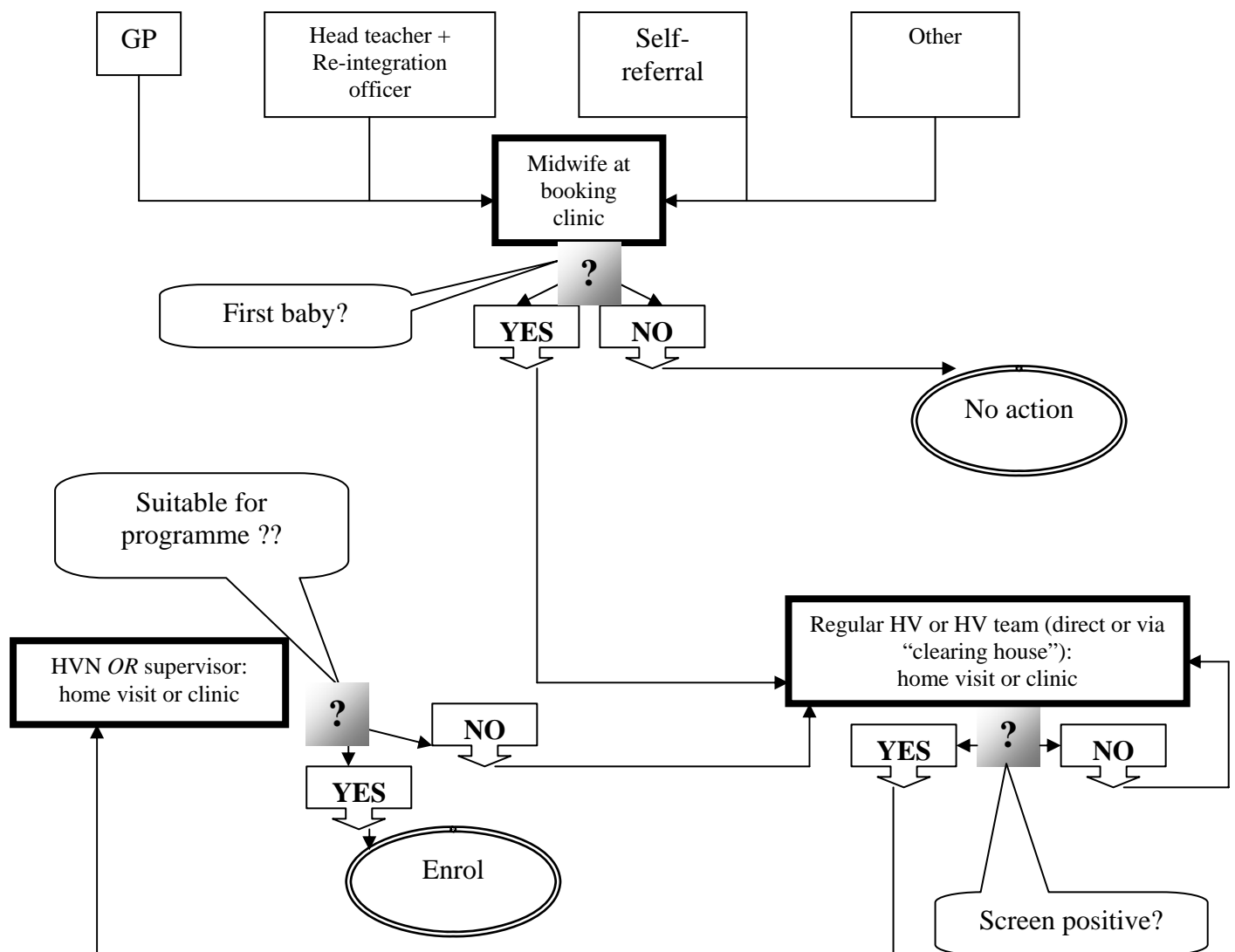
Advantages	Disadvantages
In principle, efficient – reduces time spent in second level of selection by HVN	More demanding of midwife training and time – though <i>increase</i> in demands depends on extent of <i>current</i> commitment to psychosocial interviewing at booking
Potential client goes direct to HVN – no middleman	Some important client issues will not be revealed in a single interview – especially if there are time pressures due to other booking clinic essential topics. So some potential clients will not be identified
Encourages buy-in and involvement of midwife to programme	Midwife has to explain & “sell” concept of HVN. High variability between MWs likely in using screening criteria
Number of clients and complexity of process can be adjusted by varying the criteria set out for the midwife, so action research learning is possible and numbers can be up or down regulated as desired..	Significant stigma attached as clients treated very differently from non-clients; no commitment to progressive universalism
	Clients may get lost between referral and HVN contact

**Model 4:** as Model 3 (Midwife refers potential clients to HVN); but screen negative clients referred to HV team. **N.B.:** HVN = **home visiting nurse**. (N.B. alternative model - process undertaken in booking clinic by health visitor or social worker alongside midwife)



Advantages	Disadvantages
In principle, efficient – reduces time spent in second level of selection by HVN	Selection process demanding of midwife training and time – though <i>increase</i> in demands depends on extent of <i>current</i> commitment to psychosocial interviewing at booking
Potential client goes direct to HVN – no middleman	Some important client issues will not be revealed in a single interview – especially if there are time pressures due to other booking clinic essential topics. So some potential clients will not be identified .
Encourages buy-in and involvement of midwife to programme	Workload involved in referral of all women to HV or HV team.
Number of clients and complexity of process can be adjusted by varying the criteria set out for the midwife, so action research learning is possible and numbers can be up or down regulated as desired..	May not be any structure or IT available to easily identify name / contacts of HV / HV team.
Commitment to progressive universalism	Midwife has to explain & “sell” concept of HVN. High variability between MWs likely in using screening criteria
	Some stigma still attached as clients treated differently from non-clients
	Clients may get lost between referral and HVN contact

**Model 5:** Midwife does not undertake any screening or selection – refers all first-baby clients direct to regular HV team who then select and refer to HVN. **N.B.:** HVN = home visiting nurse



Advantages	Disadvantages
Simple procedure for midwife – very little extra training required	Workload involved in referral of all women to HV or HV team.
Number of clients and complexity of process can be adjusted by varying the criteria set out for the regular HV, so action research learning is possible; numbers can be up or down regulated as desired..	Routine antenatal contact is not undertaken by all HV teams – varies by PCT. May not be any structure or IT available to easily identify name / contacts of HV / HV team
Non-stigmatising at booking clinic level	High variability between HVs likely in application of screening criteria
Commitment to progressive universalism	Some important client issues will not be revealed in a single interview. So some potential clients will not be identified at first meeting with HV.
Emphasises importance of antenatal contact – this probably raises effectiveness of HV service	HV has to explain & “sell” concept of HVN – still has to deal with issue of stigma (but easier to address if part of an array of HV and community services)
Health needs assessment in pregnancy need not be much more time-consuming than HNA after birth.	Does not encourage buy-in and involvement of midwife to programme or to psychosocial issues in general
	Adds a middleman - clients have to deal with one more professional contact - may get lost between HV and HVN

## **APPENDIX 2. The interview and the data needed for evaluation.**

### **Professional practice**

Any interview schedule must include the obstetric and medical information that is routinely collected by all staff. We did not think it necessary to include this here but we take for granted the central importance of good professional practice:

- Being honest with clients.
- Inviting the client to enquire about the reason for the questions they are asked.
- Making it clear that the answers will be the basis of professional advice - so if the answers are incorrect or untruthful the advice will likely also be incorrect.
- Probing negative responses but respecting the client's right to withhold / not disclose information.
- Establishing the client's needs & aspirations.
- Defining the boundaries - inform them about what's on offer (information, guidance and support), what could be on offer and in some circumstances what is not.
- Providing pointers to other services or resources that might be available.
- Informing clients about the duty of all staff to keep records for accountability purposes.
- Explaining about confidentiality and consent.

Appendix 2 outlines a possible interview schedule that might be used when assessing the eligibility of a potential client woman or couple and the benefit they are likely to gain. A major challenge for those who undertake evaluation of the FNP will be to obtain basic data about those women who refuse the offer of the programme or are never even told about it. We will need to compare clients who engage with the FNP with those who are eligible but have no involvement. It will be vitally important to determine whether the programme reaches the women who are likely to have the greatest need and the greatest potential to benefit. We have included at Appendix 2a a suggested minimum set of questions which, if asked routinely, would facilitate the evaluation process.

In appendix 2b, we have also compared the dataset we think is needed for evaluation purposes, with the national minimum dataset for maternity services which, at the time when we were preparing this report, was approaching its final version.

Ideally, we would like to see a working group set up including all the interested parties, to ensure that the information gathered for the FNP, the maternity dataset and the proposed paediatric dataset are all compatible with each other.

## Appendix 2: A suggested professional-led interview to determine eligibility for the Programme.

NOTE: This is a draft of an interview schedule that aims to gather data that may be needed as part of the recruitment process and would be equally important in auditing the extent to which women matching eligibility criteria are being offered, and recruited to, the Programme. It needs further discussion with midwives, health visitors, service users and the team working on the core dataset, to determine whether such a structure is feasible and useful.

1. Check the postcode – is the woman from an area where the Programme is provided?
2. Will this be the first child? (N.B.: if she has had a previous child who was stillborn or who died in infancy, the current pregnancy may be considered the first).
3. Check her age – use the EDD rather than the date of booking.
4. Ethnicity; status (refugee, asylum seeker etc)

*The order of the rest of the questions and the way each item is covered is flexible but the aim is to gather the information set out here in a way that can be coded and analysed. .*

5. Ask first about either education or employment, whichever is more appropriate:

Education – still at school; whether dropped out or excluded; GCSEs. Post 16 education. If left school, is she in Education, Employment or Training? Qualifications or skills acquired since leaving school. Literacy and language preference. Whether has enough English to participate in programme without interpreter.

Left school @ 16 No qualifications
Poor School Attendance
Adult Not literate in English
Adult not literate in any language

6. Woman's Occupation – classify as follows (ONS)–

<b>Code</b>	<b>Label</b>
1	Modern professional occupations
2	Clerical and intermediate occupations
3	Senior managers or administrators
4	Technical and craft occupations
5	Semi-routine manual and service occupations
6	Routine manual and service occupations
7	Middle or junior managers
8	Traditional professional occupations

7. Father – age, occupation

<b>Code</b>	<b>Label</b>
1	Modern professional occupations
2	Clerical and intermediate occupations
3	Senior managers or administrators
4	Technical and craft occupations
5	Semi-routine manual and service occupations
6	Routine manual and service occupations
7	Middle or junior managers
8	Traditional professional occupations

8. Married, cohabiting, father visiting, father not in touch.
9. Feelings about the pregnancy – wanted, not wanted, ambivalent. (NB – chart can be used as guide to feelings (appendix)
10. Income – poverty defined as income less than or more than £210 per week. If unwaged, whether receiving benefits. (list in appendix)
11. Relative poverty – different from absolute poverty. Money available after bare essentials. (Questions from *Measuring child poverty* - appendix).  
N.B.: many women lack budgeting skills so this may be very difficult to assess – it may be more relevant to ask about debt, though that too may not be recognised by many people. *Need further advice on this.*
12. Accommodation – type , tenure, Who does woman live with: relatives, friends. Definitions in appendix.
13. Establish whether ever or currently Looked After; whether has social worker.
14. Ditto for male partner.
15. Quality of housing – by report or by visit.
16. Cleanliness of the home – not routinely assessed but a standardised scale is available for use when considered appropriate (see appendix for details):
17. Find out about the neighbourhood – by questions or by visit:
18. Ask about other social support topics (based on ONS paper on social capital - appendix)
19. Ask if she has had any mental health problems. Formal screening has not been shown to be effective, but use of a questionnaire may be useful in some circumstances (appendix).
20. Ask about domestic abuse. Screening tools are shown in the appendix.
21. Also ask about bad experiences (including in country of origin if relevant): appendix.

22. Ask about past history of school exclusion, antisocial behaviour, offending, Court appearances.
23. Ditto for partner.
24. Ask about childhood – happy, sad, abused. A table of questions is provided in the appendix. (Note that the question about a family history of problem drinking may be a useful proxy for a range of family mental health problems, sometimes including criminal convictions).
25. Think about “self-efficacy” – how much she feels she can change her future. General self efficacy can be measured using the Schwarzer scale – there is also a proactive scale (details in appendix). These questions may be useful in some situations but in their current format they assume a quite sophisticated vocabulary and high reading age.
26. Ask about smoking. If a smoker, the Fagerstrom questions can be used to establish the extent of nicotine dependency: appendix. Are there other smokers in the household (passive smoking is a risk for the fetus and for the baby – increases risk of cot death).
27. Drug use: type of drug, occasional, regular, dependent. None of the questionnaires used for screening appear ideal for use with young pregnant women. Direct questions recommended.

28.	Used illegal drugs
29.	Concerned over drug use
30.	Treated for drug use in the last year

31. Alcohol use – regular or binge? There are several screening questionnaires in use – the 5P and TWEAK are validated for use in pregnancy: appendix.
32. Ask about recent stressful life events – questionnaire in appendix

## APPENDIX 2a – Proposed HLPP INFORMATION SUMMARY SHEET

### 1. CLINIC DETAILS

Booking clinic identifier

Midwife identifier ...

### 2. CLIENT DETAILS

NAME ..... DOB .....

NHS number ..... Hospital No. ....

DATE OF LMP ..... AGE AT LMP .....

EDD

ADDRESS AND POSTCODE

PHONE

MOBILE PHONE

TEXT MESSAGES OK?

E-MAIL

Difficulties in contacting – if yes, how to contact (e.g. phone number of mother)

DATE OF FIRST BOOKING INTERVIEW.....

PARTNER STATUS (check more than one if appropriate )

Unattached / living alone / Living with partner / father of baby / Living with family i.e. parents, siblings / Living with friends / Not asked

OTHER STATUS: Refugee / asylum seeker / traveller /none / Not asked

EDUCATION: for girls/women aged 15 or older ask:

Did you stay on at school until the end of Year 11?

Yes, completed Year 11

No

What is the last year at school that you completed?

school year

Do you have any GCSEs?

Yes

If Yes, How many?

number of GCSE passes

How many at grade C or higher?

GCSE's at C or above

ANY OTHER QUALIFICATIONS? (write in details)



**STUDYING AT THE MOMENT:**

at school / college / training course or programme / none / Not asked

**EMPLOYMENT:**

Currently employed/ not employed now but in past/ never employed / Not asked

**MENTAL HEALTH:** not asked/ self-harm / eating disorder/ depression / other mental illness / Not asked

**MENTAL HEALTH TREATMENT:** not asked/ psychiatric treatment / victimisation (abuse, racial harassment)/ other / Not asked

**HOUSING:** satisfied / not satisfied with accommodation / Not asked

**HOUSING MOBILITY:** frequent (>3 in last year) changes of address / homeless accommodation / Not asked

**LANGUAGE:** Difficulties in communicating in English YES / NO / Not asked

Interpreter needed (language) YES / NO Language: .....

**SMOKER:** not asked/ YES NOW / YES BUT GIVEN UP/ NEVER SMOKED / Not asked

**4. ACTION**

**TOLD ABOUT HLPP PROGRAMME:** YES / NO

**REASON FOR MENTIONING HLPP**

1. under 20 and first baby;
2. 20-24 , NEET, never employed
3. 20-24 NEET and No Qualifications,
4. 20-24 and other factors

**Details: TO - HLPP-HV (PRESENT AT CLINIC) NAME:**

**TO HLPP-S (PRESENT AT CLINIC).....**

**POSTED TO HLPP OFFICE**

## Appendix 2b: Comparison between proposed FNP data and the national maternity dataset

	ITEM proposed for HLPP	Appears in penultimate draft of National Maternity Dataset?
1.	Age	Yes
2.	Occupation	Yes
3.	Partner:	Occupation, employment and marital status
4.	Income and debt	Yes but little detail
5.	Address and postcode	Yes
6.	Who lives with	No
7.	Type and tenure of housing	Tenure
8.	Quality of housing	No
9.	Neighbourhood	No
10.	Social capital & support	Support at home
11.	Education – learning disability; years; exclusion or dropout; qualifications (highest)	Yes – highest achieved: not exclusion or dropout
12.	Ethnicity and country of birth; when arrived in UK	Yes
13.	English language ability	Yes
14.	Literacy (in any language; in English)	No
15.	Physical health	Yes
16.	Mental health and mental illness	Uses narrower concepts of psychiatric disorder and puerperal psychosis; lacks broad view of mental health, low level depression / malaise / anxiety.
17.	Status factors – asylum seeker, refugee, etc.	Yes
18.	Victimisation issues	Yes – domestic violence only
19.	Previous personal history	Asks about prison but not about Looked After status or offending.
20.	Previous personal history of partner	No
21.	Smoking	Yes, also household smoke exposure
22.	Alcohol use	Asks about regular use and binge drinking but definition of binge drinking not ideal. Units per week difficult as highly variable.
23.	Drug use	Yes but doesn't distinguish between occasional use of cannabis at one end of the spectrum and dependence on cocaine or heroin at the other.

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<sup>104</sup> While preparing this report a Sure Start "stay and play" session was visited with the aim of hearing parental views about the proposed HLPP. We were impressed with the quality of care and parenting shown by the mothers (and fathers) in the centre - the majority had had their first child at around 18-19 years. But there were no mothers under 18 in the group; Sure Start has experienced considerable



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difficulties in engaging these very young mothers.

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<sup>121</sup> The term "investigator-led interviewing" is used in the research literature but "professional-led" is more appropriate in the context of HLPP s. We are grateful to Dr Stephen Scott (Maudsley Hospital and Institute of Psychiatry) for advice on this and several other related topics.

<sup>122</sup> We are aware that in the Netherlands pilot project, a different view has been taken. From the UK perspective, this does not seem logical – however, this may be one of the issues for study as part of the evaluation process.

<sup>123</sup> For example, the West Midlands dataset and the proposed core dataset for maternity services.

[www.perinatal.Nhs.uk](http://www.perinatal.Nhs.uk)

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<sup>127</sup> The Plunket Society (named after the wife of the Governor-General who supported the organisation

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when it was founded in 1907) is a not-for-profit organisation that provides much of the well-child care in New Zealand. See [www.plunket.org.nz](http://www.plunket.org.nz)

<sup>128</sup> We are grateful to the health visiting staff and services manager of Cornerstone Centre in Manchester (who operate this policy) for their advice on the practicalities of this recommendation; also, Huddersfield health visitors undertake a Universal Needs Assessment (UNA) at 36 weeks .

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<sup>131</sup> In the NFP, consent for referral does not appear to be mandatory – the Sample Referral Form in the Implementation Pack has a box to indicate whether or not the client is aware of the referral. This may be acceptable in the UK if the HLPP is to be regarded as part of the spectrum of a universal service offered to all first time mothers.

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<sup>139</sup> See reference 1. .

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