Eligibility for the Family Nurse Partnership programme

Testing new criteria

Prepared by Professor Jacqueline Barnes, Beth Howden, Lisa Niven & Mog Ball
Institute for the Study of Children, Families and Social Issuesl Sciences,
Birkbeck, University of London

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Contact Details	Sam Mason FNP National Unit G17, 133-155 Waterloo Road London SE1 8UG 0207 972 4167
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i. Introduction

The Nurse-Family Partnership (NFP) programme (known in England as the Family Nurse Partnership, FNP) provides nurse home-visiting services beginning early in pregnancy and continuing through the first two years of the child's life. Initially developed in the USA in the 1970s where it has been tested in three randomised trials (Olds, 2006), it was introduced into England in April 2007 in 10 locations. With its expansion (currently initiated in five waves in 50 locations; House of Commons, 2010) the most effective ways to target the programme have been considered. In particular the current criteria for FNP eligibility are being scrutinised to ensure that it has the most potential for impact. This report is in several parts. The first is a summary of literature indicating which mothers and children might be the most likely to benefit from the FNP. The identified key risk factors are examined in relation to information commonly available to midwives and to the characteristics of the first (wave 1) FNP cohort. Then information is provided about two investigations focussing on the application of additional eligibility criteria. Lastly, the issue of the applicability of FNP for clients who require an interpreter to be present is examined. Finally recommendations are made about the future use of eligibility criteria.

From the outset in the USA the programme was developed for a specific group of mothers, those of low income expecting their first child and who could be enrolled ideally before the 16th week and definitely before the 28th week of their pregnancy. Although the first USA trial allowed the programme to be available to mothers-to-be of various ages and with different backgrounds, both on the basis of the original intention and on the basis of subsequent research it has become more often offered to young and/or single first time mothers of low socioeconomic status (Olds et al., 1986). In the UK its introduction in April 2007 in 10 sites (wave 1) was part of the action plan on social exclusion (Cabinet Office, 2006, pp. 51-52) indicating that it was being provided to give support to families experiencing deprivation. Depending on the size of the population and the predicted birth rate, in some of the wave 1 areas the intention was for clients to be all first-time mothers under 20 at the time of conception, while in areas with smaller populations and lower birth-rates mothers-to-be aged 20 to 23 were also recruited using additional criteria based on a systematic literature review (Hall & Hall, 2007). They were eligible if they were 20 or older but less than 24 at the time of conception with *any one* of the following three rules:

- Not currently in employment, education or training (NEET) *and* has never been in regular paid employment *OR*
- Is NEET *and* has no qualifications *OR*
- Does not have a stable supportive relationship with the baby's father.

Five of the 10 sites had planned to recruit older and younger clients and five only teenagers but in the event non-teens represented 13% of the first cohort of clients to be enrolled by FNP, with all but one of the sites having some clients aged 20 at enrolment although only 6% were over 20 (Barnes et al., 2008). The first eligibility investigation (Chapter 2) involved some of the wave 2a sites recruiting clients who were older than 19 years and who were deemed to have identified vulnerabilities that varied slightly from those originally specified for wave 1. The second investigation (Chapter 3) involved a wave 1 site requiring additional vulnerabilities for clients aged 19 or younger. Finally (Chapter 4) information is provided about an investigation based on wave 1 sites of whether the criterion of non-English speaker requiring an interpreter should be an *ineligibility* criterion.

In this chapter the outcomes of the three USA trials are summarised to identify the women for whom the programme has had the greatest impact. Then a review commissioned by the Department for Children, Schools and Families to develop inclusion criteria for FNP in England (Hall & Hall, 2007) is summarised together with work conducted for the Department of Health PREview project (University of York, 2009) to develop a predictive tool for targeting the Healthy Child Programme effectively. The likelihood of the most useful criteria being available in midwifery routine records is then considered on the basis of a detailed examination of systems in one site and finally the characteristics of the first (wave 1) FNP cohort of clients are compared to the criteria that seem the most useful and/or available.

ii. The USA evidence

Recruitment to the research trials
To set the USA trial evidence in context it is important to look at the criteria that were used to select each of the three samples[1]. Eligibility criteria were a compromise between the researchers' knowledge of who the programme was intended for and the practicality of identifying participants through existing structures. It provides a useful model for how a targeted group might be selected in the UK. The evidence from the trials also provides important information about which maternal characteristics identifiable during pregnancy have subsequently been related to the greatest impact of the programme.

In the first trial (Elmira, New York State) first-time mothers-to-be were to be selected if they had any ONE of the following three relatively straightforward criteria: under 19, single parent and low socioeconomic status (SES). Low SES was determined either by being eligible for means tested health insurance (Medicaid) or by having no private medical insurance. However, since the team did not want the programme to be seen as stigmatising any first-time mother in the community who wished to be part of the programme was also enrolled. Just under half (47%) were teenage, just under two thirds (62%) were unmarried and a similar proportion (61%) were in households classified as low socioeconomic status. Only 85% of the group had at least one of the three specified characteristics.

Who gained the most from the programme?
Once results started to emerge it became clear that the majority of the significant outcomes were evident for those who had at least TWO of the recruitment characteristics, namely, unmarried and low income.[2] Other impacts were only evident if they had all THREE intake factors. One not specified initially was being a smoker but two findings related to infant birth outcomes were only found for mothers who were smokers at intake. It was further identified that some effects were unlikely to be observed if the mother has certain characteristics, principally experiencing domestic abuse. Subsequent cost benefit analyses based on the child outcomes at age 15 indicated that the programme did not have benefits and worked out as a loss if offered to women who were married and higher income.

In the second trial (Memphis, Tennessee), based on the Elmira evidence, it was required that the participants had at least TWO of three characteristics: unmarried, less than 12 years of education (i.e. finishing high school), and/or unemployed. The researchers were successful with this strategy in obtaining a low income group, with 98% unmarried, 85% below the federal poverty level, and about two thirds (64%) were age 18 or younger. Reflecting the population of Memphis, they were also predominantly African American. Given that the sample was almost uniformly economically disadvantaged the analyses of impact were examined in relation to the

[1] All relevant references reporting on the outcomes of the USA trials are given in Appendix A.
[2] Full details of all significant impacts for each of the USA trials, and which were identified only for a subgroup, are given in Appendix A.

mother's "psychological resources" being above or below the median of a composite measure of: low intelligence, mental health problems, low sense of mastery and low self efficacy. The presences of maternal low psychological resources proved to be strongly related to a number of positive child developmental outcomes, although many FNP effects were also found for the whole group.

In the third trial (Denver, Colorado) only ONE criterion was used, low income, ensured by recruiting in low income neighbourhoods those mothers who qualified for Medicaid or had no private health insurance. Medicaid eligibility at the time was an income of 133% of the poverty level. Using this criterion the majority (85%) were also unmarried. There is no information on what proportion were teens but the mean age is just under 20, with a standard deviation of approximately four, indicating that just over half of the sample was teen at the start of the study. Reflecting the population of Denver, just under half were of Mexican American background. Positive maternal life course impacts such as a longer interval before a second pregnancy were identified for the whole group. Replicating the Memphis results improvements in maternal sensitivity to their infants and a range of child developmental outcomes were evident only when their mothers had 'low psychological resources'.

Which are the most consistently predictive of significant impacts?
To gain the maximum impact and cost effectiveness in offering FNP, the principal factors that are flagged up by the USA research, based on the sub-groups most often identified, are:
DEFINITE

1. Low income, at about the national poverty level or below
2. Unmarried (or 'no partner')

STRONGLY INDICATED

3. Teenage at conception
4. Below average intellectual capacity
5. Mental health problems
6. Low self esteem/sense of mastery.
7. Smoker in pregnancy

iii. UK evidence

As a precursor to implementing the NFP programme in England a review was commissioned by the government (Hall & Hall, 2007) to determine the most useful selection criteria for recruitment, based both on evidence of potential for impact and on the likelihood that factors could easily be identified during routine NHS contacts in pregnancy. The review summarised evidence indicating risk for adverse outcomes for children, both educational (e.g. few or no qualifications) and behavioural (e.g. mental health problems, criminal behaviour). There was no focus on maternal life course outcomes that are some of the main outcomes of the programme, based on the USA trials. The review highlighted the challenge of identification in pregnancy since a greater number of well-established risk factors for poor child outcomes are identifiable only after birth (e.g. child gender, insensitive or harsh parental behaviour, problematic child temperament).

What risk factors predict poor child outcomes?
Factors were divided into those relating to the mother-to-be's past history and to her current circumstances. While noting that it is not possible to specify a necessary minimum number of risk factors, the authors indicate which could most usefully be used to identify eligible mothers-to-be. However Hall and Hall also note that it might prove problematic for recruitment if the programme is perceived as stigmatising. While many factors predict both poor academic progress and delinquency or mental health problems of children, the way that FNP is 'sold' should be through its potential to "ensure that children thrive in school and benefit from their education." They note that the factors for more than one adverse child outcome with the most

robust evidence (see Appendix B for the full list) are predominantly related to social exclusion. They are:

- Maternal school failure,
- Mother in care/looked after,
- Low socioeconomic status,
- Young mother,
- Single parent or non involved father,
- Resident in a deprived neighbourhood,
- Marital/parental discord,
- Ethnic minority status, particularly Pakistani or Bangladeshi background,
- Parental criminality, and substance abuse and/or mental health problems.

These are all risks for child behaviour problems, particularly if more than one is present in conjunction with low SES. The review concludes that the majority of the evidence related to maternal mental health problems and subsequent child development is concerned with their presence postnatally so use as a selection criterion for FNP in pregnancy cannot be supported.

The Department of Health PREview project is investigating the evidence base and feasibility of a tool which will help health professionals target the NHS Healthy Child Programme effectively to optimize child outcomes (University of York, 2009). As part of the project, nationally representative data from the Millennium Cohort Study (MCS) were analysed to identify factors in pregnancy that predict poor child developmental outcomes at five years (Kiernan & Mensah, 2009). Behavioural outcomes were based on the Strengths and Difficulties Questionnaire (Goodman, 1997) completed by the main caregiver and academic performance based on the Foundation Stage Profile completed by the classroom teacher. Taking other factors into account statistically, difficulties in children's learning and academic performance and child behaviour problems were *both* associated with a number of factors that could be determined prenatally:

- Mother under the age of 24 at the child's birth,
- Mother has few or no qualifications,
- Lone mother,
- Income at or below £10,400,
- Language in the home not English,
- Pregnancy unplanned,
- Not bothered or not happy about pregnancy,
- Mother continues to smoke in pregnancy,
- Not owner occupier,
- Area deprivation bottom three quintiles.

One factor relevant only for predicting learning and academic difficulties was 'mother has never worked'. Two factors relevant only for predicting behaviour problems were 'mother has lived away from home at a young age' (i.e. in care of social services), and 'mother not married at the time of the birth'.

Which factors are the most consistently specified?
From the Hall and Hall review and the PREview conclusions a shorter list of well-established risk factors for poor child outcomes by the age of five can be identified, limited to those that can potentially be identified in pregnancy:

DEFINITE

1. Low socioeconomic status (even when identified by neighbourhood deprivation)

STRONGLY INDICATED

2. Lack of maternal educational qualifications/failure of the mother to complete school
3. Young age

4. Looked after
5. Single parent
6. Marital discord
7. Partner criminality and/or substance abuse.

It compares closely with the factors identified from the USA trials characterising clients most likely to benefit from the programme (see Table 1.1).

Table 1.1 Relationship between factors indicating positive impact of the programme in the USA and evidence from the UK literature of factors predicting poor child outcomes

USA Rank	**Factor**	**UK Rank**
1	Low Socioeconomic status/poverty	1
	[Deprived neighbourhood]	Proxy for 1
2	Single parent, no relationship with father	5
3	Mother young/teenage	3
4	Maternal low intelligence	(see #2)
	Maternal school failure	2
5	Maternal mental health problems	-
6	Maternal low self efficacy and mastery	-
-	Mother has been in care, looked after	4
-	Marital discord	6
7	Smoking in pregnancy	-
-	Partner criminality	7

It is to be expected that the list derived from the two UK studies will not exactly match the list based on the USA evidence regarding the impact of NFP in the research trials. Many of the important outcomes of the trials are maternal (e.g. wider spacing of pregnancies, see Appendix A) rather than child outcomes, which was the focus of both the Hall and Hall (2007) review and the MCS analysis (Kiernan & Mensah, 2009). However that said, the similarity between the lists is clear and clients selected using these criteria should be expected to gain substantially from the programme.

iv. Availability of relevant information in midwifery records

A detailed case study was conducted in one site, examining routine midwifery records and interviewing four local midwives, to determine the likelihood that any of the most important potential eligibility criteria would be readily available. The presence of each criterion is summarised in Table 1.2. It emerged that much of the information was kept in paper formats, some held by the clients, but much of the information on these paper documents was not entered into the electronic data system. If booking with their GP practice the client completes a *Maternity Booking Form* which is returned to the GP receptionist who leaves it in the midwife's file. The midwife then makes contact with client to arrange the booking appointment. This booking form contains only limited information (see Appendix C for full details of the content of each form). Then, depending on the midwife's personal working style the initial data on the Personal Maternity Record are either completed by the client, with the client, or by the midwife prior to the booking appointment. This is a hand-held record and there is only the one copy. From the Personal Maternity Record the *Short Booking Information* sheet is hand written with slightly more information, which is the basis of data entered by midwives into the computer-based Maternity Booking System or more commonly into the *Short Booking Summary*.

The full electronic Maternity Booking System had the capability to contain much information (more than 1000 data fields) that could be useful as eligibility criteria for referral to the FNP (e.g.

language ability, whether mother and father live together, history of mental health or psychological difficulties, drug and alcohol use, detailed smoking data both mother and father, family history learning difficulty). However in practice much of the information was either not routinely collected, or if it was collected, the timing was not early enough to be of practicable use to the FNP. Not all data items are mandatory, and typically only the mandatory items (34) were being entered at initial booking. When there is a shortage of staff or time constraints a smaller sub-set is entered, the *Short booking summary.* Of the items that could be entered in this summary (see Appendix C), in addition to the client's name, DOB, age and address, only seven are mandatory and only two (one or two parent family and smoking status at booking) could be relevant for identifying FNP clients.

At the booking appointment the *Antenatal Risk Assessment Form* is also completed for each client although midwives indicated that since this was a hand-held document and could be read by the client, partner or family member sensitive information was not always recorded. There are three copies, one of which is passed to the health visitor, the other two going into the client's hospital notes. These data are never entered into any electronic format.

After the midwives put the initial data into the computer system, unless there is a specific requirement to see a consultant, all antenatal visits occur outside of the hospital and the system is not updated unless an alert is needed, usually *'some sort of social problem or something to do with safety of the staff such as a violent family member'*. These alerts are in the form of free form text and appear any time a client's records are accessed. If any midwife has concerns over a client, such as a child protection issue, there is a nurse who is responsible for this type of situation. Referrals to social services, usually only take place after 20 weeks gestation (*'they only want to know if they know the pregnancy is definitely going ahead'*).

While there the intention is that eventually all hand held maternity notes will be consistent throughout the country for example the midwives noted that currently many areas have their own forms. *'If a client moves in from another part of the country 9 times out of 10 she'll have a set of notes that we've never seen before because they work on their own'*. Thus this example may not be representative of other areas. However it highlights the fact that the only factors that can reliably be expected in midwifery records in this site are maternal age, residence in a deprived neighbourhood – a proxy for low SES if the FNP team have access to local information from the Indices of Multiple deprivation and smoker in pregnancy (see Table 1.2). Depending on what has been written into the various forms, single parents may be identifiable and mothers with a history of or current mental health problems.

Poverty or low socioeconomic status is the main criterion that would identify those most likely to benefit from the FNP programme. However it is perhaps not surprising that this is not part of routine midwifery records. In the wave 1 FNP sites it proved a challenge even after recruitment into the programme for Family Nurses (FNs) to obtain accurate information about household income. Having been provided with specially designed forms to record demographic information, data on income was missing for 47% (Barnes et al., 2008) reflecting a combination of factors; partly a reluctance to broach the topic combined with a lack of detailed knowledge on the part of the mother-to-be about the income of household members or the value of benefits received.

The USA evidence highlighted the important of the programme for mothers with lower levels of intelligence. Failure to complete education up to the age of 16, or completion of school but gaining no GCSE qualifications at grade C or above, are not perfect indicators of intellectual limitations but are relatively easy to identify if the right questions are asked. Unfortunately this information is not generally obtained during the booking process. Asking whether a pregnant woman whether she has ever been in care is potentially intrusive, but on the basis of the evidence could be important as an inclusion criterion. The test site had a risk assessment form that included ''previous or current social work involvement' and this question could be refined so

that removal from the parental home can be identified. However the main conclusion of the review is that any selection of potential FNP clients based on vulnerability criteria is likely to be more successful if conducted by the FNs rather than by relying on the relevant information being available to midwives, and then passed on to the FNP team. Even if FNP teams have access to computerised midwifery records few of the relevant facts are available without talking directly with potential clients.

Table 1.2 Summary of data available through booking process with midwifery in one test site in relation to important factors derived from the UK and USA literature[3]

Potential eligibility factor	Maternity booking form (paper)	Short booking sheet (paper)	Risk assessment form (paper, triplicate)	Booking summary (computerised)
Low Socioeconomic status/poverty	No	No – but ask mother's occupation	Possibly , 'Financial/housing problems'	No
Deprived neighbourhood	Yes - from postcode	No	Yes - from postcode	Yes - from postcode
Mother no qualifications	Presumed if mother younger than 16	No	Presumed if mother younger than 16	Presumed if mother younger than 16
Mother teenage (USA) and under 16 (UK)	Yes – Mother's DOB	No	Yes; 'Mother aged 16 or less, or 16-19 and unsupported'	Yes
Mother has been in care, looked after	No	No	Possibly: 'Previous or current social work involvement' and 'History of child abuse or children on child protection register'	Possibly –electronic alert for social services involvement
Single parent, no relationship with father	No	Possibly - Asks 'Partner's name' and 'Partner's occupation'	Yes; 'Single parent, unsupported'	Possibly – "One or Two Parent Family?"
Partner criminality	No	No	Possibly but only if added as freehand note	No
Maternal low intelligence	No	No	Possibly: 'Learning difficulties'	No
Maternal mental health problems	'General health' and current medications only	'Previous medical history' only	Yes: 'History of mental health issues'	No
Maternal low self efficacy	No	No	No	No
Smoker in pregnancy	No	Yes	No	Yes, smoking status at booking

v. Characteristics of the first wave 1 cohort

The first English FNP cohort was identified principally on the basis of their age (under 20) and being a first-time mother. However it is useful to see what other characteristics they have to compare them with the clients thought to be the most likely to benefit. It is also useful to look at the co-occurrence of vulnerabilities. If one that is more readily available during pregnancy frequently co-occurs with a more difficult to determine indicator, then one can be used as a proxy for the second.

Table 1.3 shows details of characteristics of the first cohort recruited to Wave 1 sites when the programme was first introduced and who received at least one visit (N=1246). It is important to

[3] Information definitely present for identifying eligibility shaded in dark grey, information possibly available shaded in light grey. Full details of the four sources of information in Appendix C.

note that this information was, apart from their age at enrollment, all the information was obtained by the FNs using specially designed programme forms after the clients had enrolled in FNP. Age was available for all but for the remaining twelve indicators there was missing information. In subsequent tables information is given, first for the total group and then for a smaller sub-set (N=527) for whom there was complete information on all vulnerabilities.

Table 1.3 Information available regarding vulnerability of Wave 1 FNP clients

Vulnerability	**Format of question on FNP data form**
Age	Date of Birth at intake
Not living with mother	DOESN'T Live with mother Yes/No
Poverty - very low income	Annual income is less than £3,100 p.a. or entirely from benefits This cut-off was chosen as Job Seekers Allowance for 16-24 year olds is £50.95 pw (£2,649,40 pa) and the nearest response category on the Demographics at intake form is 'up to £3,099 pa'
No qualifications	No GCSEs at Intake
Smoker in pregnancy	Smoked at Intake Yes/No
Abused ever	Have you ever been emotionally or physically abused by your partner or someone important to you?
Maternal mental health problem	Client Receiving mental health services and/or Client has mental health issues
No Partner	No partner/husband at intake based on Do you have a partner now? and/or Marital status cohabiting or married not separated
Ever in care, looked after	Client was or still is in care
Any Social Services	Client receiving services for Child abuse and/or Child In Need and/or Domestic Violence and/or Other
Low maternal IQ, learning difficulties	Client has learning difficulty/developmental delay
Family mental health problem	Mental Health-family member receiving services
Homeless	Homeless Yes/No

Rates of vulnerability

Some vulnerabilities were present for many of the clients, such as not currently living with their own mother (50%), a very low income (43%), no educational qualifications (40%) and smoking during pregnancy (39%) (see Table 1.4; more detailed age breakdowns are provided in Appendix D, Tables D1 and D2, particularly relevant if deciding between a cut-off at age 17, 18 or 19). It is noteworthy that, despite the simple age criterion used for selection of FNP clients in the first implementation of FNP almost one third of those recruited reported some abuse in the past and one quarter were said to have mental health problems. Thus they do represent a vulnerable group. Comparing those under 20 and those who were older, the older clients were more likely not to be living with their own mother (71%) but less likely than the younger clients to have a very low income (32%) or to have ever been in care (5%). They were also slightly more likely to have learning difficulties.

How many vulnerabilities?

If one is planning to select clients with more than one vulnerability it is important to know how likely it is that first-time young mothers will have a number of risk factors. If too many factors are required then the potential client group may be reduced to nearly zero but if too few are needed then the resultant client population may be as large as the current group, selected on the basis of age and first-time mother status.

It can be seen (Table 1.5) than even using one criterion in addition to age would limit numbers by 12% since that is the proportion of the existing client group who had none of the vulnerabilities on this list. The most common pattern is for one (22%) or two (25%) of the vulnerabilities to be present. Thus if the criteria were to be 'any three or more from the list' then

the potential client group would exclude 59% of current FNP clients. In Appendix D more detailed age break-downs are given (Tables D3 and D4).

Table 1.4 Percentage of all clients who have received at least 1 visit who have each vulnerability, by under 20 and 20 plus[4]

	All		Under 20		20 plus	
	N	%	N	%	N	%
Not living with mother	1181	50	1071	48	110	71
Poverty - very low income	780	43	702	44	78	32
No qualifications	1179	40	1069	40	110	42
Smoker in pregnancy	1112	39	1007	39	105	39
Abused ever	1026	32	928	32	98	28
Maternal mental health problem	961	24	862	23	99	31
No Partner	1181	21	1071	21	110	23
Ever in care, looked after	947	13	850	14	97	5
Any Social Services	1186	9	1076	9	110	4
Low maternal IQ, learning difficulties	949	8	851	8	98	12
Family mental health problem	1186	2	1076	2	110	2
Homeless	1181	2	1071	2	110	2

Table 1.5 Percentage of clients with multiple vulnerabilities, all clients who have received at least 1 visit, by under 20 and 20 plus. The total sample and those with data for all items

	All clients	Under 20	20+	Data for all items	Under 20	20+
Number of vulnerabilities	N=1246	N=1131	N=115	N=527	N=466	N=61
	%	%	%	%	%	%
0	12	12	8	9	10	3
1	22	23	20	18	18	15
2	25	25	23	23	23	23
3	18	18	21	18	18	21
4	11	11	17	13	12	21
5	6	6	6	8	8	8
6	3	3	3	5	5	5
7	2	2	1	4	4	2
8	1	1	0	1	2	2
9	0	0	1	1	1	2

Factor Analysis to identify patterns of vulnerability

Based on the extent to which characteristics are associated, patterns or 'typologies' can be identified statistically using Factor Analysis[5]. Put simply, the method identifies which vulnerabilities occur together, creates lists of these groups which are known as factors and then shows how strongly each particular characteristic contributes to a grouping. This is shown numerically by their 'loading' or eigenvalue on the factor (see Table 1.6); the larger the

[4] N varies for each vulnerability, missing data on many forms

[5] The method used was Principal Component Analysis with Varimax rotation.

eigenvalue the more strongly that particular feature is a defining part of the factor. Only the clients for whom data were available for all vulnerabilities (N=527) could be included in this analysis. Five factors were identified showing that groups of two or three vulnerabilities were likely to be present together.

1. Social Service involvement; family mental health problem; mother ever in care, looked after.
2. Maternal mental health problem; mother ever abused; smoker in pregnancy
3. Poverty - very low income; mother with no qualifications
4. Not living with own mother; maternal age
5. No Partner; low maternal IQ or learning difficulties (those clients with learning difficulties are more likely to have partners).

Examination of these factors can help in the decision making about which indicators might be used for selection that could also be a proxy for a more hard to identify characteristic.

Table 1.6 Results of Factor Analysis to determine patterns of vulnerability for clients in wave 1 of FNP (Eigenvalues greater than .5 shown)

	Factors				
Vulnerability	**1**	**2**	**3**	**4**	**5**
Any social service involvement	.772				
Family mental health problem	.748				
Ever in care, looked after	.574				
Maternal mental health problem		.790			
Abused ever		.675			
Smoker in pregnancy		.506			
Poverty - very low income			.610		
No qualifications			.606		
Not living with mother				.780	
Age				.643	
Single parent, no partner					.690
Low maternal IQ, learning difficulties					-.610
Homeless					

vi. Recommendations

Based on all the information summarised in this chapter, eligibility criteria that could be used to select a group of clients for ongoing FNP, in addition to the current criteria (first-time mother, prior to 28 weeks gestation) are proposed.

Include ALL:

- Under the age of 16
- Ever in care or looked after.

And those with ANY THREE of the following:

- Live in deprived neighbourhood (proxy for low income)
- Smoker in pregnancy
- Single unsupported parent
- Not living with mother
- No educational qualifications
- Experience of abuse
- Maternal mental health problems
- Maternal low intelligence

Chapter 2. Using additional criteria with 20-22 year olds

i. Introduction

While it can be seen from the information presented in Chapter 1 that selection of potential clients for FNP based on being under 20 at conception does identify a vulnerable population this programme was not necessarily a 'teenage pregnancy' provision; it was intended to reduce social exclusion. Thus there may be first-time mothers who are not teenagers but who could benefit. Two wave 2a sites, where numbers were predicted to be low if recruitment was limited to under 20 year olds, tested the use of additional criteria for first-time mothers aged over 19. Based on the evidence from the USA reviewed in Chapter 1 and the experiences of the Wave 1 teams, the criteria for inclusion were changed slightly from those used in wave 1 for older clients. In particular the upper age was reduced but the requirement never to have been employed was removed and they could be NEET but have some qualifications. The eventual eligibility criteria, assuming that they had not reached 28 weeks gestation and lived in the PCT area, were that they had ALL THREE of the following:

- Aged between 20 and 22 at their last menstrual period (LMP)
- Not currently in employment, education or training (NEET)
- No educational qualifications higher than 4 A* to C GCSEs.

When determining whether a mother-to-be was currently in employment, voluntary work and informal or illegal employment were not considered as being 'in employment'. An eligibility form was developed so that FNs would be able to collect the relevant information about each referred client, either from her records or during the recruitment visit.

Methods

Data from the standardised forms completed by nurses in the two sites as they delivered the programme were extracted and comparisons made of the clients aged 20 to 22 recruited with additional eligibility criteria and the younger clients, aged under 20, recruited using only the standard FNP criteria. Client characteristics have been compared, attrition and programme delivery indicators. The delivery of the programme has been examined from the start of programme delivery in the two sites in 2008 up to July 2010 based on 45 clients in the two test sites (range 20 to 23 years) for whom additional criteria were used for recruitment and the 151 who were recruited without additional criteria. The older clients represent a slightly greater proportion of the total number in site A than in site B (site A 30/101, 30%; site B 15/95 16%). Statistical comparisons are based on the combined data from the two test sites due to the small number of older clients from each site separately, to make statistical comparisons more robust.

Semi-structured interviews were conducted with seven nurses in the two test sites, with five professionals who had made referrals and with seven older clients who were recruited using the additional criteria. Interviews were semi-structured and explored the experience of recruitment, understanding of the criteria being used for selection, and thoughts about the programme itself. Nurses were also asked about any impact that using the additional criteria had on their work.

ii. The referral process

When there are criteria beyond the mother's age and whether it is a first-time birth, the data available to potential referrers is crucial and it was documented by examining forms used in one site (Chapter 1) that this may be fairly limited. The two sites in this study had very different systems for referrals. In site A community midwives had access to a computerised system which sent referrals automatically to Additional Support Midwives so that they could accessed the system weekly to extract information about the specific needs of women who required additional support. One such midwife identified all 20-22 year olds who were not employed and were therefore potentially eligible for FNP and forwarded their contact details to the team, who then contacted the women directly. In Site B there is no comparable single database for

identifying potential clients. Instead the team relied on referrals from a number of sources in the area: Connexions, sexual health services, General Practitioners, the Health Visiting service, and midwives at two maternity hospitals who identify eligible clients at their booking in visit. Once women aged 20-22 had been referred to the FNP the procedure was the same in both sites. A recruitment visit was arranged at which time a specially designed eligibility form was completed to allow the nurse to identify immediately those women meeting the criteria.

iii. Perceptions of referral and recruitment to FNP

Managers

The lack of a similar single reliable source in Site B meant a reliance on a variety of professionals, which was a concern:

> *The referrals from the teenage pregnancy team at the (hospital) have been fantastic but a bit thin from the other services. In my experience it is dependent on individual midwives who understand the programme, get it and make referrals.*

Due to concerns over a low number of referrals, the supervisor arranged meetings with both hospitals to search together through their databases for first time pregnant under 23s who may not yet have been referred. While few were uncovered through these searches, the supervisor felt that these trawls would need to be repeated on a regular basis as staffing changes meant that awareness of FNP was easily lost unless '*someone who is within the midwifery team and actively working with them*' who could keep staff informed of FNP and encourage referrals. The project lead in site B noted the awareness of the FNP team that the midwifery teams needed to understand all about FNP.

> *Referrals from the hospital is something that we've probably spent most time on, going to speak to midwives and building relationships and awareness.*

Midwives

Midwives described variable knowledge, depended more on personal contacts than on systematic information sharing. For instance one was based in the same building as the FNP team:

> *The building I work in is owned by the PCT so the pilot is coming from that. The family nurses were doing their training here.*

Others had actively sought out the information for themselves, one by virtue of having been interested in the job of FN:

> *You have a few people, like me, who considered applying for a job so we were up-to-date on what it was all about.*

Most were able to describe the programme in broad terms including the period and frequency of engagement with clients, and a little about the selection criteria:

> *It is offered from I think its 12 weeks in until the baby is I think 2 years old.*
> *The FNP is a great thing because they visit on a regular basis, build rapport with them over 2 years.*
> *I don't know about all their training but I know about frequency of visits and especially vulnerable girls need that support.*

When asked to describe what she knew about the substance of the programme, one midwife mentioned that her knowledge was not sufficient and that the women should know about the service before she was contacted by them, and her use of the term 'cold-calling' indicates that she perceives this as a selling process for something that may or may not be useful, that women may need to be persuaded to receive FNP:

> *What the FN I know was saying is that you just need to refer people and then we'll deal with it from our end ... People don't necessarily want cold-calling. If it was me I'd want to know more about the person calling me.*

A lack of understanding of the programme raised questions about how to describe the service for the person making the referral. In some cases, it meant that details given to potential clients by midwives were simply glossed over:

> *I asked (the FN), what do we tell them? She said, just say they are support. Well this is what I say, they are there to help you with different things and they will tell you about it when they contact you, that's about it really.*

One midwife focussed less on the content of the programme and more on the clients' perception of it. She wanted to set FNP in the context of the other services available to pregnant women in an attempt to normalize the programme and avoid stigma:

> *I usually say because we are community based we have a variety of ways we provide care. I try to introduce it right at the beginning so its part of the normal.*

She also focused on practical issues that experience told her were often major concerns for pregnant women:

> *I always suggest to them that I'll do the midwifery care but these girls (the FNs) will stay with them for 2 years and are very good at sorting out housing and education. The minute I say that, it gets a good response.*

Nurses

Mirroring what had been said by midwives about lack of detailed information, the FNs commented that the recruitment visit was often the first time women who had been referred hear any details about the FNP. These visits took place at home after being arranged by telephone, with the expectation that the midwife would have given at least some brief details about FNP:

> *I usually ring them and say who I am and where I'm from, mention their midwife and say, they probably told you a bit about us.*

The manner in which the FN addressed the potential client was used to illustrate the strength-based and friendly tone for future visits:

> *I said, I understand you're expecting a baby, congratulations, how are you feeling?*

FNs generally did not have a markedly different approach for recruitment that included extra criteria, compared to their recruitment of women under 20. One did say that her approach to the visits differed due to her assumptions about the difference in the expectations and needs of the older clients:

> *With the younger ones it's all about selling the support side of things 'I'm going to be here for two years'… With (older girl) I just did it much more like this is for you to learn about you and to keep you and the baby healthy. So it was much more educational.*

The perceived impact of selection criteria on recruitment was said to be minimal by the nurses in terms of the time required. The issue of having to find out about the criteria appeared, however, to elicit some anxiety. Some described giving notice to the women that some forms should be expected at this initial visit but were not specific that this would screen them into or out of eligibility for the FNP making comments such as:

> *When I come round I'll show you lots of paperwork'*

However most trod more carefully around the specific details and did not explicitly indicate that depending on what she said she may not be eligible, which potentially could create difficulty:

> *I wouldn't say it any differently to what I'd say to anyone else, just that luckily in this area we are going on to 23. You are not selected for any other reason than your age.*

Others talked about criteria but were often non-specific about what information they were looking for:

> *I just said it was being offered to people within that age group who met certain criteria. For older girls, occasionally for some I've mentioned at that point about qualifications and the study, for others I've left it till visit one…I say that because we're testing on a small number there has to be some criteria and I think they understand that.*

Those FNs who were clearer about the selection process impressed on women that the programme is being trialled '*we're piloting it here*' as an explanation for the use of criteria, perhaps to disassociate themselves from the eligibility criteria:

> *I do make the criteria clear and explain that it is still being trialled by DH to see how effective it will be for their age group.*
>
> *It's not about you; it's about our criteria because we are testing this project.*

However some would not be eligible so FNs prepared for this eventuality by having information about alternative support services to offer, or possibly making another referral:

> *I make sure I always talk along info on other local services in case they are not eligible, so I try to use the visit as an intervention in itself and so they've got something positive out of the visit.*

Clients

Reflecting the FNs' tentative approach to explaining the criteria, clients' knowledge of eligibility was sketchy:

> *I don't know [why I was selected]. She [FN] said that we give the programme to people under 23 years. And first time when you have the baby.*
>
> *Basically it's a pilot scheme for 20s and under, but I think I'm an exception for some reason.*

Because the eligibility criteria are not made clear, clients are likely to guess:

> *Do you have to fit in a certain criteria? Because not everyone has a Family Nurse, do they? I don't know why it was offered to me but in the beginning [of her pregnancy] I was quite depressed.*
>
> *It's because I'm not studying or working at the moment so it means that I've got time. She does do a lot of appointments and I've got the time to do them.*

The majority of those interviewed were given minimal information about FNP from their midwife or the person who referred them.

> *My midwife, she said, 'Can I put you in touch with somebody who's on this pilot scheme?' I said 'yeah, if you want' and she phoned me and I had no idea who she was!*
>
> *[Connexions worker] didn't tell me much, it wasn't until I met the Family Nurse that I found out about it*.

Despite the lack of clarity around the original referral, all of the women interviewed reported accepting it straight away without needing further information; they were happy to wait until the recruitment visit with the FN to find out more.

> *Someone phoned me from the hospital and told me about the Family Nurse, I said 'OK'. They didn't tell me anything, just 'do you mind if we give the Family Nurse your number?' I said 'OK'.*

Memories of the recruitment visit were vague for most of the women, despite being fairly recent events many of them, but they generally reported positive feelings about that first encounter with FNP and their FN:

> *She came round and told me what it was all about, that she'd be helping me get ready for the baby and she seemed really nice, so I was happy.*
>
> *She said she would give me anything I need and talk about my health and the health of my baby.*

Most, however had good recall of what the FN had told them during the recruitment visit:

> *I remember she said she would tell me information that would really benefit the baby and help me understand more ... that the baby would be able to recognise my voice and if I touch my tummy it would stimulate the baby. I thought that was quite useful so I'm looking forward to hearing stuff like that.*
>
> *She's going to come every week for the first 4 weeks, then every two weeks until the baby is born, then every week for the first 6 weeks, then every two weeks until the baby is 21 months.*

The right criteria?

Some of the FNs had been working in the local area for some time and knew the needs of the women who lived there; others had more experience of younger pregnant women and their particular vulnerabilities. In light of this knowledge, each was able to talk about who they felt should be eligible to receive the FNP. Some expressed concern that women who needed the programme had been left out because selection criteria had been employed:

> *There are people who would definitely benefit from it who probably are being missed.*

Others felt that the criteria were not appropriate and especially that having educational qualifications or being employed did not necessarily mean that these women did not need extra support:

> *If someone has got five GCSEs it doesn't necessarily mean they don't need the same level of support really, or if they are employed.*
>
> *I have my doubts about whether five GCSEs would make that much difference.*

Family Nurses also thought that the potentially important vulnerability may not be revealed until a relationship had been built, so it was better to be more inclusive:

> *I think domestic abuse is an ideal one (criteria) really but the issue is if they don't disclose at booking at don't meet any other criteria then you wouldn't pick it up.*
>
> *It's only after about five visits that you start to scratch the surface and things come to light, so even though somebody appears to be fine at the beginning, there are some issues that go with it.*

iv. The clients

The 45 older clients recruited in the two test sites using the additional criteria had a mean age at enrolment of 20.7 years, the most common age being 20 (20 years, N=27; 21 years, N=7; 22 years, N=9; 23 years, N=2). The mean age of the 151 younger clients was 17.6 years (range 15-19). The presence of 23-year-olds indicates that these women were 22 at their LMP as identified by midwives but that they had their 23rd birthday prior to the programme start. A large number of clients in the other eight sites (73) were said to be 20 at enrolment and one criterion for being offered FNP in those areas was that the mother-to-be was under 20 at their LMP.

Gestation at enrolment was significantly greater in one site than the other (site A mean gestation 17.1 weeks; site B mean gestation 20.5 weeks) but within each site the mean gestation at enrolment was similar for the younger clients and the older ones selected using additional criteria (site A younger 16.8 weeks, older 17.7 weeks; site B younger 20.4 weeks, older 21.3 weeks; total younger 18.7 weeks; older 18.9 weeks) and the overall comparison of groups combining the two sites found no difference between the groups (see Table 2.2).

One of the delivery objectives is for a site to enrol at least 60% of clients by 16 weeks gestation (see Barnes et al., 2009, page 124 for details of all the objectives). Almost the same proportion of younger clients (57/151, 38%) and older clients (18/45, 40%) were enrolled by 16 weeks gestation, below the objective of 60% for both groups. Thus it appears that the need to determine whether potential clients had the additional criteria necessary for inclusion did not have a deleterious impact on the speed with which clients could be recruited and then enrolled in the programme. Presumably the lower mean gestation for all clients recruited in site A was related to their access to the computerised system whereas in site B a more complicated and paper-based process with referrals coming from multiple sources was involved.

Table 2.1 Characteristics at intake (continuous) comparing younger clients and older clients with additional recruitment criteria

	Under 20 N=151 (range)	20 to 22 with selection criteria N=45 (range)	Sig.
Mean age	17.6 (15-19)	20.7 (20-23)	p <.000
Mean gestation	18.8 (6-28)	18.9 (13-28)	n.s.
Mental health MHI-5	65.3 (25 -100)	62.9 (35 -95)	n.s.
Pearlin Schooler Mastery	21.4 (14-28)	21.4 (13-28)	n.s.

Table 2.2 Characteristics at intake (categorical) comparing younger clients and older clients with recruitment criteria [6]

	Under 20 N=151	%	20-22 with criteria N=45	%
Marital status χ^2 22.7 p<.001				
Single	107	77	18	43
Cohabiting	25	18	19	45
Married	6	4	3	7
Separated/divorced	1	1	2	5
Household structure χ^2 22.0 p<.01				
Own mother, no partner	60	42	15	36
Own mother plus partner	4	3	4	10
Partner	19	13	14	33
Partner & others, not own mother	10	7	3	7
Others, not partner or mother	22	16	0	0
Lives alone	20	14	5	12
Shelter/homeless	7	5	1	2
Ethnic group				
White	108	76	30	71
Black	16	11	3	7
Asian	1	.7	1	2
Mixed	11	8	5	12
Other	6	4	3	7
Education χ^2 5.5 p<.05				
In school/vocational programme	51	36	7	17
Not in education	89	64	34	83
Employment				
Employed full-time	13	9	3	7
Employed part-time	15	11	5	13
Not working	47	34	21	52
Never worked	64	46	11	28
Smoker				
Yes	76	62	20	51
No	46	38	19	49

[6] Demographic information not complete for all clients

At intake clients were asked three depression-related and two anxiety-related questions that provide a measure of current metal health status (the MHI-5 from the SF-36, Ware et al., 1993). Scores can range from 0 to 100 with 100 indicating optimal mental health. There is no hard and fast cut-off point but below 56 is recommended (ECHIM, 2008) with a population norm expected to be 76. There was no difference between the groups, both means below 76 (see Table 2.1). There was also no significant difference in the proportion who were below the suggested cut-off, indicate mental health problems, over one third for both groups (under 20 48/138, 35%; 20 plus with criteria 17/41, 41%).

Other questions at intake covered their 'sense of mastery' (Pearlin & Schooler, 1978), identified in the USA as an important characteristic related to gaining from the programme in that those with a low sense of mastery (together with low intelligence and more mental health problems) were able to show significant change (see Appendix A). The mean mastery scores did not differentiate the group (see Table 2.1) nor did the proportion identified as having low mastery at intake (a score of below 20 in a scale ranging from 7 to 28; Pearlin et al., 1981) differentiate the groups significantly. Low mastery was reported for just under one quarter of the younger clients (32/132 24%) and for one in five of the older clients (8/40 20%).

The older group were significantly much less likely to be single and more likely to describe themselves as cohabiting. Their household was also significantly different, particularly more likely to include just their partner or their partner and mother and none lived in households with other adults but not their partner or mother. They were also less likely to be in education at intake to FNP (see Table 2.2). There was not a significant difference in their employment status with the majority of both groups not in employment. The ethnic background of the two groups was similar, with around three quarters white, a small proportion of black clients or those with mixed ethnic background and very few Asians. Similar proportions in each group reported that they were smokers at intake to the programme.

The mean age of the infants in mid July 2010 at the point of data cut-off was 9.9 for both the clients under 20 and the 20-23 year olds (range 0 to 18 months). Thus all had completed pregnancy but only 58% (114/196) had completed infancy with a smaller proportion entering the toddlerhood phase of the programme, the majority of whom (72) were between 12 and 16 months.

v. Delivery of the programme

There was no difference in the extent to which the expected number of visits had been delivered to the two groups in pregnancy, infancy or toddlerhood (see Table 2.3). There was a trend for the average length of visits in pregnancy to be shorter with the non-teen group (see Table 2.4). During pregnancy and infancy for most content domains either the average time spent was similar for both groups and either within the suggested boundaries for both or was not within the boundaries for both (see Table 2.5). The toddlerhood coverage of content domains has slightly had more variability but is based on a small number of clients, none of whom had completed toddlerhood, so are liable to change once toddlerhood is completed. From these preliminary figures it appears that, while the means did not differ significantly, slightly more than the suggested percentage of time during visits was spent on the maternal role with the older clients while it was as recommended for the younger ones. One significant difference was that less time (and the recommended proportion of time) was spent on environment health with the older clients (see Table 2.5) which may be related to fewer being single, most cohabiting with their partner or mother but less likely to be in the less stable kind of living arrangements that included other adults (see Table 2.2). There were no differences in FNs' ratings of clients' understanding, involvement in visits or evidence of conflict with the programme's content in pregnancy, infancy or toddlerhood. Partners of younger clients were judged to have more conflict with the programme materials than partners of older clients (see Table 2.5).

Table 2.3 Delivery of visits in relation to expected visits comparing younger clients and older clients with recruitment criteria

	Under 20	20-22 with selection criteria	Sig.
Pregnancy visits	*N=151*	*N=45*	
Mean number completed	7.1	7.4	n.s.
Mean number expected[7]	11.2	11.2	n.s.
Mean % completed (objective 80%+)	64.8	64.7	n.s.
Infancy visits	*N=147*	*N=45*	
Mean number completed	9.8	10.8	n.s.
Mean number expected	20.8	21.3	n.s.
Mean % completed (objective 65%+)	47.3	51.7	n.s.
Toddlerhood visits	*N=38*	*N=10*	
Mean number completed	2.3	1.5	n.s.
Mean number expected	5.4	3.6	n.s.
Mean % completed (objective 60%+)	42.4	52.5	n.s.

Table 2.4 Extent to which the average visits meet the objectives set out by the USA National Office comparing younger clients and older clients with recruitment criteria (bold number indicates objective attained)

	Objective	Under 20	20-22 with selection criteria	Sig.
Pregnancy visits		*N=151*	*N=45*	
Mean minutes duration	60+	**79.1**	**74.4**	.08
Mean % planned material covered		88.6	90.7	n.s.
Mean % time on Personal health	35-40	33.7	34.5	n.s.
Mean % time on Maternal role	23-25	26.2	27.1	n.s.
Mean % time on Life course	10-15	**11.3**	**10.5**	n.s.
Mean % time on Family & friends	10-15	16.7	15.2	n.s.
Mean % time on Environmental health	5-7	12.2	12.5	n.s.
Infancy visits		*N=131*	*N=41*	
Mean minutes duration	60+	**73.9**	**71.9**	n.s.
Mean % planned material covered		89.7	90.6	n.s.
Mean % time on Personal health	14-20	23.0	23.0	n.s.
Mean % time on Maternal role	45-50	41.6	42.2	n.s.
Mean % time on Life course	10-15	**10.5**	**10.3**	n.s.
Mean % time on Family & friends	10-15	**13.9**	**14.0**	n.s.
Mean % time on Environmental health	7-10	11.1	10.5	n.s.
Toddlerhood visits		*N=29*	*N=7*	
Mean minutes duration toddlerhood	60+	**81.2**	**77.1**	n.s.
Mean % of planned material covered		89.0	91.5	n.s.
Mean % time on Personal health	10-15	17.3	16.6	n.s.
Mean % time on Maternal role	40-45	**40.3**	46.9	n.s.
Mean % time on Life course	18-20	13.0	13.6	n.s.
Mean % time on Family & friends	10-15	16.2	**15.1**	n.s.
Mean % time on Environmental health	7-10	13.1	**7.8**	.02

[7] The expected number of visits takes into account attrition; for pregnancy it also takes into account gestation at intake and for infancy and toddlerhood it takes into account the infant's age at the data cut-off point.

Table 2.5 Family Nurses' ratings of clients' and partners' behaviour during visits by phase, comparing younger clients and older clients with recruitment criteria[8] (rating scales range from 1 to 5)

	Under 20	20-22 with selection criteria	Sig.
Pregnancy visits, client	*N=151*	*N=45*	
Mean involvement	4.5	4.5	n.s.
Mean understanding	4.3	4.4	n.s.
Mean conflict with materials	1.3	1.4	n.s.
Pregnancy visits, partner	*N=67*	*N=25*	
Mean involvement	3.8	4.0	n.s.
Mean understanding	4.0	4.2	n.s.
Mean conflict with materials	1.4	1.4	n.s.
Infancy visits, client	*N=131*	*N=41*	
Mean involvement	4.5	4.6	n.s.
Mean understanding	4.4	4.5	n.s.
Mean conflict with materials	1.3	1.2	n.s.
Infancy visits, partner	*N=79*	*N=28*	n.s.
Mean involvement	3.8	4.0	n.s.
Mean understanding	4.1	4.3	n.s.
Mean conflict with materials	1.5	1.2	.02
Toddlerhood visits, client	*N=29*	*N=7*	
Mean involvement	4.4	4.3	n.s.
Mean understanding	4.4	4.4	n.s.
Mean conflict with materials	1.2	1.3	n.s.

The delivery indicators such as the expected number of visits take the age of the child into account but other indicators are such as the coverage of the content domains or client and partner behaviour during visits were based on a fewer visits in infancy and toddlerhood in particular. Similarly figures for attrition in infancy and toddlerhood are likely to be an underestimate.

Table 2.6 Attrition from FNP comparing younger clients and older clients with recruitment criteria (percentages in brackets)

	Objective	Under 20 N=151	20-22 with selection criteria N=45
Still in programme	>=60%	121 (80)	35 (78)
Left pregnancy	<=10%	4 (3)	0
Left infancy	<=20%	12 (8)	7 (16)
Inactive infancy		10 (7)	3 (7)
Left toddlerhood	<=10%	2 (1)	0
Inactive toddlerhood		2 (1)	0

There was no significant difference between the groups in the extent to which they left the programme (see Table 2.6; Chi Square 4.48, 5 df, p = .483) The extent of attrition for all clients,

[8] Insufficient partners were observed in Toddlerhood to enable statistical comparisons to be made. The majority of the clients had at the time of data cut-off received few Toddlerhood visits (see Table).

whether recruited with additional criteria or not, was generally in line with or better than the objectives set out by the US National Office except that more older clients left or became inactive in infancy than the objective while none had left in pregnancy. Toddlerhood attrition is likely to change since none had at the point of data cut-off completed toddlerhood, the oldest being 18 months.

vi. Perceptions of the applicability of FNP with non-teen clients

Clients

Several of the non-teen clients interviewed had some misgivings about the use of worksheets and other structured activities. These are generally used at every FNP visit and kept together in a folder provided by the FN. This 'paperwork' came as a surprise to some of the women who reported feeling at the beginning of the programme that it was like being back at school:

> *The only things is there's a bit too much* paperwork, *I think, can't we just talk about this, why do I have to write it down. I get a lot out of just talking with the nurse.*

However, for some their attitude to the materials changed:

> *When I first saw them I thought, well, I'll do them, it's a bit rude not to, but when I actually did them I found it was really interesting all this stuff.*

Another client found that writing in her folder was like keeping a diary for herself and her child so that she could look back on and see how she was feeling. Another noted that the folder would be a useful resource:

> *I read the notes and things like that. It's nice for me, this stuff I keep, so when she leaves I can look at it.*

Others noted that using the materials had proved useful as a way of gaining insight into their partner's thoughts and feelings:

> *They're (materials) fine, we complete them, they're quite useful. They look at my partner's point of view and mine … It's nice to see what he's written.*

Rather than using the materials as straight-forward pieces of information, they had been used as ways of opening up discussion:

> *She gives me these little information sheets that are quite good. Stuff about premature labour and stuff which is quite good. Then we go through each section and talk about stuff quite deeply.*

As indicated in the USA literature (Olds et al.,1997b) and reported in evaluation of the implementation of FNP in England in pregnancy (Barnes et al., 2008) the development of a close relationship with the FN was noted as one of the most important aspects of successful delivery. FNs seem to have forged close relationships with the older clients so that they felt free to discuss issues of concern:

> *She's like a friend, she comes round and talks to you, she's really nice.*
> *Now I've got to know her, if someone sees you all the time you get to know them and you get to trust them and she's pretty much like a friend that you have a natter with.*
> *It's a nice vibe, really nice. She's relaxing to talk to, I think I'd be able to talk to her about anything.*

The clients appreciated having a consistent relationship over time, which is dissimilar to many medical contacts:

> *So it's good that it can be the same person all the way through.*
> *I don't have to have a stranger coming to help with my baby, I will have spoken to her for nearly a year by then.*
> *I think it's a really good idea because it starts from early on so we get to build a bit of a bond.*

Nevertheless the relationship was seen as professional, not the same as talking to a personal friend or family member:

Sometimes it's nice to just have a conversation with an outsider about how I'm feeling and. It's nice to have that someone, who isn't there all the time, to speak to and see what they think about it.

It's nice to have somebody that's not always there, someone different to talk to about how you're feeling and stuff like that as well.

The notion of a slight distance in the relationship allowing the women to confide in the FNs, mentioned by clients, was one the FNs themselves also recognised:

Maybe you can't talk about those things with your family you wouldn't talk about them with your mum and not with your friends.

Yes you can have your mum's support but if the mum is also giving you all those other responsibilities maybe the FN is a bit of escapism, you're not all tied up in the family dynamics.

It has been established that families are more likely to participate fully in early interventions if their immediate, commonly practical, problems such as housing are addressed (Barnes, 2003). In addition to emotional support, other more practical forms of help were highlighted by the women interviewed. At recruitment the midwives had sometimes focussed on this type of support, to show that FNP was more comprehensive that a predominantly medical service:

She has helped me to fill in forms for benefits and she's written me a letter for the housing.

She said she'd help me get into college and sort out nurseries for the baby. That's what I was most worried about.

The topics most often mentioned as interesting by the women interviewed were those on healthy eating, listing things they found exciting about becoming a mother and about being pregnant, and the sessions covering sex and contraception. The interest shown in these topics revealed a lack of awareness or a renewed interest in these areas:

I never really did much at school, so to know about sex when you're pregnant that you're supposed to use a condom, I think that's good.

Nurses

The preferences identified by the clients were also noted by the FNs:

They've all loved the healthy eating thing and how you felt when you found out you were pregnant and three things you'll like and miss.

Their lack of knowledge about contraception, and consequently safe sex, was also noted by a FN who had a background in family planning but was surprised by what she had observed:

They like the contraception after pregnancy. I don't think they've been taught about that before, I don't think some of them have ever used contraception before in their lives. Certainly the contraception I've done with them, it's been quite eye opening. They say 'I took the pill but it didn't work', I ask 'did you take the pill every day?', 'well no'.

Reflecting the comments made by the clients, the nurses reported problems using some of the facilitators such as worksheets with the older clients because they found them too simplistic and uninteresting. This caused a concern about the women being put off the programme as a whole:

I'm afraid I'm going to lose her because she didn't seem interested at all. For her it just wasn't at the right level, too simplistic.

One strategy to address this was to be selective:

I pick and chose before I go, some of the stuff I leave out if I feel it would be not appropriate.

Another was to let the client have power over the selection:

The other girl has picked and chosen which facilitators she wanted to fill in. If she felt that they weren't appropriate, she wouldn't fill in. She and her partner have done most of them.

However, for the FNs it was seen as beneficial that the older clients understood the materials:

> *Sometimes for the younger girls, 14, 15, 16, they've had a negative experience of education, they can see us a little bit like an educationalist, so they say yes, but it maybe takes a bit longer to get them using or understanding the materials. Whereas, the older girls, they get it, they just get it straight away.*

While there was not on the whole more or less time spent on the different domains in the programme (see Table 2.3) the older clients were thought to relate more effectively to the content focussing on family, friends and relationships:

> *… that year or 18 months can make a difference to her willingness to try things and boyfriend girlfriend stuff. The 16 year old, it's her first boyfriend, but for the older girls it might be second or third and negotiating relationships is a bit better established.*

They were also said to have more clearly defined ambitions beyond having their baby, motivation to find things out for themselves, and to plan their life course:

> *These are quite ambitious girls. They say 'what I want to do is to complete this course', they were all doing something (a course) when they got pregnant. They had quite positive outlooks; also all three of them have quite a lot of friends.*
> *She's motivated to find stuff out from the programme, what's out there for her.*

Thus in some ways the nurses expected the materials to be received better by the older clients. However they also noted that being older it could prove more of a challenge to support them since they had been used to coping without help:

> *She was very resistant at first about me visiting. She said she wanted to do it on her own, she didn't want input – I think her words were 'interference' – from people outside*

They might also have developed firmer views about a range of aspects of their life. Advice has been hard to offer and habits difficult to influence where the older women with more experience had beliefs that were long-standing:

> *I think it has been a bit different. I think their health beliefs are a bit more ingrained. I find that a bit more challenging, using motivational interviewing to encourage change. Smoking has been a key one and in general giving of health advice. They are not so willing to take the stuff on board.*

The additional responsibilities more common for these slightly older women could cause problems in terms of missing visits. These were frequently related to them caring for younger siblings in their family:

> *She rang me up this week to cancel our visit. She lives in a hostel. Guess why she can't make it? Her mum had her baby at the weekend and she wants to help out with her brothers. That's a very common theme.*
> *They often have been more of an adult than their mum, or they've stepped in to take responsibility for younger children.*

vii. Conclusions

Overall the recruitment of women aged 20 to 22 at conception who also specific inclusion criteria had very little impact on delivering the programme. The positive way that the programme was perceived by the clients was similar to that noted in the previous evaluation reports based on predominantly teenage clients (Barnes et al., 2008; 2009). The two clients groups were surprisingly similar, the only major difference being that the older clients were more likely to be married and to be living with only their partner without other family members. The delivery of the programme was also remarkably similar starting from the age at gestation when they were enrolled. Thus the need to enquire about criteria to determine eligibility had not slowed down recruitment, though the systems available (or unavailable) in the sites did have an impact – for all clients. Comparing the systems in these two locations it was clear that the FNP

team in one site were better able to identify women who were likely to meet their criteria. In particular, apart from the computerised midwifery system being available to them, there was information on employment status.

The programme materials were received well by the non-teen clients, although some of the clients and FNs remarked that some written work appeared simplistic for this older group, who were expected to be more knowledgeable. All FNs adapt the programme to fit each client but FNs reported being aware that they were being selective with the older clients and encouraged them to decide which topics were most relevant. However only one small difference was identified in the mean amount of time on the different domains, with marginally less time spend on environmental health for the non-teen clients in toddlerhood, reflecting the likelihood that they were living in more stable circumstances as married women.

Nevertheless several of the FNs indicated that they felt uncomfortable with a process that required them to find out whether potential clients met the eligibility criteria. They were concerned about revealing that an eligibility procedure was being used and generally glossed over specific 'requirements' which was reflected in clients comments indicating that they were not aware of why they had been offered the programme, just that it was something new and available in their area. Some FNs considered that the criteria excluded mothers who might benefit and in particular did not think that five GCSE qualifications should be one factor leading to ineligibility. If eligibility criteria are introduced in any location to allow for some non-teen clients to be recruited it appears that it will not have a major impact on the FNs in their day to day work, but discussion of the relevance of the criteria may be useful, with the possibility for flexibility.

Chapter 3. Using additional criteria with under 20 year olds

i. Introduction

While some of the Wave 2a sites covered relatively small areas and therefore had the capacity to involve some older first-time mothers in FNP, it had been found in the larger Wave 1 sites that there could be too many potential clients from the under 20 year olds. In addition some commissioners and managers had expressed a concern that offering the programme to those under 20 and a first-time mother may be too inclusive, that some would not necessarily need such an intensive intervention. The question was raised as to what additional criteria would lead to a more suitable client group, but without the programme appearing to be targeted, and therefore potentially stigmatising. To determine how this might work one of the wave 1 sites conducted a test of using additional criteria so that only some of the teenage first-time mothers to be would be eligible. This site had many potential clients in the area and had never recruited non-teenage mothers.

Discussion took place within the locality and with the FNP national team and the research team about which criteria to use. Similarly to the recruitment of 20 to 22 year olds described in Chapter 2 these would need to be criteria identifiable in pregnancy, ideally present in records collected by midwifery, and criteria that would lead to a group maximally likely to benefit from the FNP intervention as far as could be ascertained from the USA trials and subsequent experience.

Using the information summarised in Chapter 1, the experience of providing the programme since April 2007 and an examination of booking information it decided that from September 2009 onwards the new criteria for recruitment to FNP in the test site would be:

- All first-time mothers aged 17 or under at the time of conception
- First-time mothers aged 18 or 19 at the time of conception with any TWO OR MORE of the following factors:
    - Not living with a parent
    - No educational qualifications – i.e. no GCSEs
    - Currently not in education, employment or training (NEET)
    - Mental health problems of the mother
    - Ever 'looked after' as a child; or lived apart from parents for more than 6 months before the age of 18
    - Living in an area of deprivation.
- If using these criteria FNs received more names than they could incorporate into their caseload, contact was limited to those who were at 18 weeks gestation or less.

After booking, midwives sent one copy of the triplicate risk assessment form (described in Chapter 1 and Appendix C) to the FNP team for all first-time mothers-to-be who were under the age of 20 years at their last menstrual period (LMP), and who had not passed 26 weeks gestation. The FNs then contacted these mothers-to-be to explain about FNP and offer the programme. When they met a standardised eligibility form was completed so that the necessary questions would be asked in order to determine eligibility with the exception of living in an area of deprivation which was determined prior to the meeting on the basis of the client's postcode.

Methods

Clients recruited using the original and the revised criteria have been compared. The delivery of the programme to these clients in pregnancy and infancy has been compared to that received by the initial cohort of clients recruited to the programme in the previous 14 months (N=106). Clients recruited during the start-up period of 6 months when nurses were still becoming familiar with the programme materials were excluded so that the comparisons of programme delivery would be based more on potential client group difference using eligibility criteria than on the

nurses' expertise. In addition the nurses involved were interviewed to find out what difference the additional criteria made to their work, first in enrolling clients and then in delivering the programme.

ii. The process of referral and recruitment

In total between September 2009 and mid-July 2010 297 names had been passed by community midwives to the FNP team in site C, of which 131 (44%) were definitely eligible and 94 were recruited (72% of those eligible, 32% of total referred) while 37 were eligible but refused (28% of eligible, 16% of total referred). Those who refused were likely to be slightly older than those who accepted (mean age at LMP: accept 16.7, refuse 17.4, t 2.95, p=.04). A small number (4) refused a recruitment visit and FNs tried but were not able to contact a further 20 of the referrals. A substantial number (61/297, 21%) were definitely not eligible which, for the majority, could be determined prior to a recruitment visit or on the telephone before visiting (see Table 3.1). For a quarter of these their gestation was the reason for ineligibility in that it exceeded 28 weeks at the time that the FN contacted them. Midwives had been given an upper limit of 26 weeks to allow for contact time but this may need to be reduced in the future to avoid many clients exceeding 28 weeks by the time that they can be offered the programme. Finally a substantial number of the referrals (81/297, 28%) were not contacted because the FNs did not have any capacity in their caseloads.

Table 3.1 Reasons for ineligibility of referred clients (N=61)

Reason	N	% of ineligible	% of total Referrals
Gestation greater than 28 weeks	25	41	8
Miscarried, no longer pregnant	12	20	4
Aged 20 or older at LMP	5	8	2
Not first pregnancy/birth	3	5	1
Not in the right geographical area	3	5	1
No criteria or only 1 after visit	13	21	4

iii. Perceptions of using the revised criteria

Indicating that the programme has criteria

The FNs were generally uncomfortable about completing the eligibility form and they did not use it openly, tending not to make it clear to clients that they were asking about particular characteristics in order to ascertain their eligibility for the programme. Reasons for not mentioning the need for criteria included concern about what to say if the client did not have the right profile:

> *I do it [completing the form] very casually because I've been caught short as we all have when you think someone fits the criteria and they don't and it's embarrassing. The way I complete the template they don't know that I am actually sussing them out for the FNP.*

Another FN explained that she never showed the eligibility form or explained why she was asking questions because she thought that the programme would become stigmatising if clients knew that they had been selected in this way:

> *Initially we offered the programme to all women under 20 and now there are more specific criteria; what I'm frightened of is that the programme becomes a targeted programme for clients who see themselves as feckless and hopeless.*

One FN thought that the process of asking questions would put the young woman off the programme so her strategy is to find out if they like the sound of the programme and then ask the questions:

> *I don't fill this in until I actually know whether the client wants to do the programme or not because sometimes with some of the clients if you ask them lots of question.*

This can create difficulties if one needs to know about those clients who do not take up the offer. It also created problems in that some could express interest only for the FN to discover that they were not eligible:

> *If they've already latched onto this and think 'yes I want to do this' then it can be quite difficult to say 'perhaps other services might be better for you'.*

Several of the FNs explained the questions as a way to match the client with the appropriate service, again to avoid having to tell them they will not receive FNP after they have expressed an interest in it:

> *I introduce it (template with questions) by saying it is to try and ensure that the clients get the services that are the most appropriate to them. I introduce it that way rather than anything specific about FNP. If I have gone through the template and they are not eligible and I have already sold them on FNP then I have to say 'you are not eligible'.*

Only one of the eight interviewed made the process of determining eligibility completely transparent to the clients:

> *What I say to them is 'I've got this referral from your MW just to see if you're eligible'*.

In contrast to some of the other FNs she did not give any details of the programme until she was sure that they were eligible to avoid disappointment:

> *I go through the form first and then explain about the FNP because if they're not eligible they might feel that they've missed out.*

Avoiding some of the questions

The list of potential eligibility criteria on the template includes mental health problems, ever having been in care as a child, educational qualifications and their current (non) employment which some clients could potentially find difficult to talk about, for example if they had difficult experiences in their home or at school. Some of the FNs indicated that they did not necessarily cover all the relevant information at recruitment, but predominantly it was the topic of mental health problems that they were reluctant to ask about.

The eligibility template indicated that information about mental health problems may have been noted by the midwife on the antenatal risk assessment sheet. However if it was not the expectation was that the FN would ask. Some of the FNs interviewed had no difficulty in finding out about mental health, though they usually found it useful to give some examples:

> *Sometimes if you say mental health problems, with younger people, 'she thinks I am mental' would be the assumption so I explain, say things like 'have you ever had any form of depression of anxiety?'*

Nevertheless questioning young women about mental health problems was avoided by some of the FNs:

> *I don't ask that one, it says on the form to be taken from records, I don't feel that the recruitment visit, it doesn't feel right to be talking too deeply, they have seen the midwife, if there is nothing on the form I don't ask.*
>
> *That (mental health question] is one that I ask when I feel comfortable enough, it might not be at the recruitment visit, it will probably be after that*

No difficulties were identified with any of the other questions.

Nurse' views about these particular criteria

Only two of the FNs interviewed thought that the criteria were fine. Most of the other FNs suggested ways that the specifications could be refined. For example changing the requirement about not currently living with her mother to not living with either mother or father since it was the stable parental relationship that mattered:

> *I've got one client who lives with her father, her mum and dad split up so she chose to live with her father and she's lived with him for over 14 years so he's a very significant person in her life but the question is do you live with your mother.*

Another commented that one needed to know about the relationship, not the residential details although this would obviously require more detailed questioning:

> *They could be living with a mother who is totally unsupportive, it's not are you currently living with your mother but have you got the support?*

Homelessness was suggested as an additional item that could be used to define eligibility:

> *I think additionally 'Have you ever been homeless?' That is another alarm bell for me.*

One FN was adding her own judgement to the criteria in that she had explained to some clients who did meet the current eligibility criteria that the programme was not for them:

> *For example they can be living in an area of deprivation, they're not living with their mother for the six months and they may not currently live with their mother so they get three ticks from that, but they may be working… so then if they hit two or above on the criteria and they agree to it then you're kind of put in a tricky situation, I might sit there thinking 'well this isn't really the best for you', and you try to sell the other services.*

One thought that, even though this area had sufficient younger clients to keep caseloads full, older women should also be eligible;

> *I had a phone call for a girl of 22 who had lots of problems and she had learning difficulties and I was saying 'I'm sorry I can't take her' and the midwife said 'she just needs that kind of support' and I said 'I'm sorry I can't'.*

Another, although she know that her team had more referrals that they could take on so needed to be selective, would still recruit only teenage clients but would have liked to return to not having any criteria apart from the client's expressed interest in the programme:

> *I think any person under 20 ought to be on the FNP if they want to be. Some of them definitely wouldn't want FNP and are managing well but for those who would like to come on even though they might have more GCSEs or haven't got mental health problems and what have you I think they deserve support as well.*

Avoiding stigma was also put forward as a reason for having few or no recruitment criteria:

> *No-one wants to be part of something that leads to them being seen as a very targeted person because no-one wants to be a targeted person.*

iv. The clients

Even though the automatic inclusion of all under 17s combined with extra criteria for those 17 to 19 might have led to a younger client group the mean age at the start of the programme for the newly recruited clients was no different to that of the clients recruited previously (see Table 3.2). In both groups a small number of clients were 20 by the time they were enrolled into the programme. While the proportion in the first cohort aged 18 to 19 at intake was marginally greater, the overall distribution of clients by age group bands did not significantly differentiate the two cohorts (see Table 3.3).

As noted in Chapter 2, one of the objectives defined by the US National Office is to ideally enrol at least 60% of FNP clients by 16 weeks gestation. While this site easily met the objective with their first cohort of clients, those recruited using the additional criteria were substantially less likely to have been enrolled by 16 weeks (no criteria 81/106, 76%; extra selection criteria 44/94 47%; Chi square 18.63 1 df, p<.000) and the mean gestational age at enrolment was significantly higher for the clients recruited using extra criteria, but none in either group exceeded the required maximum gestation of 28 weeks (See Table 3.2).

The clients in the two groups did not differ at intake in their average mental health status as measured by the MHI-5 scale from the SF 36 (Ware et al., 1993) (see Table 3.2). On this measure a high score indicates better mental health with a score below 56 indicative of mental health problems. While the rates were in the direction of fewer clients with additional selection criteria having mental health problems there was no significant difference between the groups (no criteria 36/98, 37%; extra criteria 25/87, 29%). The average sense of mastery, based on the

Pearlin Schooler Mastery Scale (Pearlin & Schooler, 1978) did not differentiate the groups (see Table 3.2) and they were similar in the proportion of clients deemed to have a low sense of mastery (below 20; no criteria 22/98 22%, extra selection criteria 21/86 24%).

Table 3.2 Characteristics at intake (continuous) comparing clients under 20 recruited with and without the revised criteria

	Under 20, no criteria N=106 (range)	Under 20, selection criteria N=94 (range)	Sig.
Mean age	17.6 (14-20)	17.5 (13-20)	n.s.
Mean gestation	14.7 (7-26)	17.7 (9-28)	p< .000
Mean mental health MHI-5	62.9 (20-95)	64.3 (5-100)	n.s.
Mean Pearlin Schooler mastery	21.3 (13-28)	21.6 (13-28)	n.s.

Table 3.3 Characteristics at intake (categorical) comparing clients under 20 recruited with and without the revised criteria [9]

	Under 20, no Criteria N=106	%	Under 20, selection criteria N=94	%
Age group				
13 to 15	7	7	7	7
16 to 17	35	33	37	39
18 to 19	61	58	45	48
20	3	3	5	5
Marital status				
Single	78	77	63	73
Cohabiting	22	22	23	27
Married	1	1	0	0
Household structure				
Own mother, no partner	49	49	39	45
Own mother plus partner	6	6	8	9
Partner	24	24	20	23
Partner & others, not own mother	5	5	2	2
Others, not partner or mother	6	6	8	9
Lives alone	7	7	7	8
Shelter/homeless	4	4	2	2
Education				
In school/vocational programme	39	39	33	38
Not in education	62	61	53	62
Employment χ^2 14.1 p<.01				
Employed full-time	8	8	6	7
Employed part-time	25	25	6	7
Not working	29	29	22	26
Never worked	38	38	52	60
Smoker χ^2 7.32, p<.001				
Yes	37	41	48	62
No	54	59	30	38

[9] Demographic characteristics not complete for all clients

All clients in both the earlier under 20 cohort and the second, selected with additional criteria were white. The marital status of the two groups did not differ (the majority single) and neither did the nature of their households, most living either with their own family or with their partner (see Table 3.3). Smoking differentiated the groups with a greater proportion of the clients recruited with additional criteria indicating at intake to the programme that they were smokers (See Table 3.3) .The only other significant difference between the groups was that those selected on the basis of the criteria were less likely ever to have worked or to currently be employed part-time (see Table 3.3).

At the data cut-off point in mid-July 2010 all but three of the initial cohort of clients (N=106) had infants over the age of 24 months (mean age 28.5) and thus would have either left the programme or completed it. Just over a third (39/94, 41%) of the clients recruited using the new criteria were still pregnant and 55 had given birth (mean age 2.5 months, range newborn to 9 months).

v. Delivery of the programme

Numbers of visits received and expected varied since many of the newly recruited clients had not completed pregnancy or infancy. However the mean proportion of expected visits received, which takes into account how long they have been with the programme, did not differ between the groups (see Table 3.4). The percentage of clients receiving the expected level of visits in pregnancy (at least 80%) was one third of both cohorts (36/106, 34%; 31/94, 33%). In infancy the percentage of clients receiving the expected level of visits (at least 65%) is greater in the first cohort than the second (48/87, 55%; 8/45, 18%, Chi 17.00, p<.000). However the proportions for the second cohort, most of whom are only a small way through infancy, are based on smaller numbers of expected and received visits and therefore more subject to the impact of missing one or two visits. Nevertheless the trend appears to be for fewer of the expected visits to be completed with the clients recruited using the extra vulnerability criteria.

Table 3.4 Delivery of visits in relation to expected visits comparing clients under 20 recruited with and without the revised criteria

	Under 20, no criteria	Under 20, selection criteria	Sig.
Pregnancy visits	*N=106*	*N=94*	
Mean number completed	9.3	6.6	<.000
Mean number expected[10]	13.0	9.7	<.000
Mean % completed (objective 80%+)	70.4	67.0	n.s.
Infancy visits	*N=87*	*N=46*	
Mean number completed	17.1	4.4	<.000
Mean number expected	26.1	8.2	<.000
Mean % completed (objective 65%+)	62.3	47.5	<.001

Visits to the second cohort were significantly longer in pregnancy although a smaller percentage of the planned content was covered (see Table 3.5). This might suggest that during visits to clients selected with the additional criteria more often had to deal with issues that were related to the client's concerns or immediate difficulty over and above the FNP materials. Though still within the range suggested to be optimal, significantly less of the time was spent on the maternal role in pregnancy for this second group of clients and significantly more on family and friends and more than the recommended amount of time (see Table 3.5). During infancy the

[10] The expected number of visits takes into account attrition; for pregnancy it also takes into account gestation at intake and at cut-off; for infancy it takes into account the infant's age at the data cut-off point.

visit lengths did not differ between the groups but again less time was spent with them on the maternal role and well below the 45-50% recommended while significantly more time was spent on their personal health, more than the recommended 14 to 20%.

Table 3.5 Extent to which the average visits meet the objectives set out by the USA National Office comparing clients under 20 recruited with and without the revised criteria (bold number indicates objective attained)

	Objective	Under 20, no criteria	20-22, selection criteria	Sig.
Pregnancy visits		*N=106*	*N=93*	
Mean minutes duration	60+	**65.5**	**76.5**	<.000
Mean % planned material covered		98.5	97.0	<.05
Mean % time on Personal health	35-40	34.0	33.5	n.s.
Mean % time on Maternal role	23-25	**23.0**	**21.3**	<.05
Mean % time on Life course	10-15	**13.0**	**13.1**	n.s.
Mean % time on Family & friends	10-15	15.6	16.9	<.05
Mean % time on Environmental health	5-7	14.4	15.2	n.s.
Infancy visits		*N=82*	*N=40*	
Mean minutes duration	60+	**70.0**	**69.9**	n.s.
Mean % planned material covered		97.5	94.9	n.s.
Mean % time on Personal health	14-20	**18.8**	26.3	<.000
Mean % time on Maternal role	45-50	**48.0**	38.6	<.000
Mean % time on Life course	10-15	**9.8**	**10.3**	n.s.
Mean % time on Family & friends	10-15	**12.2**	**13.2**	n.s.
Mean % time on Environmental health	7-10	11.1	11.6	n.s.

Table 3.6 Family Nurses' ratings of clients' and partners' behaviour during visits by phase comparing clients under 20 recruited with and without the revised criteria (scales range from 1 to 5)

	Under 20, no criteria	Under 20, selection criteria	Sig.
Pregnancy visits, client	*N=106*	*N=93*	
Mean involvement	4.7	4.7	n.s.
Mean understanding	4.4	4.4	n.s.
Mean conflict with materials	1.4	1.1	<.001
Pregnancy visits, partner	*N=58*	*N=55*	
Mean involvement	4.1	4.1	n.s.
Mean understanding	4.0	4.1	n.s.
Mean conflict with materials	1.2	1.2	n.s.
Infancy visits, client	*N=82*	*N=40*	
Mean involvement	4.7	4.5	n.s.
Mean understanding	4.4	4.4	n.s.
Mean conflict with materials	1.3	1.3	n.s.
Infancy visits, partner	*N=59*	*N=27*	
Mean involvement	3.5	3.8	n.s.
Mean understanding	3.8	4.1	n.s.
Mean conflict with materials	1.3	1.2	n.s.

On the whole, apart from the clients selected using the new criteria being judged to show less conflict with the materials during pregnancy, there were no other differences in the nurses' ratings of their behaviour during visits, or that of their partners (see Table 3.6).

A major aspect of good delivery is keeping the clients involved in the programme, which might be more of a challenge if the clients are more vulnerable, possibly involved with other agencies and leading unsettled lives. Table 3.7 shows the overall rate of retention but the majority of clients in the second cohort were only midway through infancy so the only useful comparison is the proportion leaving during pregnancy which was 18% (19/106) in the first cohort, not significantly different to the rate of 14% (13/94) for clients recruited with additional criteria. This rate could of course rise since 39 were still pregnant. The attrition rate during pregnancy for those whose infants had been born is a more reliable indicator and was even closer to the original cohort (9/55, 16%). Thus the use of the revised criteria has not so far made an impact, either positive or negative, on attrition and both the first cohort and the new clients have levels of attrition that are higher than the programme objective of 10%.

Table 3.7 Attrition from FNP comparing under 20 year old clients recruited with and without the revised criteria

	Objective	Under 20, no criteria N=106	Under 20, selection criteria N=94	Under 20, selection criteria, with infants N=55
Active or completed	>=60%	66 (62)	80 (85)	45 (82)
Left pregnancy	<=10%	19 (18)	13 (14)	9 (16)
Left infancy	<=20%	15 (14)	1 (1)	1 (2)
Left toddlerhood	<=10%	6 (6)	0	0

vi. Perceptions of delivery of FNP using the revised criteria

The quantitative analysis indicated that fewer visits were made on average to the new cohort of clients, particularly once their babies were born (see Table 3.4). Nurses' comments suggest that one explanation for this may be that these clients were unavailable more often:

> *It's been more haphazard trying to get them in, or trying to get them to keep appointments. I think it's their lifestyle, if they're very chaotic, if they've got a lot of other things going one, lots of family problems.*

FNs were divided in their opinion about more cancellations for the newer clients, four saying that they had not noticed any difference. However the remaining four were of the opinion that these, possibly more vulnerable clients, did cancel more often:

> *I actually feel that this new cohort that I've got cancelled a lot more than my first cohort. I think they're more likely not to let us know or avoid answering door on prearranged visit. If that happens your heart sinks a little bit because you wonder what's going on, why she wasn't waiting, or ready or prepared to have it.*

Cancellations were thought to have a knock-on effect on programme delivery, reflecting the finding (Table 3.5) that less of planned content was covered on average in pregnancy:

> *Depending where they are in their pregnancy and they cancel you end up by bringing more facilitators in just so that you get more out of it. So it can be more demanding in deciding what is critical and what can I leave for a little bit longer.*

They might also lead to longer visits to try and fit more in, though one FN who thought visits were longer attributed this to her being more likely to spend more time in general discussion prior to launching into the actual content:

> *Visits might be a bit longer sometimes, probably because I'm spending time chatting with them and putting them at their ease and finding out about them.*

Response to the programme and the FN

The FNs did not indicate that this new cohort of clients responded any differently to the materials than their earlier clients, apart from noting that the materials themselves were more interesting in that they had been substantially overhauled to be more colourful and up to date. Only one FN remarked that the new group of clients were likely to have issues in their lives that made it more difficult to cover what had been planned:

> *I find quite difficult to keep engaged with the materials, they tend to go off on a tangent about what's been happening, or the crises that have been occurring.*

This FN was also the only one interviewed who thought that while she was able to have the same quality of relationship with the newer group of clients it was more of a challenge:

> *I have to work harder. It's more difficult to try and figure out what's going through their heads, what they're thinking.*

The remaining FNs thought that there was no difference, or in one case that the relationship was easier to establish since the eligibility form had allowed her to open up difficult areas for discussion right at the start of the programme:

> *Having that tool (template) at the very first visit and opening some of those tricky areas for discussion, you've got that information from the beginning.*

The comparison was not straightforward to make, however, since the FNs were aware that their own familiarity with the materials had made delivery much less stressful:

> *I feel that I'm more relaxed. I used to beat myself up about maintaining the fidelity of the programme, covering every single thing you're supposed to cover now I just think it's the quality of the relationship between me and them that matters and is going to keep them on course.*

Overall there were few marked differences delivering the FNP to a group of clients recruited with identified vulnerability criteria, compared to those identified only by their age at their first pregnancy:

> *It is still the same issues that are coming up the home situation, the violence, breakdown in relationship with the father of the baby. Breakdown of the relationship with their mother, self harm, all the same as the first time around*.

vii. Conclusions

Even with the use of eligibility criteria this particular site had more referrals that they could enrol in the programme and they did not contact a substantial proportion of those referred by midwives. It was possible to tell without visiting, once there was capacity, that some referrals were in fact not eligible but the ineligibility was most frequently that the gestation was beyond 28 weeks. Thus it is possible that they had initially been eligible; the one fact that is very likely to be in all midwifery records is the date that conception is thought to have taken place. Of those who were enrolled, their gestation at enrollment was significantly greater that had been the case previously before these criteria were in use. This suggests that the need to determine eligibility was slowing down the process. A more efficient system in areas such as this, with a substantial number of teen first-time mothers, would be one that identified eligibility (or ineligibility) characteristics pertaining to educational qualifications, employment, mental health or 'in-care' experiences at the point of booking–in with the midwife. Then the FNP team would know that it was important to make contact as soon as possible with those mothers-to-be. It might also be sensible to be able to indicate to midwifery when caseloads were full so that they could temporarily suspend their referrals, to prevent them from becoming discouraged after identifying suitable clients who then do not receive FNP.

Despite the large number of potential clients some of the FNs were resistant to the use of eligibility criteria that went beyond maternal age and gestation. They were concerned that the service would become one associated with stigma. Others thought that the current criteria led to some women becoming eligible when they were in fact not that 'needy'; for instance when they had not lived with their mother but had been living with their father. The FNs were not

explicit with potential clients that they were being screened and avoided some questions, particularly about mental health problems. When eligibility criteria are in use it may be sensible to have ongoing discussions within the team about the issue and its implications so that these reservations can be addressed.

Once clients were enrolled using the new criteria there was in fact very little difference between these new clients and the initial cohort in the site, recruited with only age used to determine eligibility. However delivery did have some variability. Visits in pregnancy were on average longer and less of the planned material was covered. This could have been because the FNs expected them to be more vulnerable and focussed on issues in their lives that were not directly related to the FNP materials. It might also be that, while demographic differences were not evident, this group were actually more vulnerable in ways not covered by the data. The one difference that was identified which was not one of the criteria (the other was never been employed) was that these newer clients were more likely to smoke in their pregnancy, which is often an indicator of stress. In infancy the proportion of expected visits made was substantially lower for this group that for the earlier clients in this site. FNs indicated in their interviews that they had experienced more cancellations with the 'new' clients and that their lives were generally less predictable. There were also some variations in the coverage of the domains with a trend for the maternal role to take up less of the time in visits. This may again be due to FNs focussing more on vulnerabilities such as poor living conditions, poor health or relationship problems.

The comparisons in this chapter may be influenced by historical differences in programme delivery, although this was reduced as much as possible by excluding the clients supported in the first 6 months of programme delivery, when FNs were getting used to the recruitment process and the materials. With that in mind, it does seem that the inclusion of additional criteria led to some differences in delivery that might have implications for outcomes.

Chapter 4. The applicability of FNP with interpreters

i. Introduction

In the USA the FNP programme has been delivered to non-English speaking clients by nurses fluent in their language, principally Spanish (Olds et al., 2002) but generally is not provided through interpreters (Olds, personal communication). In England many of the locations where FNP is being offered include mothers-to-be whose primary language may be any one of a number meaning that there has been a need to provide the programme through interpreters. The purpose of this study was to provide indications as to whether the FNP programme can be delivered through interpreters and, if so, the nature of the changes needed to maximise benefits for the client group and ensure effective service delivery. Its objective was to inform the development of further proposals for more rigorously testing the delivery of FNP through interpreters.

Concern about the negative impact of the interpreter on the nurse-patient relationship led Australian nurses working with refugees preferring to manage without (Maltby, 1998). However, if interpreters are not used family members or friends are relied on, though most guidance indicates that this should be avoided (Phelan & Parkman, 1995; Tribe & Thompson 2008). Advice notwithstanding, researchers have found that nursing staff often do rely on family members (Lehna, 2005; Thom,2008) and some consider a family member preferable to an interpreter from the local community, who might not be trustworthy regarding sensitive information (Gerrish, 2001).

A Canadian review (Carnevale et al., 2009) suggested that nurses may find working with interpreters particularly problematic in that their relationship with patients is more sustained and personal than that of physicians. This close personal relationship is particularly important for nurses delivering the FNP (Barnes et al., 2008; Olds et al, 2007b) and the necessary therapeutic alliance may be adversely affected by the presence of an interpreter (Pugh & Vetere, 2009). Nevertheless, nurses in the USA and Canada, also working with refugees have remarked on the important role that interpreters had as cultural brokers (Labun, 1999).

The overarching question for this study was whether the FNP could be delivered effectively using interpreters? Specifically the study looked at how the presence of an interpreter influenced recruitment and retention, whether the presence of an interpreter had any impact on programme delivery in terms of the quantitative indicators such as the length and content of visits, and coverage of the different domains or the behaviour of the clients when visits were made with an interpreter, issues related to the tri-partite relationship between client, Family Nurse and interpreter. Finally the qualities of successful interpreters were investigated, their training needs in relation to FNP and any additional training needs of Family Nurses in order to effectively deliver FNP through an interpreter.

Methods

The study had two elements, quantitative analysis of programme delivery data in the 10 Wave 1 sites from April 2007 to February 2009, comparing clients with and without an interpreter, and qualitative interviews with clients representing a range of different interpreter experiences and with professionals to explore the issue of using interpreters to deliver the FNP. Eight clients were interviewed, 12 Family Nurses, five Family Nurse Supervisors, two interpreters and three managers of interpreting services. The client interview covered recruitment to FNP, the early visits, her relationships with the FN, the interpreter, and any involvement of other family members, her English language development and her overall satisfaction with the programme. The FN interviews covered similar topics and also asked about their previous experience of using interpreters, their perceptions of how well the programme could be delivered though an interpreter, any modifications to what was delivered, and any training that they considered important either for themselves of the interpreter. Supervisors were in addition asked about how

interpreting services were obtained, how well this worked and their overall thoughts on how well the programme could be delivered through a third party. Interpreters and their managers were questioned about the training and background of their interpreters, their understanding of FNP and perceptions of how well the collaboration with the programme was working.

ii. The extent and nature of interpreter involvement

Home visits records indicated that an interpreter had been present for just over 2% of all visits made and at least once for 43 (3.3%) of the 1304 clients (see Table 4.1). In three sites no interpreter was used and in four others an interpreter was required for only one or two clients. In the remaining three sites the proportion of clients requiring an interpreter ranged from 15% to 4% (see Table 4.1). Interpreters were required for fourteen different languages, half of which applied to only one client, with no details about language given for a further four. The languages were as follows: 13 Bengali; 7 Sylheti; 3 Polish and Urdu; 2 Albanian, Kurdish and Punjabi; 1 Chinese, Creole, Persian, Portuguese, Sign Language, Somali and Spanish.

The percent of all visits made for that particular client with an interpreter present, for the 43 clients who were thought to require an interpreter at some point, varied considerably indicating that it is not straightforward to label a client as someone who needs an interpreter or does not. The percent of visits with an interpreter ranged from 4% up to 100%, with an average of 63% (see Table 4.1).

Table 4.1 Numbers of clients in wave 1 sites who had (at any time) needed an interpreter, the percentage of clients and the percentage of visits made by the site with an interpreter present

Site Total N	Clients who ever used an interpreter		Average % of all site's visits with interpreter (N=1304)	Range	Average % of all visits, clients ever used (N=43)	Range
	N	%				
139	21	15.1	11.1	0-100	78.4	4-100
123	12	9.8	5.1	0-100	52.3	4-100
133	5	3.8	1.4	0- 71	37.7	4- 71
113	2	1.8	.3	0- 25	14.2	4- 25
118	1	0.8	.6	0- 70	70	-
153	1	0.7	.3	0- 44	44	-
124	1	0.8	.01	0-100	100	-
190	0	0	0	-	-	-
100	0	0	0	-	-	-
111	0	0	0	-	-	-
1304	**43**	**3.3**	**2.1**	**0-100**	**62.9**	**4-100**

The clients who needed an interpreter differed in many ways from the remaining FNP clients. The majority of the interpreter clients (nearly 80%) were married in comparison with only a small proportion (6%) of the remaining clients; they were mainly living with their partner, often with other family members but not their own mother while the most common circumstance for the other clients was to be living with their own mother; they were predominantly Asian while the remainder of clients were predominantly white; they were more likely never to have been employed or to be currently employed; and only 3 of the 43 requiring an interpreter were smokers at intake (7%), compared to 40% of the remainder (see Table 4.2). The only characteristics not differentiating the groups was that the majority of each group were not in education or training at the time of enrolment into FNP.

Table 4.2 Characteristics at intake (categorical) of clients requiring an interpreter and the remaining FNP clients

	No Interpreter Ever used		Interpreter used	
Age group χ^2 51.53, p<0.001	N	%	N	%
13 to 15	152	12	0	0
16 to 17	504	40	5	12
18 to 19	498	40	22	51
20 to 24	107	8	16	37
Marital status χ^2 299.01 p<.001				
Single	844	74	5	13
Cohabiting	223	20	3	7
Married	64	6	31	78
Separated/widowed	5	0.4	1	2
Household Structure χ^2 111.46, p<.001				
Own mother, no partner	487	43	1	2
Own mother plus partner	103	9	0	0
Partner	178	16	9	23
Partner & others, not own M	93	8	22	55
Others, not partner or M	91	8	4	10
Lives alone	106	9	1	2
Shelter/homeless	83	7	3	8
Ethnic Group χ^2 305.70, p<.001				
White	931	82	4	10
Black	89	8	2	5
Asian	52	5	28	70
Mixed	58	5	1	2
Other	12	1	5	13
Ever employed χ^2 24.48, p<.001				
Had been employed at some point	644	57	7	17
Never employed	485	43	33	83
Employed at intake χ^2 7.66, p<.05				
Employed full-time	115	10	4	10
Employed part-time	128	11	0	0
Not working	886	79	36	90
Education				
In education or training	313	28	9	23
Not in education or training	808	72	30	77
Smoker χ^2 17.59, p<.001				
Yes	434	40	3	7
No	638	60	37	93

In all sites where an interpreter had ever been used there were some clients for whom an interpreter had been present for only a small proportion of their visits. The pattern of interpreter presence was examined and fell into five general patterns: all or almost all visits with an interpreter (40%); a variable pattern throughout the client's visits (35%); used early on and then stopped (9%); not used initially then used (7%); and used on only one or two random occasions (9%) (see Table 4.3). The majority (13/15, 87%) of the clients with an interpreter present for all or almost all the visits were Asian, representing almost half (46%) of the Asian clients (see Table 4.4). There was no typical pattern of interpreter presence for the other ethnic backgrounds, but all have small numbers.

Table 4.3 Patterns of interpreter presence at visits in order of frequency (percentages in brackets)

	N (%)
Almost all/all with interpreter	17 (40)
Mixed, no particular pattern	15 (35)
Start with interpreter, then stop	4 (9)
One or two random visits with interpreter	4 (9)
No interpreter initially, then start	3 (7)
	43

Table 4.4 Patterns of interpreter presence by ethnic background of client (missing for 3)

Ethnic background	**Almost all/ all with**	**Mixed**	**Start, then stop**	**Random**	**None, then start**	
Asian	13 (87)	10 (67)	2 (50)	2 (50)	1(50)	**28**
Black	1 (7)	0	0	1 (25)	0	**2**
Mixed	0	1 (7)	0	0	0	**1**
Other	0	3 (20)	2 (50)	0	0	**5**
White	1 (7)	1 (7)	0	1 (25)	1 (50)	**4**
Total	**15**	**15**	**4**	**4**	**2**	40

iii. The decision to involve an interpreter

The recruitment visit is of great importance in FNP. At this point the FN explains the programme and the client decides whether or not it sounds appropriate for their needs. The details of the main language of potential clients was usually provided by the referrer but not necessarily the extent to which they also spoke some English unless it was clear that they had no English at all. Thus usually the FN needed to decide whether interpretation would be necessary. For some the involvement of an interpreter was important from the start, arranging the recruitment visit with as few details as possible shared over the telephone:

> *Then we go in with the interpreter and get them to explain what the programme is, much the same as we do with all recruitment visits. It's the same process, it just takes a little longer: a regular recruitment visit would probably take under an hour and with an interpreter probably an hour or just over.*

However, during recruitment and the early visits the FN presents herself in a positive and warm manner to highlight the strength-based focus of the programme so some thought that this would be more effective to recruit without an interpreter if at all possible:

> *At this stage it can be something of a barrier. It is harder to show warmth, especially at this early point in the relationship.*

Nevertheless this strategy was not always successful once the FN started to present the programme materials:

> *She seemed to have quite good English on the phone so I tried to deliver the programme to her but I was a bit concerned; she was saying 'Yes' a lot. I began to realise that she wasn't really hearing what I was saying. So I went back with an interpreter and it was interesting because I realised that what we had been doing - it wasn't OK. I had not been communicating with her, but I could have thought I was.*

While in some cases the FN may have made the decision to do without an interpreter to maximise her impact on the client, it other cases their absence in early visits was caused by the difficulty of arranging for one to attend. This was either due to a lack of interpreters for that particular language or because the visits were often arranged at quite short notice, to meet the

client's availability and to get them enrolled as early as possible in their pregnancy. They then sometimes reluctantly relied on a family member, although in their training materials (see Appendix E) and other guidance for medical professionals this is generally discouraged (Phelan & Parkman, 1995; Tribe & Thompson, 2008):

> *For the recruitment visit I tried to book the interpreter and was told I couldn't get one that week, and I really wanted to get the recruitment visit done, so I thought 'Let's give it a go', and the recruitment was with the husband and was fine. I did say to him in future that I'll always use an interpreter.*

Even when other medical professionals had worked with a family member, the FN involved an interpreter, with the expectation that this more intensive and psychologically oriented intervention should be delivered with the help of a less involved individual:

> *I rang the midwife to see whether the husband knew she was pregnant; he did. She said she used him at the contacts rather than an interpreter. But I arranged for an interpreter.*

One FN, who spoke some Bengali herself, reported that for the FNP work she knew that her linguistic expertise would be too limited to convey the programme content effectively.

> *I worked as a midwife [in the local area] without interpreters for several years, people understood what I was saying. It was 'How are you? How's your baby?' I could do all the set physical history; I never got into the feelings. For this work I did not want to trust myself. It is such a feeling thing, about understanding and making sure things are said in the way I wanted them to be said….I thought ' I want an interpreter for this to make sure it's done properly.'"*

Overall then the FNs involved an interpreter if it had been specified by the referring agent, if they were familiar with a regular interpreter locally for that language and if the client was from an ethnic group which had a significant presence in the area so that the FN was able to gauge the situation from previous experience:

> *You ring them up after the referral and realise they need an interpreter. You make an appointment over the phone with the interpreter and then ask her to ring and verify it with the woman.*

However, some were finding it possible to carry out recruitment without an interpreter and some found it preferable to work in that way after the initial recruitment.

iv. How should the interpreter be prepared?

There is no standard preparation but the FNP National Team's guidelines indicate that there should be some preparation of the interpreter so that the particular style of FNP can be understood (see Appendix E). If the need is widespread then the recommended situation is for Family Nurse team to have a dedicated interpreter who has an understanding of the FNP approach and can follow the development of the nurse-client relationship and if this occurred it was thought to be the ideal situation:

> *I have been lucky in working with the same interpreter for each case over time, so that we have been able to build on the initial understanding, the interpreter has become included in the 'goal-setting and achieving' culture of the visits.*

But this situation was uncommon and in some cases did not work out successfully. After working with the team for a few months one interpreter left saying that the work was stressful which raised questions about the actual status of the interpreter and the level of supervision and support that might be necessary for interpreters who worked exclusively with FNP [all FNs have regular supervision]:

> *Maybe in hindsight it was all too much, that relationship with the client, with her having an insight into the culture and the background - maybe what we were trying to do was too much? She was carrying quite a burden there.*

Questions also emerged about the distinction line between the role of the FN and the role of the interpreter, which seems to have become blurred on this occasion. With too much ongoing

involvement the interpreter may have thought that it was partially her responsibility to provide the support rather than conveying information so that the nurses could take this role.

All Family Nurses who used interpreters reported trying to brief them before they made a visit together as is advised in their training guidance although they noted that the information conveyed was variable and it sometimes amounted to a few minutes in the car before going into the home:

> *I never had the time to explain things; I just had to say 'Follow my lead.*
> *We try to prepare* (interpreter) *as best we can but it's not a set procedure.*

One FN, who always tried to contact the interpreter before beginning visits to explain FNP and her expectations of the process, also briefed the interpreter before each visit, giving a summary of her objectives for it. Another said that she had tried to explain Motivational Interviewing (MI) to an interpreter, because it was an important aspect of the intervention and she needed to use it. She hoped that this would enable the interpreter to interpret in a positive way, reflecting MI, but was unable to check if that was happening. When there was a change in a regular interpreter, there could be an opportunity for a handover between interpreters, with an introduction to the programme:

> *We sat and we talked and told her of the sensitive issues that she is likely to come across…and to hear about her working experience…and it made her, and it made us, I think, feel better and more prepared. We let her know this* (FNP) *is a bit different.*

v. Characteristics of a good FNP interpreter

One might expect that these predominantly young female clients might like a younger and female interpreter, and they would like to see the same person accompanying their family nurse for each visit but their comments suggest that they perceived interpreters in a practical manner, not in terms of the kind of person involved:

> *Age and gender doesn't make any difference. I would prefer it if I only had one consistent interpreter with* (FN) *but it is not my matter to decide. If other interpreters come it doesn't make any difference to me.*
> *I was happy with the interpreters, whatever* (FN) *used to say, they were saying. I liked them, they were not bad.*

In fact several nurses found that older, more mature interpreters were more successful, particularly if they were married woman with children of their own.

> *One woman I went to see…didn't like the first interpreter I visited with: 'She's too young'. She was younger than her and a schoolgirl as far as she was concerned.*

Being known locally might mean that the interpreter is trusted. One nurse found an association with this interpreter eased her introduction to the family:

> *She had known the dad's grandparents and his brother who had children, so she knew all the family. When I initially went there I was with her and they welcomed me in, it got my foot in the door, but I don't know how useful it was beyond that.*

Being a member of the local community could also raise concerns about confidentiality when an interpreter is from the same community as the client. One nurse explicitly explains confidentiality arrangements when she introduces the interpreter to the family:

> *This has worried clients the most - can they discuss confidential matters with this third party involved, especially since the interpreter may appear to be from their community.*

It might also mean that clients or their partners hold back about the more sensitive topics discussed:

> *For a start the dad was quite inhibited. The interpreter was a part of the community and knew everybody…some of the materials are quite sensitive, about sex and things, and he spoke much more freely when the interpreter wasn't there.*

Some of the clients tried to 'place' the interpreter in the context of their community from early visits in order to establish to what degree they can be trusted:

> *When you go into the house they want to know from the interpreter, where are you from, are you married, do you have children?*

One interpreter had been unprepared for this personal quizzing and was unsure how to respond:

> *When we started out at the beginning* (interpreter) *wouldn't tell them anything or would say something that wasn't true… After a while she relaxed a bit and was more truthful. But it was really difficult for her because she was from that community.*

For the nurses the defining feature of a good interpreter was professionalism without taking over the situation or the client. Their capacity to be informative about different cultures was not commented on by many nurses, most of whom had extensive experience working with families from a range of backgrounds. However some did note that this was useful in enriching her delivery of the programme:

> *It is good to have someone who has a bit of experience and training in this area and someone who is also an advocate and therefore knows about the area and the issues, for example about cot death, if there's anything I have forgotten to say, she'll add details within appropriate parameters.*

Another FN recalled how the interpreter's cultural awareness had been helpful early on:

> *The first time we went there the client got all her wedding photos out and the interpreter explained that this is what women do when you first visit their house. So she had informed me culturally.*

Nevertheless this could veer too far toward a focus on the interpreter having independent input with the client, which may have a deleterious impact:

> *What she said was often helpful in explaining how this complex culture and community worked - but it affected the dynamic of the relationship between myself and the client.*

Concerns were expressed by nurses that information was not conveyed as stated by some interpreters, or not in a motivational style, or interpreters' opinions were added which led many to wish that they could manage without (Barnes et al., submitted), which the variable patterns of interpreter presence may reflect (See Table 4.3). Even with the most professional interpreters FNs found that maintaining an open and sharing relationship with them could take away from the energy that is required to provide FNP effectively, which they found stressful.

vi. Programme delivery

A number of programme delivery indicators were examined to see if there was any difference between the clients who had at any time required an interpreter and those who had not. One of the aims of delivery is for at least 60% of the clients to be enrolled by 16 weeks gestation and while the mean gestation at enrolment did not significantly differentiate the groups (with interpreters 18.8 weeks, no interpreter 17.9 weeks) there was a trend for the proportion enrolled by 16 weeks to be lower when interpreters were involved (interpreter 13/43, 30%; no interpreter 552/1261, 44%; Chi Square 3.17, p=.08).

Looking at all 10 sites there were no significant differences overall in the extent to which the expected number of visits was delivered in pregnancy or infancy for those clients requiring an interpreter compared to the remainder (see Table 4.5). However examination of delivery in the two sites with at least 10 interpreter clients revealed some differences. In Site D there was no marked difference in pregnancy but in infancy clients requiring an interpreter received more than half of their expected visits, compared to less than half for the remaining clients (see Table 4.5; $t = 2.79$, $p<.01$). In contrast in site E those requiring an interpreter had receive a significantly lower percentage of pregnancy visits ($t = 2.56$, $p=0.02$) with no difference between the groups during infancy.

Table 4.5 The percentage of expected visits delivered in pregnancy and infancy for all Wave 1 sites and for sites with 10 or more clients using interpreters

	Pregnancy % expected visits, Never used Interpreter	**Pregnancy % expected visits, Ever used Interpreter**	**Infancy % expected visits, Never used Interpreter**	**Infancy % expected visits, Ever used Interpreter**
Total	N=1261	N=43	N=1049	N=36
	65.6	67.3	53.9	56.8
Site D	N=118	N=21	N=100	N=18
	67.3	73.6	46.2	59.1*
Site E	N=111	N=12	N=92	N=9
	75.9	66.6*	59.3	58.6

Full details of other comparisons of service delivery such as the proportion of time spent on the different domains in the FNP curriculum can be found in Barnes, Ball and Niven (submitted). In summary average visit length did not differ, coverage of the domains was generally similar for both groups and mainly in line with the objectives except that in pregnancy more time was spent on maternal personal health for clients requiring an interpreter compared to the remainder and less on environmental health. In infancy again less time was spent on environmental health for the interpreter group. However FNs reported that the percentage of their planned content covered in visits was on average lower with interpreters and the level of understanding and involvement of clients, as judged by nurses was also lower.

It might be expected that, with the added complication of delivering the FNP programme with the assistance of an interpreter there might be a greater likelihood that the client would decide to leave the programme. However, the clients for whom an interpreter had been involved and the remaining clients were not significantly different (see Table 4.6).

Table 4.6 A comparison of attrition by the end of infancy in relation to the need to use an interpreter

Status	**Never used Interpreter N (%)**	**Used Interpreter N (%)**	**Total N (%)**
Left during pregnancy	166 (13)	6 (14)	172 (13)
Left during infancy	217 (17)	9 (21)	226 (17)
Active client at end of infancy	878 (70)	28 (65)	906 (68)
TOTAL	1261	43	1304

vii. 'Outcomes' of FNP

Smoking cessation during pregnancy was not examined since there were only three smokers in the interpreter group. There was no difference in gestation at birth, but the average birthweight for the group requiring interpreters was significantly lower (see Table 4.7). However this is not surprising since it was found in the total group that births to mothers of Asian background were significantly lower (Barnes et al., 2009) and 70% of the interpreter group were Asian. There was no significant different in the extent to which infants in the two groups needed to spend time in the Special Care baby Unit (SCBU; no interpreter 81/915, 9%; interpreter 5/34, 15%; χ^2 1.36 n.s.). The infant birthweight for the group who required an interpreter remained significantly lower at 6 months (see Table 4.7).

Table 4.7 Comparison of infant birth and 6 month status

Outcomes	**Never used Interpreter N, Mean**	**Used Interpreter N, Mean**	**T test**
Weeks gestation at birth	961, 39.3	34, 39.0	n.s.
Birthweight (grams)	970, 3226.4	34, 2922.5	3.15, p<0.01
Weight 6 m. (grams)	559, 7967.5	20, 7257.9	3.03, p<0.01

There was only one highly significant difference between the group requiring an interpreter and the remaining clients. They nearly all (94%) initiated breastfeeding compared to just under two thirds of the remaining clients, and a greater proportion (almost three quarters) were still breastfeeding at 6 weeks, compared to one third of the remaining clients (see Table 4.8). This difference is not surprising since it was found that breastfeeding by FNP clients was strongly associated with minority ethic background and particularly likely to be reported for Asian and black mothers (see Barnes et al., 2009, page 93). In all other life course outcomes evident at six months such as the use of contraception, a subsequent pregnancy, being in education or having been in paid employment there were no differences between the groups (see Table 4.8).

Table 4.8 Comparison of postnatal parenting and life course outcomes

Outcomes	**No Interpreter Ever used**		**Interpreter used**	
Ever breast fed χ^2 14.11, p<.001	**N**	**%**	**N**	**%**
Yes	592	63	32	94
No	354	37	2	6
Breast feeding 6 weeks χ^2 18.43, p<.001				
Yes	182	34	23	72
No	349	66	9	28
Contraception, 6 months				
Yes	574	86	25	96
No	95	14	1	4
Pregnant, 6 months				
Yes	49	9	1	4
No	516	91	23	96
Visited A&E, 6 months				
Yes	61	10	3	11
No	561	90	23	89
In education or training, 6 months				
Yes	144	22	7	28
No	524	78	18	72
Paid work since birth				
Yes	87	13	1	4
No	587	87	25	96

Referrals to other agencies

One of the important roles of the Family Nurses is to identify any additional needs that the client or her family have so that other agencies can provide additional support. The clients who at some time required an interpreter received on average marginally fewer referrals to other agencies than the remaining clients (3.6 vs. 2.4, t = 1.81, p=.07). In particular they received no referrals for social care (e.g. domestic violence, child protection), none for client education, for client mental health or for child care (see Table 4.9).

Clients who at some point required an interpreter were also significantly less likely to receive referrals for housing. There was no difference in the extent to which they were referred for financial support, for their own physical health or that if their infant or for community support, breastfeeding support or job training. They were as likely to be directed to the Citizen's Advice Bureau or (though rare in either group) for legal advice elsewhere. Not surprisingly they were significantly more likely to be referred for assistance with issues related to being a refugee or asylum seeker.

Table 4.9 Comparison of the rates of referral to other agencies in relation to whether or not the client ever needed an interpreter.

Any referrals (yes/no)	**Never used Interpreter** N=1261 N (%)	**Used Interpreter** N=43 N (%)	**Significance of difference**
Financial	490 (39)	12 (28)	n.s.
Health (physical) client	445 (35)	15 (35)	n.s.
Housing	342 (27)	4 (9)	χ^2 6.73, p<.05
Health care, infant	286 (23)	10 (23)	n.s.
Community Support	113 (9)	2 (5)	n.s.
Social care	108 (9)	0	χ^2 4.02, p<.05
Citizen's Advice Bureau	107 (9)	1 (2)	n.s.
Mental health	93 (7)	0	χ^2 3.42, p<.07
Education	67 (5)	0	χ^2 2.41, n.s.
Breastfeeding support	66 (5)	2 (5)	n.s.
Job training	57 (5)	2 (5)	n.s.
Child care	47 (4)	0	χ^2 1.66, n.s.
Legal advice	31 (3)	1 (2)	n.s.
Refugee/asylum advice	4 (0.3)	2 (5)	χ^2 17.5, p<.000

Impact on learning English

The content of the curriculum is more likely to be explained in a way that the client can understand in the presence of an interpreter. However, visits from the Family Nurse without an interpreter are a useful chance, amongst an often limited number of opportunities, for clients to practice English:

> *I go out shopping and the FN comes and speaks, I go to the doctor and there I have to speak English and that's how I pick it up.*

In most cases, FNs went with their clients to local colleges to help them enrol in English classes or provide information on where classes are held:

> *(FN) told me about the classes and I found them quite easily.*

Where this did not happen, there was a sense that the women were keen to learn and had already found out about classes through local networks. Nurses frequently mentioned English classes, explaining that '*they have to do ESOL for Life in the UK.'*

The desire for one-to-one visits with the nurse has served as motivation as well as opportunity for some clients to improve their spoken English:

> *After* (interpreter) *had been a few times* (FN) *said she was working on a different project but if you need an interpreter I will bring one. I said, no, when you speak I understand so I started talking with* (FN) *without an interpreter.* (FN) *said it will be good if you practice with me, then your English will improve.*

If clients are not quite ready for visits without an interpreter then with the agreement of the interpreter and the FN the visits can serve a language support function as a step toward more independence:

I said, right we're going to make her speak English and (interpreter) *will fill in the gaps where* (client) *doesn't understand. She's actually speaking a lot more now and it's getting her into practice.* (Interpreter) *has got her a little dictionary with* (client's mother-tongue) *and English in it.*

viii. Conclusions

From the quantitative data it was clear that the categorisation of a client as someone who will require an interpreter is not a stable concept, which may lead to difficulties if a decision was to be made at recruitment that clients who require interpretation should be ineligible. Many visits to those who at some point had visits with an interpreter were made without any interpretation, not necessarily due to their increased proficiency in English. The other striking point, emerging from the comparison of the clients who ever needed an interpreter and the remaining clients, is their intake characteristics. Those for whom an interpreter was involved were mainly older, married, living with their partner and other adults (probably in many cases his family members), most had never been in paid employment and they were unlikely to be a smoker. Thus if eligibility is limited in any way, such as to teen mothers or to lone mothers, the need for interpretation is likely to be less.

If it is decided that clients needing an interpreter are eligible to receive FNP then it appears that programme delivery to these clients will be roughly equivalent to other clients in terms of the quantitative aspects of fidelity such as the length of visits, cancellations and attrition. There was a tendency for visits in infancy to be shorter with the interpreter group and for less of the planned content to be covered in both pregnancy and infancy, suggesting that the time taken to provide translations of the FN's communication may be an impediment to doing all that was hoped. Visits were not generally extended to take this into account which could be related either to the way interpreters are booked (e.g. in hourly time blocks) or because FNs found the experience stressful so did not want to extend visits.

The essential ingredient of the intervention, the close nurse-client relationship, was considered to be possible either despite or thanks to the interpreter, although some FNs and some clients remarked that it was improved if they could manage without the third party. There was a small amount of variability in the focus of the visits with more attention to the mother's personal health for clients requiring an interpreter but it varied between sites, probably related to the different language and ethnic groups being supported in the different sites. While the quantitative aspects of delivery appeared robust, it was hard to judge whether the intervention was being delivered in exact accordance with the FNP prescription. The programme is a flexible one, and the practitioner is constantly selecting materials and adapting approaches to suit clients. Some selections and adaptations may stretch the programme too far to achieve the outcomes predicted by trials, and it may be that the pressure on communication with non-English speaking clients provides such a stretch.

During qualitative interviews, despite some initial reservations, the overall conclusion of FNs was that it had been possible to deliver an FNP intervention using interpreters. However, successful delivery depended on the quality of the relationship between the FN and the interpreter and on the interpreter having a good understanding of the content of FNP and the particular mode of delivery, with a focus on Motivational Interviewing. The preparation of the interpreter was considered vital in addition to ongoing discussion with the FN. The essential ingredients were preparation for the agency providing interpreters about the FNP, ensuring that they did not send interpreters expecting to act as advocates, some preparation for the individual interpreter before being involved with FNP and time for or discussion with the FN before and after each visit. All these are already outlined in the National FNP Team's guidelines for working with interpreters (see Appendix E) but also emerged from this study.

Outcomes such as contraception use, subsequent pregnancies or visits to Accident and Emergency departments in hospital with their infants were, by 6 months, not markedly different with one exception. Those clients who required an interpreter were more likely to breastfeed, again a difference that can be linked with their cultural background on the basis of the year 2 findings of the evaluation (Barnes et al., 2009). For the most part, referrals to other agencies were comparable for the interpreter group and the remaining clients indicating that there would not be any difference in workload in relation to liaison with other agencies.

Thus, while the overall conclusion is that the need for an interpreter should not lead to ineligibility for FNP, some additional stresses were experienced by FNs. A 'virtual' working group of FNs and supervisors with some experience of working with interpreters could be important so that ideas, materials and strategies for working in a trio can be shared. This could be particularly valuable in areas where the numbers needing an interpreter are small.

Chapter 5. Overall conclusions and recommendations

Using criteria

There is a substantial amount of evidence about the criteria identifiable in pregnancy that would identify the women with the greatest likelihood of benefiting from the FNP programme. What is less clear is how to determine the relevant information. On the basis of all the evidence low socioeconomic status or poverty would be the most crucial inclusion criterion but the closest that either the midwifery service or the FNP team is likely to get is the postcode so that neighbourhood deprivation can be ascertained. This criterion will then over-select since, unlike most cities in the USA, even highly deprived neighbourhoods have some mix of residents in terms of income and occupational status. Mothers with no educational qualifications and/or low intelligence, particularly if they also have mental health problems, should according to the evidence also benefit substantially from the FNP. However midwives and nurses are often reluctant to ask about mental health status until they get to know a woman and, unless it is required, they would not automatically ask about GCSE results. FNP nurses may be particularly resistant to asking about (lack of) qualifications since the strength-based curriculum of the programme encourages clients to focus on what they can achieve in the future, not what they have failed to achieve in the past. They do not want to highlight deficiencies in the recruitment process for fear of putting-off the potential client or to prevent them thinking that the programme is only offered to women with deficits. This occurs even with non-teen mothers, many of whom could be expected to manage well, having partners, stable living arrangements and a history of employment.

In two of the studies described in this report the FNs were provided with templates so that they could go through a straightforward process to find out if any referral met the eligibility criteria. They generally kept this from the woman that they were visiting and talked in general terms about finding out what the best kind of service would be. Working in this way over time could lead to stress, particularly of any FN doubted the particular criteria being used. Examples were found both of nurses who thought there should be fewer criteria – why could they not offer the programme to a 21 year old even though they had an A-level – or that there should be more. In some cases those who were eligible were 'persuaded' that they did not need the FNP. Clinicians are more comfortable making judgements based on their professional opinion rather than following set procedures and if criteria are to be used then this needs to be raised regularly in supervision sessions. It was less problematic in areas where only some clients were subject to eligibility, those aged 20 or above. In the area where all clients had to be recruited using criteria not only was enrollment delayed in relation the gestation, there was more tension evident about using the criteria.

Impact on delivery

Once criteria had been used there were on the whole very few observable impacts either on the nature of the clients recruited or on the delivery of the programme. The lack of difference in the client group is interesting. For the older group it helped to make those aged 20-22 more comparable to the teen first time mothers, sensibly excluding those who might be more advantaged. When younger clients were recruited, the only difference was that they were more likely to be smokers. This is a positive difference in relation to what is know about the potential for impact, which was greater for birth outcomes in USA trials for mothers who smoked. Nevertheless the delivery of the programme was not influenced to a great extent by having been selected with additional criteria, nor was attrition from the programme. Thus in terms of the FN workload there should be relatively little impact once the more detailed recruitment procedure is accomplished.

Clients requiring an interpreter were not included or excluded on the basis of that characteristic but they were substantially different to other clients, more likely to be married, to live in households with a partner and extended family, without a history of previous employment. Quantitative aspects of programme delivery again were not different between these clients and

those clients who did not require an interpreter. Thus in relation to any expected impact differences are likely to be related to the client characteristics unrelated to their language – such as their level of existing support, cultural differences in beliefs about the value of breast-feeding – but are not related to conveying the programme through an interpreter. However the FNs found work with interpreters was stressful as they focussed on maintaining a positive strength-based approach while at the same time worrying about the accuracy with which information was being conveyed. Therefore this again is an issue that needs to be discussed regularly in group supervision.

Future directions

Some commissioners have expressed concern about the cost of providing FNP and a reluctance to expand the service so that all teen first-time mothers in their area can receive the support (Barnes et al., 2009). Thus, there is likely to be a need to decide how to narrow the group receiving the programme. These studies have shown that processes can be used to identify referrals that meet criteria know to increase the likelihood that they will benefit from the FNP. The local systems used by midwifery to record information and the extent to which FNP teams can access that information can make a huge difference to the ease with which the use of criteria can be implemented.

Many professions both within FNP and beyond have views on who should receive the programme. However, it is recommended that the criteria identified in the first chapter be used as the basis for any local system rather than making ah hoc decisions. This is an evidence-based programme so it makes sense to base decisions about the client group based on the evidence. Within teams it may be important to share some of the evidence so that FNs can feel comfortable about the reasoning behind eligibility criteria.

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Appendix A. Significant outcomes from the three USA trials of NFP by age of the child
(source Barnes & Belsky, 2007, pp. 11-15)

Unless indicated by an arrow, the direction of the effect is in favour of the intervention group. If not significant for the whole sample, details are given of the subgroup(s) with a significant impact [11]

Age group and domain	**Specific outcomes**	**Significant for domain in >1 study p ≤ 0.05**	**Significant in only one study p ≤ 0.05**
Pregnancy			
Service use		**E, M**	
	Knowledge of services		E
	Attended childbirth classes		E
	Food vouchers		E
	Used community services		M
Support			**E**
	Talked about problems		E
	Father interested in pregnancy		E
	Accompanied in labour		E
Complications		**E, M**	
	Kidney infection		E
	Pregnancy induced hypertension		M
	Yeast infections		M
	Hospitalised		M - in school ↑
Health in pregnancy		**E, D**	
	Adequate diet		E
	# cigarettes per day		E
	Cotinine in urine		D - smoker
Life course			**M**
	Working		M - not in school
Birth			
Infant health			**E**
	% pre-term		E - 14-16, smoker, older non-smoker ↑
	Length of gestation		E - older non-smoker ↓
	% Low birth weight		E - 14-16 older non-smoker ↑
	Mean birth weight		E - 14-16

[11] Abbreviations:
E – Elmira; M – Memphis; D – Denver.
P – Poor/low socioeconomic status
U – Unmarried
T - Teen
ψ - Psychological

Infancy year 1			
Child temperament		**E, D**	
	Positive mood		E
	Emotional vulnerability		D
	Resists eating		E
Child health			E
	# ER visits		E
Parenting		**E, M, D**	
	Worry-concern		E
	Avoids restriction		E - PUT
	Play materials		E - PUT
	Attempted breastfeeding		M
	Responsive interaction		D
Life-course			**E**
	Enrolled in education, 6m		E
	Enrolled in education, 10m		E - unmarried
2 year olds			
Child behaviour & development		**M, D**	
	Standardised IQ/ DQ		D - low ψ resources
	Less delay in language		D - low ψ resources
	Child responsive		M - low ψ resources
Child health		**E, M**	
	# ER visits		E
	ER/outpatient visit for accidents or poisoning	E, M	
	Injury or ingestion health care encounters		M
	# days hospitalised for injury or ingestion		M
Parenting		**E, M**	
	HOME total		M - low ψ resources
	Avoids restriction		E - PUT
	Play materials		E - PUT
	Abuse/ neglect		E - PUT
	Risky child rearing beliefs		M
Life-course		**E, M, D**	
	Sense of mastery		M
	Months employed (13-24)		D
	# pregnancies	E, M, D	
	# live births	E - PUT M - more ψ resources D	
	Months AFDC		M - more ψ resources

3 year olds			
Child behaviour			**E**
	Standardised IQ		E - prenatal smoker
Parenting			E
	Home hazards		E
	Observed control		E - maltreated
	Observed involvement		E
	Language stimulation		E - PUT
	Play materials		E - PUT
	Seat belt use		E - maltreated↓
4 year olds			
Child behaviour & development		**E, D**	
	Standardised IQ		E - prenatal smoker
	Executive functioning		D - low ψ resources
	Language development		D - low ψ resources
	Behavioural problems (told to doctor)		E
	Behaviour during testing		D - low ψ resources
Child health			**E**
	Doctor visits, injury or ingestion		E
	#ER visits		E
	# days hospitalised		E ↑
Parenting		**E, D**	
	Language stimulation		E - PUT
	Educational materials		E - PUT
	Play materials		E - maltreated
	Home hazards		E
	HOME total		D - low ψ resources
	Avoids punishment		E
	Seat belt use		E - maltreated↓
Life-course		**E, M, D**	
	# Pregnancies (0-48 m)	E, M	
	Pregnancy spacing	E - PUT , M, D	
	Months employed (0-48m)		E
	In workforce at 48m		E - PUT
	Days on AFDC (0-48 m)		M
	Food stamps		M
	Living with partner		M
	Living with father of child		M
	Domestic violence, past 6m		D
	Help with child care		E - PUT
	Child in preschool		D↓

6 year olds			
Child behaviour & development			**M**
	Clinical level behaviour problems (CBCL)		M
	Dysregulated aggression (story stems)		M - low ψ resources
	Incoherent stories (story stems)		M - low ψ resources
	Language development		M
	Standardised IQ		M
	Maths achievement		M - low ψ resources
Life-course			**M**
	# pregnancies (0-72 m)		M
	# live births (0-72 m)		M
	Spacing births (0-72 m)		M
	Months on AFDC (54-72 m)		M
	Food stamps (54-72m)		M
	Months with current partner		M
9 year olds			
Child behaviour & development			**M**
	Tennessee reading and mathematics test		M - low ψ resources
	GPA reading and Mathematics		M - low ψ resources
Life-Course			**M**
	Months between first and second child		M
	Total # subsequent births		M
	Months on food stamps per year from 6 to 9		M
	Months with current partner at 6 and 9 years		M
	Months with current partner at 9 years		M
	Months with employed partner at 6 and 9 years		M
	Months with employed partner at 9		M
	Sense of mastery 6 to 9		M
	Child enrolled in preschool/ day care (24-54 m)		M

15 year olds			
Child behaviour			**E**
	# sexual partners		E - PU
	Stopped by police		E↑
	Arrests – police data		E
	Arrests – mother's report		E - PU
	Convictions & probation violations		E
	Person in need of supervision (PINS)		E
	Run away		E - PU
Life-course			**E**
	# subsequent births		E - PU
	Birth spacing		E - PU
	Months on welfare		E - PU
	Arrests of mother		E - PU
	Impairment due to substance abuse		E - PU
Parenting			**E**
	Child abuse substantiated, mother perpetrator		E - PU E - lower domestic violence

Published sources of information in chronological order, relevant trial in brackets

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Appendix B. 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 (source Hall & Hall, 2007, Box 5, page 45**)**

Current status of mother:

- Young age at first pregnancy and first birth
- 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 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

Additional circumstances:

- Ethnic, cultural and linguistic barriers
- Traveller lifestyle
- Refugee
- Illegal immigrant
- Asylum seeker

Appendix C. Data fields in each of the case study maternity forms

Maternity Booking Form

Name
DOB
Address
Day and evening telephone numbers
GP
Surgery address
LMP
No. and date of previous pregnancies
Any problems in previous pregnancies/deliveries
General health, any problems.
Any medications being taken at present
Are you taking folic acid?
Your approximate height
Your approximate weight
Date form completed.

Short Booking Information

Date completed:
Hospital number
Name
Gestation
Mothers occupation
Smoker
Partners name
Next of Kin
Partner occupation
Past pregnancies
Previous Medical History
Family Health
Infant feeding intentions
LMP
EDD
Height
Weight
BMI
Blood pressure
Maternal serum screening
Consultant/Midwifery Led care

Risk Assessment Form

Name and address (mother and partner)
DOB (mother and partner)
GP (mother and partner)
Hospital number
NHS number
EDD
Parity
Yes/no for the following:
Late booking >20 weeks
Mother aged 16 or less, or 16-19 unsupported
Single parent, unsupported
Previous neo/perinatal infant mortality or congenital abnormality
Previous obstetric or neonatal problem
Frequent pregnancy e.g. 3 in 5 years
Persistent defaulter in previous pregnancy
History of mental health issues (either parent or dependent relative)
Learning difficulties (either parent)
Communication difficulties
Financial/housing problems
Medical or anaesthetic referral
Domestic violence
Previous or current social work involvement
History of child abuse or children on child protection register
Issues regarding staff safety
BMI >30

Electronic Short Booking Summary

Social History
Type of review
Review Deletion allowed
Date of Initial Assessment
Gestation at initial assessment
Date of review (Mandatory)
Booked time of review (Mandatory)
Gestation at review
Days
One or two parent family (Mandatory)

Mother
Mothers Occupation
Occupational Status of Mother
Country of origin
Ethnic category (Mandatory)
Smoking status at booking (Mandatory
Before pregnancy
Currently
Date stopped smoking
Reason for stopping smoking
Prompted by
Text

Page 2
Husband/Partner
Partner's surname
Forename
Work phone number
Partner's occupation
Partner's occupational status
Partner's country of origin
Partner's ethnic category
Is partner the baby's father?
Father's name
Address 1
Address 2
Address 3
Address 4
Postcode
Daytime telephone
Evening telephone
Baby father's occupation
Baby father's occupational status

Page 3
Summary of Past Pregnancies
No. of past pregnancies
No. of registerable pregnancies
No. of non-registerable pregnancies
Summary of past births
No. of registerable livebirths
No. of registerable stillbirths
No. of non-registerable births
Gravida and parity

Page 4
Children
No. of children living now
No. of children who have died
No. of neonatal deaths
Plans for pregnancy
Feeding Intention at booking
Thalassaemia risk
Sickle Cell risk
Should BCG be recommended?
Special issues
Suppress sensitive data (Mandatory)
Final due date (Mandatory)

Appendix D. Wave 1 vulnerability data by age group

Table D1: Percentage of Wave 1 clients with each vulnerability, all clients with at least 1 completed visit (N=1246)

	All N	13-15 N (%)	16-17 N (%)	18 N (%)	19 N (%)	20+ N (%)
Not living with mother	1181	134 (25)	461 (47)	268 (47)	208 (64)	110 (71)
Poverty - very low income	780	66 (39)	292 (46)	195 (50)	149 (32)	78 (32)
No qualifications	1179	134 (90)	459 (37)	268 (28)	208 (31)	110 (42)
Smoker in pregnancy	1112	132 (45)	433 (43)	246 (36)	196 (31)	105 (39)
Abused ever	1026	119 (28)	404 (34)	225 (32)	180 (30)	98 (28)
Maternal mental health problem	961	102 (17)	369 (25)	218 (24)	173 (23)	99 (31)
No Partner	1181	135 (30)	460 (20)	268 (22)	208 (17)	110 (23)
Ever in care, looked after	947	103 (260	361 (12)	214 (16)	172 (8)	97 (5)
Any Social Services	1186	136 (19)	464 (11)	269 (6)	207 (3)	110 (4)
Low maternal IQ, learning difficulties	949	103 (8)	360 (9)	215 (8)	173 (6)	98 (12)
Family mental health problem	1186	136 (4)	464 (2)	476 (2)	69 (1)	41 (2)
Homeless	1181	134 (0)	461 (2)	268 (3)	208 (3)	110 (2)

Table D2: Percentage of Wave 1 clients with each vulnerability, those with data for all vulnerabilities (N=527)

	All	13-15	16-17	18	119	20-21	22+
	N=527 %	N=43 %	N=189 %	N=129 %	N=105 %	N=38 %	N=23 %
Not living with mother	55	30	50	47	64	41	83
Poverty - very low income	41	37	48	50	32	22	13
No qualifications	36	86	34	28	31	24	39
Smoker in pregnancy	42	53	47	36	31	24	52
Abused ever	31	23	32	32	30	19	26
Maternal mental health problem	24	16	23	24	23	15	48
No Partner	21	37	18	22	17	12	30
Ever in care, looked after	13	21	13	16	8	0	13
Any Social Services	8	16	11	6	3	0	9
Low maternal IQ, learning difficulties	8	5	8	8	6	6	9
Family mental health problem	3	7	3	2	2	1	4
Homeless	2	0	2	3	3	1	0

Table D3. Percentage of Wave 1 clients with multiple vulnerabilities, all clients who have received at least 1 visit (N=1246)

Number of vulnerabilities	All	13-15	16-17	18	19	20+
	N=1246	N=147	N=486	N=284	N=214	N=115
	%	%	%	%	%	%
0	9	8	12	15	11	8
1	18	18	24	22	24	20
2	23	24	23	24	30	23
3	18	24	17	18	18	21
4	13	12	13	9	7	17
5	8	7	6	6	6	6
6	5	4	3	3	1	3
7	4	1	2	1	2	1
8	1	2	0	1	1	0
9	1	0	0	1	0	1

Table D4: Percentage of Wave 1 clients with multiple vulnerabilities: all clients who have received at least 1 visit and have data for all items, by age group (N=527)

Number of vulnerabilities	All N=527 %	13-15 N=43 %	16-17 N=189 %	18 N=129 %	19 N=105 %	20+ N=61 %
0	9	2	10	12	10	3
1	18	12	19	16	21	15
2	23	26	23	25	22	23
3	18	21	14	22	18	21
4	13	16	14	8	12	21
5	8	7	8	7	10	8
6	5	9	5	5	2	5
7	4	5	5	2	4	2
8	1	2	1	2	1	0
9	1	0	1	2	0	2

Appendix E. National team guidelines for working with interpreters in FNP

Introduction

FNP is an intensive preventive programme, which has at its core a therapeutic relationship between nurse and client. Where clients do not speak English, the programme will need to be delivered through interpreters. This is a complex practice issue, but can be aided by a number of measures, both at organisational and at practice levels. This paper sets out guidance about good practice for the use of interpreters in FNP.

General principles of service delivery

Non-English speaking clients eligible for the programme should be offered the service through an interpreter. Family members should not be used as interpreters. If clients request this, nurses should explore the issue with them and encourage the use of a professional interpreter.

Team based interpreters

Where the local community served by FNP has a majority second language, it will be advantageous if the team includes an interpreter. This will ensure consistency for clients and enable the interpreter to understand the aims and methods of FNP. Teams planning to appoint interpreters should, if possible, recruit those with a diploma in public services interpreting or similar qualification. Interpreters should be given a thorough induction that should include an understanding of the programme, its aims and methods.

Sites should be clear about the role of the interpreter, especially the extent to which they want the interpreter to act as a cultural consultant to the team (e.g. highlight issues which may be culturally difficult or sensitive for clients). They should also clarify the mode of interpreting they wish to use and the accountability and reporting arrangements for the interpreter. Interpreters should receive regular supervision along with other team members.

Non-team based interpreters

Sites with a variety of second languages within the local community will need to work with agency interpreters. Sites should work with the agency to develop an understanding of the programme so that it can inform interpreters of the potential nature of the visits. Accountability arrangements should be clear to all

Sites must ensure that they book sufficient time to brief interpreters before a visit and de-brief with them at its conclusion (see below). Every effort should be made to engage the same interpreter for each visit with a client, to gain consistency. Interpreters engaged in this way will need an induction meeting to learn about the programme.

Use of interpreters within home visits

Nurses working with interpreters should follow the guidance set out below.

Before the visit

Make time to speak with the interpreter before the visit

This will provide an opportunity to:

- Outline the nature and expected content of the visit with the interpreter. It is important that the interpreter knows what to expect as this will help them to start thinking about vocabulary and will put the visit in context.
- It will also give them warning of issues that will be raised which may be difficult for them personally and this issue can then be managed between the nurse and interpreter
- Specify if Consecutive or Simultaneous interpreting is preferred. Most people prefer consecutive, this is where the interpreter interprets when someone has finished speaking (as opposed to simultaneously interpreting as the person is speaking).
- Agree in advance who takes responsibility for interrupting the client if they speak for long periods of time. It is very important when working with an interpreter that both the client and the nurse speak in short units of speech (2-3 sentences at a time). With longer

speech it is difficult for the interpreter to interpret accurately and valuable information may be lost. It is probably best if the interpreter takes responsibility for interrupting the client as they will have a better idea of when to interrupt sensitively. They also know how much information they are capable of retaining. The interpreter should also feel comfortable enough to interrupt you if you are speaking too long.

- Ask the interpreter to speak in the first person e.g. say “I”, “me”, instead of “she says”.
- Let the interpreter know they can ask you and the client to repeat or clarify what has been said. However they should not ask any additional questions or offer their own advice without first consulting you.
- Agree expectations with the interpreter. E.g. are you asking the interpreter to interpret everything that is said in the room? Are you asking her to interpret meaning rather than only words? (i.e. do you wish her to act as a cultural broker to help the clinician and client reach a mutual understanding of culturally influenced issues)
- Often when working with interpreters, the client or professional can feel excluded when lengthy discussions are taking place in a language they don’t understand. If you have a discussion with the interpreter in front of the client, ask the interpreter to explain the content of the discussion to the client
- Confirm confidentiality expectations and discuss how these will be shared with the client.

During the visit

- Explain to the client that both you and the interpreter will maintain confidentiality.
- Consider the layout of chairs, if possible. A triangular arrangement will allow each person to communicate easily.
- Speak directly to the client in the first person e.g. say “Can you tell me...” instead of “Ask her to tell me...” Look at the client rather than the interpreter when you are speaking to the client. Speaking in the first person helps to establish a rapport with the client.
- Speak as simply as possible. Remember that certain phrases, metaphors and colloquialisms do not directly translate into another language. Also, certain words and concepts do not translate into other languages e.g. there is no Urdu word for “depression”, so be prepared to explain what certain words mean.
- If there is a lengthy dialogue between the interpreter and client it is okay to interrupt and ask for an update on the conversation.
- Pay attention to non-verbal communication while the client is speaking as this can give important cues as to how the client is feeling.

At the end of the visit

- Give the interpreter time after the visit
- Allow the interpreter to ask any questions or make any comments about the visit. Often interpreters may be able to add a cultural perspective to the interaction e.g. they may be able to let you know of any culturally inappropriate behaviours or questions on your behalf. Or, they may be able to shed light on behaviours or answers from the client.
- The interpreter should always be allowed time to debrief from troubling or difficult visits.

Recommended reading: Tribe, R & Ravel, H. (eds.) (2003) *Working with interpreters in mental health.* Hove: Brunner-Routledge.