

MARCH 2018

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# FNP ADAPT

KEY DOCUMENTS  
FOR CLINICAL  
ADAPTATION  
DESIGNS



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## FNP ADAPT: Key documents for clinical adaptation designs

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### Introduction

The Family Nurse Partnership (FNP) Accelerated Design And Programme Testing (ADAPT) project is an ambitious and cutting-edge collaboration that began in April 2016, aiming to identify adaptations that will enable FNP to better meet the needs of families and changing demands in the local and national context, and develop and document a method for rapid cycle adaptation and testing. ADAPT is, in part, a response to a number of significant challenges that FNP has faced in recent years, including: changes to commissioning arrangements; funding cuts; and disappointing results from a randomised controlled trial of FNP in England, which found that by the time children of clients were aged two, there was no effect on the primary outcomes when compared with usual services and small effects on a handful of secondary outcomes, such as cognitive and language development and maternal self-efficacy.<sup>1</sup>

ADAPT has developed and tested two types of adaptation: clinical changes, adapting the FNP programme in relation to a specific outcome (for example, smoking); and system changes, aiming to increase efficiency, improve outcomes, and allow nurses to personalise FNP to better meet the needs of clients.

There are 10 ADAPT sites, eight of which opted to make clinical adaptations. All sites are testing system adaptations based around personalisation.

Each clinical adaptation is concerned with adapting programme content and delivery in relation to a specific outcome. Between them, adaptations in the eight sites focus on five outcomes – attachment, breastfeeding, healthy relationships, maternal mental health and smoking cessation. Sites were free to choose which outcome to focus on, and were therefore influenced to a large degree by local factors, although they were encouraged by the Dartington Service Design Lab (the Lab) and FNP National Unit to focus on outcomes where there was no effect in the RCT and levels of local prevalence were concerning.

This booklet contains the six key documents created by each site that designed a clinical adaptation as part of the ADAPT project: an adaptation description; a logic model diagram; a logic model narrative; a dark logic model; a context map; and a clinical flow chart. The remainder of this introductory section outlines briefly the design process and progress thus far with implementation and testing. Further information about ADAPT can be found at [www.fnp.nhs.uk/fnp-next-steps/adapt](http://www.fnp.nhs.uk/fnp-next-steps/adapt).

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<sup>1</sup> Robling, M., Bekkers, M-J., Bell, K. et al. (2016) Effectiveness of a nurse-led intensive home visitation programme for first-time teenage mothers (Building Blocks): a pragmatic randomised controlled trial. *The Lancet* 387, no. 10014: 146–55; Barlow, J., Barnes, J., Sylva, K. et al. (2016) Questioning the outcome of the Building Blocks trial. *The Lancet* 387, no. 10028: 1615–16; Robling, M., Torgerson, D., Pickett, K. et al. (2016) Questioning the outcome of the Building Blocks trial—authors' reply. *The Lancet* 387, no. 10028: 1616–17.

## Process

Each site formed a co-production team with responsibility for the design, implementation and refinement of adaptations. These teams were expected to draw on a range of perspectives and include family nurses, the team supervisor, the commissioner of the FNP team from the local authority, local subject-specific experts and FNP clients. From the outset the co-production teams worked closely with the Dartington Service Design Lab and the FNP National Unit.

Clinical adaptation designs, captured in the key documents, were developed iteratively over a series of meetings, telephone calls and written exchanges between partners. In order to ensure that this process was informed by scientific evidence, sites were provided with summaries of relevant literature – including rapid reviews of intervention effectiveness relating to the different outcomes – and a number of subject experts were consulted. Co-production teams also received a summary of existing FNP content in relation to the respective outcome, which facilitated a useful comparison with the evidence. Completed designs were signed off by the FNP ADAPT Project Board when they were deemed to meet a series of criteria (see pp.16-17 of the ADAPT interim report <http://fnp.nhs.uk/media/1246/fnp-adapt-interim-report.pdf> for more information).

## Documents

There are six documents per adaptation. The first document is the adaptation description, which was written using the TIDieR checklist.<sup>2</sup> This checklist was originally designed to ensure that interventions are adequately described in research reports so that findings can be replicated or built upon by other researchers who were not involved in the original design. It was used in ADAPT to ensure a systematic and comprehensive description of each adaptation.

The TIDieR checklist specifies that the description should include a brief name, why it is needed, what materials are required, what procedures are followed, who provides the intervention, how it is delivered (modes of delivery), where this takes place (location), when and how much (number of sessions, duration, frequency, intensity or dose), and what tailoring is or was permitted. For ADAPT, the last two criteria on the TIDieR checklist, namely how well it was planned to be implemented and how well it was actually implemented, are not covered in the adaptation description but will be reported in the final evaluations.

The second and third documents are the logic model diagram and the accompanying narrative respectively. These documents go together and are used to explain how the adaptations are intended to work, including underpinning assumptions and logical connections between components. Each component in the logic model is numbered and has a corresponding numbered section in the narrative. They are organised under five headings: ultimate outcomes; intermediate outcomes; mechanisms; activities; and supports. The narrative starts by explaining the ultimate outcome(s) and then works backwards to explain how each element contributes to the next one, such that read together there is a clear account of how the adaptation is intended contribute to the desired outcomes.

<sup>2</sup> Hoffmann, T. C., Glasziou, P. P., Boutron, I. et al. (2014) Better reporting of interventions: Template for Intervention Description and Replication (TIDieR) checklist and guide. *BMJ* 348 : g1687. <https://doi.org/10.1136/bmj.g1687>

The fourth document is the dark logic model. Dark logic models are recommended when designing complex interventions to anticipate how the intervention might have adverse effects, and the underlying mechanisms that might generate these effects.<sup>3</sup> For the ADAPT project the co-production teams were asked to consider how the adaptation they were proposing could cause harm, and the likelihood of this materialising, and to suggest some steps that could be taken to prevent or mitigate this harm.

The fifth document is the context map, in which the co-production team outlines the different contextual factors (political, organisational, cultural, economic and other) that are considered likely to affect the implementation of the adaptation and its success in achieving the specified outcomes. They detailed any potential threats and how these factors could work to support the success of the implementation of the adaptation.

The final key document is a clinical flow chart. This was originally designed as an *aide memoire* for data entry, but it also provides a visual representation of what happens and when for each adaptation. Specifically, it represents the material delivered during each programme phase (pregnancy, infancy and toddlerhood) and, where appropriate, delineates where materials are universal or targeted.

### Progress

The design phase across all eight sites started in April 2016 and lasted approximately eight months. Once designs were signed off, sites worked with the FNP National Unit to develop any client materials needed and nurses completed any necessary training. This took approximately three months per site. At this point implementation and testing commenced. The first sites started to implement their clinical adaptations in January 2017 and by May 2017 all eight clinical adaptations were operational (for more information see [www.fnp.nhs.uk/fnp-next-steps/adapt](http://www.fnp.nhs.uk/fnp-next-steps/adapt)). It is important to note that the documents for each site represent the original signed-off design and do not capture the changes that have been made subsequently as a result of the rapid cycle testing procedure. These changes will be described in the final reports on each clinical adaptation, which will be shared later in 2018/19.

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#### *Suggested citation:*

Axford, N., Lowther, K., Cuffe-Fuller, B., Rothman, R., Buckley, J., Cruise, K., Evans, C., Linton, E., Mackinnon, L., Porter, D., Wragg, C., Wren, M. (2018) *FNP ADAPT Key Documents for Clinical Adaptation Designs*. London, UK. Available at [www.fnp.nhs.uk/ADAPT](http://www.fnp.nhs.uk/ADAPT)

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<sup>3</sup> Bonell, C., Jamal, F., Melendez-Torres, G. J. et al. (2015) 'Dark logic': theorising the harmful consequences of public health interventions. *J Epidemiol Community Health* 69, no. (1): 95-98.

## Acknowledgements

We hope this document will serve as a record of the hard work and creativity that went into the design of these adaptations. At each site, the supervisor and the co-production team also worked extremely hard with the Lab, the FNP National Unit, FNP clients and other stakeholders to ensure the quality of these adaptations. We also wish to acknowledge the contributions of the academic experts who gave their time to help us refine the designs. In particular, we would like to thank Marian Bakermans-Kranenburg, Linda Bauld, Jane Barlow, Vashti Berry, Marion Brandon, Amy Brown, Catherine Chamberlain, Louise Condon, Gene Feder, Vivette Glover, Louise Howard, Susan Jack, Mary Renfrew, Anita Schrader-McMillan and Nicky Stanley. Needless to say, we – the FNP National Unit, the Lab and the respective ADAPT sites – take full responsibility for the final adaptation designs as represented in the documents here and, accordingly, for any errors or omissions.



1.  
**BLACKPOOL**

BLACKPOOL

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# ADAPTATION DESCRIPTION

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### Name of adaptation

Improving breastfeeding in Blackpool – initiation and continuation rates

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### Target group

FNP clients in Pregnancy and Infancy stages, wider family and partners

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### Rationale

See logic model visual and narrative.

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### What it comprises

The adaptation has several strands to it:

- An increase in breastfeeding-related materials used by Family Nurses with clients in key pregnancy and infancy home visits, using those currently available in a different place in the programme or new materials. These are designed to: increase clients' understanding of the benefits of breastfeeding in health, financial and practical terms; consider practical ways to overcome potential difficulties before they arise; and support clients via skills practice to have challenging conversations with others.
  - New materials to be used by Family Nurses with the client's family in key pregnancy and infancy home visits, especially targeting grandmothers to increase their understanding of the benefits, thus amending their attitudes and perceptions of breastfeeding, and encouraging the family to continue to support clients to breastfeed. This will give the family the skills to offer practical and emotional support.
  - An increase in client partner materials used by Family Nurses in key pregnancy and infancy home visits, both using those currently available earlier and developing new ones. This is designed to: increase the partner's understanding of the benefits, thus amending their attitudes and perceptions of breastfeeding; encourage and enable partners to support clients to start breastfeeding and continue to do so; and increase partners' understanding of their role in supporting clients to breastfeed.
  - The development of a peer support group comprising past or present clients who have successfully breastfed for one month and who can give clients practical and timely advice and support in a way that is meaningful to clients. This will include sharing their experiences of breastfeeding and problems they had and overcame. This will involve both face-to-face and telephone/text contact as required by the clients over a period of a month following delivery, with an earlier cut-off if clients no longer require support.
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### Materials needed for delivery

- New facilitators to be developed as above by FNP National Unit (NU) and co-production team, including Smart Choices.
- Training to be provided by NU to develop Family Nurses' skills to deliver new materials and support behaviour change in what is likely to be a complex and tricky area where family may have deep-seated and fixed views already.
- Training for peer supporters to enable them to practise in a safe manner, both for themselves and the clients they support. Areas to explore will be how best to train peer supporters, either by using the Breastfeeding Network to provide training or developing an in-house FNP training package. The training will address boundaries and interpersonal and communication skills. As Blackpool has Baby Friendly accreditation, peer supporters will also need to complete that training.

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### **Procedures for delivery**

Family nurses will offer and discuss the new materials with all clients in pregnancy, providing opportunities for skills practice; for those clients who are breastfeeding family nurses will offer and discuss the new materials in infancy. For the wider family and partner the family nurse will offer and discuss the new materials in client visits (these will include materials that demonstrate how the wider family and partners can practically support clients who choose to breastfeed). These will be introduced with agreement from clients. Peer support to be offered; if agreed by the client, a plan will be drawn up to facilitate this.

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### **Mode of delivery**

Delivered face-to-face individually by the client's Family Nurse at weekly or fortnightly pregnancy or infancy visits. Material for partners / family will be delivered in the context of these visits with the client's consent. Peer supporters will provide both face-to-face and telephone / text support, with the Family Nurse monitoring.

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### **Provider(s)**

Family nurses and trained peer supporters.

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### **Where it takes place**

In clients' homes or community settings on an individually agreed basis with the nurse or peer supporter.

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### **When/ how much**

During pre-arranged weekly or fortnightly pregnancy or infancy visits incorporating other materials as per programme design. Visits last 60-90 minutes and agreed with clients. Peer support requires individual assessment and provision and will be offered as a standard package which can be tailored to fit.

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### **How it can be tailored**

All current visits are agenda-matched to suit the individual needs of the client; however, if this subject is challenging to the client the Family Nurse will use her skills to judge if and when to return to the new materials at a later date.

Peer support will be tailored for each individual client. But a standard package will be offered to incorporate an antenatal meeting towards the end of pregnancy, then an initial postnatal visit in the first 24/48 hours. Agreement will then be reached between the client and peer supporter on how to manage future support.

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### **How fidelity is monitored**

Family nurses will record what they have covered in each home visit with clients, family or partners. Supervision will allow for opportunities to monitor and discuss issues arising. Peer supporters will require supervision to ensure that they are working safely and to allow for feedback and reflection and report on visits completed (e.g. how many, what they covered) and outcomes achieved.

BLACKPOOL

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# LOGIC MODEL

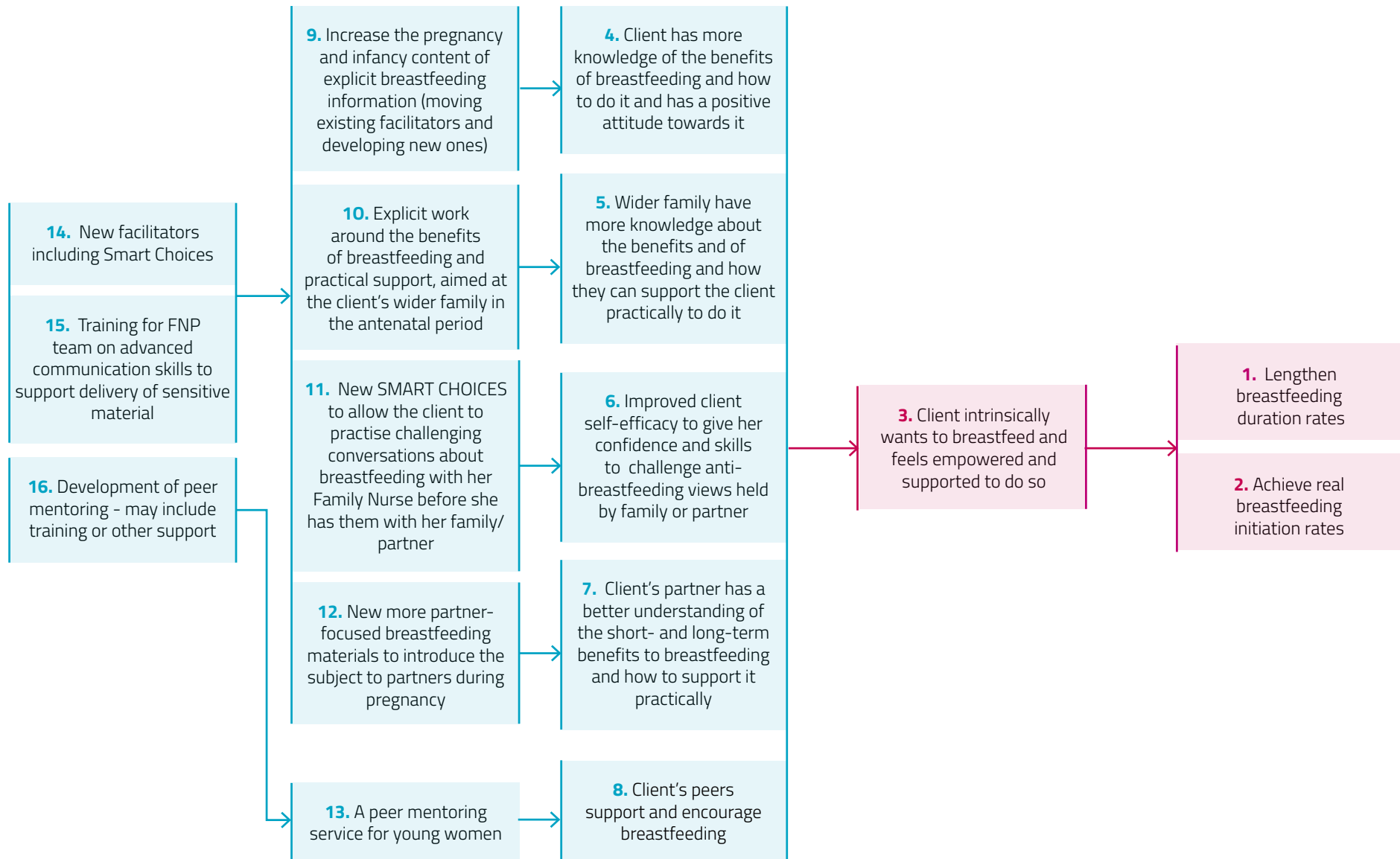
SUPPORTS

ADAPTATION ELEMENTS

MECHANISMS

INTERMEDIATE OUTCOMES

ULTIMATE OUTCOMES



A narrative of each element of the logic model is provided below - numbers in the boxes in the diagram relate to corresponding points in the narrative.

### Ultimate outcomes

There are two ultimate outcomes:

1. The first is to lengthen breastfeeding duration rates i.e. increase the proportion of clients who are still breastfeeding at six months.
2. The second is to achieve the real initiation of breastfeeding. This will contribute to the longer duration of breastfeeding because clients will have started to fully breastfeed.

### Intermediate outcome

3. The ultimate outcomes are more likely to be achieved if the intermediate outcome is achieved: The client intrinsically wants to breastfeed and feels empowered and supported to do so. Having the intrinsic motivation to breastfeed will help her to initiate breastfeeding even if she finds it difficult to start with and to continue even if she encounters difficulties or there is a temptation to stop.

### Mechanisms

Several mechanisms contribute to the intermediate outcome:

4. Clients have an increased knowledge of the many benefits and the mechanisms of breastfeeding and will have a positive approach to it. Understanding the benefits for the baby and themselves (e.g. financial, health, practical) will mean that clients are more likely to want to breastfeed and they will feel empowered to initiate and continue breastfeeding even when they encounter difficulties, as they have learned how to initiate breastfeeding well and have already considered how to manage problems if they arise and are better prepared for the ups and downs of breastfeeding.
5. Wider family have more knowledge about the many benefits of breastfeeding and how they can support the mother practically so that she can breastfeed. This will encourage the client to want to breastfeed, as those who are strong influences in her life are supporting her decision and encouraging and helping her practically if she encounters any challenges or is tempted to stop.
6. The client's self-efficacy is improved because she has practised the skills and developed the confidence to challenge any anti-breastfeeding views held by her partner or wider family. This will support her to feel further empowered to make her own choices and defend them to others and be able to persuade others of the benefits of breastfeeding (for both baby and mother). This will then ensure that she has her partner's and wider family's support to initiate and continue breastfeeding.

**7.** The client's partner has a better understanding of the short- and long-term benefits of breastfeeding (for baby and mother) and his role in supporting that practically, and as a result he will be likely to encourage breastfeeding. This will support the client to initiate and continue breastfeeding because her partner is actively supportive of this choice.

**8.** There is support from one of the client's peers, who can be very influential; with their practical and timely support and encouragement she will be more motivated to breastfeed and feel supported in doing so. They can offer practical lived experiential advice when the client may encounter challenges and be tempted to stop and so support her to continue for longer.

### Adaptation elements

The elements of the adaptation that enable these mechanisms are as follows:

**9.** The amount of material for clients focusing explicitly on breastfeeding in pregnancy and infancy will be increased in two ways:

#### *Moving existing materials*

There are facilitators in the Infancy phase of the programme which could be brought forward to the Pregnancy phase, particularly from visit Infancy 1 (I1) "*baby's first feeds, a checklist....*" to a later Pregnancy visit, perhaps P11.

#### *Developing new materials in pregnancy and infancy*

To include one facilitator that considers solutions for potential difficulties which may be encountered and one that explores with clients the long-term benefits of continuing breastfeeding to at least 6 months (not currently covered in pregnancy). These could be designed in conjunction with clients, the co-production team and the FNP National Unit and could be trialled with clients. This allows clients to be: fully prepared for what breastfeeding may bring; able to identify solutions to potential problems; more likely to choose to breastfeed and continue even if problems are encountered (because they will have the knowledge to manage this).

**10.** Materials should target people who are powerfully influential in supporting clients to make their choice, including parents and grandparents of clients, during the antenatal period to ensure that any discussions within the family are fully informed before the arrival of the baby and can be re-addressed in the postnatal period. These materials will primarily be educative in nature to inform parents and grandparents of clients of the benefits of breastfeeding for both the mother and baby in terms of physical health, cost, convenience, bonding and attachment. In addition, parents and grandparents of clients should be supported to understand why the choices they made in the past may have been based on less accurate information than we have now about breastfeeding. It will be important that their past decisions are affirmed and celebrated while acknowledging that there is now the opportunity for them to support their daughter to make the best choices possible based on the available information/ evidence we have. The aim is that the decision making process is inclusive for all the family, because if families can be engaged in supporting breastfeeding, and can be guided in how they influence the client, then they may be more likely to encourage and support the client in the long term. In turn, the client will face less



opposition to breastfeeding from within her own support network and in particular her own mother (a particular issue in Blackpool, as the culture in the town is deep rooted and firmly fixed in bottle-feeding as the absolute norm). This will contribute to the client feeling better able to make the decision to breastfeed and to continue to do so, as she will have the support of her extended family network.

**11.** SMART CHOICES are already used within the programme to help the client consider conversations she may have with others that may be uncomfortable or challenging and to help her develop her skills using tools such as role play to be able to manage them with more confidence. Developing a SMART CHOICE with a focus on a challenging conversation around breastfeeding will allow the client to be mindful that these are possible conversations she may have and allow for a degree of preparation on her part. Working together with her nurse she will be supported to identify what those conversations may look like, who they may be with and how she can best steer her way through them without antagonising those who will be supporting her in the future. The use of role play allows her to practise the conversations, identifying what words and strategies she could use; this will allow her to identify the best approach for her before the conversation happens. Being prepared in this way will build the client's confidence and self-efficacy and skills to challenge anti-breastfeeding views held by her family, partner or friends, thereby maximising her potential for achieving the best outcome from her conversations that she can.

**12.** The amount of material for partners focusing explicitly on breastfeeding in pregnancy will be increased in two ways:

#### *Moving existing materials*

There are materials in Infancy visits which could be brought forward to Pregnancy – for example, bringing the partner-focused facilitator “*How can I help with breastfeeding?*” forward from I1 to perhaps P6 so that the partner is better prepared to understand their role in supporting the client when she is exclusively breastfeeding.

#### *Developing new materials*

This is to give the client's partner the information he needs on infant feeding choices so that he might support the client to make the healthiest choices. Including a partner in a more focused way to build their understanding of what is important for their baby, including not only the health benefits of breastfeeding, but also how he can support it practically and the chance to have a positive influence on his baby's long-term outcomes, may increase his ability to be supportive of a client's choice to breastfeed. We know from comments fed back to the Blackpool FNP team in previous engagement activities that partners, in particular young men, often feel excluded from the pregnancy, and although FNP is proactive in encouraging young men to be involved in the programme, there is more that can be done. Building his knowledge and understanding and showing him how vital he is for his baby's wellbeing may be key to addressing this. If some work is directly targeted at the partner around infant feeding, then he will be more likely to take on board the benefits and how he can help practically and therefore be more likely to support his partner to make the healthiest choice. Partners will also benefit from understanding the ways in which clients can breastfeed without exposing their bodies to others.

**13.** Clients can take advantage of the currently available breastfeeding peer support but it is not always a true peer offering to young women in Blackpool. Developing a peer support network may take some time and involve training for the peer supporters, and although this was initially considered to be a future adaptation, as it may take longer to design and implement the adaptation, the overwhelming majority (90%) of clients recently asked identified that peer support from someone who had had a Family Nurse would be helpful. In this case, this becomes an important adaptation to focus on. There is the potential for taking a more staged approach to developing this kind of support with the opportunity to use text or telephone support initially, then face-to-face support (the latter is arguably the most important). By offering genuine peer support, by young women who are peers and therefore better able to connect with the issues faced by young breastfeeding mums, the clients will be supported to manage the particular challenges faced in Blackpool, and it is hoped that this will extend the length of time clients breastfeed for.

### Supports

The supports that facilitate the delivery of these adaptation elements are:

**14.** The National Unit, in collaboration with the Family Nurse team in Blackpool will develop new materials to support the nurses to deliver this adaptation. This will include the new SMART CHOICES to allow the client to practice challenging conversations about breastfeeding with her Family Nurse before she has to have them with her family. There will also be new facilitators to increase the explicit breastfeeding content during Pregnancy and Infancy, and some aimed at the partner and wider family, to introduce the subject to partners during Pregnancy and highlight the importance of practical support.

**15.** Family Nurses will receive additional training to use the new materials and SMART CHOICES; this will include training in advanced communication skills to enable tricky and challenging conversations to take place.

**16.** To develop peer mentoring, either a peer mentoring service needs to be initiated by the FNP team, or more likely and more feasibly, potential FNP peer mentors will receive Baby Friendly accredited training and either Breastfeeding Network from the existing services, which will give them the skills, confidence and support to be an effective peer supporter.

BLACKPOOL

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# DARK LOGIC

POSSIBLE ADVERSE EFFECTS	LIKELIHOOD	MITIGATING ACTIONS
<b>The amount of materials on breastfeeding will increase</b>		
<p><b>Some of the material already used in visits may need to be left out, in order to ensure the new materials are discussed. As visits are carefully designed to meet outcomes this could lead to important sections of the programme being missed.</b></p>	Moderate	<p>Nurses will agenda-match visit content and will negotiate with the client that some elements are left with them to complete before the following visit or moved backwards or forwards in the programme schedule. The development of tools to support flexibility within the programme to personalise it for individual clients will help with this. Peer supporters could also offer emotional/practical support if trained, thereby freeing up time of the nurses.</p>
<p><b>Client may feel overloaded with breastfeeding information and zone out of the visit or disengage from the programme.</b></p>	Low	<p>Family Nurses will be able to read subtle non-verbal cues of disengagement and address the reasons for this with the client. Negotiation and agenda-matching will help. (NB. Clients who were consulted felt that nurses already use their skills to identify how much of the programme materials were used for them and did not feel this would be a problem.)</p>

POSSIBLE ADVERSE EFFECTS	LIKELIHOOD	MITIGATING ACTIONS
<b>Breastfeeding to be discussed with parents and grandparents of the client during the antenatal period</b>		
<b>Grandmothers in particular may feel guilty if they did not breastfeed and the information being shared is that breastfeeding is the best choice. They may resist the idea and influence other family members to resist also, potentially contributing to family conflict.</b>	Moderate/ High	Family Nurses will use their enhanced communication skills to judge grandmothers' response and be mindful of their delivery of these items, ensuring that grandmothers' own choices are endorsed for being right for them in their time. A team-based or regional learning event will clarify which communication skills may best be used to support nurses to respond to ambivalence accordingly and so lessen the risk of disengagement. Family Nurses will encourage grandparents to be present and engaged in visits beforehand; this will enable them to develop a positive relationship with them, which will help when challenging views and beliefs.
<b>Other family members may be resistant to considering breastfeeding based on their own history.</b>	Moderate/ High	Family Nurses can be prepared for potential resistance by a team-based learning event and employ those skills in practice to minimise risk of harm.

POSSIBLE ADVERSE EFFECTS	LIKELIHOOD	MITIGATING ACTIONS
<b>New SMART CHOICES on breastfeeding</b>		
<p><b>Clients may feel patronised at the level/tone of the SMART CHOICES and may disengage from the discussion or dismiss the information as not relevant to them. (Some clients have said that the cartoons in SMART CHOICES are too immature for them.)</b></p>	<p>Low/ Moderate</p>	<p>Care will be required when designing new materials to aim at the right level for all clients. It is easier to explain in more detail to those clients who do not grasp information initially than to re-engage those who find the level too low and therefore patronising; materials will be designed with this in mind.</p>
<b>Additional materials for partners</b>		
<p><b>Partner may fear exclusion from their baby's care if clients decide to breastfeed and so may be resistant to the idea (and therefore potentially to the client's involvement in the programme per se). Clients also identified that partners were wary of clients breastfeeding outside the home and exposing themselves and so against the idea of breastfeeding (one client stopped breastfeeding outside the home because of this). There could be conflict between partners if they differ over what to do.</b></p>	<p>Moderate</p>	<p>Designing materials which list all the positive ways the partner can still be involved and introducing these early in pregnancy will help, perhaps using some interactive modelling with the dolls to reinforce the message. Working closely with partners to understand their fears and working with both clients together will help to identify areas for potential conflict which can quickly be addressed to minimise the risk of actual conflict escalating. Use of specially designed facilitators and materials will demonstrate how breastfeeding can be done without exposing any body parts, again using interactive modelling with dolls.</p>

POSSIBLE ADVERSE EFFECTS	LIKELIHOOD	MITIGATING ACTIONS
<b>Peer support</b>		
<p><b>Clients not selected to provide peer support for breastfeeding (i.e. because did not breastfeed themselves) may feel stigmatised and have their confidence knocked. Clients are often in touch with others via social media (if not face to face) and therefore are likely to be aware of their exclusion. (NB. Clients identified that a generic peer supporter rather than an exclusively breastfeeding supporter may be better received.)</b></p>	<p>Moderate/ High</p>	<p>Ensuring clients who wish to be peer supporters are offered the opportunity to be involved in some other area of peer support could be a more inclusive approach, with a general peer support network which hones in on particular skills/experiences of clients and links them with clients requiring support in that area. Clients identified that peer breastfeeding supporters would need to have at least tried to breastfeed (it did not matter how long for). (NB. Peer supporters will likely be ex-clients, and preferable if they successfully overcame challenges.)</p>
<p><b>Peer supporters may lack skills or experience to do meaningful work with clients to achieve some positive outcomes in terms of breastfeeding initiation/duration and may be unable to identify appropriate boundaries in their approach with clients.</b></p>	<p>Moderate/ High</p>	<p>Training in appropriately bounded work and approach will be essential, including work around confidentiality, safeguarding etc.</p>
<p><b>Another barrier to peer support is recruiting and retaining enough volunteers for the programme to run.</b></p>	<p>Moderate/ High</p>	<p>This requires good training, management and even incentives for participation. In addition, will FNP pay client expenses (e.g. for text messaging, phone calls).</p>

BLACKPOOL

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# CONTEXT MAP



	Factor and likely influence	Actions to address
<b>POLITICAL</b>	The local context with the local authority (LA) as commissioners is to increase breastfeeding rates in Blackpool as one of their priorities, so this is a positive driver in this work	Communication with and inclusion of LA commissioners and A Better Start colleagues to keep them updated about progress and outcomes
<b>ORGANISATIONAL</b>	Support will be required from the FNP National Unit (NU) to help produce facilitators and materials	Work closely with the NU and local co-production team ensuring clear communication and a collaborative approach
	Enhancing nurses' current skills to support behaviour change and the successful implementation of the new materials will be necessary	Work with the NU to identify what training is needed and how it will be delivered
	Enhancing the skills of peer supporters to work safely and within appropriate boundaries using evidence-based information will be required	Work with the NU and partners to develop an appropriate training package for peer supporters
	There is a level of reliance on the co-production team to be engaged in the work required locally – this may at times be dependent on their capacity and ability to attend meetings	FNP Supervisor to use communication skills to support engagement with other professionals and be flexible in the methods of communication used

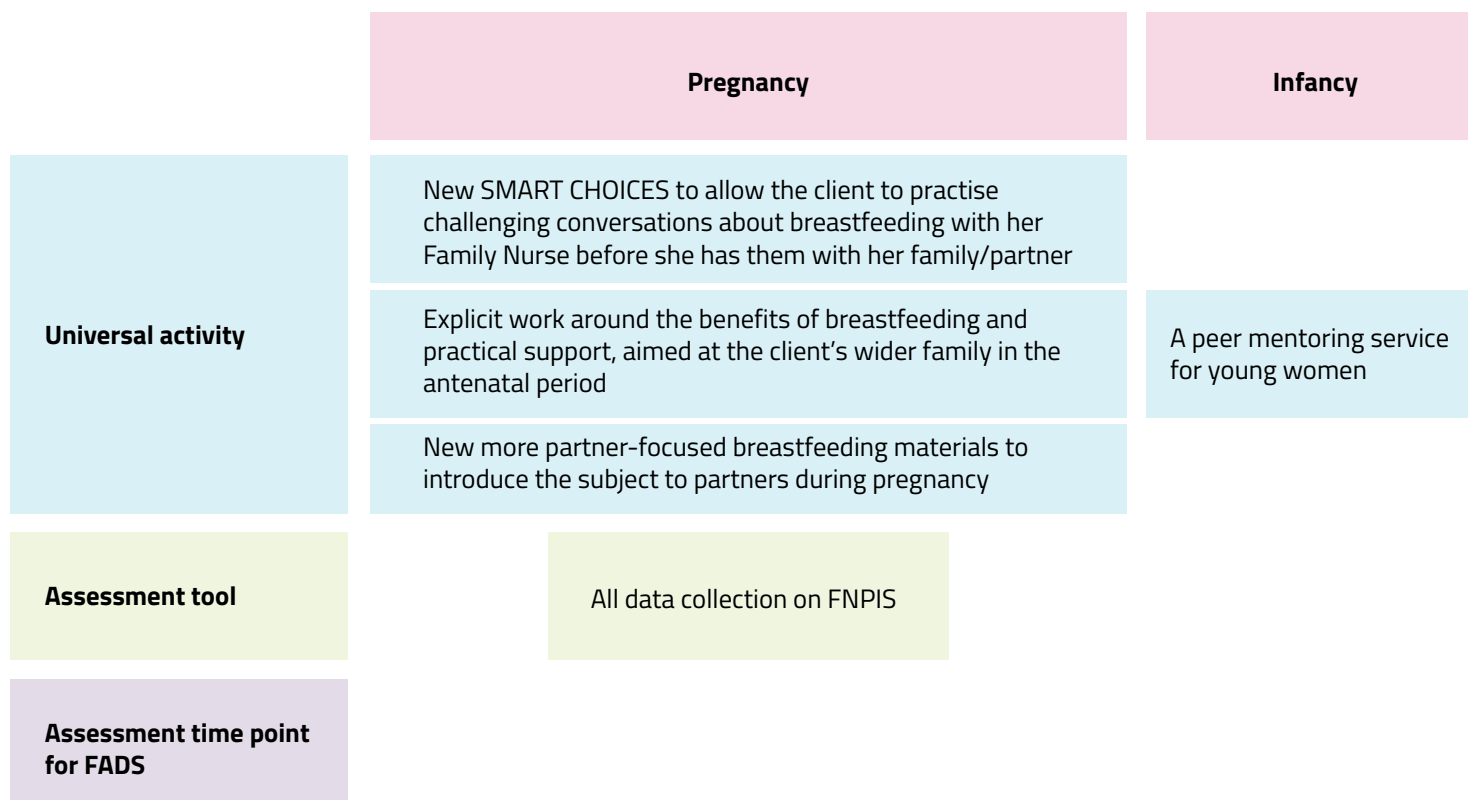
	Factor and likely influence	Actions to address
<b>CULTURAL</b>	Families in Blackpool are not always accepting of health messages, in particular if it is different from their own health practices when parenting	Ensure Family Nurses are able to challenge in a non-threatening way attitudes and beliefs that are often hard-wired, through additional enhanced communication skills training. Ensure that materials are developed in a sensitive and non-threatening manner, acknowledging that we know more now than we did then ensuring clients and co-production team are consulted in the design process
	There is a deep-seated Blackpool culture of bottle-feeding being viewed as the norm and as good as if not better than breastfeeding	Ensure materials are designed to respectfully challenge this view and offer an alternative and credible viewpoint which can be adopted by clients, family and partners
	Clients may have already made up their mind to bottle feed based on their family experience, so it may be difficult to change their mind about how they choose to feed their baby	Enhanced communication skills training and access to expert opinion around complex behaviour change would be beneficial for nurses to have access to
<b>ECONOMIC</b>	Cuts to services may mean there are constraints on the quality of training offered	Dissemination of learning to deliver locally or via Moodle/for the team. Check other funding sources or opportunities for client development and training to be peer supporters.

BLACKPOOL

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# CLINICAL FLOW CHART

The clinical flow chart is a visual representation of what materials are used and which assessments are triggered on the FNP ADPT data system during each programme phase (Pregnancy and Infancy). In Blackpool all data is collected by the pre-existing data system for FNP, the FNP Information system.







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# ADAPTATION DESCRIPTION



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**Name of adaptation**

Attachment and bonding between first time mothers and their child.

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**Target group**

Offered to: All first-time mothers aged 19 and under in Better Start Bradford (BSB) and District. All first-time mothers aged up to 24 in BSB area.

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**Rationale**

The adaptation focuses on improving parents' ability to mentalise their child and therefore enhance the bonding and attachment between first-time mothers and their child. As a result, this will improve the child's social and emotional development. The methods to do this include a form of video-based guidance (VIPP), new pregnancy facilitators and DANCE cards.

New pregnancy facilitators will focus on encouraging the mother to mentalise her unborn child, helping her to see that her unborn child has thoughts and feelings of their own and is influenced by the mother's environment. This is to support the mothers understanding that what happens to her can impact on her unborn baby. For example her stress could increase cortisol which could affect her unborn baby. For example, stresses she faces may induce cortisol production in her that could negatively affect the developing foetal brain. The increased use of DANCE cards when the baby is born will support conversations with clients about the importance of sensitive and responsive parenting and its impact on their child. They can help the mother see what she is doing well and help her to identify areas she would wish to develop. The DANCE assessment tool is routinely used to assess the quality of the mother child interaction and identify areas for enhancement and/or development. The DANCE STEPS manual will be consulted to help identify which materials in the FNP programme address any deficits in development identified. In this adaptation, the DANCE STEPS will be supplemented with a series of sessions of Video-feedback Intervention to Promote Positive Parenting (VIPP) in mothers who are identified (using the Ainsworth Sensitivity and Availability scales) as needing more support to develop a sensitive and responsive parenting approach. VIPP is a supportive way to help parents 'mentalise' their child i.e. become more sensitive, attuned and responsive to the way their child communicates both verbally and non-verbally. It does this by showing the mother videos of her actual interactions with the child, focusing on positive interactions in order to reinforce the sensitive parenting that is taking place. This also helps link the mother's own thoughts and feelings to those of the child, helping her to understand the child and to ensure that the child's emotional needs are met. This leads to improved communication and increased attuned interactions between the caregiver and their child, and more quality parent-child time. These attuned interactions promote secure attachment and reduce insecure and disorganised attachment, which in the longer term contributes to the child having fewer social and emotional problems. We anticipate that this will enable the children to be more ready to learn when they attend nursery at 2 years, and therefore better able to benefit from this provision.

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## What it comprises

### *New pregnancy facilitators*

These are designed to be used monthly from 12 weeks pregnancy. They focus on basic foetal development, enabling discussions to take place about the foetal brain and development of the senses. They ask questions from the developing baby's perspective, such as 'What am I hearing now I can hear?' This may stimulate discussions about issues such as domestic violence / arguments and the impact they have on the developing foetus.

### *DANCE cards*

These are designed to be used with the caregiver at any point in infancy. They can help reinforce what the client is doing well and why it is important for her child's development. They would also, through discussion, help the mother to identify which areas she felt she may need to work on.

### *DANCE assessment tool*

This tool can be used with all clients to assess the mother / child interaction. It is first utilised when the infant is 2 months, 5 months, 9 months, 16 months and 22 months of age. If areas for growth or enhancement are found, interventions from the FNP materials can be identified using the DANCE STEPS manual.

### *Video-feedback Intervention to Promote Positive Parenting (VIPP)*

VIPP will be implemented with mothers who are found to be 'highly insensitive' or 'insensitive' through assessment with the Ainsworth sensitivity score. This assessment will be performed for all clients at 6, 18 and 24 months. Mothers who are found to be somewhat sensitive, sensitive or highly sensitive will continue to be offered DANCE cards and FNP materials that stress the importance of continued sensitivity. All clients will continue to be monitored at the standard time points, using the Ainsworth scale and the DANCE assessment, regardless of any findings. VIPP is a video-based intervention to promote sensitive parenting. Viewing filmed footage of the parent and child interacting allows the parent to see for themselves their interactions with their child. This is coupled with support from the VIPP practitioner who highlights the child's experience and perspective of the interaction, thus supporting increased mentalisation and sensitive and responsive parenting.

As the relationship develops between the VIPP practitioner (one of the specially trained Family Nurses or the team supervisor) and client over the course of 7 visits, less sensitive aspects of the parent's interactions with their child can be identified and developed. At each visit the VIPP practitioner will film the interactions and then feed back on the filming from the previous visit. When the VIPP practitioner feeds back the videos she speaks with the voice of the child, saying what the child might be thinking and feeling to the mother, to illustrate to the mother that the child has their own thoughts and feelings. It also helps the mother see the positive effects on their child when they feel they are being understood. The mother may identify areas in which she feels she does not interact well with her child and these can be gently acknowledged. Overview of the home visits (duration 45-

60 minutes): In the first home visit the VIPP practitioner and client become acquainted; the nurse gives an overview of the home visits, explains the format and ensures she is aware that initially it is just the client with her child. The initial video recordings include child playing alone (3 mins), mum and child playing together (5 mins) and 'don't touch' (4 mins). The VIPP practitioner takes an assortment of toys suitable for each of the activities. During home visits two and three the VIPP practitioner continues to speak through the child and builds a relationship with the client. This includes showing the client instances in the video play back when they are doing well. Clients will also be invited to speak for the child through the nurse asking questions in a supportive manner. Visit 2 recordings are the child playing alone with toys (2-3 mins), playing together with toys (4 mins), clearing up toys (2-3 mins) and reading a book together (5-6 mins). The video recording in visit 3 is 20-30 minutes of a meal time from preparation to when everything is cleared up. During home visit four and five the practitioner makes a profile of the parent-child interaction – listing what the parent is already doing well against a list within the VIPP manual, whilst actively seeing opportunities for change. They will also check for sensitivity chains (child signals, the parent responds and the child reacts) that form the basis of positive feedback for the parent and areas for growth. Feedback is structured by starting with positive messages, with corrective messages left until a quarter of the video has been shown. Corrective messages start with 'I notice that...' and end with 'here you could have done'. Highlighting a similar instance of positive management is beneficial when a parent does not manage a situation well (i.e. saying 'here you did it really well'). Compliments can be given at any time and the video should end with a positive message. In visit four the recordings are: the child plays alone and the parent reacts only when the child invites her to (4 mins); the child and parent sit opposite each other and play a singing game (2-3 mins); and the parent and child perform a task together (e.g. building a tower) and the parent can teach the child in her own way (5 mins). The recordings made in visit 5 are parent and child play together (5 mins), clearing up toys (2-3 mins) and reading a book together (5 mins). Home visits six and seven are booster visits to ensure that messages are being utilised by the client in their interactions with the child. Partners can be introduced at this time. It is important that throughout the visits the VIPP practitioner shows empathy towards the mother i.e. when the child's behaviour is difficult. They also show empathy towards the child, such as acknowledging it is hard for a child to wait for something. The Family Nurse will also talk about child development in relation to what the child is doing to develop the parent's understanding and insight.

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### Materials needed for delivery

1. New pregnancy facilitators for each client.
2. DANCE cards: a set for each Family Nurse.
3. DANCE assessment tool: available for all Family Nurses and nurses trained by the FNP National Unit.
4. Video cameras to film the parent and child interacting, and the facility to download video recordings onto a computer. Information technology to enable the video to be played to the VIPP supervisor during supervision. Equipment to enable client videos to be put onto a DVD for the client to keep. Laptop to play footage to the client if they did not have a television. Appropriate parent consent form for being filmed.
5. Toys suitable for the age of the child.
6. Appropriate tools to assess change in maternal sensitivity pre/post intervention.

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## Procedures for delivery

### *New pregnancy facilitators*

These have been developed by the Bradford FNP team. They introduce the concept that babies have thoughts and feelings of their own and respond to the world around them, even in utero. The discussions that take place while using the facilitators will assist the Family Nurse to assess the prenatal attachment that is taking place between the mother and baby in pregnancy. These new facilitators will be used monthly from recruitment or 12 weeks in pregnancy (whichever is sooner) until the baby is born to help the mothers mentalise their child. The facilitators will be left with the mother after completion. Areas of concern which arise from the facilitators will be discussed in supervision.

### *DANCE cards*

These will be used in infancy visits to trigger and facilitate discussions about sensitive and responsive parenting.

### *VIPP*

Mothers will be identified as suitable to be offered the VIPP intervention at 6 months following assessments and with the Ainsworth parental sensitivity scale, as previously described ('highly insensitive' or 'insensitive' eligible for VIPP). This will be discussed with the parent and full written informed consent will be obtained and scanned onto the electronic record. If consent is not given, the reasons why will be documented. The Family Nurse will arrange with the client a date/time for the VIPP session to take place. VIPP will be delivered by one of three trained practitioners from the FNP Bradford team: either the team supervisor or one of two Family Nurses. The clients do not need to have these practitioners as their Family Nurse, as VIPP has been proven to be effective outside a long-term therapeutic relationship. The practitioners will continue to hold their own caseload of clients (probably slightly reduced) and will deliver VIPP in a peripatetic way. The VIPP practitioner will use the video camera to video interaction between the mother and child of about 10-30 minutes depending on the stage of the VIPP filming and visit. As described, the video clip will be taken away and a script prepared by the VIPP practitioner which will facilitate the feedback for the mother. This will focus on what the child is feeling and thinking and how this impacts on their behaviour. This script will be reviewed during clinical supervision. During the following visit the VIPP practitioner will show the mother the video, using the prepared script to speak for the child (i.e. to suggest what they may have been thinking during the video). VIPP is designed to help the mother to recognise when she is parenting well or less well, and encourage her to notice and comment on what she could have done differently. The Family Nurse will use communication skills to allow the mother to try to verbalise things for herself. The video will then be deleted or sent to the mother according to the decision taken at the time of consent.

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## Provider(s)

The Family Nurse Supervisor and two Family Nurses from the FNP Bradford team have been trained in VIPP and will provide this aspect of the programme. Other programme components will be delivered by the client's own Family Nurse.

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### Mode of delivery

On a one-to-one basis with the client and child. Facilitators and DANCE cards may be delivered with the client and their partner if present.

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### Where it takes place

During home visits, but with the option for the video to be filmed at other suitable venues, such as children's centres or other agreed venues.

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### When/how much

New facilitators will be used from 12 weeks in pregnancy and monthly thereafter until the baby is born. This could be a maximum of 7 times. DANCE cards will be used at any point to reinforce sensitive and responsive parenting and also help identify if there are any issues where video-based guidance may be useful following discussion in supervision. The DANCE assessment will be completed at 2, 9, 16 and 22 months as a minimum (unless a client graduates when their child is 1 year, in which case there will be 2 DANCE assessments). VIPP will be delivered in 6-7 sessions over a 4-month period. Each visit will last about one hour.

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### How delivery can be tailored

#### *Core content*

All clients receive new facilitators and DANCE assessment and DANCE cards.

#### *Flexible*

Not all clients will receive VIPP after their child is 6 months old. As described, this will be only appropriate in cases where mothers are found to be 'insensitive' (according to the Ainsworth scale) at 6 months of age. The venue will also be adaptable depending on the client and her child. Practice will be supported by age-appropriate toys.

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### How fidelity is monitored

In the FNP ADAPT Data system (FADS), fidelity will be monitored through recording the frequency of usage of the new pregnancy facilitators, DANCE Cards and DANCE assessments. DANCE assessments will also be recorded using the usual FNP information system. The FADS will also record the Ainsworth sensitivity scores (at 6, 12, 18 and 24 months) and, after the 6 month score is recorded, if the clients did or did not consent to video-based guidance taking place (and the reasons why if not). The FADS will also record when VIPP interactions have taken place. Qualitative data collection to record fidelity will include a focus group with the Bradford FNP team after the first quarter to look at how well it is embedded (including why it may not be taking place and issues with applying it). All of these data will be reported to the FNP Bradford ADAPT co-production team and used to inform decision making when the innovation cycle is completed and before making any further adaptations.

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# LOGIC MODEL

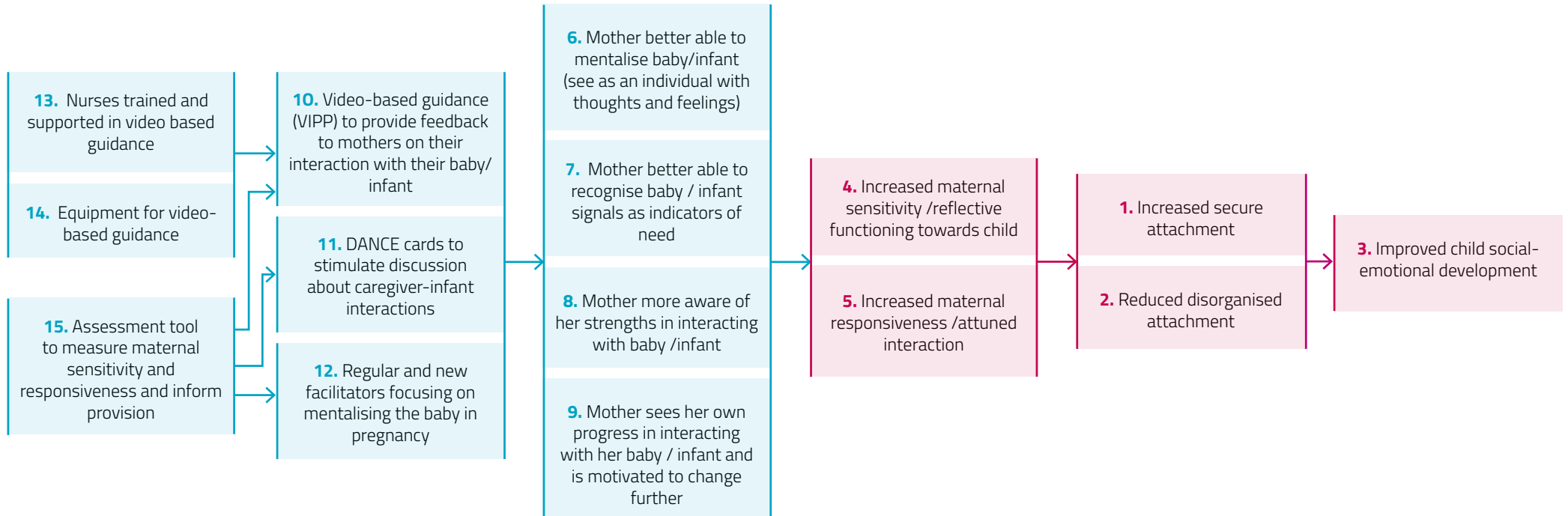
SUPPORTS

ADAPTATION ELEMENTS

MECHANISMS

INTERMEDIATE OUTCOMES

ULTIMATE OUTCOMES



A narrative of each element of the logic model is provided below - numbers relate to the relevant boxes in the diagram.

### Ultimate outcomes

The adaptation is seeking to achieve three ultimate outcomes:

- 1.** To increase secure attachment, which is where the main caregiver (usually the mother) provides sensitive and appropriate emotional communications in response to their child, giving the child a sense of being understood, having worth and being deserving of love and comfort, in turn giving them a safe base from which to explore the world.
- 2.** To reduce insecure and disorganised attachment, which is where the child receives unpredictable interactions from their caregiver, meaning that their need for understanding, security and love is not being met. This can impact negatively on the child's social-emotional development, with long-lasting effects (e.g. difficulties forming attuned interactions in relationships in later life). Attachment will be measured by the Maternal Antenatal Attachment Scale at 36 weeks gestation and the Maternal Postnatal Attachment Scale at 6 weeks, 4 months and then again at 12, 18 and 24 months to monitor any development.
- 3.** To improve children's social-emotional development, which includes the child's experience, expression and management of emotions and the ability to establish positive and rewarding relationships with others.

### Intermediate outcomes

The route to achieving these ultimate outcomes in this adaptation is through two intermediate outcomes:

- 4.** One is by increasing the mother's sensitivity to the child. Sensitivity is defined as a mother's ability to perceive and infer the meaning behind her infant's behavioural signals, and to respond to them promptly and appropriately. Promoting this will contribute to the ultimate outcomes because a caregiver responding sensitively to a child shows empathy and respect for their child's feelings, helping them learn to feel safe and secure. This promotes secure attachment and reduces insecure and disorganised attachment. Maternal sensitivity will be measured by the Ainsworth Sensitivity scale at six, 12, 18 and 24 months.
- 5.** The other intermediate outcome involves increasing the mother's responsiveness, which refers to the use of warm and accepting behaviours to respond to children's needs and signals. This will contribute to the ultimate outcomes because responsiveness encourages a child to continue to communicate their needs and to engage in learning interactions. Such children are more likely to have better problem-solving, language and social skills, as well as improved emotional skills and behaviour.



## Mechanisms

There are several mechanisms through which these intermediate outcomes are achieved:

- 6.** The first is by helping the mother to mentalise, which refers to 'the ability to reflect on the mental state, that is the thoughts and feelings, of others'. This helps to achieve the intermediate outcomes because it will increase the sensitivity of the mother towards her child.
- 7.** The second mechanism is by helping the mother to recognise baby/infant signals as indicators of certain needs, for example when a child is distressed. This contributes to the intermediate outcomes because the mother will be more responsive and able to have more attuned interactions with her baby.
- 8.** The third mechanism is by helping the mother to be more aware of her strengths in interacting with her baby – for example, the way she responds to her child's distress and comforts the child. This helps to promote the intermediate outcomes because the mother can see that she is responsive to her child's needs and understand the reasons why she did that.
- 9.** The fourth mechanism through which intermediate outcomes are achieved involves the mother seeing her own progress in interacting with her baby, especially 'exceptional moments of interactions', and feeling motivated to change further. This contributes to the intermediate outcomes because she has more understanding of why sensitivity and responsiveness are important for her child's long-term development.

## Adaptation elements

These mechanisms are activated by three elements of the adaptation:

- 10.** The first is video-based guidance (VIPP – Video-feedback intervention to promote positive parenting). This involves videoing, with the caregiver's consent, interactions between the caregiver and the child, and then sharing and discussing the video with the caregiver. This activates the mechanisms identified above because it enables the caregiver to look at positive interactions between themselves and their child and then, through discussion with the nurse, to reflect on what the child was thinking in the video when the caregiver interacted with them in the way they did. It also asks the caregiver to say what they were thinking, thereby linking mother and child thoughts. This reinforces and promotes sensitive parenting.

**11.** The second element involves the DANCE cards and DANCE assessment. Using the DANCE cards entails showing the caregiver a card with a quote on it, such as 'If my baby gets upset I try to make it better', which then stimulates a discussion about what the client feels they do well and where they feel they need to develop. This helps to activate the mechanisms identified above because it leads to discussions about the importance of sensitive and responsive parenting. These discussions may be supplemented with the use of an app, such as Getting to Know Your Baby, that teaches parents to learn their baby's cues and respond appropriately. The DANCE assessment is a naturalistic assessment so, although the mother knows there will be times when the family nurse is observing her, she will not know when the assessment takes place. Once an assessment is completed using the sheet provided, the positive interactions are fed back to the mother. Any areas for enhancement or development are supported using FNP programme materials.

**12.** The third element comprises the regular FNP facilitators and new facilitators developed for pregnancy which focus on encouraging the mother to mentalise her child in pregnancy. These contribute to the mechanisms by helping the mother to see her unborn child as having thoughts and feelings of their own, which can be built on when the baby is born.

### Supports

Implementation of the adaptation depends on the following supports being in place:

**13.** The nurses need to be trained in VIPP and receive ongoing support to ensure that the training is embedded in practice. In addition, they require skills in filming videos with clients and their children and preparing a script to feed back to the client.

**14.** Equipment is needed for video-based guidance and IT support.

**15.** Assessment tools are needed to measure maternal sensitivity and responsiveness. Nurses will require relevant training for these.

**16.** Training for Family Nurses in using the new facilitators in pregnancy and support to help embed them in practice.

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# DARK LOGIC

POSSIBLE ADVERSE EFFECTS	LIKELIHOOD	MITIGATING ACTIONS
<p>Negative impact on other areas of FNP which may need to be scaled back (e.g. smoking, breastfeeding) to allow for time to (a) develop the client's ability to mentalise the baby in pregnancy and (b) apply video-based guidance (VIPP) when child is 6 months old if appropriate. This may mean other needs of the client are not sufficiently addressed.</p>	Medium	<p>Utilise an assessment tool such as the New Mum Star to personalise the programme to best meet client's needs. In order to address client needs that cannot be addressed by FNP, signposting to other existing services that are currently commissioned, needs to take place. Monitor quarterly FNP Advisory Board (governance) data. This will enable the board to see if the adaptation has adversely affected areas such as breastfeeding or smoking, using the previous 5 years of data as a comparison.</p>
<p>Information Technology not being able to support the need for the Family Nurse, undertaking VIPP training, to access supervision with trainers via a platform that provides video conference and voice call services while showing VIPP footage.</p>	Medium	<p>Family Nurses to explore possibilities to resolve this IT problem with the available resources and within own organisation.</p>
<p>There will be only 2 Family Nurses and 1 supervisor trained in VIPP. There may be a lack of capacity to deliver VIPP to all the clients who are assessed as requiring the VIPP intervention.</p>	Medium	<p>The Ainsworth sensitivity scale will highlight those clients requiring VIPP, hence limiting the resource needed.</p>

POSSIBLE ADVERSE EFFECTS	LIKELIHOOD	MITIGATING ACTIONS
<p><b>Negative impact on client’s feelings associated with issues such as their past negative personal experiences of being videoed, body consciousness and discomfort at looking at oneself. This may trigger feelings of disempowerment and low self-esteem, and the client may be pre-occupied with looking at themselves and not their child in the video.</b></p>	Low	<p>Work with client to address issues using relevant methods and training and signpost client to services such as counselling or other mental health services if further support is required.</p> <p>Ensure staff are trained in cultural competence and trained interpreters are available.</p> <p>Engage with clients and gain client feedback on the use of VIPP. Train staff in sensitive ways to introduce VIPP to clients. This will be that by promoting it shows the positive interactions between the client and their child. This may include a demonstration video. The video may be one that is part of the training, but as more clients take part in VIPP and are positive, the video may be one produced locally.</p>
<p><b>If VIPP is only offered to the client, there may be a negative impact on the partner of the client (e.g. they may feel left out and think that their input with the child is not valued in the same way).</b></p>	Medium	<p>Following discussion with the client and their partner, offer the partner VIPP at session 6, so that their positive interactions with their child are identified and acknowledged to build up their ability to mentalise their child.</p>
<p><b>The introduction of VIPP may cause some stresses on staff as they feel it is additional training and workload as well as dealing with complex clients.</b></p>	Low	<p>Limit delivery of VIPP to three nurses, and to clients who have demonstrated poor maternal sensitivity. Keep staff informed of developments and training. Identify resources as necessary to support development. Have regular team and individual supervision and ongoing embedding of training to support staff.</p>

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# CONTEXT MAP

## Factor and likely influence

## Actions to address

**POLITICAL**

There has been a recent review of children's community services in Bradford and budgeting priorities. There is identified funding via local authority and Better Start Bradford for FNP until March 2018. The adaptation needs to be in place and have evidence of effect to help support the case for FNP after March 2018

A fit-for-purpose service based on targeting the most appropriate clients and deprived wards. Ensure the best use of resources provided by Local Authority and Better Start Bradford

**ORGANISATIONAL**

Family Nurses will require training in implementing the video-based guidance (VIPP). This needs to be high quality and adequate for implementation of VIPP. It needs to be completed in a timely manner. Training on how to use mobile phone to video and edit the videos

Training has been provided

Family Nurses will require ongoing support while embedding VIPP into practice. Also ongoing supervision will be required to ensure staff are supported with this development

Ongoing training package to embed VIPP into team practice

**CULTURAL**

A trusting relationship is important both for introducing and explaining VIPP and for conducting VIPP with clients. Initial feedback on VIPP with clients has highlighted reticence to being videoed

It will be important for nurses to establish trust with clients before introducing the idea of VIPP and to plan the wording for introducing it. Conducting VIPP and providing feedback will also require a trusting relationship

We estimate that 16% of pregnant women aged 19 or under in the geographical area concerned require an interpreter. The language barriers make VIPP difficult to implement, or affect whether clients benefit from the feedback. Alternatively, VIPP may help to overcome language barriers

Understanding of demographic of the population being served. Appropriate interpreters who have basic knowledge of VIPP. Record any issues delivering VIPP when language barriers exist. Explore what other services delivering VIPP have done to overcome any language issues they may have faced. Appoint bi-lingual Family Nurses where possible with relevant language skills to avoid delivering VIPP through an interpreter where possible (in accordance with VIPP guidance)

	Factor and likely influence	Actions to address
<b>ECONOMIC</b>	The Family Nurse will need access to a device that they can use for video recording (e.g. video camera). The Family Nurse may need IT equipment to enable SKYPE with supervisors	Agree these with provider after recommendation from VIPP trainers.
<b>OTHER</b>	Time and flexibility of FNP programme: Family Nurse will require time with clients in order to implement VIPP. They will also need guidance on which aspects of the FNP programme they could drop/scale back in order to spend time on VIPP	Require agreement with FNP National Unit in terms of the core FNP programme to be delivered. This would also be achieved using a robust assessment tool (such as the New Mum Star) with the families and supervision to guide the flexibility of the programme

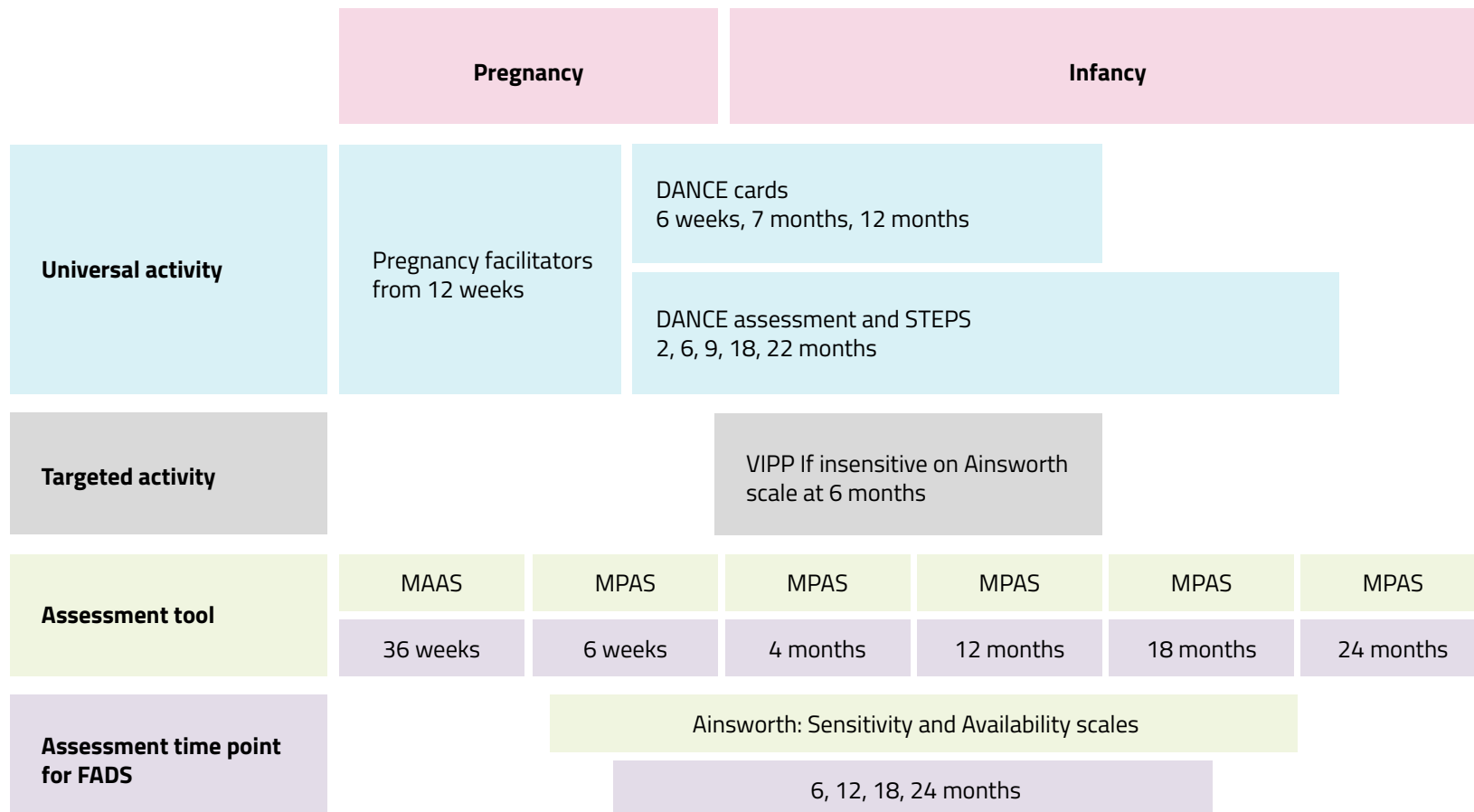


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# CLINICAL FLOW CHART

The clinical flow chart is a visual representation of what materials are used and which assessments are triggered on the FNP ADPT data system during each programme phase (Pregnancy and Infancy). In Bradford, the universal and targeted materials offered to clients depend on the Ainsworth assessment of sensitivity and availability, performed at 6 months and then repeated at 6 months intervals until the end of the programme. Attachment is also regularly measured in the antenatal period using the Maternal Antenatal Assessment Scale (MAAS), and in the postnatal phase using the Maternal Postnatal Assessment Scale (MPAS).







3.

# **CHESHIRE EAST**

CESHIRE EAST

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# ADAPTATION DESCRIPTION

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**Name of adaptation**

Smoking Cessation in Pregnancy and Post Natal Period

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**Target group**

Young parents and associated family and friends with whom they spend time on a regular basis and who influence their lifestyle choices and smoke

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**Rationale**

See logic model diagram and narrative.

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**What it comprises**

- Clear information (including visual aids) about the effects of smoking on the foetus, baby and child up to two years in various formats so that suitable resource can be chosen for each quitter.
- Mindfulness techniques will be used alongside the existing PIPE topic of 'emotional refuelling' to help reduce parental stress. (Parents tell us that their motivation for quitting decreases and their likelihood of relapsing increases when they feel anxious or stressed.)
- Quitters will be signposted to apps such as Smoke Free Baby, NHS Smoke Free
- Nicotine Replacement Therapy (NRT) for all target group who wish to quit and E-Cigarette starter packs for associated family and friends (i.e. non-pregnant quitters)
- Peer support via FNP Facebook Pages. Parental blog in progress and parent co-production members are proposing to manage the peer support on Facebook
- Regular CO monitoring
- Parent co-production members have suggested recognition of achievement of quitting in stages such as first week, first month, 4 months etc. Facebook recognition could be used to support motivation. Monetary rewards in the form of High street vouchers were discussed by the co-production team<sup>1</sup> but the decision is to use certificates of recognition.
- Motivational support for behaviour change to quit smoking – advanced communication skills based on motivational interviewing – will underpin all of the above, alongside Level 2 NCSCT (National Centre for Smoking Cessation and Training) training for all Family Nurses.

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### Materials needed for delivery

- New facilitators aimed at quitting rather than reducing smoking, with clear pictures and information about the effect of smoking on the foetus (e.g. Baby Clear)
- Apps (information, motivational, mindfulness)
- YouTube videos e.g. Tommys on effect of nicotine on the foetus
- Informational quizzes about smoking
- CO monitors
- NRT samples and vouchers. Regular smokers in pregnancy should be given combination therapy (i.e. >1 form of NRT e.g. patch + gum, or patch + nasal spray).
- E-cigarette starter kits to be used for non-pregnant quitters (i.e. mother's family/partner/friends)
- Individualised rewards, including certificates of recognition
- Emotional refuelling currently used in FNP and visuals of relaxing activities book
- Facebook peer support group where materials/ideas/supportive feedback can be shared
- Tar bottles from ASH (Action on Smoking and Health)

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### Procedures for delivery

- Parents are assessed for smoking status at visit P1
  - CO readings taken routinely
  - Information about the risks of smoking and benefits of quitting delivered using new facilitators and visual aids (e.g. flash cards, Tommys video, tar bottles from ASH).
  - Enquiry about close family and friends who smoke, and other persons of influence in client's life who smoke, and invite them to quit too
  - Influential others (i.e. partners, family and friends who spend significant amount of time with the FNP client) could be included in the smoking cessation part of the visit if available and utilise the same equipment and e-cigarette starter packs. For pregnant FNP clients, the e-cigarettes should be secondary to NRT (i.e. used if that fails) but if clients are using them as an alternative to cigarettes it shouldn't be discouraged as it is better than smoking cigarettes. Some women will be smoking cigarettes and using e-cigarettes, in which case they should be strongly encouraged to use e-cigarettes to replace cigarettes.
  - Commence on quit programme, supporting with NRT, e-cigarettes (for non-pregnant quitters), stress reduction / distraction strategies.
  - Peer support via Facebook: mothers are able to share what works for them, how they have overcome triggers for relapse and celebrate milestones of quitting. Parent members of the co-production team would like to manage the Facebook page by encouraging posts from clients attempting to quit, celebrating their success in time stages and sharing successful strategies for staying stopped. The co-production team have expressed a keenness to allow parents self-governance and not be moderated by FNP.
  - Home visit programme provides an opportunity to encourage clients to quit and maintain motivation to stay smoke free, by using the CO monitor.
  - Measure success and record on Systmone using a smoking cessation template which has been added.
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**Provider(s)**

- Family Nurses
  - Peer support
  - Technology (Apps – NHS Smoke Free, Mindfulness etc.)
- 

**Mode of delivery**

- One-to-one during FNP home visit
  - May also in some cases end up being a small group if partner, peers and/or family are involved.
  - Facebook peer support
- 

**Where it takes place**

- Home or place requested by young parent
  - Facebook
- 

**When/how much**

- Visits P1 and P3 and then at each contact as the antenatal check list requests
  - Visits I1 and I3 to link in with prevention of SIDS and safer sleeping practices
  - Ongoing through the programme should client continue to smoke
- 

**How delivery can be tailored**

Family Nurses will be able to use their communication and agenda-matching skills to ensure that the ADAPT project is matched at an individual level. This will include individualising reward moments and using certificates or public celebration on Facebook.

The FNP programme will be adapted so that the engaged parents can share their smoking history at P1 (including the smoking habits of their family and close friends).

The 'core' service offer will be the effect of smoking on the foetus using new facilitators and the offer to quit. Subsequent service delivery to smokers choosing not to quit will involve careful agenda-matching by the Family Nurse and offers of support to quit with interventions as the FNP programme currently suggests.

Enhanced service offer will be to motivated quitters:

- A toolkit of information, advice and guidance in different formats will be collated so that the Family Nurses can choose the best format for the quitter based on their knowledge of the clients and clinical judgement. The toolkit will consist of new facilitators, NRT, e-cigarette starter packs (for non-pregnant quitters), apps, visual aids, informational quiz.
- Mothers will be able to identify the friends and family they think can support them to be offered quit support.
- A range of stress reduction techniques and tools will be collated so that the tool can be matched to the quitter. The time spent on smoking in future visits will depend on the success and motivation of the quitter (if they quit then less time, and if they don't but are motivated then more time will be spent supporting change behaviour). Quitters will have time spent on maintaining their behavioural change and smokers who become motivated will require more time to support their quit process.

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#### **How fidelity is monitored**

Systemone template for delivery and measurement of change, also FADS system (FNP ADAPT Data System).

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# LOGIC MODEL

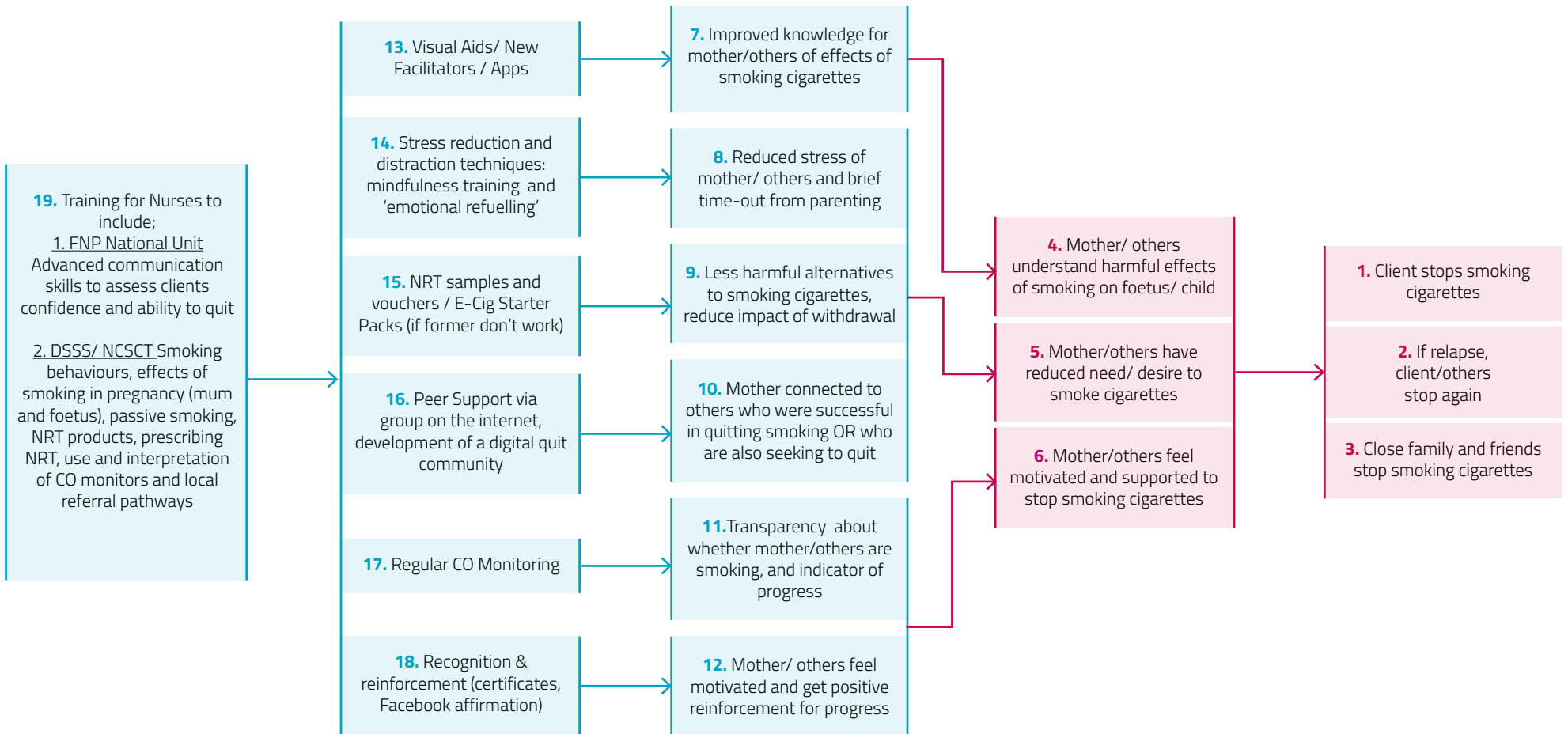
SUPPORTS

ADAPTATION ELEMENTS

MECHANISMS

INTERMEDIATE OUTCOMES

ULTIMATE OUTCOMES



A narrative of each element of the logic model is provided below - numbers relate to the relevant boxes in the diagram.

### Ultimate outcomes

There are three related ultimate outcomes:

1. The primary ultimate outcome is for the client (mother) to stop smoking cigarettes.
2. A secondary ultimate outcome is for close family (including partner) and friends of the client to stop smoking cigarettes. If close family and friends stop smoking, it is more likely that the mother will stop.
3. If the mother or others (family/friends) stop smoking and then start again (i.e. relapse) then a further ultimate outcome is for them to stop smoking again and stay quit.

### Intermediate outcomes

These ultimate outcomes are more likely to be achieved if three intermediate outcomes are achieved:

4. The mother and others (family and friends) understand the harmful effects of smoking on the foetus / child. They are more likely to stop smoking because they do not want to harm the foetus/child.
5. The mother and others (family and friends) feel less need/desire to smoke cigarettes. This makes it easier to stop smoking.
6. The mother and others (family and friends) feel motivated and supported to stop smoking cigarettes. This makes it easier to stop smoking.

There are connections between these intermediate outcomes. Specifically, understanding of the harmful effects of smoking will reduce the need/desire to smoke, as will feeling motivated and supported to stop smoking.

### Mechanisms

There are several mechanisms through which these intermediate outcomes are likely to be achieved:

7. The first is by improving the knowledge of mothers and others (close family and friends) about the harmful effects of smoking at each stage of the offer: pregnancy, infancy and toddlerhood. This will help them to understand the harm to the foetus/child caused by smoking cigarettes.

**8.** The second is by reducing the stress of the mother and others (close family and friends) and giving them a time-out from parenting. Smoking may be a symptom of stress, so if these techniques reduce the stress, stopping smoking will be easier because it will reduce their desire to smoke. Mindfulness also teaches smokers to be mindful about their smoking and ability to choose less harmful relaxation strategies. This awareness can improve quitting success. It also gives mothers a brief time-out from parenting, which is one of the things that mothers in Cheshire East report smoking does for them (i.e. a healthier time-out option replaces smoking).

**9.** The third mechanism for achieving the intermediate outcomes is by providing mothers and others (close family and friends) with less harmful alternatives to smoking cigarettes. This will reduce their need/desire to smoke cigarettes by helping to break the addiction to nicotine, and reduce the impact of withdrawal.

**10.** The fourth is by connecting mothers and others (family and friends) to other people similar to them who have either successfully quit or who are seeking to quit. This will help them to feel motivated and supported to stop smoking cigarettes because they realise it is possible, get tips from others, encourage one another, want to be like one another and feel accountable to one another. It will also help to change the norm (i.e. not smoking is acceptable), which will reduce their need/desire to smoke.

**11.** The fifth is by ensuring that there is transparency about whether the mother and others (close family and friends) are smoking. Highlighting if they have started smoking again provides an opportunity to revisit discussions about the benefits of not smoking.

**12.** The sixth mechanism for achieving the intermediate outcomes is by helping the mother and others (close family and friends) to feel motivated to stop smoking and to receive positive reinforcement for any progress made.

### **Adaptation elements**

These mechanisms are enabled by the following elements of the adaptation:

**13.** New smoking-related facilitators and other resources (notably visual aids) will be identified or developed. This is needed because current smoking-related facilitators are delivered too late in the programme and do not contain sufficient information regarding the adverse effects of smoking on the foetus. The new materials will include apps, YouTube videos, flash cards and information leaflets. They will include information about risk and the health (and financial) benefits for adults and children of stopping smoking. A wide selection of resources will be developed so that the Family Nurse can choose resources that are suitable for their client and family. They will be developed with FNP families to ensure that they are accessible in terms of content and delivery for the target audience. They will be developed in partnership with Dudley [the other FNP ADAPT site focusing their clinical adaptation on smoking cessation]. FNP Nurses will receive training in all the resources. These will be introduced as early in the visits as is considered feasible.

Once information has been shared with the mother, the difficulty of quitting when others around you smoke will be discussed and the Family Nurse will offer to discuss smoking with any family and friends the mother identifies. These new resources will contribute to improving the knowledge of mothers and others (close family and friends) of the harmful effects of smoking cigarettes. The resources will be revisited at regular intervals i.e. pregnancy, infancy and toddlerhood; this will encourage motivation to continue. It will give the quitter an opportunity to discuss if they are struggling. It will also provide an opportunity for a new quit attempt if they chose not to quit earlier or have been unsuccessful.

**14.** Stress reduction and distraction techniques will be offered to mothers, family and friends:

- Family Nurses will receive training in Mindfulness. Nurses will offer to share these techniques with family and friends either during FNP visits or in groups. Mindfulness groups may have the added benefit of encouraging peer relationships.
- Apps or other resources that can support Mindfulness in between visits/groups will be identified and shared.
- Emotional refuelling will be used to support quit attempts (e.g. using lolly sticks with activities that take 5-10 minutes that quitters can give to friends/ family members). If these are branded with FNP logos, mothers can say their Family Nurse has recommended them, which adds validity to the request.

These stress reduction and distraction techniques will contribute to mothers and others (close friends and family) feeling less stressed, and give mothers an excuse to take a non-smoking break or 'time-out' from their parenting responsibilities.

**15.** Family Nurses will offer the mother and others (close friends and family) who want to quit smoking a combination of nicotine replacement therapy (NRT) to support their quit attempt (e.g. NRT patches, gum, inhalers). Administration of NRT will be in line with the most recent research and recommendations. These less harmful alternatives to smoking will reduce the impact of withdrawal. E-cigarettes will be encouraged if NRT does not work. In the event of loss or damage to the e-cigarette, NRT will be available.

**16.** Peer support will be encouraged:

- FNP already has an active Facebook page (closed i.e. for FNP clients only). One of the mothers on the co-production team has started blogging and linking the blog to the Facebook page. She has been given administrator rights to the page. The aim is to develop the Facebook community. It is hoped that other mothers will read, comment on and potentially write their own blogs. In the first instance this will not be about smoking or health. Blogs on quitting smoking can be added when the programme is launched.

- The mother on the co-production team currently smokes. She is willing to try and stop for 'Stoptober'. She will use the Facebook site to recruit other clients who want to quit. This group will be able to identify what support they need and the FNP team will try to provide this where it cannot be provided from the group themselves.
- Facebook pages will be set up for dads and family and friends to try and develop similar peer support.
- A family who were supported to quit by one of the Family Nurses will be encouraged to share their story.
- Over time it is hoped that the team can recruit successful quitters who are willing to buddy those who are starting a quit attempt.
- Family and friends will be offered support, as this will provide peer support for FNP mothers.

This peer support will connect quitters with others who are seeking to quit. This will add to their support network. Support on Facebook will potentially be available outside office hours and alongside a quit app could provide an activity that could be an alternative to smoking. It is easier to quit if other people around you are smoke free.

**17.** Regular CO monitoring will be used to provide an objective measure of quit attempts. As well as ensuring transparency, it can be used as a platform for providing recognition of success and allowing positive reinforcement to be given.

**18.** The FNP team will provide recognition to reinforce quit attempts and affirm success. The mothers on the co-production team have suggested that it would be good to have regular rewards to keep the motivation going. These could be in the form of certificates at key stages and public affirmation and congratulation on Facebook. These rewards will help mothers and others (close family and friends) to feel motivated to quit smoking, partly because they want positive reinforcement and also the incentive to stay stopped.

### Supports

**19.** Family Nurses will receive the following training and support to help them deliver this adaptation:

- FNP National Unit Advanced Communication Skills: which includes motivational interviewing techniques to hear change talk, to consider how to work with resistance as well as assessing clients confidence and ability to quit
- National Centre for Smoking Cessation and Training (NCSCT): smoking behaviours, effects of smoking in pregnancy (mum and foetus), passive smoking, NRT products, prescribing NRT, use and interpretation of CO monitors and local referral pathways



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# DARK LOGIC

POSSIBLE ADVERSE EFFECTS	LIKELIHOOD	MITIGATING ACTIONS
<p>Family Nurses may be seen as the “smoking police” because of additional emphasis on this issue, meaning that clients disengage on this and other issues.</p>	Medium	<p>FNP nurses will maintain a focus on the therapeutic relationship and use their judgement about when it is appropriate to have further conversations about smoking. Smoking cessation will be approached from a positive perspective i.e. quitting is a positive action and smoking is a behaviour which can be changed and does not mean the client is a failure.</p>
<p>Regular CO monitoring may lead clients to disengage due to feelings that Family Nurses are being intrusive or ‘checking up’.</p>	Low	<p>FNP nurses will maintain focus on the therapeutic relationship and use their judgement about when it is appropriate to use CO monitoring. The CO monitoring can also act as a motivator for clients who are trying to quit i.e. it shows their progress, so its use will be framed positively.</p>
<p>Smoking quit attempts may contribute to family/partner tensions and conflict. In some families, lack of knowledge leads to older family members not realising the effect of passive smoking on children. On some occasions, partners smoke cannabis and can have difficulty in giving this up. If a mother wishes to quit and her partner/family does not, this creates tension which may transfer to the baby. If the partner is controlling/coercive, then a focus on the mother quitting smoking could add to his feelings of being in control.</p>	Medium	<p>The focus on stress reduction will reduce family/partner tensions. The client’s partner and family will be included in smoking quit attempts to reduce tension / conflict. Where relevant, the client’s partner / family members will be referred to relevant stop smoking services to help them attempt to quit.</p>

POSSIBLE ADVERSE EFFECTS	LIKELIHOOD	MITIGATING ACTIONS
<p>The focus on smoking cessation may impact on how other professionals perceive FNP. Family Nurses may be seen as smoking cessation experts rather than experts in delivering the FNP programme for optimising parenting. Referrals into the service may reflect this. Clients may be averse to meeting the “stop smoking nurse”, negatively impacting on recruitment.</p>	Low	<p>Opportunities to communicate and explain the programme changes to other professionals will be identified. Efforts will be made to continue to communicate to new/would-be clients the positive focus of FNP on helping the mother (and her family) to give the baby the best start in life, and that this involves support across a wide range of areas.</p>
<p>The focus on smoking cessation may require a reduced focus on other parts of the FNP programme.</p>	High	<p>This needs to be reviewed regularly. There may be parts of the programme that can be reduced without negative impact. This can be done safely through personalisation and a focus on flexing the content.</p>
<p>The 0-19 service in the area has recently changed provider. This has led to a lot of change for the team, with negative impacts on their morale and emotional wellbeing. Additional change as a result of ADAPT may further challenge their wellbeing, which could adversely affect their normally high ability to motivate behavioural change with clients.</p>	Medium	<p>The team requires support and encouragement to implement ADAPT changes, with regular opportunity in supervision and team learning to identify their own needs for wellbeing at work.</p>
<p>Online peer support may be negative and lead to collusion to start smoking again. A failed attempt to quit may encourage a client to devalue the process.</p>	Medium	<p>Online peer support will be monitored by nurses and coproduction leads.</p>
<p>E-cigarettes do not break the addiction to nicotine. Therefore if the e-cigarette breaks the quitter may choose to smoke again if they cannot afford a new device.</p>	Medium	<p>E-cigarettes are mainly for the mother’s partner/family; they will only be used as a last resort during pregnancy.</p> <p>Combination NRT therapy will enhance quit success and ameliorate the affects of withdrawal should an e-cigarette device fail/break.</p>

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# CONTEXT MAP

## Factor and likely influence

## Actions to address

**POLITICAL**

Use of e-cigarettes are a relatively novel approach to support smoking cessation and have attracted considerable debate. Due in part to their newness and to this debate, although electronic cigarettes are one of the most popular stop smoking aids in England and there is evidence that they can help people to quit, they are not licensed in pregnancy. This means that unfortunately starter packs cannot be given out by Family Nurses. The kits can be given to non-pregnant family members. NRT can be prescribed for pregnant clients

Cheshire East will remain open to changing this approach should evidence for e-cigarettes in pregnancy change. Advice from Use of Electronic Cigarettes in Pregnancy (Smoking in Pregnancy Challenge Group) is:

1. If you feel able to stop using electronic cigarettes or to switch to nicotine replacement therapy without going back to smoking then you should try to do so. However, if you think stopping using electronic cigarettes is likely to cause you to relapse into smoking, you should continue to use your electronic cigarette. While not completely risk free, existing evidence suggests that using an electronic cigarette while you are pregnant is much safer than smoking.

2. Pregnant women who smoke should be advised to access behavioural support and, if needed, licensed nicotine replacement therapy (NRT) products, which are free when prescribed, to help them quit smoking and stay smokefree. However, if they choose to use an electronic cigarette and this helps them to quit and stay smokefree, it is safer for both them and their unborn baby than continuing to smoke

## Influencing factors

## Factor and likely influence

## Actions to address

**ORGANISATIONAL**

Family Nurses will need to enhance their communication skills, knowledge of Nicotine Replacement Therapy (NRT) prescribing, use of e-cigarettes and mindfulness techniques. Failure to do this will make it harder to deliver the adaptation well

Joint training will be held with Family Nurses in Dudley. A training day focusing on communication skills will be run by a member of the FNP National Unit Clinical team. This will fit well with the nurses' existing Level 2 NCSCT training conducted in 2015. There will be ongoing support and supervision with the site supervisor, and team data analysis

Commissioners plan to vary the contract to increase capacity in FNP from 5 to 8 Family Nurses. The nurses will not be able to provide smoking cessation support in line with the adaptation until they have been trained by the National Centre for Smoking Cessation and Training (NCSCT)

Training will be made available for these new staff. This will be challenging as they will be in the process of learning the role of the Family Nurse

**CULTURAL**

For some young parents the process of change may be a challenge as they have grown up in a family with intergenerational smoking. Young parents will be influenced by peer groups, family and partners who smoke. These factors will make it harder for the mother to quit

Smokers around the FNP young parents will be involved in the intervention. Once members of the extended family and friends who smoke are identified, they will be invited to join a programme to support their quit attempt. This will be with the consent of the enrolled mother. Successful quitters will have the opportunity to contribute to Facebook with their stories of success

A proportion of the site's mothers are in their late teenage years. As a result, a significant minority of FNP mums live alone in independent accommodation, meaning that involvement of family and friends may have less impact

Peer support will be provided online and available for quitters to access when home alone. The Family Nurse will explore with quitters the person or people with most influence on their quit decisions and focus on them accordingly

When FNP clients in the site become pregnant they lose contact with their non-pregnant peer group and are reluctant to make friends with other FNP clients, so online peer support may have more power to attract and connect mothers attempting to quit. Furthermore, this will be helpful for them in the evenings, which is a time local mothers say that they feel isolated

The site has noticed that mothers are more likely to engage with each other through social media, so this will be encouraged

	Factor and likely influence	Actions to address
<b>ECONOMIC</b>	Cost of e-cigarette starter kits at £30 per kit may prove to be prohibitive. (NB. These will be the last resort in pregnancy but not necessarily for relatives and close others, which is where it is anticipated that they will be used most)	The Public Health Consultant, Cheshire East, will secure funding for the first 100 e-cigarette starter kits. Payment by results will go towards replacing the starter kits
	There is the opportunity to submit a business case to pump prime the ADAPT change from public health	Initial costs will be identified so that they can be included in a business case
	Wirral Community Trust has a payment by result contract for smoking cessation	Quits in FNP clients and family/friends can be claimed as part of the contract. This may be able to provide sustainable funding for resource. This needs modelling to understand if it is sufficient
<b>OTHER</b>	IT agreement required to use Systemone to ensure fidelity and capture data	IT will be approached to implement a smoking cessation template

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# CLINICAL FLOW CHART



The clinical flow chart is a visual representation of what materials are used and which assessments are triggered on the FNP ADPT data system during each programme phase (Pregnancy and Infancy). In Cheshire East, during Pregnancy all clients are offered support through programme facilitators and materials such as mindfulness exercises, which extend throughout Infancy. Smoking prevalence is collected using the FNP information system at several time points. Addition time points have been added to the FNP ADAPT data system to continue to monitor progress and detect relapses. Data is also collected on whether the child is living in a smoke free home at intake, 36 weeks gestation, 6 weeks postnatal, and 4, 6, 10 and 12 months.

	Pregnancy		Infancy			
<b>Universal activity</b>	New and existing facilitators used earlier in the programme with clients, family and partner if present.					
	Routine use of CO monitors with accompanied facilitators					
	New more partner-focused breastfeeding materials to introduce the subject to partners during pregnancy					
	Mindfulness and relaxation for stress reduction					
<b>Targeted activity</b>	Prescription of NRT via local patient group directive and referral to specialist services for client/partner/ family if wanted					
<b>Assessment tool</b>	Smoke free home	Smoke free home	Smoke free home	Smoking prevalence	Smoking prevalence	Smoking prevalence
				Smoke free home	Smoke free home	Smoke free home
<b>Assessment time point for FADS</b>	Intake	36 weeks	6 weeks	4 months	6 months	10 and 12 months



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# ADAPTATION DESCRIPTION

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**Name of adaptation**

Smoking cessation

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**Target group**

All clients enrolled onto FNP Dudley, including influential people in the client's social circle who also smoke (partners/family/peers)

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**Rationale**

See logic model visual and narrative

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**What it comprises**

- Family Nurses and the Healthy Pregnancy Support service (employed by Dudley Public Health) will be given additional training over 2 full days:
  - Dudley Stop Smoking Service (DSSS) will provide training on: the effects of smoking and second-hand smoke in pregnancy and beyond, engaging with women who smoke during pregnancy, understanding behaviour change (PRIME THEORY & COM- B model), CO testing in pregnancy, the evidence to support smoking cessation, smoking cessation medications, e-cigarettes
  - FNP National Unit will provide training on: advanced communication skills (behaviour change, motivational interviewing, change talk, assessing clients' confidence and ability to quit, as well as working with resistance to change)
- Introduction of earlier discussion of smoking in pregnancy and infancy. This will support the message by all professionals that it is not 'OK' to smoke in pregnancy and help prevent relapse in the postnatal period
- Production of new facilitators: health information on effects of smoking for mum and foetus/ baby (presented in a timeline), a new version of smoking in pregnancy quiz, and a pictorial measure of client's motivation, all with a clear quit message
- Use of more visual aids, including apps (e.g. Smiling Minds, Calm), video clips, Youtube, silicon fetuses, flash cards, NRT samples and CO monitors
- Use of skills such as compassionate minds, mindfulness, relaxation techniques and suitable apps to reduce anxiety, improve coping skills and give clients an alternative activity in place of smoking. (Dudley Family Nurses have already completed Mindfulness Training with Spiritual Care.)
- Supporting clients/ partners/ family/ peers to quit together if possible. The Family Nurse will give clear quit messages to all family members involved in the visit and will use the same methods for all involved in quitting if supporting the client to quit. A pathway will be developed for referral to Dudley Stop Smoking Services (DSSS) for family and friends who wish to quit if the client does not smoke or does not want to quit.

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**Materials needed for delivery**

Additional training, new materials, CO monitors, visual aids, flash cards, Apps, NRT samples and flexibility in programme

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**Procedures for delivery**

- Delivery will identify and include clients/partners/family/peers
  - Discuss smoking cessation earlier in pregnancy and infancy (P1, I1 face-face between Family Nurse and client)
  - Regular discussions with use of new materials as led by the antenatal checklist, including CO readings discussion with the client, prescribing NRT by Family Nurse and clear pathways for referral following discussion with the client
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**Provider(s)**

Family Nurses, DSSS and Healthy Pregnancy Support Services

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**Mode of delivery**

One- to-one, including partner/family/ peers if present during home visits and client consents (if client does not smoke, family/ friends who wish to quit will be referred to DSSS following positive CO reading)

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**Where it takes place**

Home (or community setting such as children's centre or café if this is where regular visits take place)

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**When/how much**

Every opportunity antenatally from P1 and all visits if suitable/possible as led by antenatal checklist. Commencing as early as first infancy visit to identify motivation or prevent relapse and every suitable visit afterwards as identified by client/Family Nurse/ FNP programme materials

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**How delivery can be tailored**

By agenda-matching (and personalisation) with client at every visit and all core visits identified through the programme for smoking cessation (P1, P3, P4, I1, I10, I17)

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**How fidelity is monitored**

Discussions with National Unit to change data to reflect (fidelity data to be recorded via the FNP ADAPT Data System – FADS). Nurses to collect data on referrals to DSSS for family and friends.

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# LOGIC MODEL

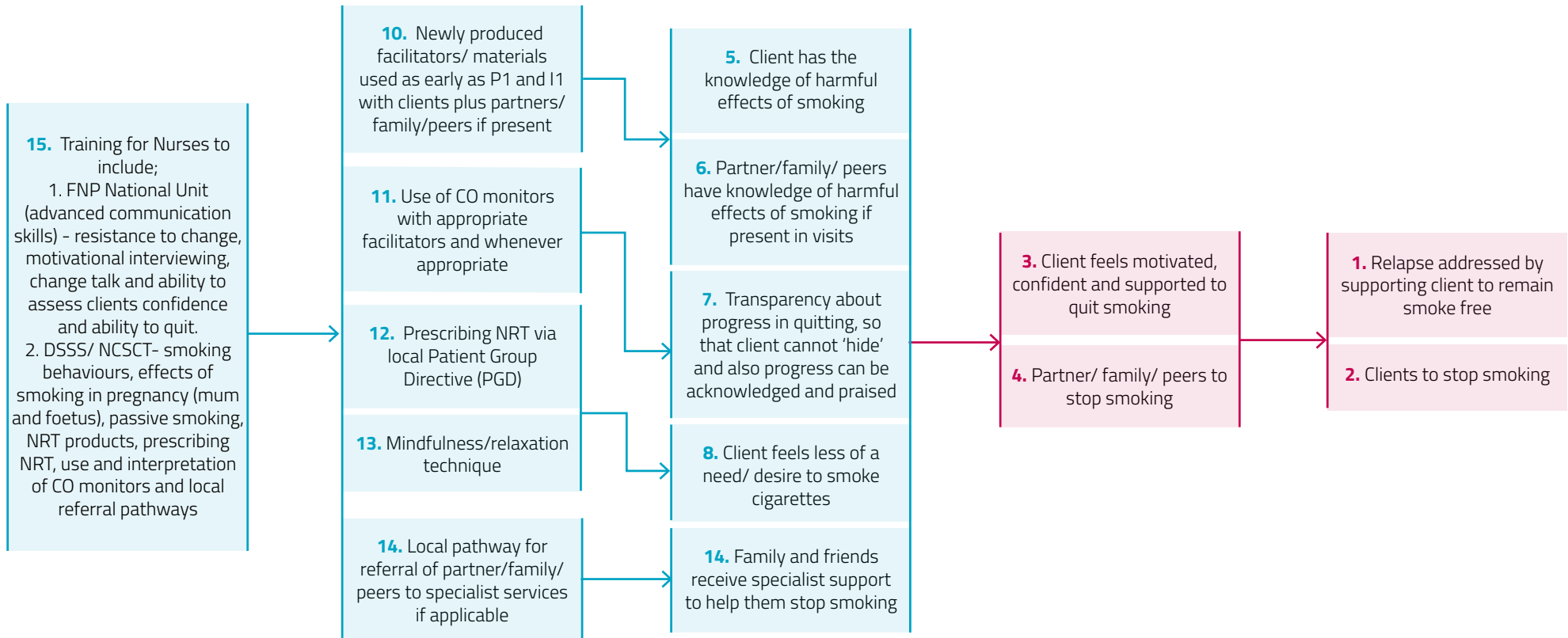
SUPPORTS

ADAPTATION ELEMENTS

MECHANISMS

INTERMEDIATE OUTCOMES

ULTIMATE OUTCOMES





A narrative of each element of the logic model is provided below - numbers relate to the relevant boxes in the diagram.

### Ultimate outcomes

1. The primary desired outcome of the adaptation is that in Dudley FNP we increase the stop smoking rates for clients enrolled onto the programme both in the short and long term. This relates to supporting them to quit as early in the programme as possible and also at any point in time whilst on the programme. A stop smoking quit is registered when a client has stopped smoking for 4 weeks. The aim would be to support these criteria and encourage smoking cessation long term. The quit would be confirmed by a CO recording of 4ppm or less.
2. A secondary outcome would be to support clients who relapse during the programme to remain smoke free. This would include: reassessment of smoking status; activity to motivate the client to remain / continue smoke free; and reassessment of NRT needs, followed up with appropriate prescription.

### Intermediate outcomes

3. One intermediate outcome is that clients are motivated and feel confident and supported to quit smoking, thereby increasing the likelihood of them quitting and not relapsing.
4. A further intermediate outcome is for partners/family/peers of clients to quit smoking. This would be monitored in both the short and long term by CO readings (as above). This will contribute to helping the clients to stop smoking because clients can feel pressure and/or desire to do what significant others are doing (and if they aren't smoking then clients are less likely to feel this pressure and/or desire).

### Mechanisms

5. Ensuring that the client is knowledgeable about the harmful effects of smoking on themselves, the foetus and baby and this will increase the client's motivation to quit. Knowledge increases self-efficacy and the confidence to make choices for oneself and achieve better health outcomes for the baby. It also empowers the client not to follow or be pressured by partner/family/peers if they continue to smoke.
6. If significant others (especially those who smoke) – namely partner/family/ peers – are engaged at home visits then they will be knowledgeable about the harmful effects of smoking and can support the client in her quit attempt. They can also be supported by the Family Nurse during these home visits to quit along with the client.
7. Transparency (from CO readings) in discussions about progress in quitting mean that (a) clients will be unable to hide their smoking if they still smoke and (b) positive CO readings will enable the nurse to praise and affirm success in quitting, thereby increasing the client's motivation to continue not smoking.

**8.** The client will have fewer nicotine cravings and ultimately less urge to smoke, helping them to feel confident about and supported in quitting (and not relapsing).

**9.** If the client is quitting, the Family Nurse will also support their partner/family/ peers with their quit attempt during the home visits together with the client. If the client does not smoke or does not want to quit, their partner/family/peers will be supported to quit smoking through a new local pathway that will be developed between FNP and the Stop Smoking Service. This should increase local stop smoking rates and also support the client in her quit attempt.

### **Adaptation elements**

**10.** New materials and facilitators will be introduced and shared early in the client's journey with FNP. During pregnancy, smoking cessation will be discussed as early as visit P1. This supports the message that it is not 'OK' to smoke in pregnancy and will improve the client's knowledge of the harmful effects of smoking as early as possible in the programme. Addressing smoking cessation with the antenatal checklist will support routine discussion, follow on from midwives' assessment and CO reading and open up the opportunity to discuss cessation honestly. This repetition will support relapse prevention and cultural changes. Postnatally, content on smoking cessation will be brought forward as early as visit I1 to encourage clients to quit smoking, support maintenance and address relapse. Use of newly produced facilitators with a clear quit message, delivered with advanced communication skills, will enhance a client's knowledge of the harmful effects of smoking on themselves and the foetus/baby. Visual aids such as apps, videos, YouTube clips, use of silicone foetuses, flash cards and NRT samples when used with quit smoking facilitators at visit P3 will all support client engagement, interest and motivation.

**11.** Each Nurse will have a CO monitor: this will enable opportunistic testing as well as routine planned testing of CO. The CO reading will give an indication of the client's smoking status. CO monitors that demonstrate % of foetal COHb readings will support and maintain motivation to quit, because clients will be unable to 'hide' their smoking habits if they are struggling and positive efforts to quit will be acknowledged and affirmed.

**12.** Nurses will prescribe NRT products (depending on number of cigarettes smoked, CO reading and time to first cigarette) via the local Patient Group Directive. This will contribute to the client feeling less of a need/desire to smoke cigarettes.

**13.** Family Nurses will use mindfulness and relaxation techniques with clients, based on training from Spiritual Care. This will help reduce clients' stress levels, provide them with an alternative activity (to smoking) and enable them to have less need or desire to smoke cigarettes.

**14.** The partner, other family members and peers will be referred to suitable specialist services as appropriate (see above). This will make them more likely to stop smoking.

### **Supports**

**15.** Underpinning the elements, mechanisms and outcomes of this adaptation is additional training for Family Nurses, designed to increase their confidence and skills in delivering the stop smoking message in a strengths-based, consistent manner. Training by the FNP National Unit will consist of advanced communication skills training (motivational interviewing, change talk, assessing clients' confidence and ability to quit, as well as working with resistance to change). Training from Dudley Stop Smoking Services (DSSS) will cover: the effects of smoking in pregnancy and secondhand smoke; engaging with clients who smoke; understanding behaviour change (PRIME theory and COM B model); CO testing; evidence supporting smoking cessation; and E-cigarettes.

Knowledge and skills developed in smoking cessation products and prescriptions for NRT will increase nurses' confidence to prescribe appropriate products that will have the best outcomes and chance of success.

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# DARK LOGIC

POSSIBLE ADVERSE EFFECTS	LIKELIHOOD	MITIGATING ACTIONS
<p><b>Clients disengage if they do not want to address their smoking status.</b></p>	<p>Medium</p>	<p>Nurses' increased confidence and skills in smoking cessation will ensure that up-to-date information and research are tailored to each client's needs.</p> <p>Nurses' enhanced communication skills will support therapeutic relationships.</p>
<p><b>Tension in relationship with partner/family/peers if clients wish to quit and partner/family/peers do not wish to quit.</b></p>	<p>Medium</p>	<p>Include partners/family/peers in smoking cessation discussions, including the benefits for the baby of quitting smoking Refer partners/family/peers to Dudley Stop Smoking Services (DSSS) or Family Nurse to provide support if appropriate Develop clients' self-efficacy to voice their choices/desires, regardless of external pressures from others.</p>
<p><b>FNP becomes known as a 'smoking cessation programme'; this may deter clients from enrolling onto the programme.</b></p>	<p>High</p>	<p>Data will be monitored in supervision to identify any negative impact on enrolment, fidelity and outcomes Ensure changes made to the FNP programme through ADAPT are communicated with both internal and external services, including commissioners and members of FAB As the Family Nurses' confidence and skills increase, they will become more time-effective in dealing with smoking cessation (i.e. it will take less time).</p>

POSSIBLE ADVERSE EFFECTS	LIKELIHOOD	MITIGATING ACTIONS
<b>Client feels guilty for smoking (may adversely affect their mental health).</b>	Medium	<p>The Nurses' knowledge of the client can be utilised to determine if a CO reading will be a positive way to affirm a client's progress or detrimental (if she is struggling with her quit attempt).</p> <p>Compassionate minds, mindfulness, relaxation techniques and use of apps by clients may help if the client has anxieties.</p> <p>The Nurses will become more skilled at delivering a clear quit message without blame as their knowledge and communication skills improve.</p>
<b>Negative changes in other FNP outcomes – if time spent addressing smoking is at the expense of other key FNP outcomes (it will affect fidelity / % domains – this could be seen as an expensive use of FNP skills and resources).</b>	Medium	<p>Effect on outcomes will be monitored and negative effects mitigated through use of the personalisation tool, as Nurses focus their attention on what matters most for each client.</p> <p>Fidelity will be monitored to ensure that holistic care is given.</p>
<b>Client's anxiety may increase if coping skills are not in place.</b>	Medium	<p>Use of HADS (or similar mental health measure) to monitor if there are concerns about client anxiety .</p> <p>Involve partner/family/peers for support.</p> <p>Explore alternative coping strategies that the client could use, such as compassionate minds, relaxation, apps and mindfulness.</p> <p>Use CO monitoring and provide affirmation if client is successful in quitting.</p> <p>Encourage distraction techniques, such as playdough/modelling putty.</p> <p>Build on client's self-efficacy, affirming her strengths in dealing with challenges and anxieties.</p>

DUDLEY

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# CONTEXT MAP

	Factor and likely influence	Actions to address
<b>POLITICAL</b>	The structure of Dudley Stop Smoking Service (DSSS) is going to change and the capacity for referrals to this specialist service will be reduced	Be aware of alternative expert support available, such as through pharmacies
<b>ORGANISATIONAL</b>	Supervisors' time is often spent on non-FNP issues, reducing their capacity for ADAPT Changes, such as new Partnership arrangements and multispeciality community providers, may not support FNP or ADAPT	Discuss with manager, requesting support to concentrate on FNP ADAPT Ensure managers in the Trust understand the programme and promote it at every opportunity
<b>CULTURAL</b>	There is a strong generational culture of smoking in Dudley: rates of smoking at time of delivery are above the national average (15.7% vs 11.4% 2015). Short-term outcomes will be difficult to demonstrate	Involve family/peers in discussions as often as possible to increase their awareness of the health risks of smoking Encourage and support family/peers to quit and refer them to specialist services if the Family Nurse is unable to support their quit attempt(s)
<b>ECONOMIC</b>	Financial constraints in the Local Authority may influence the future of FNP FNP budget currently will not accommodate external training re. smoking cessation, therefore skills/ confidence of Nurses in smoking cessation may be adversely affected	Continue to gather evidence of outcomes in Dudley to promote the service widely Source internal training from DSSS



DUDLEY

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# CLINICAL FLOW CHART

The clinical flow chart is a visual representation of what materials are used and which assessments are triggered on the FNP ADPT data system during each programme phase (Pregnancy and Infancy). In Dudley, during Pregnancy all clients are offered support through programme facilitators and materials such as mindfulness exercises, which extend throughout Infancy. Smoking prevalence is collected using the FNP information system at several time points. Addition time points have been added to the FNP ADAPT data system to continue to monitor progress and detect relapses. Data is also collected on whether the child is living in a smoke free home at intake, 36 weeks gestation, 6 weeks postnatal, and 4, 6, 10 and 12 months.

	Pregnancy		Infancy			
<b>Universal activity</b>	New and existing facilitators used earlier in the programme with clients, family and partner if present.					
	Routine use of CO monitors with accompanied facilitators					
	New more partner-focused breastfeeding materials to introduce the subject to partners during pregnancy					
	Mindfulness and relaxation for stress reduction					
<b>Targeted activity</b>	Prescription of NRT via local patient group directive and referral to specialist services for client/partner/ family if wanted					
<b>Assessment tool</b>	Smoke free home	Smoke free home	Smoke free home	Smoking prevalence	Smoking prevalence	Smoking prevalence
				Smoke free home	Smoke free home	Smoke free home
<b>Assessment time point for FADS</b>	Intake	36 weeks	6 weeks	4 months	6 months	10 and 12 months





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# ADAPTATION DESCRIPTION

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### Name of adaptation

Reduction and prevention of IPV through the promotion of healthy relationships

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### Target group

All FNP clients will benefit from a universal offer around promoting healthy intimate partner relationships utilising existing and new FNP programme materials.

Some clients will receive additional targeted support. Which clients this applies to, and the nature of that support, will depend on whether clients are experiencing:

- (i) high levels of conflict often escalating to aggression and violence (commonly termed 'situational couple violence' in the academic literature).<sup>1</sup>
- (ii) domestic violence (or IPV) as defined by the UK government.<sup>2</sup>

These differing types of violence require differing approaches to resolution, and careful assessment to differentiate between the two.

Partners will be included in the universal and targeted [stream (i) above] parts of the intervention at the discretion of the client and subject to the Family Nurse being satisfied that there is no obvious safeguarding risk of doing so (i.e. that the mother and baby will not be adversely affected by the partner's participation). If the client wants her partner to be involved, the nurse will still identify sessions where the young woman is seen alone (e.g. the completion of the data relationship form). If it becomes clear in the course of delivering the adaptation that a partner is abusive and controlling (i.e. IPV according to the definition cited above), it will not be appropriate for the Family Nurse to continue to work with the partner. In such cases, Family Nurses may make a referral to an appropriate service. Work with the couple will also not take place in front of any child aged 18 months or older.

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### Rationale

For a full description, see the logic model visual and narrative. In brief, the adaptation seeks to help the client to have healthier intimate partner relationships (including no or reduced IPV), which in turn will reduce the baby's exposure to IPV and the harm that ensues. In order to achieve this: clients (and partners) need to make more positive relationship choices, and be less accepting of relationship violence; clients (and partners) need to be aware of the harmful impact of IPV on themselves and their baby/infant, and be motivated to behave non-violently with each other; and clients (and partners) need to be better able to deal non-violently with conflict in their relationship. For these things to happen: the client and her partner need to know what constitutes healthy and unhealthy relationships and the harmful effects of unhealthy relationships and IPV on victims and the baby/infant (achieved via digital, online and other new materials); and they need stronger skills to deal with conflict non-violently (achieved via new materials on emotional intelligence and skills in communication and conflict resolution).

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<sup>1</sup> Johnson, M. P. and Leone, J. M. (2005) The differential effects of intimate terrorism and situational couple violence: findings from the National Violence Against Women Survey', *Journal of Family Issues* 26, (3): 322–349.

<sup>2</sup> "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial or emotional. Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim." <https://www.gov.uk/government/news/new-definition-of-domestic-violence>

In the case of IPV, the reduction in conflict/violence and the child's exposure to this come about primarily through specialist services. Specifically: clients (and partners) need to receive help from specialist services to: reduce IPV and/or help the client to find a point of safety (achieved via referrals to appropriate services and support to ensure that contact is made); find and remain in a place of safety, which may or may not involve leaving a relationship (supported via new materials to boost self-efficacy); and (if a relationship involving IPV has ended) remain out of such relationships and recover from the trauma they have endured (achieved via FNP materials on choosing a new partner and/or referral to the Freedom programme if the client is interested).

Underpinning these supports will be: training and supervision for nurses; suitable assessment tools to identify IPV; and clear and robust referral pathways to specialist services.

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### What it comprises

The adaptation will focus on: (i) the assessment of IPV; (ii) the use of new/adapted materials; (iii) referrals to specialist services where necessary; and (iv) training for Family Nurses. These are now outlined in more detail:

#### *Assessment*

All clients will complete an assessment with their nurse. The assessment is a revised form of the short form of the Conflict in Adolescent Dating Relationships Inventory<sup>3</sup> with three questions added from the Mediator's Assessment of Safety Issues and Concerns (MASIC).<sup>4</sup> This will cover whether the client (i) is the victim or perpetrator of physical abuse, threatening behaviour, sexual abuse, relational abuse and verbal/emotional abuse, (ii) is a victim of coercive control and (iii) fears being harmed in the relationship. One additional question has been added at the suggestion of a local expert, namely whether the client has changed her behaviour as a result of her fear of her partner's actions (deemed to be a common indicator of abuse). The outcome of this assessment determines whether clients need the targeted offer and, if so, which of two targeted streams are relevant. Thus, there are three possibilities:

- (i) If a client reports no violence in her relationship, she will continue to be offered the universal offer. This will protect her against future abusive relationships and will counter a culture of acceptance of violence in relationships.

If the client reports that there is any violence in the relationship, she will be eligible for the targeted offer in some form:

- (ii) If the client describes incidences of conflict or violence, but there is no suggestion of control, fear of her partner or changing her behaviour due to fear of being harmed by her partner, it is likely that the relationship is unhealthy but not abusive in the sense of experiencing IPV according to the UK definition. This client will be offered the first stream of the targeted offer (as outlined below).

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<sup>3</sup> Fernández-González, L. Wekerle, C. and Goldstein, A.L. (2012) 'Measuring adolescent dating violence: development of "Conflict in Adolescent Dating Relationships Inventory" Short Form', *Advances in Mental Health* 11(1), 35-54.

<sup>4</sup> Pokman, V., Rossi, F. S., Holtzworth-Munroe, A. et al. (2014), 'Mediator's Assessment of Safety Issues and Concerns (MASIC): reliability and validity of a new intimate partner violence screen', *Assessment* 21(5) 529-542.

<sup>5</sup> <https://www.gov.uk/government/news/new-definition-of-domestic-violence>



(iii) If the client reports attempts by her partner to control her actions or contact with others outside her relationship, or if her partner's behaviour means that she is fearful for herself or others, or if she has changed her behaviour for fear of what her partner might do, it is more likely that she is experiencing IPV according to the UK government definition<sup>5</sup> Any one of these criteria will be sufficient for the client to be offered the second stream of the targeted offer.

All clients will be offered the universal component of the intervention. This applies whether they are in a relationship or not.

#### Materials <sup>6</sup>

Materials will be developed or adapted as follows:

##### *Universal*

For all clients, in each phase of the FNP programme (Pregnancy, Infancy and Toddlerhood) Family Nurses will spend one visit focusing on relationships and will use new materials that have been developed to enable clients to consider healthy and unhealthy relationships, and to identify what kind of relationship they are in. (In line with personalisation and flexing the content, nurses will also be encouraged to use the materials regardless of where the client is in the programme if it becomes apparent during the programme that the client is having difficulties in her relationship.) These materials include:

New or adapted FNP materials:

- providing information and prompting discussion on healthy and unhealthy relationships
- providing information on what IPV is, including its extent, nature and causes
- providing information on the harmful effects (on victims' physical and mental well-being) of unhealthy relationships and IPV
- encouraging clients (and their partner if present and safe) to see the world from their baby's perspective (i.e. mentalisation) and providing information on and prompting consideration of the impact of unhealthy relationships and IPV on the baby/infant
- developing emotional intelligence i.e. helping clients (and their partner if present and safe) to identify and name their own and their partner's emotions and feelings, and to be able to deal appropriately with strong feelings
- developing communication skills i.e. helping clients (and their partner if present and safe) to communicate clearly and respectfully
- building conflict resolution skills i.e. helping clients (and their partner if present and safe) to resolve conflict non-violently
- building self-efficacy for making changes or taking decisions (about their relationship specifically in this context)

Supplementary online educational (video) content to reinforce the materials (e.g. to help clients identify the signs of controlling or coercive behaviour)<sup>7</sup>

<sup>6</sup> All new or adapted materials will be tested with a focus group of FNP graduates and the LEAP young parent champions group.

<sup>7</sup> For example: [https://www.youtube.com/watch?v=sHLlCUU\\_L7k](https://www.youtube.com/watch?v=sHLlCUU_L7k)

Digital materials such as apps (e.g. myPlan or Love Smart) that comprise questionnaires designed for use with adolescents to build on the work of the facilitators that help the young person to work out the degree to which their relationship is healthy, unhealthy or potentially dangerous.

In addition, some materials will be re-ordered in the programme schedule to ensure that they are used at the most appropriate time:

- The data relationship form will be moved from P3 to P6. By delaying the introduction of this form, the client will have had more time to develop an open and trusting relationship with the Family Nurse and may be more likely to disclose IPV or any other concerns.
- The “Effects of DV on children” facilitator will be moved from Infancy (I17) to Pregnancy (P10/11 or 12). This will enable discussion of this issue at an earlier stage and complement the materials on mentalisation.
- Materials covering descriptions of abusive and unhealthy relationships will also be moved to earlier in the programme.
- The introduction of the Teen Power and Control Wheel will be piloted with clients and moved from P3 (which is a very content heavy visit) to P4.

#### *Targeted*

If a Family Nurse identifies that a client is (a) in a high conflict relationship or (b) currently (or has been in the past) in an abusive relationship (i.e. one where there is IPV according the UK government definition), then the targeted intervention will be offered. The exact content of this targeted offer will depend on the needs that the client presents with, but effectively there are two streams:

For clients presenting as high conflict couples, this will include:

Focused time spent on facilitators designed to enhance conflict management skills

- What are we fighting for?
- How to get what you want
- Rules for the floor
- What can I do to change how I feel and behave in difficult situations?

Introduction to One Plus One’s Couple Connection online resource for relationship support, and encouragement to use it regularly for information and ideas (<http://www.oneplusone.space/couple-connection/>). This resource covers relationship problems, and conflict resolution in addition to quizzes about how the couple argue and manage other potential sources of conflict.

For clients presenting in abusive relationships (i.e. those involving IPV), support will include:

- Referral to specialist services (see below)
- Support for successful and smooth referral, to ensure that victims or perpetrators get the help they need. (Many clients in this situation will feel reluctant to seek help and so this process needs to be effective in joining clients with appropriate support, otherwise they may not seek help again and will continue to be in danger.)
- Emphasis on using FNP materials designed to build self-efficacy to support the client to get to a point of safety (which may or may not involve leaving the relationship).
- Guidance through the “New partner” facilitator to support the client to assess the potential risks posed by new relationships, either in the case of a new relationship or if the client is tempted to restart the old (abusive) relationship, and the use of mindfulness to promote emotional well-being.

### Training

This will cover key content in the adaptation, namely:

- healthy and unhealthy couple relationships
- IPV
- the impact of unhealthy relationships and IPV
- conflict resolution
- local services for the woman, partner or couple
- referral pathways for when IPV is disclosed (including services for male perpetrators)
- how to identify IPV (including but not limited to the use of assessment tools)

It will also cover the style of intervention, in particular:

- how to talk with clients about IPV and what to do with the responses of clients and their partners (if relevant)
- how to work with couples, particularly where there is conflict and/or violence within the couple relationship<sup>8</sup>

### Referrals to other services

All clients identified as experiencing IPV will be referred to social care and the Gaia Centre<sup>9</sup> for follow-up and support:

- Referral to Social Care due to the presence of and risk to a child (which could be the baby or the client if she is under 18)
- The Gaia Centre provides confidential, non-judgemental and independent support services for those living in the London borough of Lambeth who are experiencing gender-based violence. It supports women and girls aged 13 and over, and men aged 16 or over. Clients will be referred to the Gaia Centre for risk assessment, safety planning, advocacy, peer support and access to the appropriate services

<sup>8</sup> Nurses report feeling scared that they could make the situation worse.

<sup>9</sup> <http://www.refuge.org.uk/what-we-do/our-services/gaia-centre-lambeth/>

In addition:

- A DASH (Domestic Abuse, Stalking and Honour Based Violence) assessment will identify immediate risk of serious harm where there is suspicion of high risk and trigger a Multi-Agency Risk Assessment Conference (MARAC) for those clients scoring 14 or above. Referral to MARAC will ensure management of the acute risks and that steps can be taken to ensure safety in the short term.
- Clients who are interested, once at a point of safety, will be offered a referral to the Freedom Programme<sup>10</sup> for further support and training in IPV and ways they can protect themselves and their children. The Freedom programme is an 8-week course that supports those who have experienced domestic violence and who are no longer in that relationship.<sup>11</sup> Each referred client will receive support from her Family Nurse to engage with these services.

In the case of partners who are seeking help with their behaviour:

- Referrals might be to perpetrator programmes or support groups for fathers (e.g. Caring Dads, St. Michael's Fellowship). Caring Dads is a group intervention aiming to help fathers improve their relationship with their children. The work focuses on developing skills for interacting with children in healthy ways, and understanding the impact on children of controlling, abusive and neglectful actions, which include witnessing domestic violence. St. Michael's Fellowship offers practical, therapeutic and emotional support to disadvantaged families.

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### Materials needed for delivery

- New and revised facilitators on identifying healthy and unhealthy relationships
- New facilitators on the effects of unhealthy relationships / IPV on the child
- New facilitators on conflict resolution
- New facilitators on emotional intelligence
- New facilitators on asking for support and decision making
- Established facilitators supporting communication skills and self-efficacy
- Information about local specialist services supporting families who have domestic abuse issues, supported by clearly articulated referral pathway

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### Procedures for delivery

All clients will receive a revised universal offer to refocus resources on promoting healthy intimate partner relationships. This includes using existing programme materials (revised or moved) and the development of new materials identifying what makes a relationship healthy (or not), the harmful effects of unhealthy relationships / IPV on victims and children, and how to resolve conflict non-violently in intimate partner relationships. This will be supplemented by digital and online resources that reinforce these messages and strengthen clients' – and, where appropriate, partners' – emotional intelligence, conflict management and communication skills.

<sup>10</sup> <http://www.homestartlambeth.co.uk/domestic-violence-freedom-programme/>

<sup>11</sup> It has previously been attended by FNP clients and has received positive reviews.

A more targeted offer will be available to clients (i) in high-conflict (or unhealthy) relationships [but not IPV] or (ii) in relationships where the client is or has been the victim of IPV (as defined by the UK government).

Clients who have identified that they are experiencing high conflict or unhealthy relationships will be encouraged to engage in the materials that seek to improve conflict resolution skills to promote conflict management, and the One Plus One online relationship resource for relationship management.

Clients reporting IPV will be supported to build self-efficacy to enable them to get to a point of safety. The DASH assessment will be used by the nurse to identify clients who need to be referred to MARAC and trigger this referral. If the client finds a point of safety, she will be supported to participate in the Freedom Programme (if she wants to) and, should she start a new relationship, guided with the New Partner facilitator.

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### **Provider(s)**

Family Nurses will deliver the adapted/new materials as part of the FNP Programme. The specialist services to which clients, partners or children are referred will be provided by relevant professionals or trained volunteers. Training for nurses has been provided by the Tavistock and Portman NHS Foundation Trust.

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### **Mode of delivery**

The adaptation will mainly be delivered on a one-to-one basis (i.e. the Family Nurse working with the client). However, if the client is in a relationship, the Family Nurse will work with the couple (client and partner) where it is appropriate and safe to do so (this will depend on known safeguarding risks and the wishes of mother). If the partner is not actively involved with the client and/or baby, they could be invited to a specific session with clear rationale for why the partner should be present i.e. to focus on the needs of the baby (mentalisation) and the risks of IPV for the baby.

Some elements of the adaptation will be delivered online via websites or apps that clients can view wherever they want in their own time and at their own pace. If the client receives other support from specialist services, the mode of delivery may vary.

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### **Where it takes place**

Visits by the Family Nurse will take place in the client's home or an alternative venue if the client feels unsafe at home. Services provided following referral to other agencies will be provided in a suitable venue (i.e. if the client and/or partner are referred to specialist services).

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### **When / how much**

The universal offer involves one session per phase of the programme (one in each of Pregnancy, Infancy and Toddlerhood), although agenda-setting and personalisation mean that materials may also be used at other times.

The volume of new material delivered will depend on the Family Nurse's assessment of the client's ability to receive new information and on need based on the findings from the NMS assessment.

If the client is unable to engage with topic area, and/or denies that there are areas to work on, contrary to the view of the Family Nurse, the nurse will continue to do supportive work with the client but will focus on the need for safety for the client and her baby and will make a referral to Lambeth Children's services for a safeguarding assessment. The supportive work will include an emphasis on mentalisation and facilitators that bring the child's voice into the interactions and thoughts of the parents, to build on the opportunity presented by the new baby and the chance to do things differently in this new context of parenthood.

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### **How it can be tailored**

Ongoing agenda-matching and personalisation of the programme using the New Mum Star will determine which elements are covered and when. This will vary according to each client's needs.

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### **How fidelity is monitored**

The visit section of FADS (FNP ADAPT Data System) will record for each visit (i) what is delivered in relation to the FNP Themed Index and New Mum Star, and (ii) which elements of the adaptation listed above are delivered. Details about what clients receive from the services to which they are referred will not be recorded.

In addition, clients will be asked for feedback on the clinical adaptation, including what they received and how well they engaged with it.

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# LOGIC MODEL

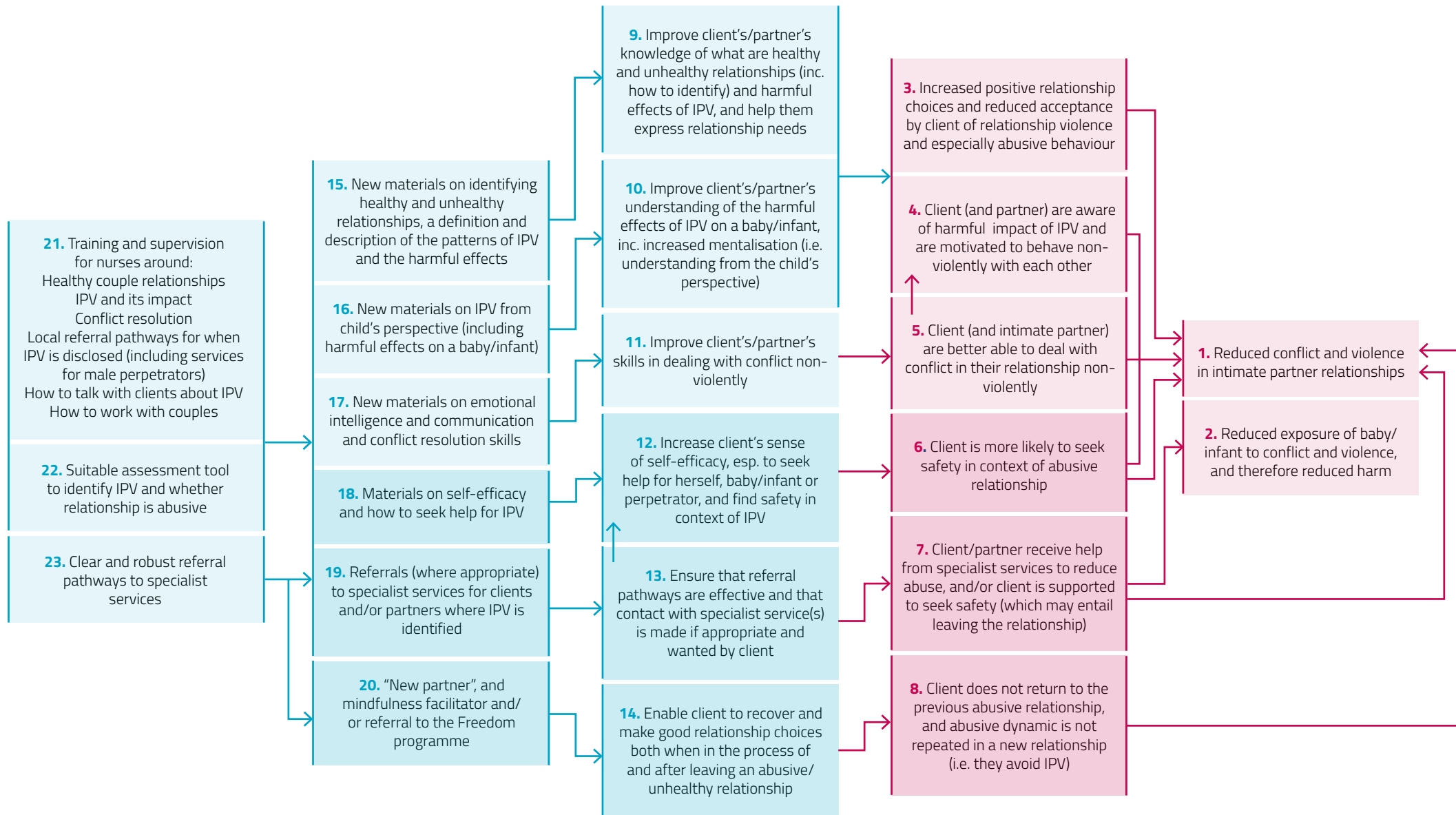
## SUPPORTS

## ADAPTATION ELEMENTS

## MECHANISMS

## INTERMEDIATE OUTCOMES

## ULTIMATE OUTCOMES





A narrative of each element of the logic model is provided below – numbers relate to relevant boxes in the diagram. It is important to note that the darker shading in the logic model reflects the stream that Family Nurses will follow if they detect an abusive relationship. The unshaded parts refer to the management of situational couple conflict where communication skills and conflict resolution skills might be more relevant.

### Ultimate outcomes

There are two ultimate outcomes.

1. Reduced conflict and violence in client's intimate partner relationship(s). This will contribute to the second ultimate outcome.
2. Reduced exposure of baby/infant to conflict and violence, and therefore reduced harm.

### Intermediate outcomes

There are six intermediate outcomes.

3. Whether they are in a relationship or not, through learning about the nature of unhealthy relationships, how to identify them and their harmful effects on the victim and the baby/infant, clients will be (a) less accepting of relationship violence (especially abusive behaviour), thereby eroding the culture of acceptance of violence and abusive behaviour, and (b) more likely to make positive relationship choices. This will lead to reduced violence in the client's intimate partner relationships.
4. The client (and her partner if suitable) are aware of the harmful impact of violence in intimate partner relationships and are motivated to behave non-violently with each other. This will contribute to (i) the client (and her partner) dealing with conflict in their relationship non-violently and (ii) the client seeking safety (in the context of an abusive relationship).
5. The client (and her partner if suitable) are better able to manage conflict in intimate partner relationships in a non-violent way. This will reduce the number of relationships that are, or become, violent as a result of conflict (i.e. 'situational couple violence'), which in turn will reduce harm/exposure for the baby/infant.
6. The client is more likely to leave an unhealthy intimate partner relationship. This will reduce the client's exposure to IPV and, in turn, reduce harm/exposure for the baby/infant.
7. Support from specialist services (e.g. through therapeutic means with the partner) will be available to reduce the abuse and therefore risk to the client and baby/infant. Should this prove ineffective, the client will be supported to find a place of safety, possibly outside the relationship should she want to. This will mean that she is less exposed to IPV and the baby will be less exposed to, or directly harmed by, IPV.
8. The client does not return to an abusive relationship she has left (where relevant) or repeat the abusive dynamic in a new relationship. This will prevent or reduce conflict and violence in the client's intimate partner relationships.

## Mechanisms

The following mechanisms enable these intermediate outcomes:

- 9.** Improved client (and partner if suitable) knowledge of what constitutes healthy (and unhealthy) relationships, and the harmful effects of IPV on victims' physical and mental well-being. With this knowledge, the client (and partner if relevant) is more likely to make positive relationship choices, to be less accepting of relationship violence and to be more motivated to behave non-violently with each other. She may also be more likely to address violence when she sees it in the relationships of her peers, thus reducing the culture of acceptance of unhealthy intimate partner relationships.
- 10.** Improved client (and partner if suitable) understanding of the harmful effects of IPV on a baby/infant. Because they care about the baby/infant's well-being, this knowledge means that the client (and partner if relevant) is more likely to make positive relationship choices, to be less accepting of relationship violence and to be more motivated to behave non-violently with each other. She may also be more likely to address violence when she sees it in the relationships of her peers, thus reducing the culture of acceptance of unhealthy intimate partner relationships.
- 11.** Improved skills in dealing with conflict non-violently will enable the client (and partner if relevant) to deal better (especially non-violently) with situational couple violence in their relationship (and they will feel more motivated to apply these skills because of the knowledge they have gained about the harmful effects of IPV).
- 12.** In the case of an unhealthy (abusive) relationship, greater self-efficacy and skills in help-seeking will enable the client to get help, whether to deal with the harmful effects on herself and her baby, or to help the perpetrator to get help, or for the client to find a place of safety.
- 13.** In the case of an unhealthy relationship and referral to specialist services, the Family Nurse will ensure that referral pathways are effective and that contact with relevant specialist services is made if appropriate and wanted by the client. This will contribute to (a) the client and partner receiving appropriate help from specialist services to reduce abuse and/or (b) the client being supported to find a place of safety if she wants to.
- 14.** After the client leaves an unhealthy or abusive relationship and/or when she is in the process of doing so, she will be supported to make positive choices about her subsequent relationships. This will contribute to her not returning to the abusive relationship and not repeating the abusive dynamic in a new relationship.

### Adaptation elements

The following adaptation elements will trigger the mechanisms identified above:

**15.** First, materials, including videos designed to appeal to the client group, apps and other online tools, will illustrate what healthy (and unhealthy) relationships look like,<sup>1</sup> and the extent, nature, causes and effects on victims of IPV. These will help to improve the client's (and partner's if relevant) knowledge of what constitutes a healthy and unhealthy relationship and what IPV and its harmful effects are.

**16.** Second, videos and materials will demonstrate the harmful effects of unhealthy relationships and IPV on a baby/infant and the experience of IPV from the perspective of the baby/infant.<sup>2</sup> This will increase the client's (and partner's if relevant) understanding of the harmful effects of IPV on a baby/infant.

**17.** Third, new materials on emotional intelligence and skills in communication and conflict resolution will equip the client (and partner if relevant) to be more in touch with their own and their partner's feelings and better able to deal with strong feelings and resolve situational couple violence non-violently.

*NOTE: At the nurse's and client's discretion, and subject to the Family Nurse considering that there are no safeguarding risks that would make this an undesirable option, the partner can be included at appropriate points with materials in elements 15, 16 and 17, so that couples have a shared understanding of healthy and unhealthy relationships and the harmful effects of IPV on the adult victim(s) and the baby/infant.*

**18.** Fourth, new materials on self-efficacy and how to seek help for IPV (especially abusive behaviour) will increase the client's self-efficacy in terms of being able to make decisions in the interest of herself, her baby/infant or the perpetrator, including seeking help from formal (specialist services) or informal sources or leaving an abusive relationship.

**19.** Fifth, where IPV is identified or disclosed, and particularly where it involves a dominant partner who is emotionally, physically or sexually abusive or who exerts coercive control over the client, the Family Nurse will make appropriate referrals for the client and/or her partner to specialist services, including those for male perpetrators. This will contribute to the client and/or partner receiving appropriate help or treatment to reduce violence and its effects, or to the client being supported to find a place of safety, possibly outside of the relationship if she wants to.

**20.** Lastly, for clients who have left or are in the process of leaving abusive partners, support from the Freedom Programme will be offered, as will input from the Family Nurse in the form of the 'New partner' facilitator to offer advice about how she might choose a more supportive and healthy relationship next time (and avoid returning to the abusive relationship). Mindfulness training will be used to promote the client's positive emotional well-being.

## Supports

**21.** For the use of new materials to have the desired impact, new training and enhance supervision for nurses will be in place. This will support them to work with the new and adapted materials, and will focus on:

- Supporting the client to understand what healthy couple relationships look like
- The nature, extent, causes and harmful impact of IPV
- Conflict resolution, including working with the partner at the client's discretion
- Local referral pathways for when IPV is identified or disclosed (including services for male perpetrators)
- How to talk with clients about IPV
- How to work with couples to support healthy relationships

**22.** Suitable assessment tools will be needed to help nurses to identify clients who need additional support, whether from nurses or from specialist services.

**23.** Finally, there will need to be a clear and robust local referral pathway. (This pathway is being developed through A Better Start in Lambeth and will be linked to the wider Lambeth Violence Against Women and Girls (VAWG) services.) This will help nurses to have the required knowledge and confidence to refer clients experiencing IPV to specialist services.

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# DARK LOGIC

POSSIBLE ADVERSE EFFECTS	LIKELIHOOD	MITIGATING ACTIONS
<p>The adaptation is likely to involve raising unwanted issues for the client, her partner and the wider family; violence may be entrenched in family and they may not be receptive to family nurses raising issues that are seen as “personal” or interfering in family life. This applies particularly if IPV materials are introduced early in the programme before the trusting therapeutic relationship has been established. This may mean that the client disengages from the FNP programme, which may impact negatively on a range of outcomes for client and her baby.</p>	High	<p>The nurses are skilled at developing trust with the client and would ensure that any discussions around potential IPV are raised in a respectful and safe way. The extra training will increase their confidence in delivering the intervention and they will introduce it sensitively, focusing on the unborn baby/child. Also, all clients receive at least part of the adaptation, which reduces stigma.</p>
<p>If the client’s partner is the perpetrator of IPV, raising the issue of IPV may cause risk to the client as the partner may be angry that these issues have been disclosed and become increasingly violent. [NB. This may be difficult to assess as not all clients disclose abuse.]</p>	High	<p>Family Nurses will receive additional enhanced training on IPV and its risks to the baby. The adaptation includes training on specialist support services and referral pathways, including safeguarding protocols. Materials on IPV will only be left with clients after careful discussion to ascertain that this is safe (i.e. in the event that the partner sees them).</p>
<p>Greater focus on IPV could require the displacement of other programme elements that are important and that would benefit the baby in terms of other outcomes.</p>	Medium	<p>Family Nurses will undertake a full assessment of the client’s needs to ensure that other areas important to the client and baby are not missed. If there is confidence in the New Mum Star, and personalisation is applied as intended, nurses will know which elements of the programme can be flexed if there needs to be greater focus on IPV.</p>
<p>Involving the client’s partner in the programme may lead to a lack of disclosure by the client (if the partner is a perpetrator of violence). The partner may not “allow” the client to attend sessions alone.</p>	Medium	<p>Family nurses will ask to see the client alone in order to complete the relationship questionnaire (Relationship Data form). If this proves very difficult, this may provide an insight into potential controlling behaviour by the partner and highlight the need for further work on IPV with the client. The involvement of the partner is dependant on whether the client wants their involvement and when it is deemed safe (for the client and the nurse) to do so.</p>

POSSIBLE ADVERSE EFFECTS	LIKELIHOOD	MITIGATING ACTIONS
<b>Midwives might not ask questions about IPV if they think FNP is covering this, potentially missing an opportunity for the client to disclose.</b>	Medium	Family Nurses will link with midwives where questions regarding IPV should have been raised antenatally at least three times, to ensure that all statutory questions have been asked. The pathway between midwifery and the FNP (and other services) will be explored as part of Lambeth's integrated early years pathway.
<b>Increasing a client's self-esteem and knowledge of healthy and unhealthy relationships is positive. However, if the client continues to experience violence then the risk is that she may blame herself for not preventing it. It will need to be clear that if the client is not the perpetrator then she cannot be held responsible for the actions of a violent partner.</b>	Medium	Family Nurses will reinforce the message that the client is not responsible for IPV against her. Increasing knowledge of what constitutes healthy relationships may enable the client to be aware of risks in future partners. Also, parenthood provides, maybe for the first time, an opportunity for the client to do something well and further increase her self-esteem.
<b>The client may experience guilt if she feels that violence has already impacted adversely on her child's development (i.e. owing to her increased knowledge of the impact of violence on a baby's development). This guilt could lead to anxiety or depression that would negatively affect her parenting ability.</b>	Medium	Family Nurses will work with the client to keep the baby in mind and to offer strengths-based solutions on how to minimise any further potentially harmful effects on the baby and the potential gains if the abuse is stopped.
<b>The disclosure and referral rate may increase if more IPV is exposed. This could have a negative impact in that if other local services do not have the capacity to pick up cases it leaves the clients in a very vulnerable position.</b>	Medium	IPV is a priority in Lambeth, so increased referrals will be viewed as a success of the intervention.
<b>Some partners monitor visits through Facetime etc. and the Family Nurse may be unaware of this.</b>	Low	Nurses will work to build trust and transparency and at all times will convey full respect for the client and her partner, with their baby as a focus and a drive for an improved life. This may help the surveilling partner to understand that the priority is the safety and well-being of their child.

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# CONTEXT MAP



## Factor and likely influence

## Actions to address

**POLITICAL**

Public health funding for FNP could be at risk as part of the overall cuts to the public health grant; the local authority focus on social care at the expense of prevention and early intervention services is also a risk. This would create pressure on early intervention services that clients/partners might be referred to, and resources to tackle IPV may be reduced

ABS sites (including LEAP) have the potential to demonstrate the value of investing in early years. A reduction in IPV could contribute to savings across a range of other services such as social care, early help and the criminal justice system, although these may take considerable time to materialise. It is not clear what can be done at a local / FNP level to mitigate possible cuts to IPV services

**ORGANISATIONAL**

Family nurses will need good training and support to deliver the intervention well

Identify gaps in training; FNP National Unit to provide or work with Lambeth local players (e.g. GAIA, MOSAIC, St. Michael's Fellowship, Violence Against Women and Girls (VAWG) Strategic Lead) to source relevant training

Understanding needed from commissioner that time is needed to test the new adaptation and that this may impact on fidelity goals

Seek early support from commissioner and explain rationale to enable testing of new adaptation

Changes in health visiting: cuts in health visiting numbers will impact on support available for young parents experiencing IPV if they graduate early from FNP or disengage from the programme. This could result in an escalation of IPV

Seek assurance from provider lead that FNP graduates will receive targeted support from Early Intervention Health Visitors

**CULTURAL**

Some clients may come from families where violence is the norm i.e. clients/partners think that violence is a way to resolve conflict and don't see the need to change their behaviour as that is how their families/peers behave

Where appropriate, engage the partner in discussions about what constitutes a healthy relationship. The involvement of the partner is dependant on any identified safeguarding risks (nurse's responsibility) and at the request of the client (i.e. the client decides if she wants her partner to be present)

Equally, some clients may not have the knowledge or experience of how to deal with conflict in any other ways besides violence (physical, emotional etc.); even if they want to change they don't have models of alternative ways of being. Some cultures (to be confirmed) may have a patriarchal view of familial relationships and expectations of female partners

The adaptation includes training for nurses on how to deal with conflict within the couple relationship and to offer alternative strategies besides violence. The content on healthy/unhealthy relationships may help the client to understand that violence within relationships is not the "norm". The teen power and control wheel also addresses this issue

## Factor and likely influence

## Actions to address

**CULTURAL**  
(cont'd)

Cultural norms in some demographic groups re: divorce/separation i.e. the "shame" of divorce/separation is worse than continuing to live in a violent/coercive relationship. Clients may therefore not be receptive to any intervention that may imply leaving the relationship

As part of negotiations with the client, consideration will be given to solutions other than leaving partner where it is safe to do so (e.g. focus on conflict resolution skills, work with couples to explore the effect of conflict on the baby in order to raise awareness of potential damage to the developing child)

**ECONOMIC**

Cuts to services in the wider system (i.e. housing, changes to benefits etc.) will limit options for those clients wanting to leave violent relationships. Clients may not be able to afford to live independently and there may be a lack of suitable accommodation

The focus within FNP on improving self-efficacy and increasing aspirations may lead to clients accessing education, employment or training. This would lead to less reliance on state support in terms of benefits and enable clients to obtain paid employment that will give them more options financially. As part of the adaptation and also as part of plans to develop an integrated early years pathway, gaps may be identified i.e. specialist support for fathers; perpetrator programmes etc. LEAP has identified this area of work within its plans and therefore there is potential that additional services could be developed

**OTHER**

Clients may be reluctant to disclose relationship difficulties/violence owing to fear of repercussions from violent partners or family

Importance of family nurse building trust with client; skills training on how to raise the issue of IPV and to manage disclosures in as safe a way as possible

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# CLINICAL FLOW CHART

The clinical flow chart is a visual representation of what materials are used and which assessments are triggered on the FNP ADPT data system during each programme phase (Pregnancy and Infancy). In Lambeth outcomes are measured using the short form of the Conflict in Adolescent Dating Relationships Index (CADRI-SF) at the seventh Pregnancy visit, and then at 6-8 weeks postnatal, and then when the child is six months, 12 months, 18 months and two years old. Targeted activity is triggered by an elevated CADRI-SF score. The content depends on whether the assessment identified a high conflict couple or an abusive relationship.

	Pregnancy		Infancy		Toddlerhood		
<b>Universal activity</b>	Facilitators covering healthy and unhealthy relationships, effect of IPV on the baby/infant and self-efficacy, emotional intelligence and conflict management and communication skills. New teen power and control wheel						
	Digital and online resources to supplement the messages of healthy and unhealthy relationships, effect of IPV on the baby/infant and self-efficacy, emotional intelligence and conflict management and communication skills.						
<b>Targeted activity</b>	High conflict couple: Focus on <b>facilitators to address conflict</b> and improve conflict management. Introduction on One Plus One online resources for relationship management						
	Abusive relationships: Focus on building <b>self-efficacy, referral</b> to Gaia Centre for specialist support, Social Care, and a DASH assessment if severe abuse is suspected for potential MARAC involvement. Fns also provide support throughout referral. After the client is in a place of safety, and if appropriate referral to Freedom programme and work using New Partner facilitator						
<b>Assessment tool</b>	CADRI-SF	CADRI-SF	CADRI-SF	CADRI-SF	CADRI-SF	CADRI-SF	CADRI-SF
<b>Assessment time point for FADS</b>	p7	6-8 wks	6 months	1yr	18 months	2 yrs	





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# ADAPTATION DESCRIPTION



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### Name of adaptation

Promotion of an understanding of healthy intimate partner relationships focusing on the positive effects for the child

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### Target group

All FNP clients will receive the universal offer, namely a visit in each phase of the programme (Pregnancy, Infancy, Toddlerhood) where they will cover materials on: the nature of healthy and unhealthy relationships and how to identify them; the extent, nature, causes and effects on victims of intimate partner violence (IPV); the harmful effects of IPV on children; and some materials promoting skills in healthy communication and conflict management.

At this visit, if the client is in a relationship the nurse will complete an assessment tool which will identify whether there are high levels of conflict in the relationship. If conflict or abuse is identified the client will be offered materials from the targeted version of the adaptation, which includes either (i) additional input on emotional intelligence and skills in communication and conflict resolution or (ii) an emphasis on referral to specialist services, new inputs on self-efficacy, and guidance on choosing a new partner / avoiding a return to the abusive partner.

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### Rationale

The logic model explains this in more detail but in essence:

- Materials designed to improve clients'/partners' knowledge of what constitutes healthy and unhealthy relationships and the harmful impact of IPV on the victim and child will encourage clients (and partners where relevant) to practise healthy relationship behaviour, desist from unhealthy relationship behaviour and proactively protect their children from IPV.
  - Clients who need additional support with managing unhealthy relationships will benefit from the facilitators designed to support emotional intelligence and skills in communications and conflict resolution.
  - Clients in abusive relationships will be identified quickly and receive support to help them find a point of safety, recover from the effects of the abuse and avoid entering into another abusive relationship.
  - The adaptation will be underpinned by: additional training for nurses so that they can implement the adaptation well; an assessment tool to help identify clients who are in abusive relationships (so that the right support can be offered); and a clear referral pathway complemented by support to ensure that clients receive the specialist help they need.
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## What it comprises

### Assessment

All clients will complete an assessment with their nurse using the CADRI-SF scale (Conflict in Adolescent Dating Relationships Inventory Short Form<sup>1</sup>), which has been modified for this adaptation, taking questions from the MASIC (Mediators Assessment of safety issues and Conflict<sup>2</sup>) and local expert suggestions. This assessment asks the client to rate whether she was the victim or perpetrator of IPV in several domains: physical abuse, threatening behaviour, sexual abuse, relational abuse and verbal/emotional abuse. We have added four items to help identify relationships that feature controlling behaviour. These items cover whether the client has experienced her partner trying to control her activity or who she sees, whether she feels fearful of physical harm to herself or others and whether she has changed her behaviour due to fear of her partner. If the client is not in a relationship, the CADRI-S may be completed as a reflection tool to assess past relationships, but not be entered into the FADS (FNP ADAPT Data System), as this reflects current relationships only.

The outcome of this assessment determines whether clients need the targeted offer and, if so, which of two targeted streams are relevant. Thus, there are three possibilities:

- (i) If a client reports no violence in her relationship, she will continue to be offered the universal offer. This will protect her against future abusive relationships and will counter a culture of acceptance of violence in relationships.

If the client reports that she has been a victim or a perpetrator of violence on this scale with a score of 27 or above, she will be eligible for the targeted offer:

- (ii) If she does not report any experience of being controlled (last four questions) it is likely that this relationship, although unhealthy and potentially damaging for her child, is not abusive as defined by the UK government's definition of domestic violence.<sup>3</sup> This client will be offered the first stream of the targeted offer (as outlined below).

- (iii) If the client reports experiencing controlling behaviour from her partner, she will be offered the second stream of the targeted offer.

Assessment points are during pregnancy, 6 weeks, 6 months, 1 year, 18 months and 24 months.

<sup>1</sup> Fernández-González, L. Wekerle, C. and Goldstein, A.L. (2012) 'Measuring adolescent dating violence: development of "Conflict in Adolescent Dating Relationships Inventory" Short Form', *Advances in Mental Health* 11(1), 35-54.

<sup>2</sup> Pokman, V., Rossi, F. S., Holtzworth-Munroe, A. et al. (2014), 'Mediator's Assessment of Safety Issues and Concerns (MASIC): reliability and validity of a new intimate partner violence screen', *Assessment* 21(5) 529-542.

<sup>3</sup>Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial or emotional. Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim." <https://www.gov.uk/government/news/new-definition-of-domestic-violence>

### *Universal offer*

All clients will receive one visit in each stage of the FNP programme (Pregnancy, Infancy and Toddlerhood) where they will focus on IPV. In these sessions Family Nurses might use any combination of the following materials:

- Facilitators covering definitions of IPV and some information on the extent, nature and patterns observed in IPV (“Domestic abuse – the facts”, “Cycle of abuse”, “Being alert!”, “Domestic abuse true or false”).
- “Love Me/love Me not” – a card game that describes behaviours and ask the client to identify whether a certain behaviour is a loving or not loving behaviour.
- The Duluth Wheel (“Power and control wheel”), where the client is encouraged to identify correct and incorrect use of power within relationships, and to reflect on her own relationships, identifying any abuses.
- A new facilitator developed by the FNP National Unit for this adaptation, called “Mum I feel scared”, which encourages the mother to imagine the child’s experience of conflict and the effect it might have on them.
- Cycle of abuse activity, developed by the National Unit for this adaptation; this encourages the client to consider the possible impacts of IPV on both a baby and a growing child. It is also designed to allow time for the client to consider how exposure to IPV might ‘feel’ for the child, trying to help them understand the impacts through the eyes of a child.
- PIPE activity on attachment which encourages the client to: reflect on the effects of significant attachment relationships throughout her life (and bearing in mind her relationship with her child); and consider the effect that modelling a violent relationship might have on her child.

### *Targeted offer*

As described above, the targeted offer is for clients who score more than 27 on the revised CADRI-S:

- (i) Clients who score more than 27 on the CADRI-S but do not report experiencing controlling behaviour in the final four questions will be offered the first targeted stream. This stream comprises increased time spent on facilitators that address issues that might help them to resolve the conflict in a more healthy (non-violent) way. This will include facilitators to encourage: emotional intelligence – “What can I do to change how I feel and behave in difficult situations”, “Emotions and feelings can be so complicated”, “Keeping a mood diary”, “Emotional and relationships” or “Emotions weather map”; and conflict resolution and communication skills – “What can I do to change how I feel and behave in difficult situations”, “What are we fighting for”, “How to get what you want”, “Rules for the floor” and “What’s all the fussing and fighting about”.

(ii) Clients who report experiencing controlling behaviour will be offered the second targeted stream. This stream comprises facilitators to: encourage the client to reflect on her relationship in light of what she's learning about healthy and unhealthy relationships through the universal offer and its effect on her child; and build the client's self-efficacy and help facilitate good decision-making, such as "Making choices and decisions is not always easy" and "Being brave and asking for help and support". These clients will also be referred to Athena who are commissioned in Lewisham to provide the Independent Domestic Violence Advisors (IDVA). They are able to offer specialised support to women experiencing abusive relationships and will be able to facilitate access to specialist services. A client will be referred to the Children's Social Care department if there are concerns about the safety of her child and will be referred to the Multi Agency Risk Assessment Conference (MARAC) if the abuse is judged to be severe by the Family Nurse and the IDVA through a DASH assessment. The Family Nurse will work with clients to help mitigate the trauma of the abusive relationship, using facilitators designed to enhance mindfulness, as there is evidence that mindfulness is effective in addressing anxiety. If they are interested, they may also be referred to the Freedom Programme, a 10-week programme in Lewisham for women experiencing domestic violence, offering safety, guidance and support to help them understand and manage their situation with confidence. Should clients get a new partner or consider a new partner, they will also spend time discussing the "New Partner" facilitator, which is designed to help them to recognise danger signs and protect themselves and their child.

#### *Training*

Family Nurses will receive 2 days training on couple relationships and working with domestic abuse from the Tavistock Unit and Portman NHS Trust.

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#### **Materials needed for delivery**

- New and revised facilitators on identifying healthy and unhealthy relationships
- New facilitators on the effects of IPV on the child
- New facilitators on conflict resolution
- New facilitators on emotional intelligence
- New facilitators on asking for support and decision-making
- Established facilitators supporting communication skills and self-efficacy
- "Love me love me not" game
- Good partnership working with local specialist services supporting families who have domestic abuse issues, supported by clear referral pathway

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### Procedures for delivery

- Selected materials from the universal offer of the adaption will be offered in each of the three stages of the FNP programme once the CADRI-SF and relationship (FNPIIS) questionnaire has been completed. This is planned for early pregnancy, at 6 weeks of age (i.e. infancy), 6 months and then once more when the child is one year old (i.e. toddlerhood).
  - If any conflict or violence are discovered, the client and her partner (if appropriate) will be offered materials from the corresponding stream of the targeted offer.
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### Provider(s)

Family Nurses for the universal offer and the first stream of the targeted offer.  
Specialist services for the second stream of the targeted offer (after the Family Nurse has made the referral), notably Independent Domestic Violence Advisors (IDVA), Freedom Programme, Children's Social Care and MARAC.

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### Mode of delivery

One-to-one visiting of the client by a Family Nurse. Partners will be included if this is safe and wanted by the client.

Once the referral has been made, and if the client takes the offer of support, then specialist services may be delivered in a different location.

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### Where it takes place

In the client's home or a suitable alternative venue (e.g. children's centre).

For clients who are referred for specialist intervention, joint visits with another agency will occur as appropriate, and may occur in any suitable location, depending on safety and the needs of all involved.

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### When / how much

- One focused visit on relationships in every phase of the programme (Pregnancy, Infancy, Toddlerhood), delivering the materials described in the universal offer
  - Targeted offer delivered according to need
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### How it can be tailored

Use of the New Mum Star and personalisation will reinforce agenda-matching to ensure that clients are offered the most relevant parts of the programme in the universal offer. Use of the modified CADRI-SF will identify which clients would benefit from materials to address each stream of the targeted offer.

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### How fidelity is monitored

Visit content will be monitored using the FADS (FNP ADAPT Data System). This will enable Family Nurses to record which elements of the adaptation listed above are delivered, including referral to specialist services (the nature of support provided by specialist services will not be monitored).

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# LOGIC MODEL

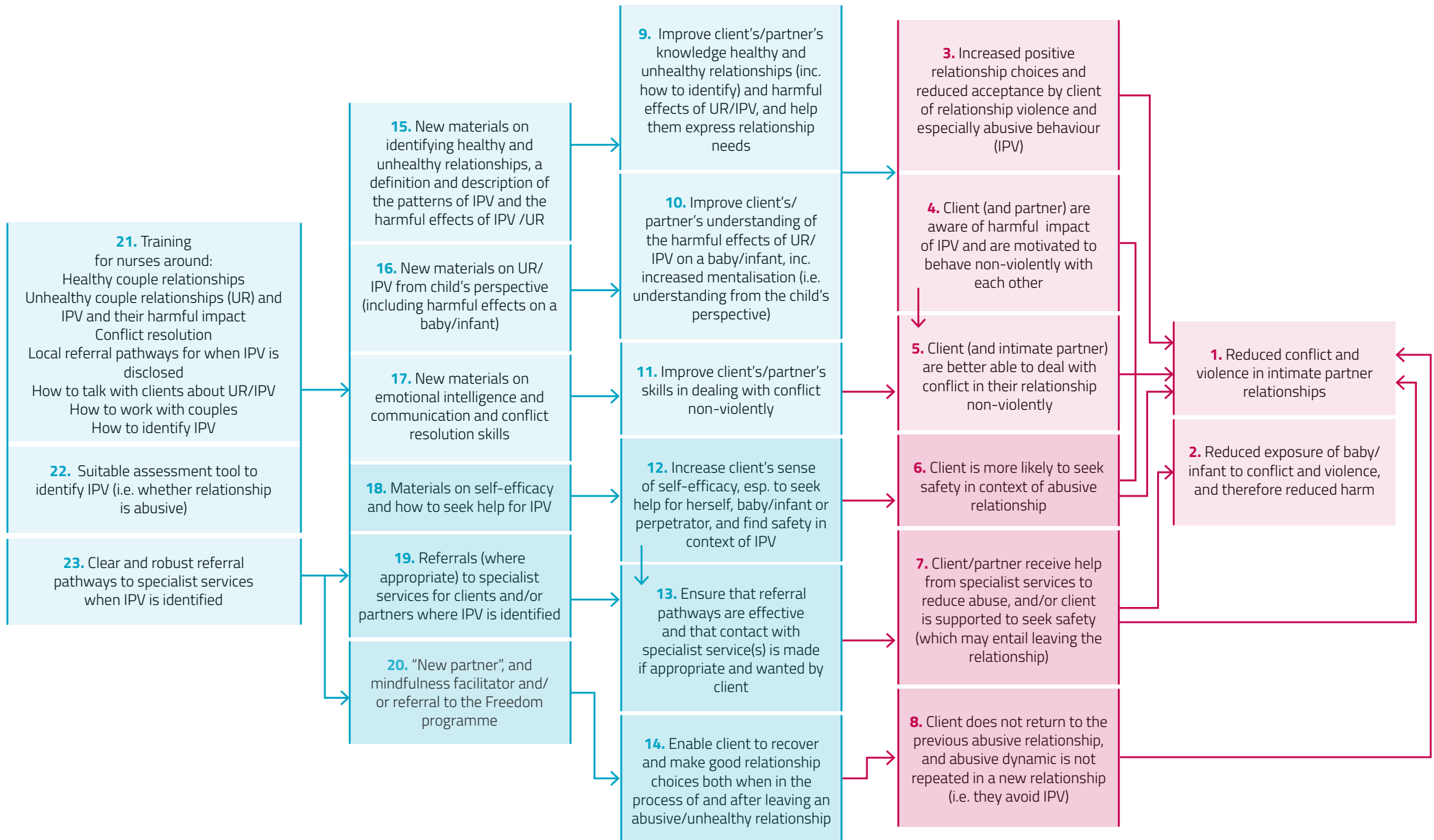
SUPPORTS

ADAPTATION ELEMENTS

MECHANISMS

INTERMEDIATE OUTCOMES

ULTIMATE OUTCOMES



A narrative of each element of the logic model is provided below – numbers relate to relevant boxes in the diagram. It is important to note that the darker shading in the logic model reflects the stream that Family Nurses will follow if they detect an abusive relationship (IPV). The unshaded parts refer to management of an unhealthy relationship where communication skills and conflict resolution skills might be more relevant.

### Ultimate outcomes

There are two ultimate outcomes:

1. The client will have healthier intimate partner relationships (including reduced conflict and violence). This will contribute to the second ultimate outcome.
2. The baby/infant will have reduced exposure to – and therefore harm from – conflict and violence in the mother's intimate partner relationships.

### Intermediate outcomes

The following intermediate outcomes contribute to the above ultimate outcomes:

3. Regardless of her current relationship status, the client will be less accepting of relationship violence and especially abusive behaviour. This will contribute to a reduction in conflict and violence in intimate relationships because the client (and her partner if relevant) are more prepared to address it and the client is more likely to make positive relationship choices (less likely to initiate or remain in abusive relationships).
4. The client and her partner will be more aware of the harmful effects of conflict / IPV (on themselves and their baby/infant), which will motivate them to reduce conflict and violence in the household. This will contribute to them being better able to manage conflict non-violently and, if relevant, for the client to pursue a point of safety if she finds herself in an abusive relationship.
5. The client / partner will be better able to manage conflict in their relationship(s) non-violently. This will contribute to reduced conflict and violence in intimate partner relationships.
6. The client will be more likely to seek a point of safety if she finds herself in an abusive relationship due to increased understanding of the harmful effects of such relationships on herself and her baby/infant and an increase in self-efficacy. This will contribute to a decrease in conflict and violence in the client's intimate partner relationships.
7. Where appropriate, the client or their partner will receive help from specialist services to reduce abuse, and/or the client will be supported by the specialist services to find a point of safety (which may entail leaving the relationship). This will contribute to reduced conflict and violence in intimate partner relationships and to reduced exposure of the baby/infant to violence and therefore harm.



**8.** Where relevant, the client will not return to an abusive partner or start a serious relationship with another abusive partner. This will contribute to reduced conflict and violence in the client's intimate partner relationships.

### **Mechanisms**

The following mechanisms enable these intermediate outcomes.

**9.** Improve client (and partner if suitable) knowledge and awareness of what constitutes healthy and unhealthy relationships, and encourage them to reflect on their own relationships (current and past). With this knowledge, the client is more likely to make positive choices for her current and future relationships and less likely to accept violence in relationships (this includes being less likely to initiate or remain in an unhealthy or abusive relationship, and more likely to challenge violence when she sees it in the relationships of her peers, thereby addressing the culture of acceptability). Also, the client – and partner if relevant – will be more aware of the harmful impact of intimate partner violence (especially on each other's physical and mental well-being) and therefore motivated to practise healthy (non-violent) relationship behaviours and desist from unhealthy (violent) relationship behaviours.

**10.** Improve client (and partner if suitable) understanding of the harmful effects of IPV on a baby/infant through greater mentalisation and an improved understanding of the situation from the child's perspective. Because they care about the baby's well-being, this knowledge will help the client to make positive relationship choices, erode the culture of acceptance around relationship violence (and especially abusive behaviour), and also help to motivate the client and her partner to behave non-violently with each other (i.e. deal with common couple conflict non-violently).

**11.** Improve client (and partner if suitable) skills in dealing with conflict non-violently. These skills will enable the client (and partner if relevant) to deal better (especially non-violently) with conflict in their relationship.

**12.** Increase the client's sense of self-efficacy. In the case of abusive relationships (IPV), this will help her to seek support for herself, the baby/infant or the perpetrator and/or to find a point of safety.

**13.** Ensure that referral pathways are effective and that contact with specialist services is made (for the client) if appropriate and wanted by client. This will help to ensure that clients receive the specialist help they need in order to ensure the safety of themselves and their child.

**14.** Enable the client to make good relationship choices when in the process of and after leaving an unhealthy (abusive) relationship. This will help to ensure that decisions that the client makes about her future relationships are considered and well informed (i.e. she less likely to return to the previous abusive relationship or to repeat the abusive dynamic in a new relationship).

### Adaptation elements

The following adaptation elements will trigger the mechanisms identified above:

**15.** First, new materials will cover how to identify healthy (and unhealthy) relationships and the extent, nature, causes and effects of violence in intimate partner relationships. This will include FNP facilitators and, if appropriate, apps with quizzes for the clients to complete that give a healthy relationship score (e.g. myPlan and Love Smart). Together, these will help to improve the client's (and partner's if relevant) knowledge in these areas, and enable them to articulate what they want and need in a relationship for them and their child.

**16.** Second, new materials will cover the impact of intimate partner violence on a child. This will include visual facilitators on witnessing violence through the eyes of the child and its physical and emotional effects on a child. This will help clients (and partners if relevant) to understand the harmful effects of violence on a baby/infant and how it makes them feel. The materials include a PIPE activity to demonstrate the effect of modelling a violent relationship on the child and their attachment security.

**17.** Third, new materials will focus on developing clients' skills in emotional intelligence, communication and conflict resolution. These will equip the client (and partner if relevant) to be in touch with their own and their partner's feelings and to deal better with strong feelings and address situational couple conflict non-violently.

*NOTE: At the nurse's and client's discretion, the partner can be included at appropriate points with materials in elements 15, 16 and 17, so that the couple have a shared understanding of what constitutes healthy and unhealthy relationships, the harmful effects of IPV on the adult victim(s) and a baby/infant, how to parent in a sensitive and responsive way and how to deal with conflict non-violently. Safeguarding the client and her baby/infant will be the priority for nurses at all times.*

**18.** Fourth, materials will cover self-efficacy and how the client can seek support for herself, her baby/infant or her partner vis-à-vis violence in her intimate partner relationship. These will help the client to take good decisions about whether it is right for her to seek external support and where that should come from (formal and informal sources), and whether she needs to consider finding a point of safety (if she is not safe in her current relationship).

**19.** Fifth, where appropriate, referrals will be made to specialist services for clients and/or partners. These will be made to Children's Social Care in the case of an abusive relationship where there is a child at risk (this child may be also the mother), the Independent Domestic Violence Advisors and then escalated to a MARAC through a DASH assessment. The nurse will ensure that contact is made with the specialist services if appropriate and if wanted by the client. These referrals will ultimately contribute to the client and/or partner receiving appropriate help, whether for being a victim or a perpetrator (and potentially also to the child receiving help).

**20.** Lastly, for clients who have left abusive partners or who are in the process of leaving abusive partners, the “New Partner” facilitator and/or referral to the Freedom Programme<sup>1</sup> will educate clients about the danger signs in relationships and help them to identify healthy and unhealthy prospective partners. This will help clients to make good relationship choices. They will also be introduced to mindfulness to support them in managing anxiety and their recovery from the trauma they have experienced.

### Supports

The following supports help to ensure that the above adaptation elements are delivered well:

**21.** Training for the nurses around the topics of: healthy and unhealthy couple relationships; IPV and its harmful impact; conflict resolution; local referral pathways for when IPV is disclosed (including services for male perpetrators); how to talk with clients about IPV; how to work with couples; and how to identify IPV. This training will complement core training and enable new and experienced nurses’ to discuss relationships and domestic abuse competently with clients (and their partners), help them to deliver new materials on healthy relationships and conflict resolution, and promote effective referrals to specialist services where appropriate. It will be complemented by reviews in team meetings and supervision to ensure a high standard of delivery.

**22.** Suitable assessment tools will be used to identify IPV and to direct the Family Nurse towards the most appropriate care to offer the client (and in particular inform decisions about whether and where to refer clients).

**23.** Clear and robust referral pathways to specialist services, notably Children’s Social Care, Independent Domestic Violence Advisors, the Freedom Programme and MARAC. These will be essential if nurses are to make referrals in order to support those clients and their infants/babies most at risk of harm.

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# DARK LOGIC

POSSIBLE ADVERSE EFFECTS	LIKELIHOOD	MITIGATING ACTIONS
<b>Overload of facilitators and programme materials: clients may disengage from the programme.</b>	Medium / high	Extra training for Family Nurses may reduce this risk as they will be more skilled in delivering the 'sensitive' parts of the FNP programme such as relationships and domestic abuse.
<b>The opportunity cost of focusing on IPV i.e. parts of the programme that would benefit the mother/baby in terms of other outcomes might be displaced.</b>	Medium / high	The skill of the Family Nurse to agenda match / personalise programme materials for clients. Family Nurses will undertake a full assessment of client's needs to ensure that other areas important to the client and baby are not missed. If there is confidence in the New Mum Star, and personalisation is applied as intended, nurses will know what elements of the programme can be flexed if there needs to be greater focus on IPV.
<b>The disclosure and referral rate may increase if more domestic abuse is exposed. This could have a negative impact in that if other local services do not have the capacity to pick up cases it leaves clients in a very vulnerable position.</b>	Medium / high	IPV is a priority in Lewisham, so increased referrals will be viewed as a success of the intervention.
<b>The adaptation is likely to involve raising unwanted issues for the client, her partner and the wider family; violence may be entrenched in family and they may not be receptive to Family Nurses raising issues that are seen as "personal" or interfering in family life. This applies particularly if IPV materials are introduced early in the programme before the trusting therapeutic relationship has been established. This may mean that the client disengages from the FNP programme, which may impact negatively on a range of outcomes for client and her baby.</b>	Medium	The nurses are skilled at developing trust with the client and would ensure that any discussions around potential IPV are raised in a respectful and safe way. The extra training will increase their confidence in delivering the intervention and they will introduce it sensitively, focusing on the unborn baby/child. Also, all clients receive at least part of the adaptation, which reduces stigma.

POSSIBLE ADVERSE EFFECTS	LIKELIHOOD	MITIGATING ACTIONS
<p><b>Increased risk of IPV for some clients who have highly dangerous partners who may view the materials or otherwise become aware that the issue has been discussed; this may make them increasingly violent and/or controlling. [NB. This may be difficult to assess as not all clients disclose abuse.]</b></p>	High	<p>Materials will only be left with clients after careful discussion to ascertain that this is safe. Nurses will receive additional enhanced training on IPV and its risks to the baby, also on specialist support services and referral pathways, including safeguarding protocols.</p>
<p><b>Some partners monitor visits through Facetime etc. and Family Nurses may be unaware of this.</b></p>	Medium	<p>Nurses will work to build trust and transparency and at all times will convey full respect for the client and her partner, with their baby as a focus and a drive for an improved life. This may help the surveilling partner to understand that the priority is the safety and well-being of their child. In addition, Family Nurses will have a discussion about this at the start of the programme with all clients.</p>
<p><b>Involving the client's partner in the programme may lead to lack of disclosure by the client (if the partner is a perpetrator of violence). Partner may not "allow" client to attend sessions alone.</b></p>	Medium	<p>Family Nurses will ask to see the client alone to complete the relationship questionnaire (Relationship Data form). If this proves very difficult, this may provide an insight into potential controlling behaviour by the partner and highlight the need for further work on IPV with the client. The involvement of the partner is dependant on whether the client wants their involvement and when it is deemed safe (for the client and the nurse) to do so.</p>

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# CONTEXT MAP

	Factor and likely influence	Actions to address
<b>POLITICAL</b>	Budget cuts may impact adversely on other support services that FNP clients can access for help with IPV issues (i.e. reduce their capacity to help clients who are referred by FNP)	The adaptation currently recommends referral to Children’s Social Care department (statutory service), Independent Domestic Violence Advisors (based at the women’s refuge) and the Freedom programme. If these services are unable to provide support, alternative support services will be found i.e. online/London-wide/helplines
<b>ORGANISATIONAL</b>	Family Nurses will need training to enable them to utilise the new materials	Protected time for training for Family Nurses agreed with commissioner/provider lead
<b>CULTURAL</b>	<p>Some clients may not be willing to engage with ADAPT materials due to fear of disclosure/past experiences etc. and this will reduce the effectiveness of the intervention. For example, they may be fearful that Children’s Social Care will be contacted and their children will be removed, or that their partner may find out that they have spoken about the abuse and it may escalate the situation (see dark logic model)</p> <p>Some clients (and their partners) may not have the knowledge or experience of how to deal with conflict in any other ways besides violence (physical, emotional etc.); even if they want to change they don’t have models of alternative ways of being (i.e. it is the norm). Some cultures may have a patriarchal view of familial relationships and expectations of female partners</p> <p>Cultural norms in some demographic groups mean that the “shame” of divorce/separation is worse than continuing to live in a violent/coercive relationship. Clients may therefore not be receptive to an intervention that may imply leaving the relationship (even an abusive one)</p>	<p>Nurses will deliver in line with advanced training received and offer thoughtful and honest explanations about the importance of the intervention for clients and their children. They will seek to build on clients’ intrinsic motivation to make changes for the good of their baby/infant by focusing on the benefits to the child, and discussing the negative implications for the child (i.e harm) if the situation continues</p> <p>The adaptation includes training for nurses on how to deal with conflict within the couple relationship and to offer alternative strategies besides violence. The content on healthy/unhealthy relationships may help the client to understand that violence within relationships is not the “norm”. The teen power and control wheel also addresses this issue. In addition, where appropriate, the partner will be engaged in discussions about what constitutes a healthy relationship</p> <p>As part of negotiations with the client, consideration will be given to solutions other than leaving partner where it is safe to do so (e.g. focus on conflict resolution skills; work with couples to explore the effect of conflict on the baby in order to raise awareness of potential damage to developing child)</p>



## Factor and likely influence

## Actions to address

**ECONOMIC**

Budget constraints in the present economic climate may impact on training time and the use of external materials

This project has support from the FNP commissioner, therefore resources should be made available for nurses to attend training to support implementation. All external materials will be selected on the basis that they are of high quality and freely available

Cuts to services in the wider system (i.e. housing, changes to benefits etc.) will limit options for those clients wanting to leave violent relationships. Clients may not be able to afford to live independently and there may be a lack of suitable accommodation

The focus within FNP on improving self-efficacy and increasing aspirations may lead to clients accessing education, employment or training. This would lead to less reliance on state support in terms of benefits and enable clients to obtain paid employment that will give them more options financially

**OTHER**

Client reluctance to disclose relationship difficulties/violence owing to fear of repercussions from violent partner or family

Importance of the Family Nurse building trust with client; skills training on how to raise the issue of IPV and to manage disclosures as safely as possible

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# CLINICAL FLOW CHART

The clinical flow chart is a visual representation of what materials are used and which assessments are triggered on the FNP ADPT data system during each programme phase (Pregnancy and Infancy). In Lewisham outcomes are measured using the short form of the Conflict in Adolescent Dating Relationships Index (CADRI-SF) at the seventh Pregnancy visit, and then at 6-8 weeks postnatal, and then when the child is six months, 12 months, 18 months and two years old. Targeted activity is triggered by an elevated CADRI-SF score. The content depends on whether the assessment identified a high conflict couple or an abusive relationship.

	Pregnancy		Infancy		Toddlerhood			
<b>Universal activity</b>	<b>Facilitators</b> covering healthy and unhealthy relationships, effect of IPV on the baby/infant and self-efficacy, emotional intelligence and conflict management and communication skills. New teen power and control wheel							
	<b>Digital and online</b> resources to supplement the messages of healthy and unhealthy relationships, effect of IPV on the baby/infant and self-efficacy, emotional intelligence and conflict management and communication skills.							
<b>Targeted activity</b>	High conflict couple: Focus on <b>facilitators to address conflict</b> and improve conflict management. Introduction on One Plus One online resources for relationship management							
	Abusive relationships: Focus on building <b>self-efficacy, referral</b> to Social Care and other specialist services, support throughout referral. After relationship end if appropriate then referral to Freedom programme and work using New Partner facilitator and mindfulness to address trauma and anxiety							
<b>Assessment tool</b>	CADRI-SF		CADRI-SF		CADRI-SF	CADRI-SF	CADRI-SF	
<b>Assessment time point for FADS</b>	P7		6-8 wks		6 months	1yr	18 months	2 yrs



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# ADAPTATION DESCRIPTION

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**Name of adaptation**

Nottingham City Maternal Mental Health Intervention (MMH)

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**Target group**

All FNP clients will benefit from a Universal Offer (a refocus of FNP programme materials to raise greater awareness and understanding of maternal mental health).

For clients where the probable presence of a mild to moderate mental health disorder has been identified, there will be a new targeted offer.

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**Rationale**

Perinatal mental health illness is common. Between 10% and 20% of women will develop a mental illness during pregnancy or within the first year after having a baby. Suicide is also one of the major causes of maternal death. Many women will have mild to moderate illness, including depression, anxiety and PTSD, but some will have severe depression, PTSD or pre-existing serious illness like schizophrenia or bipolar disorder or they may develop postpartum psychosis with no previous history.

There are four main intervention components: a revised universal offer; a targeted offer for mothers with identified mental health problems; the assessment of maternal mental health; and referral to specialist services for those mothers needing greater support (accompanied by specialist training for Family Nurses). Collectively these will increase: clients' understanding and recognition of mental health problems and their impact; clients' knowledge of and skill in using self-help and coping strategies; clients' knowledge of sources of help and how to ask for help, and the likelihood that they will ask for help when needed; clients' willingness to disclose mental health concerns where they exist; the likelihood of clients receiving appropriate and timely specialist help for mental health concerns where they exist; and clients' knowledge of and skills in responsive and sensitive parenting. In turn, these will help to prevent and/or address mental health issues for clients in the ante- and post-natal periods.

For clients, this will help to increase their social capacity and sensitive and responsive parenting. For children, this will help to improve their attachment, social-emotional development and school readiness.

Effective identification by screening tool leads to higher rates of detection of perinatal mood disorders which enables appropriate support to be put in place and a greater ability to support women to improve their mental wellbeing and their relationship with (and the wellbeing) of the baby.

In order to enhance support for MMH, Nottingham FNP will offer a new targeted 'dialling up' in intensity to 4-6 weekly visits to clients where the probable presence of a mild to moderate mental health issue is identified through the mental health assessment tool(s) and supplemented by contextual information gathered by the Family Nurse. This enhanced package of care will result in a closer focus on mental health, through a combination of conversations and time to listen due to the dial up in intensity, and the introduction of new and existing FNP facilitators and activities, newly developed self-help materials and the use of an App which will focus on improving the mother's mental wellbeing. As recommended, Citycare is in the process of developing a perinatal support pathway (outside of ADAPT), identifying routes for interventions and step up to specialist treatments. This will be an intrinsic part of ADAPT and mean being able to offer routes to robust care where clients are experiencing more serious conditions or levels of MMH.

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### What it comprises

There are five main elements, as follows.

#### *Universal offer*

A revised FNP programme to highlight and refocus resources to better identify and raise awareness of mental health issues will be delivered to all FNP clients. This includes existing materials (some revised and/or moved) plus new materials. As part of this universal offer, Family Nurses will continue to ask about client's emotional health at every visit.

In pregnancy the universal offer will cover topics such as common worries, life stressors (and their impact on the client), how to ask for help and support, Baby Blues and post-natal depression. In infancy it will cover topics such as taking care of oneself when stressed and emotional refuelling.

#### *Targeted offer*

A targeted intervention will be delivered to clients with mild to moderate anxiety and/or depression as determined by one of the new assessment tools or FN/client assessment of need (see point 3 below). It will address the mother's mental wellbeing and her relationship with – and therefore also the wellbeing of – the baby. Includes existing (some moved) and new materials. Broadly this will cover three subject areas:

The first is information and discussion about depression, anxiety and other mental health conditions (e.g. psychosis, bipolar) – what they are and how they impact on the client, their child and their relationships:

- Card activity – information about a variety of common mental health concerns

The second subject area is information and advice about self-help and coping strategies:

- Existing facilitators: "How are you feeling?", "Life stressors", "How I cope" (Parts 1 and 2), "What I do when upset and angry", "How I ask for help and support", "What have I done well?"



- Mood diary to help clients to recognise and express how they are feeling, triggers for mental health concerns and what helps to address them
- Introduction to mindfulness and relaxation (possibly to include one or more apps)
- Information on different types of counselling (what they are, what they feel like, benefits) and guidance for clients thinking about using it
- Emotional well-being self assessment – this could be conducted using an app such as “Well Mind” or “What’s up?”, or a paper-based self-assessment, similar in structure to the Boots Trust emotional well-being plan.

The third subject areas is information, advice and coaching on sensitive and responsive parenting (to support parental responsiveness / attunement to infant cues, build self-esteem in parenting, and support the cognitive and emotional development of the infant):

- DANCE – observation and assessment of mother-child interaction (includes a focus on strengths)
- PIPE (inc. baby cues, joy and laughter, tune in tune out, Love needs a safe base)
- Supporting Relationships (evidence that maternal mental health affects relationships and mental health issues in fathers)
- Technology such as: Getting to know your baby, Baby Buddy app, Vroom app Following facilitation of the Targeted offer, a follow-up assessment will be carried out to identify improvement or requirement for a specialist intervention.

Following facilitation of the targeted offer, a follow-up assessment will be carried out to identify improvement or requirement for a specialist intervention.

#### *Assessment*

Before ADAPT, in Nottingham, Family Nurses used the Hospital Anxiety and Depression Scale (HADS) to identify the presence of anxiety or depression. Nottingham will be testing the Edinburgh Postnatal Depression Scale (EPDS) and the GAD-7 (Generalised Anxiety Disorder Assessment). These are both well validated and reliable assessment tools. Assessment will take place at the following time points: Antenatal (P4); Early Infancy (I6); Later in Infancy (4–6 months). As such, each client will receive a minimum of three opportunities for assessment. If mild, moderate or severe depression or anxiety are identified, the client will be offered the targeted offer.

#### *Referral to specialist intervention*

If the client has severe needs, specialist intervention may be performed simultaneously with the targeted offer. The approach of the perinatal mental health pathway will determine route and next steps. In addition, and in order to support the above three elements, Family Nurses will receive specialist mental health training.

*Training*

Family Nurses will receive training on maternal mental health from a Specialist Health Visitor using the Institute of Health Visiting training package, adapted for FNP. This will cover specialist information on aspects of maternal mental health and how to recognise them. They will also learn how and when to refer clients to services and which services to access depending on the level of need.

**Materials needed for delivery**

- Effective self-report assessment tools for depression and anxiety: the EPDS and the GAD-7
- The materials that constitute the revised universal offer
- The newly developed themed toolkit of resources as outlined above for addressing identified mental health problems (to include one or more internet-based / media tools)
- New/revised practice guidance to support delivery (includes additional training for Family Nurses)

**Procedures for delivery**

- Deliver the FNP programme (revised universal offer, with enhanced focus on maternal mental health) to all clients
- Use validated maternal mental health assessment tool(s) [EPDS and GAD-7] on three occasions:
  - Antenatal (P4)
  - Early Infancy (I6)
  - Later in Infancy (4-6 months)
- Deliver new targeted offer (according to assessment cut-off score) to clients where the probable presence of a mild-to-moderate mental health disorder is identified. This will entail a 'dial up' to weekly visits, over a period of 4-6 weeks, dependent on the client's presentation and progress made. The Toolkit will match resources and self-help tools to client need.
- Reassess clients following intervention using the EPDS and the GAD7.
- Refer clients to the perinatal pathway for additional services if required (according to assessment tools or professional judgement)
- Carry on delivering the FNP programme (agenda match / personalise to individual need). Consider 'missed' materials that would have been covered during the period that the intervention took place.

**Provider(s)**

Nottingham City Care: Family Nurse Partnership, Specialist Health Visitor - Maternal and Infant Mental Health and ABS

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### Mode of delivery

- One-to-one home visiting by Family Nurses
- Virtual (via use of one or more apps that Family Nurses encourage clients to use)
- Possibly other modes of delivery for clients referred to specialist services

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### Where it takes place

- Assessments and visits will take place in the home or a mutually agreed venue.
- For some clients there will be a virtual element (if one or more apps are used).
- For clients who are successfully referred to specialist help, such provision will be provided in appropriate venues (e.g. clinics).

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### When / how much

*Universal offer* – as per personalisation guidelines

*Targeted offer* – depending on the client's presentation and wishes, this may vary through agenda-matching and personalisation, but the standard offer will consist of a weekly intervention over 4-6 weeks consisting of visits that last 60-90 minutes Specialist help – to be determined on a per client basis

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### How it can be tailored

Agenda matching and personalisation will determine which elements are delivered and when. This may vary according to client need. (Applies to both the universal and the targeted offers.)

Resources from within the revised universal offer and the new (targeted) toolkit will be selected according to client need and suitability. (This includes the use of apps.)

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### How fidelity is monitored

The Visits section of FADS (FNP ADAPT Data System) will record for each visit (i) what is delivered in relation to the FNP Themed Index and New Mum Star, and (ii) which elements of the adaptation listed above are delivered (this will include whether clients completed the assessment tools).

Clients will be asked for feedback on the clinical adaptation, including what they received and how well they engaged with it.

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# LOGIC MODEL

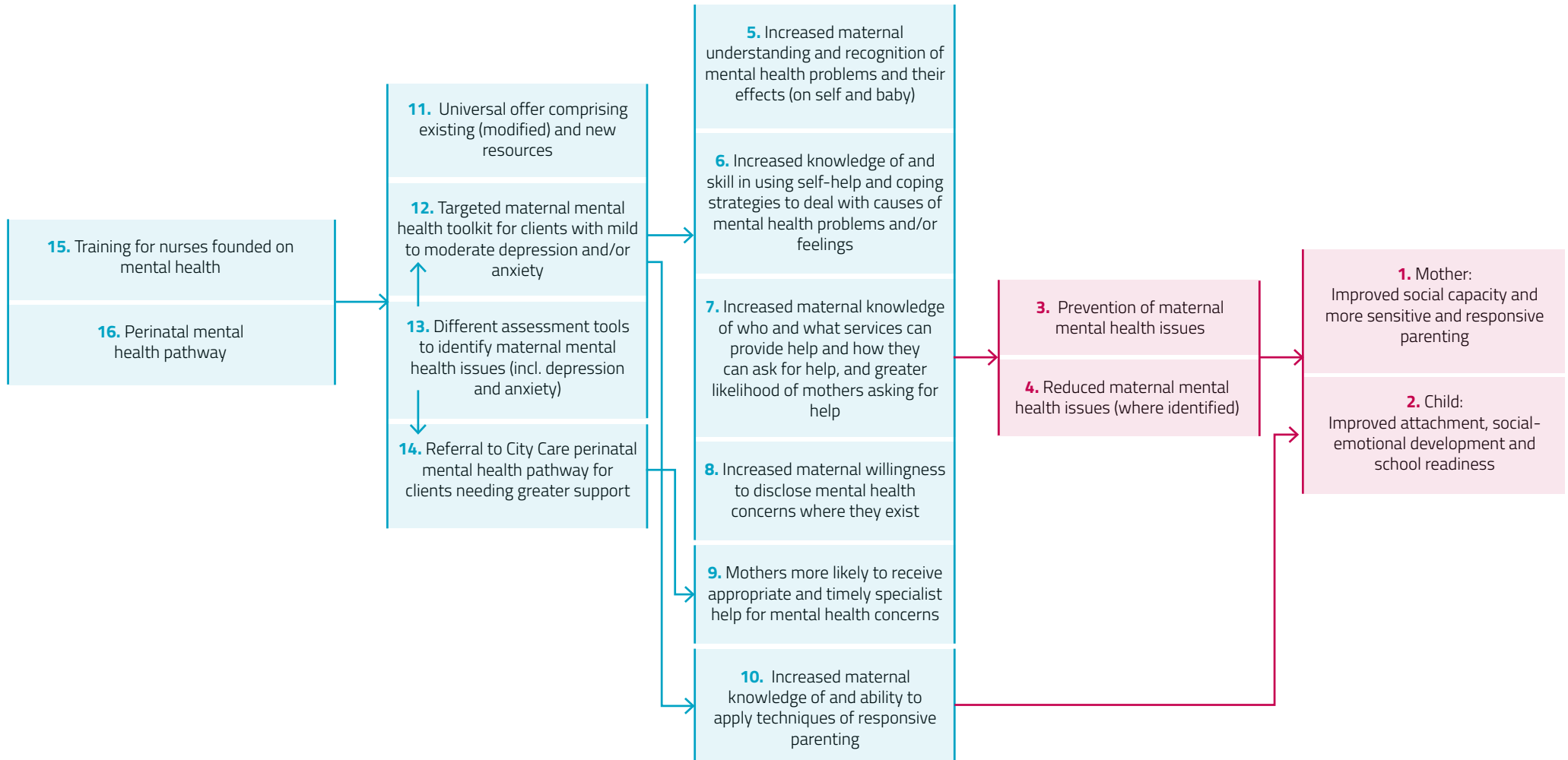
SUPPORTS

ADAPTATION ELEMENTS

MECHANISMS

INTERMEDIATE OUTCOMES

ULTIMATE OUTCOMES



A narrative of each element of the logic model is provided below - numbers relate to the relevant boxes in the diagram.

### Ultimate outcomes

There are two groups of ultimate outcomes:

- 1.** The first group of ultimate outcomes relate to the mother. One aim is to improve maternal social capacity, which can be defined as the network of social connections that exist between people, and their shared values and norms of behaviour, which enable and encourage mutually advantageous social cooperation. The other aim is to increase mothers' sensitive and responsive parenting, which refers to the use of warm and accepting behaviours to respond to children's needs and cues.
- 2.** The second group of ultimate outcomes relates to the child. One is improved attachment, a strong emotional and physical attachment to at least one primary caregiver that is critical to personal development. Another is improved social-emotional development, which refers to the child's experience, expression and management of emotions and the ability to establish positive and rewarding relationships with others. It encompasses both intra- and interpersonal processes. The final ultimate child outcome concerns school readiness, defined as the child having strong social skills, being able to cope emotionally with being separated from their parents, being relatively independent in their own personal care, and having a curiosity about the world and a desire to learn.

### Intermediate outcomes

The likelihood of achieving these ultimate outcomes is increased if two intermediate outcomes are achieved.

- 3.** The first is the prevention of maternal mental health issues in both the antenatal and postnatal periods. This includes depression, anxiety and post-traumatic stress. This will contribute to the mother's social capacity because she will feel able to access social support networks such as peers, professionals and community activities. It will also help to increase the mother's sensitive and responsive parenting by enabling her to understand how her wellbeing impacts on her child and strategies that help her to respond to her baby and its cues.
- 4.** The second intermediate outcome is reduced maternal mental health issues for mothers who already have identified problems, including depression, anxiety or other mental health conditions. This will contribute to the mother's social capacity because by providing coping strategies and access to the right level of support she will be better able to engage with supportive social networks. It will also help to increase the mother's sensitive and responsive parenting by helping her to understand her own emotional wellbeing and its impact on her parenting, and support her to respond with warmth to her child's signals and needs.

## Mechanisms

The adaptation elements are connected to the intermediate outcomes by several mechanisms, as follows.

- 5.** Clients will have an increased understanding and recognition of mental health problems and their effect on the client themselves and their baby. This will contribute to the prevention of mental health problems because being able to recognise symptoms of mental health issues enables the clients to seek early help. It will also contribute to reducing mental health problems where they exist because discussing issues with a trusted practitioner may reduce anxiety and enable the right support to be provided. This might include providing coping strategies or referral to additional support.
- 6.** Clients will have an increased knowledge of and skill in using self-help and coping strategies to deal with (a) the causes of mental health problems and/or (b) feelings of depression and/or anxiety. This will contribute to the prevention of serious mental health problems because early intervention and the client's ability to implement a useful strategy may prevent escalation of their mental health condition. It will also contribute to reducing mental health problems where they exist.
- 7.** Clients will have an increased knowledge of who and what services can provide help and how they can ask for help, and will be more likely to seek the appropriate networks of support when needed. This will contribute to the prevention of serious mental health problems. In addition, having the right information, particularly about the frequency of mental health problems, has a destigmatising effect such that clients are more likely to seek help early.
- 8.** Clients will have an increased willingness to disclose mental health concerns where they exist, in part owing to a reduction of stigma surround the issue. This will contribute to the prevention of serious mental health problems, in that a better understanding of the prevalence of mental health issues on many mothers should make clients feel less isolated and more likely to seek early help.
- 9.** Clients will be more likely to receive appropriate and timely specialist help for mental health concerns where needed. This will contribute to reducing serious mental health problems where they exist because intervening early will prevent their escalation.
- 10.** Clients will have an increased knowledge of and skills in responsive and sensitive parenting, which will help parents feel empowered due to learned strategies to enable them to respond appropriately to their child's needs. This will contribute to secure attachment, positive child social-emotional development and school readiness.

### Adaptation elements

The adaptation comprises the following elements, which enable the mechanisms that contribute to the intermediate outcomes.

**11.** The first is a revised universal offer (i.e. for all clients) comprised of existing (modified) and new resources. In pregnancy these will comprise: information and discussion about common worries, life stressors, baby blues and post-natal depression; and guidance on how to ask for help. In infancy there will be information and advice on how the mother can take care of herself when she is stressed, and emotional refueling. This will increase a mother's understanding of mental health problems, their effects on herself and her baby, and how to use self-help and coping strategies, and increase her confidence and ability to disclose mental health difficulties when they arise.

**12.** The second element of the adaptation is a maternal mental health toolkit for clients identified – through the assessment tools or nurse/client judgement (see point 13 below) – as having mild to moderate depression and/or anxiety. This will comprise: information and discussion about what depression, anxiety and other mental health conditions are and how they impact on the client herself, her child and her relationships; information and advice about self-help and coping strategies; and information, advice and coaching on sensitive and responsive parenting. Through use of the toolkit with clients on an individual basis, nurses will be able to agenda match to address relevant issues, and help clients to understand their emotional health and its impact on their children and relationships.

**13.** The third element of the new adaptation involves well-validated and reliable assessment tools to identify maternal mental health issues (including depression and anxiety but also post-traumatic stress) that are new to FNP. The Edinburgh Postnatal Depression Scale (EPDS) will be used to help identify depression, and the Generalised Anxiety Disorder Assessment (GAD-7) will be used to help identify anxiety. These will be applied at the following points in the programme: Antenatal P4/5. Early Infancy I6, later in Infancy 4-5 months of age. This will enable improved identification of mental health problems, in part because of increased opportunities for clients to disclose difficulties, which could lead to earlier and improved support (via the mental health toolkit or specialist services).

**14.** The fourth and final element of the adaptation is referral of clients identified as needing greater support to appropriate services via the perinatal mental health pathway in Nottingham. This will mean that clients with severe mental health issues are identified early and are more likely to receive the most appropriate specialist help in a timely manner.



## Supports

Alongside regular training and support, two main supports need to be in place in order for these adaptation elements to be delivered well.

**15.** The first is training for nurses focused on mental health. This covers how and when to refer to services and which services to access (depending on which category the concerns fall into: mild to moderate, moderate to severe, or crisis). This will contribute to the successful implementation the toolkit because the Family Nurses will have improved knowledge across all areas of mental health and will be better placed to support clients to prevent or address mental health problems.

**16.** The second support is the perinatal mental health pathway, which is being developed in Nottingham outside of ADAPT. This will provide a framework across all children's services to enable practitioners to direct clients to the right agencies and levels of support, which in turn will help to ensure that clients with mental health problems receive appropriate help.

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# DARK LOGIC

POSSIBLE ADVERSE EFFECTS	LIKELIHOOD	MITIGATING ACTIONS
<p><b>Clients with mental health (MH) issues will not accept support and could disengage from the FNP programme, as they do not want to address these issues.</b></p>	<p>Low (clients' feedback prioritises MMH)</p>	<p>The family nurse will work towards developing a therapeutic relationship with the client. Use familiar resources (FNP format)</p> <p>Agenda match (and personalise) using the new toolkit.</p>
<p><b>Assessment tool may not effectively identify all maternal maternal health (MMH) issues. This may result in MH issues being missed or not addressed, or conversely, in resources being wasted on clients who are wrongly identified as having a MMH problem.</b></p>	<p>Low</p>	<p>Use of well-validated outcomes measures to detect MMH.</p> <p>Use of New Mum Star, which also invites exploration of mother's health and well being.</p>
<p><b>By offering intensive focus on MMH, through the new intervention, other parts of the programme cannot be covered, which in turn means that other outcome areas suffer.</b></p>	<p>Low</p>	<p>Short intervention in comparison to entire programme (i.e. should not take up too much extra time).</p> <p>Agenda matching and personalisation should mean that priority is given to outcomes of most concern for each client – especially through the New Mum Star. Benefits of intervention contribute to other programme outcomes, such as positive attachment between mother and child through responsive parenting. Increased confidence of the mother may also lead to improved outcomes for mother and baby.</p>
<p><b>Clients may feel their non-MH issues are not being addressed, and may disengage from the FNP programme as a result.</b></p>	<p>Low</p>	<p>Family Nurse will use their skills in effective communication and active listening. Agenda matching; work with personalisation guidance and New Mum Star to evidence and agree with clients areas where work is required.</p>

POSSIBLE ADVERSE EFFECTS	LIKELIHOOD	MITIGATING ACTIONS
<b>MMH intervention in FNP is different to chosen approach for universal children's services which may be confusing for clients transferring between services and professionals.</b>	Low	Work closely with universal services to develop ADAPT model and to deliver the pathway for perinatal mental health developed citywide for service providers in Nottingham City. If issues remain unresolved, clients will be referred to the MMH support pathway which will be used across universal services and FNP.
<b>Capacity in FNP is reduced (vacancies in service).</b>	High	Request vacancy filled.
<b>Nurses are unable to dial up intensity of visits for targeted offer due to numbers of clients. Therefore adaptation not able to implemented as designed and not able to evidence results.</b>	High	Operate waiting list for clients to ensure service not over-subscribed. Consider implementing adaptation without dial-up element.

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# CONTEXT MAP

## Factor and likely influence

## Actions to address

**POLITICAL**

Mental health highlighted as a priority by Nottingham City Council. Children and Young Peoples. Plan 2015/16 has identified priority of 'Promoting the health and wellbeing of babies, children and young people'

ADAPT to evidence impact FNP has on MMH and use its learning to enhance support and service offered through wider children's services through exchange of skills and knowledge

**ORGANISATIONAL**

Local priority to enhance maternal mental health (MMH) support as part of the wider offer to improve mental health across the City's population

Adaptation is in line with local priorities. FNP to be able to evidence outcomes of improving MMH

Citycare (FNP provider) aims to increase support to impact on mothers' and babies' emotional health. Small Steps Big Changes (A Better Start) has a priority to improve children's social and emotional health. As part of the universal services offer, a Specialist Health Visitor has been appointed to address perinatal and children's emotional health needs. The development of a perinatal pathway is underway. PoNDER training will be rolled out across universal health visiting teams

FNP is able to offer a targeted intervention to improve MMH and link with organisation pathway for additional support. Transitions from FNP to universal services offer client continuity in support of MMH. Adaptation includes use of the EPDS

Continuity of support for MMH through integrated service provision across children's services

Transitions from FNP to universal services offer client continuity in support of MMH

Strong steer from provider to test the Edinburgh Postnatal Depression Scale (EPDS) assessment to offer consistency, especially as through ADAPT personalisation clients may stay for shorter periods with FNP

Adaptation includes use of the EPDS

	Factor and likely influence	Actions to address
<b>CULTURAL</b>	<p>Stigma still exists around acknowledgement of MMH and MH, especially within young people. FNP clients express that they have concerns in admitting that they have mental health issues. They fear they will be judged as a bad parent and that their children will be removed from their care</p>	<p>Through ADAPT, additional training of FNP workforce to enable practitioners to address and discuss MMH and to de-mystify stigmatised issues</p> <p>Development of resources to highlight issues of MMH and de-mystify stigmatised issues</p> <p>Ensure that clients continue to view Family Nurses with respect and trust, so that they are able to share worries and concerns</p>
<b>ECONOMIC</b>	<p>Economic crisis. Saving cuts across all services, including FNP. This creates pressure on FNP to demonstrate clear value for money</p>	<p>Adaptation potentially offers value for money through evidence of improved outcomes</p> <p>Improved mental health for mothers leads to more sensitive and responsive parenting, which benefits the child. It also benefits the mother in reducing her morbidity and enables her to contribute to society, in particular through engaging in education and employment</p>
<b>OTHER</b>	<p>It is an auspicious time for FNP Nottingham to develop this adaptation, as the perinatal pathway is currently being developed to improve inter-agency working and outcomes for women with perinatal health problems</p>	<p>Through ADAPT, Nottingham FNP hope to strengthen existing processes through which they are working with other service delivery partners. They anticipate that this adaptation will help them to influence future service models of working with MMH across services. Learning from ADAPT will be shared across wider children's services provision to inform practice</p>

NOTTINGHAM

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# CLINICAL FLOW CHART



The clinical flow chart is a visual representation of what materials are used and which assessments are triggered on the FNP ADPT data system during each programme phase (Pregnancy, Infancy and Toddlerhood). In Nottingham, Family Nurses will use the Edinburgh Postnatal Depression Scale (EPDS) to identify postnatal depression (PND) and the Generalised Anxiety Scale (GAD-7) to identify anxiety in the perinatal phase. Targeted activity will be triggered by a score on the assessment tools that indicates mild to moderate anxiety or depression.

	Pregnancy	Infancy	Toddlerhood
<b>Universal activity</b>	Pregnancy facilitators - common worries, life stressors, asking for help Baby Blues and PND	Facilitators: Taking care of self when stressed and emotional refuelling; Information about depression and anxiety	
<b>Targeted activity</b>	Information and discussion about depression, anxiety and other MH disorders assessment (card activity) Information and discussion about self-help (Facilitators, mood diary, mindfulness, counselling, emotional well-being assessment) Information, advice and coaching on sensitive and responsive parenting (DANCE, PIPE, Supporting relationships, apps) Referral for specialist support - perinatal mental health pathway		
<b>Assessment tool</b>	EPDS + GAD-7	EPDS + GAD-7	EPDS + GAD-7
<b>Assessment time point for FADS</b>	16+ weeks	2 months	4 -6 months



8.

# PORTSMOUTH

PORTSMOUTH

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# ADAPTATION DESCRIPTION

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### Name of the adaptation

Working with FNP families to prevent neglect through early identification and targeted intervention

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### Target group

All FNP clients, and their partners if appropriate, will receive facilitators in pregnancy through which they will: learn what neglect is and why it happens; and participate in a discussion of parenting styles, and an exploration of the child's day that highlights the child's need for care and attention (to be delivered alongside a facilitator exploring the mother's day).

Clients who (1) present with any risk factors for neglect (uncovered as the therapeutic relationship develops), or (2) score lowly on certain prongs of the New Mum Star, or (3) are witnessed providing neglectful parenting by a professional will receive the Graded Care Profile 2 (GCP-2) assessment to identify whether they are potentially or actually neglectful in their parenting style.

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### Rationale

The aim of this adaptation is to reduce the short- and long-term effects of neglect on the child.<sup>1</sup> This requires preventing or reducing neglect and promoting good parental care and supervision. For this to happen, nurses need to be able to recognise and respond to risk factors and support sensitive and responsive parenting. Clients need to become more knowledgeable about appropriate childcare, understand neglect (including its often intergenerational nature) and its adverse impacts on the child, and become more attuned to their child's needs and emotions. They may benefit from stronger formal and informal support to avoid later crisis.

The assessment of neglect can be difficult. The adaptation will therefore include a new assessment tool to help identify neglect, and mothers who need extra help (beyond FNP) will be referred to specialist services. The materials to support the adaptation will include new and revised facilitators and activities that cover these subject areas.

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<sup>1</sup> Neglect can fluctuate both in level and duration. A child's welfare can, for example, improve following input from services or a change in circumstances and review, but then deteriorate once support is removed. This adaptation seeks to improve the approach taken by the Family Nurse so that there is a residual impact on parenting and reduction in neglect.

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## What it comprises

### *Assessment*

Where neglect is suspected, the client and her household will be assessed using the GCP-2, a low burden, highly valid and reliable assessment tool, to identify the presence or potential of neglect. There are three triggers for this assessment: (1) clients with risk factors for neglect (previous history, history of attachment disorder, substance abuse, mental health problems or domestic violence) which will become evident through the client records and/or nurse's assessment at recruitment and may also be disclosed as trust builds between the nurse and client; (2) if a client scores 4 or below on the New Mum Star on any of the prongs of 'Keeping your baby safe', 'Looking after your baby', 'Baby's development' and 'Connecting with your baby'; or (3) if a professional has observed parenting behaviours that indicate that the infant's needs are being neglected. If the client displays no neglect the universal stream of the adaptation will be offered.

Otherwise, targeted support will be provided (see below).

If at the initial assessment the family score a grade 5 in two areas on the GCP2, indicating that there is severe neglect, a referral to Children's social care will be made in conjunction with work using the FNP revised materials, to ensure that the welfare of the children in the family is safeguarded at all times.

The GCP-2 will be repeated six months after the initial assessment if actual or potential neglect was identified, to check progress (i.e. after implementation of revised FNP materials on neglect). Should no or insufficient improvement be found, after discussion with the supervisor clients will be offered a repeat of the revised FNP materials and, if the problem of neglect is not improved (i.e. new score of 4 or 5 on the GCP-2, indicating that the child's needs are not met most of the time or never met), the FN will escalate to specialist services (i.e. the Children and Families social care department), in accordance with local protocols. This is also in line with the guidance from the NSPCC who state that: Where care is grade 5 in more than one area, a referral to children's services will be required.

### *Training*

Nurses have been trained in internal working models and parenting styles to enable them to integrate this understanding into the way they communicate the materials to tackle neglect. They have also been trained on neglect – its prevalence, signs, precipitating factors, impact, identification and 'what works' to prevent or address it, and how it is assessed using the GCP-2.

### *Revised content*

#### Universal

All FNP clients, and their partners if appropriate, will receive facilitators that will be delivered in the pregnancy phase. If clients are already in the infancy or toddlerhood phase when the adaptation begins, they will also be offered these facilitators as soon as possible, if they have not yet been used. The facilitators are titled "What is neglect?" and "Why does neglect happen?", and are designed to increase the client's knowledge and understanding of neglect in a non-judgemental or non-blaming way and to highlight the nature of sensitive and responsive parenting.

Clients will also be taken through a facilitator that outlines the child's typical day; this is to be completed alongside the facilitator that outlines the mother's typical day, which is already in routine use. The purpose of this is to help the mother or main carer think about and become more aware of her baby's needs and feelings. It will highlight the needs of the child alongside the needs of the mother, show how they might compete, and encourage the mother to consider adjusting schedules to ensure that children receive proper care.

All clients will also participate in a traffic light activity, which is designed to help parents see how some parenting practices (e.g. prop feeding or putting babies in front of the TV) may seem innocuous but, cumulatively, could result in a neglectful parenting approach. It has been created specifically for this adaptation and is designed to be fun and engaging but also educational.

If risk factors for neglect such as mental health problems or domestic violence arise during the delivery of the programme, the nurse will continue to work with the client to address these issues, alongside this adaptation, and will refer to specialist support (mental health services, local protocols for domestic abuse).

#### Targeted

If neglect is identified through the GCP-2 assessment, the family will receive a more targeted offer of support which is a combination of new and revised FNP materials. This will include a selection of relevant facilitators that address the child's needs as identified through the GCP-2 assessment. This might include extended time spent on appropriate and inappropriate parental care and supervision, such as home safety (accident prevention), hygiene, feeding (importance of emotional connection), babysitters, TV and social media, and the appropriate use of services (e.g. attending appointments).

Clients will also be supported to consider actual or potential sources of help (formal and informal), how to ask for help, and having a positive attitude towards asking for help.

Lastly, further activities have been developed to highlight the issue of parenting style and its effect on sensitive and responsive parenting for clients identified as potentially or actually neglectful. These are a facilitator called "Do you have a [parenting] style?", a parenting styles game activity and a puzzle called the "Neglect Bear puzzle".

Mothers who are found to require further support as evidenced by static GCP2 score on repeat assessment would be referred to Children's social care.

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#### **Materials needed for delivery**

- Copies of the Graded Care Profile 2 (GCP-2) measure
- New and revised FNP facilitators and materials for educational activities for both universal and targeted elements
- Clear documentation on process for making a successful referral to specialist services

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#### **Procedures for delivery**

All clients will receive the universal part of the revised offer on neglect during the pregnancy phase.

As described above, the GCP-2 assessment tool will be used in pregnancy with FNP clients with increased risk of actual or potential neglect and/or when the parent discloses a history of neglect, substance abuse, mental health problems or domestic violence in their own childhood (the literature pertaining to neglect identifies these as particularly important risk factors). At any time during the programme, the assessment can be also triggered by scoring low on certain prongs of the New Mum Star (see above) or if a professional witnesses parenting behaviours that indicate that the infant's needs are being neglected. If the first assessment identifies a problem with neglect, the GCP-2 assessment will be repeated six months after the first assessment to see if there is improvement.

At any point in the programme, if the client and her household are identified via the GCP-2 as being neglectful or at risk of neglect they will receive the revised FNP materials as part of the targeted intervention.

Where appropriate (i.e. for mothers who are found to require further support because they do not respond to the adaptation as evidenced by a static GCP-2 score), clients will be referred to the Children and Families social care department, in accordance with local protocols.

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#### **Provider(s)**

Family Nurses will complete assessments with clients and deliver the revised content, with support from Supervisors (via supervision).

The FNP National Unit / Clinical Team will support the supervisor and FNP team to develop the materials they require and ensure that the team receive adequate training in the GCP-2 from the NSPCC to deliver the adaptation.



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### Mode of delivery

- The assessments and delivery of revised content will take place on a one-to-one in-person basis with FNP clients.
  - Provision via specialist services may involve different modes of delivery.
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### Where it takes place

- The assessment and intervention will take place in the client's home or another suitable venue.
  - Provision via specialist services may take place in different settings.
- 

### When / how much

#### *Assessment*

The GCP-2 assessment will be triggered in pregnancy by clients who present with risk factors for neglect (previous history, history of attachment disorder, substance abuse, mental health problems or domestic violence). At any point in the programme it might also be triggered by when a client scores 4 or below on the New Mum Star on any of the prongs of 'Keeping your baby safe', 'Looking after your baby', 'Baby's development' and 'Connecting with your baby' or if a professional has observed parenting behaviours that indicate that the infant's needs are being neglected.

#### *Revised content*

Facilitators "What is neglect?", "Why does neglect happen?" and the "Typical child's day", and a traffic light game designed to identify potentially neglectful parenting practices, have been developed to be delivered in the universal component of the adaptation. They will be delivered in pregnancy with new clients and as soon as possible with clients who are already in the programme.

The universal component is made up of existing facilitators, drawn together for the first time, and some newly devised activities described above. These may be used as many times as the Family Nurse feels it is useful, once neglect is identified.

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### How it can be tailored

The content can be tailored depending on the neglectful behaviours that have been identified. For example, if the nurse hears that the client sometimes props the bottle against the child, rather than holding it, the facilitator on safe infant feeding that discourages prop feeding can be used. This tailoring is in line with standard FNP practice where the nurses constantly match the agenda of the client with the agenda of the programme, and will ensure that the client receives relevant information.

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### How fidelity is monitored

The FNP ADAPT Data System (FADS) will record whether the New Mum Star, GCP-2 and aspects of this adaptation are applied.

PORTSMOUTH

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# LOGIC MODEL

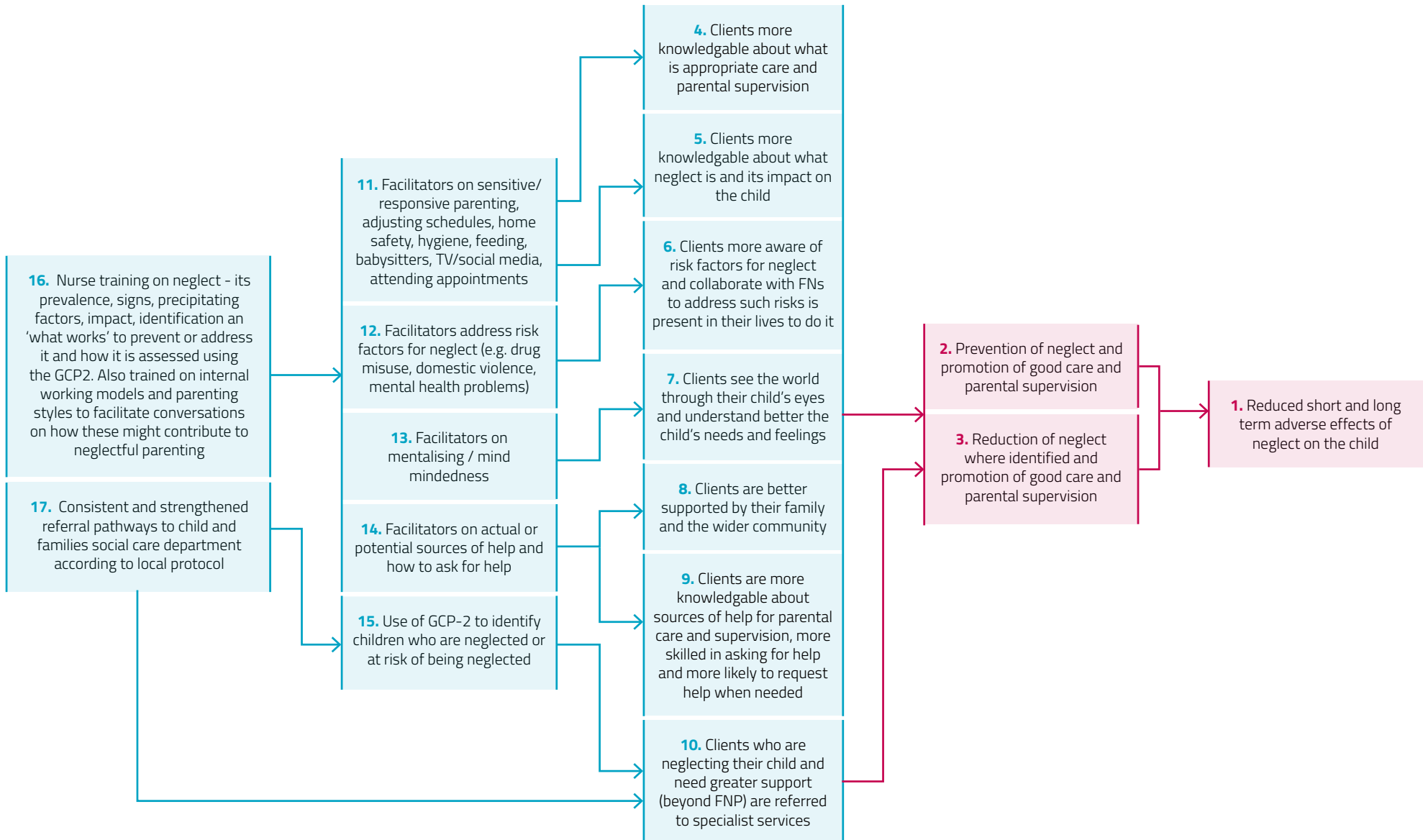
SUPPORTS

ADAPTATION ELEMENTS

MECHANISMS

INTERMEDIATE OUTCOMES

ULTIMATE OUTCOMES



A narrative of each element of the logic model is provided below - numbers relate to the relevant boxes in the diagram.

### Ultimate outcome

**1.** The ultimate outcome is to reduce the short- and long-term adverse effects of neglect on the child, including attachment difficulties, problems forming healthy relationships, difficulties with learning and education and poor mental health.

### Intermediate outcomes

There are two intermediate outcomes that contribute to this ultimate outcome.

**2.** One is the prevention of neglect and the promotion of good parental care and supervision for the baby, including sensitive and responsive parenting. This helps to reduce the adverse effects of neglect because the client is more likely to care for the child appropriately.

**3.** The second intermediate outcome is the reduction of neglect where it is identified and the associated promotion of good parental care and supervision for the baby, including sensitive and responsive parenting. This helps to reduce the adverse effects of neglect because the client is helped to parent more appropriately.

### Mechanisms

These intermediate outcomes are enabled through several mechanisms.

**4.** Clients will become more knowledgeable about what constitutes appropriate childcare and parental supervision (across a range of areas).

**5.** Clients will become more knowledgeable about what constitutes neglect and its adverse impact on the child.

Together, these will contribute to preventing or reducing neglect because parents will be more attuned to the baby's needs, more alert to signs of neglect and more motivated to avoid neglect because they are aware of its adverse effects on their child.

**6.** Clients will become more aware of risk factors for neglect and collaborate with Family Nurses (and potentially others) to address such risks where they are present in their lives. This will help to prevent or reduce neglect because mothers will have better well-being and healthier relationships and find it easier to focus their attention on caring for their child.

**7.** Clients will develop mind-mindedness, meaning that they will learn to see the world through their child's eyes and understand better how their child is feeling. This will contribute to preventing or reducing neglect because the mother will be more sensitive and responsive to her child's needs.

**8.** Clients will become better supported by members of their family and the wider community. This will help to reduce neglect because mothers will get help with parenting tasks and other aspects of their lives where they are struggling, making it easier for them to care for their child.

**9.** Clients will become more knowledgeable about sources of help with parental care and supervision, more skilled in asking for help and more likely to ask for help when it is needed. This will contribute to preventing or reducing neglect because they will receive help before a situation reaches crisis point, making it easier for them to care appropriately for their child.

**10.** Clients who are neglecting their child and who require greater support than that available through FNP will be referred to appropriate specialist services, and the Family Nurse will ensure that the referral is successful. This will help to reduce neglect because clients will receive the additional support they need to provide appropriate care for their child.

#### **Adaptation elements**

**11.** Facilitators will be used that cover sensitive and responsive parenting, adjusting schedules to ensure that children receive proper care, home safety (accident prevention), hygiene, feeding (importance of emotional connection), babysitters, TV and social media, and the appropriate use of services (e.g. attending appointments). As such, they will contribute to the mother being more knowledgeable about what is appropriate (i.e. good parental care and supervision) and what is inappropriate (i.e. neglect).

**12.** Facilitators will be used to help address risk factors for neglect, including drug misuse, domestic violence and maternal mental health problems (depression, anxiety, stress). These will contribute to preventing or reducing such problems, which in turn will help the mother to have better well-being and healthier relationships.

**13.** Facilitators will be used to help the mother to think about and become more aware of the baby's needs and feelings. This will help her to develop stronger mind-mindedness and pay more attention to considering how to meet her child's needs.

**14.** Facilitators covering actual or potential sources of help (formal and informal) and how to ask for help, and encouraging mothers to ask for help where needed, will make it more likely that the mother will seek (and receive) help when she feels that she is struggling – or in danger of struggling – to meet the child's needs.

**15.** Use of the Graded Care Profile (GCP-2) will increase the likelihood of children who are being neglected or who are at risk of neglect being identified earlier and, where appropriate, referred to specialist services.

### **Supports**

**16.** Training in the GCP-2 from the NSPCC will provide a solid base for this adaptation, increasing nurses' confidence to identify and tackle neglect where they suspect it in their clients. Training in internal working models and parenting styles will facilitate conversations between the nurse and client on how these might contribute to neglectful parenting.

**17.** The referral pathway from FNP to specialist services that address neglect (notably child and families social care) will be strengthened.

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# DARK LOGIC

POSSIBLE ADVERSE EFFECTS	LIKELIHOOD	MITIGATING ACTIONS
<p>The use of an accessible and effective neglect assessment tool has the potential to highlight neglect but may inhibit appropriate intervention because it only focuses on assessment (i.e. perpetuates problem of assessing but not acting with regard to neglect).</p>	Medium	<p>New materials will be developed for Family Nurses to use with clients to raise clients' awareness of what constitutes appropriate parental care and supervision, to address risk factors for neglect, to help clients to identify and access appropriate help and to enable the referral to specialist agencies of clients whose needs in relation to neglect cannot be met by FNP. Some materials will be used with all clients (i.e. not dependent on the GCP-2 assessment). In other words, the assessment is only part of the adaptation, which is primarily action-focused.</p>
<p>The adaptation reduces the attention that Family Nurses can pay to other important outcomes and therefore potentially dilutes FNP's impact.</p>	Medium	<p>The adaptation pertaining to neglect complements and enhances current FNP programme materials; indeed, to some extent it will require deliberately using existing materials that contribute to the prevention of neglect. Further, personalisation will require that Family Nurses work with clients to agree the needs that require the greatest focus and to tailor the intervention accordingly.</p>
<p>Families are offended by the perceived judgement they are neglecting their child, causing them to disengage from the FNP programme.</p>	Medium	<p>The materials and training will help Family Nurses to present the issues sensitively and through a no-blame approach.</p>
<p>Work with the mother to address risk factors for neglect and/or improve parental care and supervision could contribute to difficulties in her relationship with her partner if he has a different approach to childcare and/or is not involved in the discussions with the Family Nurse.</p>	Medium	<p>Where both parents are involved in the child's care then both should be engaged to complete the work to promote a consistent approach and parenting style to meeting their child's needs. Family Nurses will make great efforts to include the fathers in this aspect of the programme.</p>



POSSIBLE ADVERSE EFFECTS	LIKELIHOOD	MITIGATING ACTIONS
<p>If Family Nurses see improvement (i.e. reduced neglect) they may conclude that further intervention is not needed. However, the assessment of neglect can be difficult as it can fluctuate both in level and duration. A child's welfare can, for example, improve following input from services or a change in circumstances and review, but then deteriorate once support is removed. Professionals should be wary of being too optimistic. Timely and decisive action is critical to ensure that children are not left in neglectful homes.</p>	Medium	<p>The adapted intervention needs to have a residual effect on parenting. This will be verified by reassessing the family using the GCP-2 six months after the initial assessment – if the first assessment identified a problem with neglect – and tailoring subsequent care according to the findings of this assessment. At any point in the adaptation, if the triggers for a GCP-2 are noted, an initial assessment should be conducted.</p>
<p>With a focus on trying to improve the issue of neglect, nurses might delay or omit to refer eligible clients to social care. This could result in a serious incident in the worst case scenario if a serious case of neglect is not referred for specialist care.</p>	Medium	<p>The threshold for referral to children's social care will be if there are two areas of the GCP that are marked as red (score 5), indicating that the child's needs for either physical care, safety, emotional care or developmental care are classed as severely neglected. This is in line with the guidance from the NSPCC, who state that: "Where care is grade 5 in more than one area, a referral to children's services will be required."</p>

PORTSMOUTH

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# CONTEXT MAP

## Factor and likely influence

## Actions to address

**POLITICAL**

In general, society tends to be respectful of parenting choices if they do not perceive them to impact adversely on children's ability to reach their potential. This means that neglect is not always treated as seriously as it should be

Put in place (via the adaptation) earlier and timelier interventions to eliminate the long-term insidious risk and impact of neglect. Revised and new FNP materials will educate parents about the adverse effects of neglect on child development if it is left unaddressed

**ORGANISATIONAL**

It is possible that there are organisational barriers to addressing neglect in Portsmouth because despite neglect being a problem in Portsmouth, there has been poor uptake of previous attempts by the health visiting service to design an assessment tool that addresses it in a comprehensive way. This poor uptake was suspected to be because the assessment was extremely long and complicated and practitioners did not feel that it added much value to their practice

Work to engage and support the FNP team to implement this adaptation well and then use this experience as a model for other service providers in the trust who may use the assessment tool and materials in time. Use an externally produced, validated and recognised assessment tool for neglect

**CULTURAL**

Neglect can be insidious and therefore difficult to identify. Professionals report feeling confused and disempowered when challenging it for fear of seeming judgemental of parenting styles

Stress to Family Nurses the importance of addressing neglect because of its adverse effects on children in the short- and long-term. The resources created for this adaptation and associated training will provide guidance for how Family Nurses can deliver the adaptation with sensitivity while also being skilled in having difficult conversations

**ECONOMIC**

The assessment tool (GCP-2) may be seen as adding to Family Nurses' workload, and there will be a cost associated with workshops and training

The assessment of neglect will only be triggered if there is reason to believe there will be a problem, minimising unnecessary work. It will be stressed to nurses that neglect is an important form of abuse that can and should be addressed effectively by FNP nurses, and forms part of the safeguarding assessment

PORTSMOUTH

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# CLINICAL FLOW CHART

The clinical flow chart is a visual representation of what materials are used and which assessments are triggered on the FNP ADPT data system during each programme phase (Pregnancy and Infancy). In Portsmouth, neglect is being measured by the Graded Care Profile (GCP2). This assessment will be performed when a behaviour is observed by the nurse that causes concern that the child is being neglected or a low score on any one of three New Mum Star prongs 'Keeping your baby safe', 'Looking after your baby', 'Baby's development' and 'Connecting with your baby'.

	Pregnancy	Infancy	Toddlerhood
Universal activity	Facilitators covering definitions and causes of neglect, and child and mother's typical day. Traffic light activity to demonstrate problematic parenting behaviours	Facilitators covering definitions and causes of neglect, and child and mother's typical day. Traffic light activity to demonstrate problematic parenting behaviours	
Targeted activity	Facilitators on parental care and supervision, accident prevention, hygiene, feeding, babysitters, TV and social media, and the appropriate use of services (e.g. attending appointments). Also to facilitator to help to find sources of support, eg. My world of support.		
	Education on parenting styles and their effect on sensitive and responsive parenting: one facilitator "Do you have a [parenting] style?", a parenting styles game activity and a puzzle called the "Neglect Bear puzzle".		
Assessment tool	GCP2	GCP2	GCP2
Assessment time point for FADS	If risk factors at recruitment	Any point neglect witnessed or 3 or 4 on NMS prongs	6 months after first assessment

# GLOSSARY

## A

### AGENDA MATCHING

Agenda matching is the process by which the family nurse maintains alignment between the goals of the client/her infant and those of the programme. This can mean some digression from the planned content of a visit to consider the programme aims and goals, the client's 'heart's desire', the client's immediate concerns and stage of the programme as well as considering any anticipatory information that may be needed.

## C

### CARBON MONOXIDE MONITOR (CO MONITOR)

Carbon monoxide is exhaled in higher concentrations in individuals who smoke, therefore monitoring exhaled carbon monoxide levels is a good indicator of levels of smoking, and can be used to monitor progress towards a quit attempt and to verify a successful quit attempt.

### CLINICAL ADAPTATIONS

Clinical areas that have been chosen by the FNP site (nurses, supervisors, commissioners, providers) in collaboration with the FNP National Unit and the researchers from the Lab, as areas where clinical outcomes could and should be improved. All stakeholders have contributed to the designs, and additional nurse training and materials have been provided by the FNP National Unit.

### CONTEXT MAP

This is a systematic assessment of the external context to a project, considering all the factors that may not be under the direct control of the team implementing the project, but may affect their ability to deliver as planned and achieve desired outcomes. These contextual factors have been grouped into five headings: political, organisational, cultural, economic and other. Teams were also asked to suggest mitigating factors that could be put in place anticipating that these issues might arise, to reduce any negative consequences for the project.

### CO-PRODUCTION

The practice of involving all stakeholders in the design and development of an idea or project. In ADAPT it refers to including clients, nurses, supervisors, commissioners, provider leads, FNP National Unit staff, researchers and academic experts in the design stage of the clinical adaptations. Clients, nurses, supervisors, researchers, FNP National Unit staff have been involved in subsequent revisions and changes through the rapid cycle testing process.

## D

### DARK LOGIC

In the same way that a logic model highlights the desired outputs and outcomes of a service, a dark logic model highlights the potential harmful unintended outputs and outcomes of a service. This is particularly important in complex interventions such as FNP where there are multiple components that interact in multiple and unexpected ways to produce sometimes unexpected outcomes.

### DYADIC ASSESSMENT OF NATURALISTIC CAREGIVER-CHILD EXPERIENCE (DANCE)

DANCE is a licensed, observational tool used to assess the qualities of the caregiver/infant relationship and to promote responsive and sensitive parenting which is a key goal of the FNP programme. Observations are made in the child and client's natural setting during a home visit. The DANCE tool enables nurses to organise, analyse and record these observations and then use the DANCE STEPS materials to enable them to plan their interventions effectively as well as to gauge the efficacy of those planned interventions in terms of whether the client shows measurable positive changes in any of the identified areas for growth. The information collected through use of the DANCE tool supports the nurse to match the client's strengths and challenges in caregiving, with the FNP programme content for promoting sensitive and responsive parenting behaviours.

### FACILITATOR

Family nurses' delivery of programme content in each home visit is enhanced by the use of specifically designed discussion facilitators and educational materials which support sharing information with the client.

### FIDELITY

Fidelity is the extent to which the programme is delivered according to the original design, in particular the core components that are presumed to be essential mechanisms or ingredients for impact on outcomes. High fidelity would indicate that the programme delivery has been monitored and data suggest that the core components are being delivered as designed.

### LOGIC MODEL

A typically graphical depiction of the logical connections between resources, activities, outputs and the desired outcomes of a service. Ideally these connections will have some research underpinning them. Some logic models also include assumptions about the way the service will work.

### NEW MUM STAR (NMS)

This is an assessment tool bespoke to FNP, developed by Triangle Consulting in collaboration with the ADAPT team. The assessment is holistic – covering all areas of the client's life and her parenting ability – and is completed collaboratively by the client and her family nurse. The assessment is designed to be completed every four to six months depending on the client, and is designed to inform personalisation decisions.



### NICOTINE REPLACEMENT THERAPY (NRT)

This is a way of delivering nicotine to those who are addicted to it that does not involve using cigarettes, thus avoiding any of the associated hazards of using cigarettes. The nicotine might be delivered using patches, gum, lozenges, microtabs, inhalators or nasal sprays.

## O

### OUTCOMES

Outcomes refer to the 'impact' or change that is brought about, such as a change in behaviour or physical or mental health. In FNP outcomes are grouped into maternal outcomes such as self-efficacy, and child outcomes such as cognitive development.

## P

### PARTNERS IN PARENTING EDUCATION (PIPE)

A parenting education model and curriculum that uses a carefully designed instructional process to teach the concepts and skills of emotional connectedness using a range of materials which focus on and strengthen the parent-child relationship. PIPE's use of supervised parent-child activities allows the client to teach, which validates and empowers the parents. PIPE was developed by the "How to read your Baby" organisation. <https://www.howtoreadyourbaby.org/pipe/>.

### PERSONALISATION

Changing the programme from a predesigned pattern of visits for clients, to a schedule of visits adapted according to need. As part of personalisation of FNP, visit frequency can be changed, visit frequency and content can be changed and the duration of the programme can be reduced.

## R

### RANDOMISED CONTROLLED TRIAL

An evaluation that compares the outcomes of children and young people who receive a service to those of a control group of similar children and young people who do not. Within an RCT the control group is identified by randomly allocating children and young people who meet the target group criteria to either the service receipt or control groups.

### RAPID CYCLE TESTING

The practice of developing the design of a project, implementing it and then assessing the progress and making changes at regular intervals through the project lifespan. Each implementation phase that ends with assessment and change is termed a cycle. A cycle can last for days, weeks or months depending on the outcome or change in question.

## S

### SELF-EFFICACY

The belief held by an individual about their ability to succeed in specific situations or accomplish a task. This belief is integral to how they approach both goals and challenges. Self-efficacy is one of the key theories that underpin the FNP programme.

### SMART CHOICES

SMART Choices are a series of 'lessons' designed for family nurses to use with their client. They aim to help the client think about their own communication style and how to negotiate or have difficult conversation with other people who are important to them. They support the client to understand the views of others but also to be assertive in making their own SMART choice. Most SMART Choices are situational and use fictional characters i.e. mum and daughter. They are particularly helpful if the client has expressed limited support from those around them, such as their partner, family or community.

### SYSTEM ADAPTATIONS

System adaptations are changes that have been proposed that adapt the FNP programme at a system level. They include personalisation of the programme to fit more closely to client need, and changing the eligibility criteria so that a more vulnerable client group are targeted.

## V

### VIDEO INTERACTIVE POSITIVE PARENTING (VIPP)

An approach designed to help build strong attachment relationships between parents and children. It helps parents to see the world through their child's eyes and supports them with their parenting. It is based on the premise that the client can be her own role model, encouraging positive parenting behaviours through filming interactions between the client and her child, and using this film to demonstrate and encourage positive parenting behaviours, and suggest changes she could make to develop the parenting relationship further. The programme lasts for four to six months and includes up to seven visits. Visits are usually between two weeks and one month apart.



