

Sustaining Practice Innovation in Child & Family Health

REPORT TO PARTNERS

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EXECUTIVE SUMMARY

This study aimed to examine the experience of practice innovation in child and family health (CFH) services in Australia and New Zealand. Following government policy initiatives, CFH services in both countries have adopted the Family Partnership Model (FPM – Davis, Day and Bidmead 2002) as the preferred model for providing support to families with young children. Despite positive evidence on the outcomes of the FPM for families, children and health professionals, there has been little research to date on how this new approach to practice has been learned, implemented and sustained within service provider organisations. This project sought to identify specific gaps in knowledge and to explore the implications for the development of innovative forms of practice in health services more generally.

The study generated a large volume of detailed and insightful data from health practitioners on their experiences in learning and developing a new approach to their work and their efforts to incorporate it into their daily practice. It has also elicited insights into the process of developing and sustaining new forms of practice in busy CFH organisations. This report summarises some of the major themes identified by the study.

Participants' responses indicate the multi-faceted nature of the process of adopting and sustaining practice change, and the complex inter-relationships between practitioners, clients, organisations and the wider policy environment in which they work. They presented many rich accounts of how their approach changed and how they aimed to involve families more respectfully and collaboratively in their work, and how they became more self-aware and insightful about their own practice. Although potentially time-consuming and uncomfortable for them and their colleagues, they identified the longer-term benefits and implications of partnership practice for organisations and clients alike.

FAMILY PARTNERSHIP TRAINING

Without exception, this group of participants valued the principles of the FPM and the

experience of the training program, and remained committed to partnership with parents. They discussed changing their ways of working and communicating with parents, sometimes subtly, in a great variety of situations and practices.

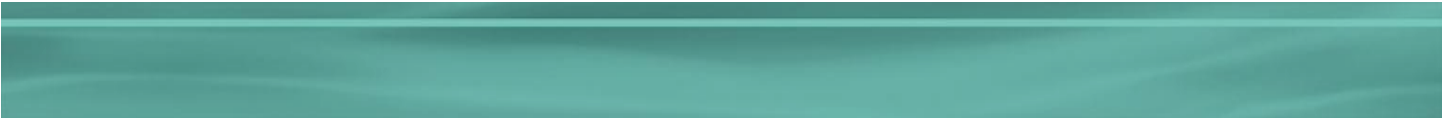
PRACTICE

Participants' reflections on their practice ranged from new ways of carrying out specific tasks through to often profound shifts in attitudes and approaches towards their clients. Many identified the demands – in terms of time, expertise and energy – of working in partnership with families in diverse and often complex circumstances. They also highlighted the satisfaction and confidence gained from new ways of practising, as well as a commitment to partnership and a determination to avoid reverting to a didactic, 'expert' approach to CFH practice.

SUSTAINABILITY

The study focused specifically on sustaining the FPM within the three CFH service providers and identified many diverse factors that facilitated and inhibited this major cultural shift. Participants recognised that providing access to FPM training is only the first stage of embedding partnership practice into an organisation. They described the complex inter-relationships between clinicians, colleagues, management and clients in maintaining and developing partnership, and the impact of factors within the immediate workplace, the organisation and beyond.

Participants discussed the ways that organisations can nurture the implementation and growth of partnership practice, and requirements that can stifle that growth. For instance, specific processes such as allocating performance measures or rosters, or introducing new information systems or technology may all have a concrete impact on the nature and quality of partnership that health professionals are able to practise. Overall, participants' comments particularly pointed to ways in which organisational commitment and leadership are essential to supplement the substantial changes made by individual practitioners.



These findings have implications for organisations practices and to commit to a more collaborative involvement with their clients. Particular requirements include follow-up or refresher courses for FPM trained staff, complemented by more FPM-oriented supervision, as well as

seeking to implement and sustain partnership consideration of work practices and recognition of the time and energy required to be more deeply engaged with clients and to communicate more fully and effectively.

INTRODUCTION

THE RESEARCH

This report presents the findings of a small exploratory study of the Family Partnership Model (FPM) (Davis, Day & Bidmead 2002) as it operates within three organisations providing Child and Family Health (CFH) services in Australia and New Zealand. The study is part of a wider program of research that investigates aspects of professional practice, especially health professional practice, in the context of public policy change, and health service reform and redesign (see <http://www.rilc.uts.edu.au>).

The project consisted of a partnership between several universities and service provider organisations:

- Centre for Research in Learning & Change (L&C), UTS Faculty of Arts & Social Sciences;
- Centre for Midwifery, Child & Family Health, UTS Faculty of Nursing, Midwifery & Health;
- Discipline of Paediatrics & Child Health, University of Newcastle;
- Centre for Parent & Child Support and the Child & Adolescent Mental Health Services Research Unit, Institute of Psychiatry, King's College, London, UK;
- Tresillian Family Care Centres;
- Kaleidoscope Hunter Children's Health Network; and
- Royal New Zealand Plunket Society ('Plunket') (from May 2009).

As a consequence of significant health policy initiatives advocating a partnership approach between CFH health professionals and parents (eg Council of Australian Governments 2009, NSW Health 2009, Government of Victoria 2010), all Australian States and Territories have adopted the FPM as the preferred approach to providing CFH services. CFH service providers have embarked on a program of training and development for clinical and other staff. The NZ Government, through the Ministry of Social Development, funded FPM training in selected locations for clinical and other service providers. Other courses have been funded by charitable trusts, Plunket and course commissioners.

While several studies have evaluated the FPM and found beneficial outcomes for clients (see Context & Background below), there has been little research on how the FPM operates in practice within organisations, nor on how practice changes arising from the FPM are sustained over time. This project aimed to examine these issues, contributing new knowledge about how practice innovations are implemented and sustained within CFH services.


PROJECT AIMS

The specific aims of the project were:

1. to describe and analyse the experiences of health professionals who have participated in the FPM education process and who have returned to practise within a health service committed to partnership practice
2. to describe and analyse the ways in which senior clinicians, supervisory staff and management within the participating organisations conceptualised and responded to the implementation and sustainability requirements of partnership practice
3. to provide feedback – commentary and analysis – to the management and staff of the participating health services
4. to utilise the findings and insights identified from the research, in conjunction with the findings of published research, to inform the development of a further and more expansive program of research addressing key implementation, sustainability, change management and outcome issues related to the FPM, in particular, and to partnership approaches, more generally.

The findings of this research will also be taken up as part of an international research collaboration that is engaged with research and knowledge development in the areas of health service redesign, workforce development and curriculum renewal in health professional education.

This current report aims to provide feedback for partner organisations. It presents a summary description of what we have learned about implementing and sustaining FPM practice within three services: Tresillian and Kaleidoscope in NSW Australia, and Plunket in New Zealand.



Research findings are based on individual interviews followed by focus group discussions with 20 health professionals in NSW and five in NZ. Given the small sample size and the exploratory nature of the research, we did not aim to reach definitive or generalisable conclusions. Rather, the research and this report presents and explores the range of issues presented by participants as constituting their experience of developing and implementing the

FPM within the broader context of what is required to successfully implement and sustain significant service innovation.

Importantly, the research does not aim to evaluate either the FPM or the practices of any of the participants or participating organisations (see pages 4-5 for a discussion of existing research on the effectiveness of the FPM).

CONTEXT & BACKGROUND

FAMILY PARTNERSHIP MODEL

The FPM was developed by the Centre for Parent and Child Support (CPCS) in UK, a partner in this project, as an innovative approach to providing health care and interventions for families with young children. This approach aims to support parents by involving them as partners in the process of caring for their children, ‘enabling their problem-solving abilities, self-esteem and self-efficacy, facilitating their interaction with their children, and hence fostering their development and well-being’ (Davis et al. 2002: x). It provides a theoretical and practical basis to assisting families that contrasts with the traditional ‘expert’ model of health service provision which, by emphasising the expert knowing of the health professional, tends to confirm the experience of client/parent as unknowing and in deficit (Dunston et al. 2009). Co-founders Davis, Day and Bidmead (2002:ix-x) have summarised the FPM approach:

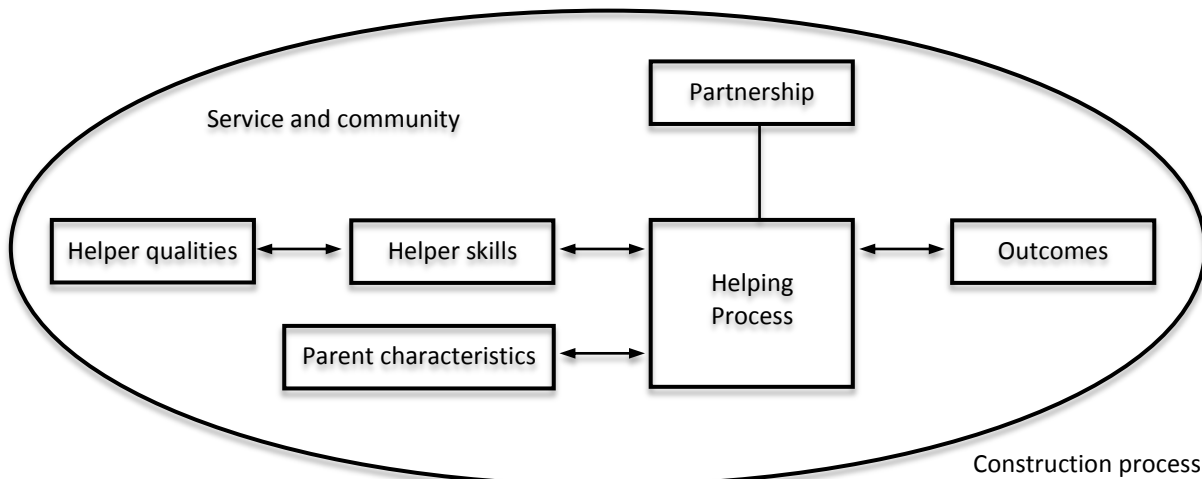
[Partnership practice is] not just about giving advice, which is notoriously variable in outcome ... it is about engaging with parents fully and being with them in a relationship that is potentially supportive in itself ... [Involving parents] as partners in the process has the advantage of enabling them to use their own skills and expertise

fully, and hence maximizing the chances of them finding solutions on their own.

The FPM links an explicit model of care with training interventions for child and family health professionals. Originally developed at the CPCS as the Parent Advisor Model, the FPM has become the basis for work with families of children at risk or with wide-ranging problems including chronic illness, emotional and behavioural difficulties (Davis et al. 2002). Parents’ interactions with their children, confidence and capacity to cope with challenging circumstances can build resilience and mitigate against risks that could adversely affect children’s development and wider family wellbeing (Davis & Meltzer 2007, Donald & Jureidini 2004, Farrall & Arney 2010). The model responds to poor uptake and variable outcomes when help is delivered as advice-giving (Davis & Fallowfield 1991). Help is reframed as enabling parents to use their own resources to find ways of managing problems in the longer term, engaging parents fully in a relationship that is potentially supportive (Davis & Day 2010). This underlies a focus on communication skills needed by professionals. Figure 1 below illustrates different components of the model.

The stages of the helping process begin with exploring a problem from the parents’ perspective. The professional may then assist parents construct a clear model of the problem as a basis for negotiating goals.

Figure 1 Overall framework of the Family Partnership Model (adapted from Davis and Day 2010)



Actions are then planned, implemented and reviewed. The contribution of partnership to this process is elaborated through the listing of key characteristics: working together, power sharing in decision making, agreeing aims, complementary expertise, mutual respect, openness, clear communication, and negotiation. The associated training helps professionals develop qualities including: respect, genuineness, humility, empathy, quiet enthusiasm and personal integrity. The FPM provides guidance as to how they can be enacted through key skills such as active listening, empathetic responding, encouraging, negotiating, making use of expertise. The conceptual underpinnings of the model are drawn from psychotherapy, counselling literature, and studies of child development and parenting (Bowlby 1988, Kelly 1991, Rogers 1959). Outcomes are conceived in terms of helping families identify and build on strengths, manage problems, foster resilience, facilitate social support and community development, and enhance the development and well being of children. The construction process underpinning the model assumes individuals construct models of the world that help them anticipate and adapt to challenges, and that the helping process may involve clarifying, testing and changing these models (Davis et al. 2007).

Clinical health professionals complete the Family Partnership Foundation Course, usually delivered through 5 full or 10 half days at weekly intervals. Additional training is available for supervisors, or those who wish to facilitate the Foundation Course themselves.

POLICY CONTEXT

The adoption of FPM is part of a well-developed direction in social and public policy aiming to redefine the scope and focus of professional practice in health, education, community services and other human services (eg Head and Redmond 2011, Bovaird 2007). This public policy direction emphasises active citizenship and views citizens as having the capacity to be active partners in service development and delivery rather than merely passive consumers or recipients of services (Newman 2001, Dunston et al. 2009). Within CFH services, this has translated into a pervasive policy focus on the development

of partnership approaches (NSW Health 2009, National Public Health Partnership 2005 and Council of Australian Governments 2009).

RESEARCH ON THE FPM

Bidmead et al. (2002) reviewed evidence relating to the FPM training itself, suggesting it improves professionals' knowledge of helping, perceptions of their helping ability and listening skills, and that families recognise these qualities in FPM-trained helpers. Similar results were reported in the European Early Prevention Project (EEPP) (Layiou-Lignos et al. 2005, Papadopoulou et al. 2005). In Australia, a small body of survey-based research (Keatinge, Fowler & Briggs, 2008, Fowler & Rossiter 2007, Jackiewicz 2004) has focused largely on the implementation of the FPM and on practitioners' perceptions of its strengths and limitations. Keatinge et al. (2008) interviewed seven nurses 18 months after they completed FPM training. These nurses felt FPM had had a profound influence on their practice.

In terms of outcomes, Barlow et al. (2007) report a UK-based randomised controlled trial that compared standard help with 18 months of weekly visits by FPM-trained home visitors; the latter group fared better in outcome measures of maternal sensitivity and infant cooperativeness. Qualitative interviews with parents in this study suggested their values coincided with the FPM's stated aims (Kirkpatrick et al. 2007). The EEPP, spanning five countries, included the FPM in a non-randomised intervention. Evidence of differences favouring the intervention group was apparent at 24 months (Davis & Tsiantis 2005, Davis et al. 2005). Wider reviews of research support the general claim that FPM training can enhance outcomes for families (eg Day & Davis 1999, Davis & Meltzer 2007), as do evaluation studies of early experimental (Avon Premature Infant Project 1998) and quasi-experimental (Davis & Spurr 1998, Davis et al. 1997) interventions.

Considerable unexplained variance in outcome measures suggests the full potential of partnership remains untapped. Experimental studies are limited in their capacity to document local particularities that shape practices. In aggregating quantifiable outcomes, they lack

sensitivity to situation-specific responses to practice innovation (Elkan et al. 2000). A key challenge concerns the social and organisation context that may not always sustain new initiatives (Crawford & Brown 2009). Bidmead and Cowley (2005) noted this in their evaluation of FPM practice, identifying time pressures and lack of clinical supervision as barriers to partnership. Such barriers and other contextual factors influencing how partnership is implemented in practice are poorly understood.

Thus, fundamental questions about *why* and *how* FPM works in different settings and with different

client groups remain unanswered. Partnership models require very different forms of practice, dispositions and communication skills of health professionals, compared with those required by traditional, expert-based, provider-centric models of practice (eg Dunston et al. 2009). There is little systematic understanding of how knowledge and experience of FPM is developed and passed on beyond initial training; how FPM and its methods of dissemination can be further developed and improved to meet its users' needs; and how partnership practice can be supported and sustained in specific organisational settings.

METHODOLOGY

APPROACH

The project was developed as a participatory inquiry, using semi-structured reflective interviews and focus groups with health professionals working with the FPM. The development and subsequent analysis of the information gathered from the interviews/focus groups utilised the theoretical resources of practice and activity theories (Schatzki 2001, Engeström, Mietinen and Punamäki 1999). Practice theories understand practice and change as complex accomplishments that are situated (always related to the circumstances of practice); relational and social (developed through and shaped by the relationships that exist between service providers and service recipients and between human and non-human factors); and continually evolving.

The study targeted two groups of participants in the three service organisations:

- clinicians who participated in FPM training programs, and
- clinical supervisors, educators, team leaders and managers who were engaged with the above clinicians and had a role in supporting and enabling the development of partnership practice.

The researchers contacted managers within the three organisations, who arranged a briefing session with staff who were potentially interested in taking part in the study following an initial promotion by service managers. The briefing provided information about the study and requirements for participants; it stressed that participation was voluntary and that all input would be treated as confidential. All staff who agreed to take part signed consent forms. The project received ethics approval from each of the participating organisations.

THE SAMPLE

The sample consisted of 25 participants: 10 from each NSW organisation (five each from two sites per organisation) and five from Plunket. The Tresillian sample consisted of staff from the Belmore and Nepean Family Care Centres,

including clinicians working in residential, day stay and outreach units. The Kaleidoscope sample included staff from the Upper Hunter cluster and the Greater Newcastle area. One participant worked in an acute care setting in the John Hunter Hospital; the remainder worked in community-based CFH services. The New Zealand sample consisted of four Plunket staff and one individual employed by a government agency based in Wellington.

Within the two NSW organisations, the 10 participants consisted of:

- four clinicians involved in care delivery
- two managers / team leaders
- two health professionals offering clinical supervision, and
- two educators who had undertaken the FPM Facilitators Training Program and who had conducted one or more FPM training sessions for their organisation.

In NZ, the sample consisted of half the number in each category, i.e. two clinicians, one manager, one clinical supervisor and one facilitator. The facilitator was not a Plunket employee but had undertaken the FPM Facilitators Training Program and had conducted several FPM training sessions.

All Tresillian and four Plunket participants were nurses. The fifth NZ participant was an educator. The Kaleidoscope sample included a social worker and a doctor; the remainder were nurses. There was overlap in some of the participants' roles as listed above. Clinical supervisors were generally also managers, although in this case they were interviewed in the context of their supervisory role. Similarly, some facilitators were also clinicians and/or managers. In most services managers worked 'on the floor' and had regular contact with clients. Participants' comments throughout the study reflect these overlapping responsibilities and insights.

All participants were female, reflecting the demographic of this workforce in all three organisations. All had previously attended the FPM Foundation training program (delivered in either five full days, ten half days or a

combination of both half and full days). The length of time since attending the training ranged from six months to seven years prior to the interview, with a mean of 4.25 years. Three participants reported attending one of the original training programs presented by Professor Hilton Davis (one of the FPM originators) when the FPM was first introduced in Australia. In addition, at least eight had also attended a more advanced Facilitators' Training program.

All but one participant took part in a focus group. One Kaleidoscope participant was unable to attend either focus group as she was on one month's leave.

The interviews took place in September 2009 (November 2009 in NZ) and were audio recorded. Researchers (four in NSW and one in NZ) conducted the interviews at the participants' workplace or another convenient location. Following analysis of the interview data, researchers conducted the focus groups in May and June 2010 (August 2010 in NZ). The interviews and focus groups were recorded and professionally transcribed, resulting in a rich source of qualitative data about many aspects of FPM. The data were then loaded into MAXqda software for analysis. This software program enables the manipulation of large bodies of qualitative data and facilitates content analysis by sorting material into relevant themes. It is ideal for exploratory work of this kind, enabling researchers to link the data to a range of complex and inter-related concepts.

DATA ANALYSIS

Data analysis was developed in three stages. The first stage grouped data into broad categories aligned with the interview structure.

- The experience of training in the FPM
- Learning a new approach to CFH practice
- Adapting the lessons of FPM to daily practice
- Developing FPM practice and what helped/hindered this development
- Organisational support for FPM practice
- The role of informal and other supports in developing FPM practice
- The future of FPM within each organisation.

Researchers then conducted a second level of analysis utilising MAXqda. This more detailed process identified the complexity of comments made by participants. For example, as participants discussed their experience of the training, they frequently referred to other matters, such as organisational conditions that enabled or constrained their ability to develop what they were learning in the training, and the way the FPM needed to be adapted for particular client groups and client situations.

The third stage identified cross-cutting themes that we believe provide a useful structure for representing and presenting the experiences of participants and, additionally, for discussing the interconnected issues. There are three cross-cutting themes.

1. The initial training experience (**FAMILY PARTNERSHIP TRAINING**): a process that was reflective, challenging and, for some, transformative.
2. Putting the FPM to work (**PRACTICE**): a process of purposeful adaptation, learning and unlearning.
3. Sustaining and supporting FPM practice (**SUSTAINABILITY**).

Within each broad theme, we identified more nuanced issues or sub-themes, to represent the diversity of comment provided in each.

In the following sections, the three broad themes are used to structure what we learned from participants. Each section (theme) presents the range of experiences discussed. Representative statements provide the flavour of what was discussed and illustrate the direction and tenor of participants' reflections and comments. We have also used these statements as a starting point for further elaboration. The final section of this report is used to extend this elaboration into a series of *issues, challenges and implications* related to implementing and sustaining practice innovation.



Theme 1: FAMILY PARTNERSHIP TRAINING



THEME 1: FAMILY PARTNERSHIP TRAINING

THE TRAINING EXPERIENCE: A PROCESS THAT WAS REFLECTIVE, CHALLENGING AND, FOR SOME, TRANSFORMATIVE

The majority of the participants commented on the positive and frequently challenging impact of participating in the FPM training. Many were surprised at the beneficial outcomes of this experience. Although not antagonistic towards FPM training, many participants indicated that they had commenced the program thinking that they had little to learn, as they had believed their practice already demonstrated a respectful and collaborative approach – a partnership approach. However, several stated that during the course of the training they were surprised and challenged by what they experienced. One participant referred to this kind of experience as a ‘light bulb moment’ about their practice and consequently realised that they had much to learn about working in partnership.

A consistent observation was that participation in a reflective training process made participants more aware of their practice and how their application of partnership practice could be improved. Some participants noted they recognised where they were not working as collaboratively as they had previously thought.

I always thought that I was a very good listener until I did this course; then I realised that I had a lot to improve. So this course very much helped me with that and helped the relationship-building.

Facilitator 4

I found it quite nice and confirming because to a large degree it's how I work anyway so it really just put words to a lot of what you do. The whole communication process and helping, that's something that I practise in anyway. However, it still made me view it a lot closer up and made me think a lot more about how I go into relationships with families.

Clinical Supervisor 3

Several participants found that elements of the course enabled them to improve their practice with clients, albeit subtly, and to build on their existing knowledge and skills, making them more aware. Some mentioned their newfound capacity for self-reflection, which they felt enhanced their practice and helped them to better monitor their relationship with clients.

For some participants, their experience of the training generated strong emotional responses or even physical reactions.

I came home and sort of slept for 13 hours or something; so, [the training was] not draining but really full on. If you really start to think about all the processes involved in it, it makes you just evaluate the way you work with families but also the way you talk to people – anybody.

Clinical Nurse 3

Several participants talked about colleagues who found FPM training ‘very challenging’. These colleagues experienced either professional challenges (suggesting a very different approach to their work) or emotional ones (for instance, responding to personal issues that emerged during the training).

Especially if you have some participants who are very concrete ... there were some situations [in] which there was conflict between the participants because of one way a person works.

Manager 2

Some people that are very black and white find it harder to embrace that way and perhaps, I don't know, maybe never work that way.

Clinical Nurse 10

The aspect of the training process that generated strongest reactions in the interviews were the ‘skills practice sessions’, in which participants present real, current, personal issues to a small group for discussion and simulated interaction. (These were described by some participants as

'role-plays', despite being fundamentally different to role-plays in that participants are never required to act as anyone other than themselves.) Several participants found these uncomfortable, as they did not like speaking in public or discussing personal issues. However, there was a sense that using 'real issues' from participants' personal and professional lives were more valuable than role-plays of artificial situations.

I think the role-plays were really beneficial because they actually put you in a situation that made you actually look at how what you say to people and how you say it and your body language.

Manager 1

Whilst many participants noted their familiarity with partnership approaches, the FPM model and the training experience gave them a coherent framework and a language to better explain their practice. For some, their formal introduction to the model legitimated what they believed they had already been doing. One clinician stated that FPM allowed her to 'work the way I want to work'.

You often classed as a waste of time to spend extra time with people. So that validated what I did. I knew I was right, that was good.

Manager 1

Because you've kind of been working that way, it kind of gives you a bit of trust in doing it, that that is the right way to do things.

Clinical Nurse 10

Several participants distinguished their own practice and their commitment to partnership from other expert-based approaches they saw in the field.

It's easy to be in our comfort zone and some nurses haven't yet moved from that comfort zone because the reality is, because I've worked with babies for a long time, and if I came to your home and you tell me that, I could probably say, 'well yes, if you go yeah, yeah, yeah, I probably do have the answer'. But what's the purpose of that?

Supervisor 4

I just see it so much in the health profession of – not only nurses but medical people and everything – of being very direct and judgmental of the most needy people. I find it quite a challenge in my work of the lack of empathy and very judgmental comments and approaches to people's needs.

Clinical Nurse 4

Although some participants felt that their experience of FPM training did not result in significant change, the majority of participants believed that through participation in the training they had learned something new or had consolidated existing skills. Of note are the identification of improved clinical practices and the acknowledgement of the increased capacity to reflect on practice. The participants identified they now had a coherent framework and a language to better explain their practice. In some cases, participants felt this set them apart from co-workers who did not embrace the FPM or had not been exposed to the FPM model or training.



Theme 2: PRACTICE



THEME 2: PRACTICE

PUTTING THE FPM TO WORK: A PROCESS OF PURPOSEFUL ADAPTATION, LEARNING AND CHANGE

The majority of comments from participants focused on how they had taken the principles and key activities of the FPM and put them to work in their day-to-day practice. This was a rich area of discussion, with many 'case' examples being given to illustrate more general statements. In addition to changes in practice itself, a number of participants identified significant changes in their perceptions and understandings about their role and focus, the capacity of mothers and families, about problem solving and change, and about a more participatory form of partnership with clients.

The presentation of this theme is organised into four sections.

- **Practice development – key dimensions of change**
- **A new approach to achieving effective client outcomes and change**
- **Challenging the client – a critical dimension of implementing the FPM**
- **Doing FPM practice**

PRACTICE DEVELOPMENT – KEY DIMENSIONS OF CHANGE

Working respectfully with clients

Participants reported changes in their focus and in the way they carried out specific tasks. Some indicated that, although their work had not changed substantially, FPM training had instilled a greater self-awareness that resulted in subtle but significant changes in approach. Many participants gave specific instances of how their work had changed and how they incorporated the tenets of the FPM into practice in a new way. There was a strong emphasis on working respectfully with clients, often in complex situations, to promote a more lasting and open engagement.

This little young mum ... she's rung up afterwards and said 'could I see the same

nurse because she treats me like I'm a real person and a mum, not a naughty girl that had a baby'. So yeah we're getting a lot more of that.

Clinical Supervisor 3

Recognising and working to parents' specific skills and knowledge

Closely related to the notion of respect was the importance of recognising parents' specific skills and knowledge. Participants reported that they aimed to value individuals and recognise that every family is different, challenging previous attitudes and pre-conceptions. They discussed this as a significant change from the 'traditional' approach to working with families, in which the nurse was the expert, directing the client what to do. Participants regularly spoke of 'rapport' and 'mutual respect' between clients and clinicians who had trained in the FPM, and the positive impact this has for parents.

Some of them (parents) will comment when they first arrive and after you've done the initial interview and they'll say 'oh I thought you were going to tell me what to do' and they'll be much more relaxed about it. They like it because we do make sure that everything fits in with what they do at home.

Clinical Nurse 9

I try to focus on – while I talk to them – about the positives of what they're doing, not the negatives.

Clinical Nurse 4

You know you've got expertise but it's about acknowledging that the family's got a different expertise and it's how you share your expertise and work together.

Clinical Supervisor 1

They [nurses] get to the point where they feel like they can't tell them anything, and I said, 'No, no; it's family partnerships, so you may know more about your field of specialty than the families, but they know their child more and their temperament, what their favourite food is, etc, etc, their

personality', so it's a partnership seeing.

Facilitator 4

The clients, they're really proud of themselves. It's empowering. At times I try and get the client to, as they're doubting themselves as hard workers, [acknowledge] all these things when they're dealing with a child, and I say, 'so if you look back and see what you have managed or done, do you see how you made that decision yourself?'

Clinical Nurse 6

Focusing on the mother

A number of participants discussed a change in their practice orientation, from an exclusive focus on the baby, to a focus on the mother as the primary caregiver.

Because I'm seeing the mother, I'm working with the mother. I'm not doing anything with the baby, she is.

Clinical Nurse 7

For me the whole workplace changed, the structure of how we were doing everything and putting out their models of care ... [before] we didn't really talk about her goals each day ... whereas now we've got Care Pathways which are all about the mum, so the mum has goals that she wants to achieve for herself separately to what she wants to achieve for her baby.

Clinical Nurse 9

Just listening to the girls [nurses] talk to these women, it's much more, sort of, collaborative; they're teasing out what they can do, they're always checking in with the mother, you know, do you feel okay with this? So, it's – they're very mindful of where the mother's at and what changes she's prepared to make or what she feels comfortable with. If the answer's no, then they'll renegotiate.

Manager 4

Supporting parents to identify their own goals

Participants particularly emphasised the process of setting priorities in partnership and assisting parents to identify their own goals and to direct the interaction with the nurse, even if this contradicts the nurses' professional judgement. This requires specific skills to facilitate effective priority setting rather than simply doing what clients wish.

I say there's no point me picking out all the goals and going like this, after listening, this is what you want to do, it has to come [from the mother] – what do you want and what do you think you can achieve to make more realistic kind of goals?

Clinical Nurse 8

I think with the Family Partnership Training [focusing on] what's on top for this family, not what I think is on top, what strengths has this family got and therefore how are they going to then often find their own solutions if we give them enough room and space to actually do that – instead of roaring in, telling them what to do and roaring out again.

Clinical Supervisor 3

I guess it's empowering not doing things for people because you feel sorry for them, it's actually getting them to take responsibility in making the changes.

Clinical Nurse 4

Just that whole concept of handing it to them and saying okay, you've identified you know that these are the sort of issues you have and handing the controls over to them; which one to choose; what things have worked for you before, what have you tried. Just drawing from the client the strengths that they have and being supportive of those – the strengths that they have already; what they've already done. It's just a total different shift I think for thinking.

Clinical Nurse 1

Exploring issues with parents

Many participants discussed exploring issues with parents using partnership rather than a more didactic expert approach. Nearly all participants described using qualities of empathy, respect and quiet enthusiasm to explore problems from the parents' perspective and to canvass a wide range of strategies. The processes of sensitive listening, questioning and communication, as presented in the FPM training, all require complex skills and restraint to implement partnership effectively and to facilitate the move from advice-giving to a collaboration that utilises the expertise and strengths of both parties.

I think that's what partnership training gives you: the depth into – a window into other people's lives, where you can help them facilitate their own problems and work through the maze of what's going on with them just from new eyes I guess – looking at all that they're going through; and appreciation for their struggles.

Clinical Nurse 1

... Really trying to understand the client's picture, where they were coming from and what kind of influenced them, and then working with them, keep working around 'til you felt that you'd got that and kind of reflecting back to them.

Clinical Nurse 10

The more you talk about it you bring up ideas that you could try. So ... asking them how do they think they can - you know, 'what do you think you could do?' 'What have you tried and has it worked?' Rather than 'this is what you need to do'.

Clinical Nurse 5

If somebody arrived for a six-to-eight week check and ... I looked at the baby and clinically I could see that the baby was going to be fine and the mother had a burning issue, then that half hour now... would be given to the burning issue and another appointment set up for the six-to-eight week check, rather than as a

nurse, me thinking, 'it's a six-to eight-week check; I have to have that done and then we'll get onto that side issue'.

Clinical Nurse 1

The mother might say 'well I don't have a problem with my child's eating and I don't have a problem with the child's behaviour so I just want you to focus on the sleep', whereas once we would have focused on the whole thing. So even in the dining room if we see the mum just – we don't think she's all that appropriate with the eating, we don't jump on her anymore.

Clinical Nurse 9

A NEW APPROACH TO ACHIEVING EFFECTIVE CLIENT OUTCOMES AND CHANGE

Many of the comments about practising differently demonstrated a different appreciation of how effective outcomes and change were achieved from the didactic/prescriptive approach of the expert-based practitioner model. There was a shift from relying on a standard and pre-determined response, what was described as going 'by the book', to an increased focus on working interactively with families to design unique solutions that were specific to them and their situation.

Nurses, I think, we like to say, 'I'm going to tell you blah, blah, blah. Here we go. You heard it, you understood it and now you're going to go and do it'.

Clinical Supervisor 5

Based on my experience, I know – I think I know – what would really work and work well, so I'm sort of mindful that I have to be aware of that just because I've got 20 odd years' experience it doesn't mean that it might work for that particular family.

Manager 4

Participants gave many examples of how very different approaches to change were applied to problems being experienced by parents. These changes were often presented in terms of 'before' and 'after' the FPM training.

Before we used partnership you'd say 'okay, so your baby's unsettled, I'm going to wrap it up, put it to bed, you've got to let it cry for this long' ... So now you're looking at all the things that she's telling you and you just take it so slowly. It might be that she's going to cuddle that baby 'til it falls asleep the first time. And then, 'how do you feel about that now?' ... It's all about being able to see where she's coming from and what she can manage.

Clinical Nurse 9

[When a nurse ascertains that a client feeds her child fruit juice in a bottle] So instead of saying 'you shouldn't give the juice', you might talk a little bit about the empty carbohydrates that – 'you're just filling the baby up on' – you do it in a different way ... But not telling them they shouldn't do it. You might talk about other – 'does your baby like water?'

Clinical Nurse 9

The difference for me is that I [always] was good at identifying but maybe I then was allowing them to speak more freely and just listened. I think that that's changed my practice.

Clinical Nurse 3

But I think my main changes have been allowing the client to make their own decisions – I'm here to give you the information and support – and giving them the education and it's throwing it out – like the open-ended question, how do you feel about that or how do you think the child feels?

Clinical Nurse 4

They [clinicians] are finding out more things ... about the families that they would have brushed over and not realised.

Facilitator 4

I found it very difficult to sit and listen initially, to do the attentive listening. So I think it made a difference. Because I consciously have – I still have to – I

consciously have to think 'Now stop. Don't just jump in. Just listen.' Because I do tend to just [say] 'oh yeah, what about, try this.'

Facilitator 2

One nurse talked of using a partnership approach to an issue that for many participants constituted a significant challenge: that of addressing child safety whilst at the same time maintaining a partnership approach.

Whereas you might have just done the action, stopped it [unsafe behaviour] happening and that was it, after partnership you actually probably would sit down with her and you'd ask her a little bit more about how often it happens and things like that and then give her some strategies for when it does happen and maybe suggest some reading, suggest a whole lot of things. That might then move on and then she'll tell you about other things.

Clinical Nurse 9

CHALLENGING THE CLIENT – A CRITICAL DIMENSION OF IMPLEMENTING THE FPM

Challenging a client in order to set effective goals and to implement change is clearly one of the most complex elements of the FPM, requiring subtle professional and interpersonal skills. Some, but not all, participants discussed working with clients in this delicate aspect of practice.

The FPM identifies 'challenging' as a skill to help parents change, especially when the clinician considers that the parents' perspectives on their problem may be blocking their openness to possible strategies and alternative options. Clinicians may provide additional information, give alternative constructions of the situation or point out gently that the parents' 'construct' may need to change. 'The task for the helper is to spot these gaps, inconsistencies or unhelpful views, help the parents to see them too and to enable them to change in order to adopt a more useful or effective model' (Davis et al. 2002:117). Challenging is a difficult and subtle skill and process, requiring particular attention to ensure that parents do not feel criticised or diminished.

Some participants discussed developing skills to challenge parents and the difficulties they have experienced with this aspect of the FPM. The most common client construct that participants reported challenging is that the nurse will 'fix' their problem ('we're going to wave the magic wand they're going to walk out of here with a brand new baby that will sleep and eat' – Manager 5).

I said to her, I really think I need to be honest with you and you need to be honest with me. It was quite amazing and she told me more than she's ever told me and told me what was going on exactly in the household.

Clinical Nurse 4

You can just sense a disappointment when they think that you're not going to fix everything when you're here for this visit but most people are polite enough and they'll go on the journey with you. Then they see that it's just been so much more beneficial that they've solved their own problems at a rate that they feel comfortable with rather than us stepping in and solving their problems for them.

Clinical Nurse 7

It was also clear from participants' comments that achievement in this complex area was variable. In particular, some senior staff participants identified reservations about the ability of some clinical staff to successfully implement this aspect of practice.

So they engage well, they do all the right things, but when it's time to actually understand the construct and challenge it in a very prolific way and creative way, I don't see much evidence of that. It needs all practice and the only way to do it is do a lot of it and have supervision so you can work through it. That I feel is lacking.

Clinical Supervisor 5

They get to the point where they feel like they can't tell them anything, and I said ... 'it's still all right for you to impart your

professional knowledge' ... They do get that fear that it's so much that 'We'll just let the mother or the parents lead and we'll follow them.' I said, 'No, it's a balancing act.' ... They explore and they listen, and they can quite commonly challenge their ideas, but then they slip into expert model. They find it difficult creating mutual goals and strategies.

Facilitator 4

A supervisor summed up the importance of challenging the client:

To me all the emphasis is on the engagement and I have a thing about being nice. ... You have to be more than nice, you have to sometimes, if the person has to grow they have to grow. That's your job, to make them grow without being an expert. Them growing with your help and be sensitive about it.

Clinical Supervisor 5

DOING FPM PRACTICE

Whilst for many participants the experience of the FPM training confirmed and extended their repertoire of FPM-aligned practice, some experienced taking on the practice as difficult. The comments below identify a range of challenges and implications for practitioners and organisations taking on the FPM.

The 'reluctant' client

Some participants discussed the challenge of sustaining the exploratory approach of the FPM, especially with clients who are reluctant to work collaboratively.

Certainly at the end, very much more open-ended questions – you know, 'how do you feel about that?' and 'what do you think you could do differently?' – slipped a little bit. It depends on your day whether you're really full-on or not. Some people still don't want open-ended questions; they want you to say what it is. I think you can pretty well pick that up when you've asked them a few things and then they just sit there because they're not willing to go on, and I'm not sure

whether I've still got quite that art to probe further to take it on ... I've got one right at the moment that I find really difficult, and I'd love the partnership tutors to come in and do it because I'd love to see them work it and see how they managed it again.

Clinical Nurse 6

[Clinical staff] work and they explore and they listen, and they can quite commonly challenge their ideas, but then they slip into expert model. They find it difficult creating mutual goals and strategies. They tend to explore, listen—okay, now, this is, now go ... 'now you've put your baby down, you la, la, la, la, la'—so yeah, which I think, well, isn't the best, but at least we've taught them to listen and so they're halfway there.

Facilitator 4

Just as some participants seemed uncertain and ambivalent about what this new approach would require, some clients were also identified as having difficulty with a model that challenged the well-established 'rules' about clients posing problems and nurses providing solutions.

People do come with a notion of 'well, you're going to tell me' and really struggle with the notion of a different kind of engagement.

Facilitator 5

[Clients] will often say 'but I really want you to tell me' but we'll say 'no, that's not how we do it anymore. We're working with you and you're telling us'.

Clinical Nurse 9

I'm pretty assertive that I'm not there to solve their problems. I'm there to help them solve their problems.

Clinical Nurse 7

Increased practitioner responsibility

Some participants, having undertaken FPM training, felt that they were then expected to take on more complex professional roles, 'almost

like a social worker job' (Clinical Nurse 10), especially in community and/or rural settings. This is perhaps linked to their learning more of the client's real situation, resulting from enhanced communication and listening skills.

One nurse reflected on the pressure she experienced following her initial FPM training:

Some people were psychologists and social workers in that group, [who] had much more extensive counselling experience than the nurses who went. So I thought that it was a little bit unrealistic to expect that we might be able to actually do that without some sort of further training... I feel sometimes that we're expected to be all things to all people and that some things are just outside your expertise. I'm not mental health trained... you find that you're the only one there and the mental health team come only every six months and nobody's watching this family.

Clinical Nurse 1

But if you're a sole practitioner at the back of Bourke and you dredge up these things ... it can be negligent that you've brought them to the surface but that's one of the things. We're not saying this model is fantastic; there are implications.

Clinical Nurse 7

Conversely, one supervisor asked,

How can we not be mental health workers? My job is not to give them mental health therapy and not to do CBT with them... but my job is to actually help you acknowledge that you need this support from the expert in that field.

Clinical Supervisor 4

Some participants noted that their work in CFH services found them confronted by increasingly complex problems amongst their clients, making for longer and more demanding discussions with parents to fully explore issues. Clients' expectations are also very high. They contrasted this approach with more traditional approaches

to CFH nursing, which focused on the baby and 'glossed over' more complex and frequently undisclosed problems experienced by parents.

They disclose, you know, a lot of sexual abuse, a lot of bad things that are happening in their home or have happened in their life.... If you're working a long time with families like that, it's quite a lot of pressure on yourself.

Manager 1

Clearly work with clients with complex problems requires longer and more sensitive intervention from CFH nurses, who need to call on sophisticated knowledge to provide the necessary support and to facilitate the helping process in partnership.

The challenge for professional expertise and role

In the literature on practice change, the question of the knowledge and expertise implications of taking on a different approach to practice is critical, often determining professionals' views of a new approach to their practice. The FPM approach works to recognise the expertise and capability of families and to actively include and utilise this expertise as a key ingredient in achieving positive outcomes. We were interested to understand how participants viewed this issue. The majority of participants considered that rather than requiring practitioners to relinquish previous expertise and experience, the skilful application of the FPM model required them to extend their practice repertoires, learning new forms of expertise to facilitate and support clients in exploring and solving their own problems.

I've found that sometimes if people take on the partnership model they forget, they think that it means that they can't bring their expertise in so it's almost like they go to the other end of the spectrum. It's all client-led and forgetting about that they actually come to us for – our professional knowledge. I think that the person that can recognise that they're trying to do it a bit differently they might be able to learn and do it differently whereas the people that actually think – and they're usually the

ones that don't like it in the course – that think that they're already working in it so they haven't actually got anything to learn.

Facilitator 5

In terms of expertise, I think I'd be fairly direct. I'd say ... 'you've got expertise but it's about acknowledging that the family's got a different expertise and it's how you share your expertise and work together'. So I think I'd be fairly direct about that because I think it is a misconception.

Clinical Supervisor 1

The tension between implementing a FPM approach and the demands of busy service settings

Reflecting on the impact of FPM on their work practices, participants articulated very different views about whether and how utilising the model required additional time and about the implications for practice in busy settings. Several participants identified several aspects of partnership practice as more time-consuming than previous models of working. Conversely other participants felt that partnership practice imposed no greater effort or commitment of time.

Most of the participants who considered that FPM was more time-consuming were clinicians, whereas most of those who perceived this was not the case were in managerial roles, possibly removed from day-to-day practice in busy work environments.

The participants who commented on the time-consuming nature of partnership practice related this to the elements of the helping process outlined in the FPM training and to changing expectations of practitioners. They commented that the FPM training itself required a substantial commitment of time and concentration. Some, however, recognised that the time taken to deliver a FPM approach was not just about doing the interpersonal side of practice differently, but also involved a range of procedural and administrative changes that had been introduced concurrently, took additional time and were now a routine part of delivering service. For the organisations involved in the study, FPM was

adopted at a time of change, and in some ways, its impact cannot be separated from that of other new policies and procedures, such as new or additional documentation, audits of medical records and the introduction of new computer technology in CFH organisations.

I actually don't believe my work with the client takes longer, I believe it is getting it down in the paperwork seems to be the thing that takes the longer time

Clinical Nurse 10

Reflecting partnership practice in clients' notes constituted a challenge for some staff, not only in terms of time, but also the need to accurately describe how the interaction incorporates the FPM helping process.

If you're documenting, you're also talking to the parent and I think that's the challenge If you're working in a FPM, you actually should be able to see it in the documentation and I'm still seeing the expert model in the documentation...

Manager 2

Several participants felt the expert model posed fewer challenges for both parties and had a better fit with busy CFH practice settings. They described the partnership approach and the time necessary to establish a relationship with parents as taking longer, because it entails deeper, more engaged and less superficial contact. This view of short-term expediency was contrasted with the longer-term benefits identified by other participants, who recognised that over time a collaborative approach was likely to yield greater benefits for families.

I realised the importance of ... quality time with your clients and the quality of the outcome so that you achieve – certainly through this Family Partnership Model – good listening skills and trying to empower the client to recognise their problems and make the changes to gain their own confidence and self-esteem sort of thing. But you can't do it in a short period of time and you need an hour...

Clinical Nurse 4

We know now from family partnership the importance of having to build that relationship and getting to know someone. It feels ... like there's a tension between that and this to get through and be able to tick off a number of boxes at the end of an interview

Facilitator 3

Some participants noted that using a FPM approach could also save time, for example, by achieving more relevant and targeted discussions.

I think that's why for the second, third time mums, I think I have a much better relationship, you know, just because you need that time to build up your relationship

Clinical Nurse 5

I actually think people who complete the course, at the end of it they see that by practising it and working with families in a family partnership way in fact can speed up the process because you're not having a lot of conversations about things that are irrelevant to the family

Manager 3

The impact of the work environment

Many participants discussed the question of the fit between the FPM and different practice settings. They associated different types of organisational and practice settings with very different experiences of partnership practice. Not surprisingly, participants identified the most positive environment as one where the practitioner is surrounded by others also working in partnership.

Where I work is very supportive about those things and they [managers] try really hard to lead by example as well

Clinical Nurse 3

In terms of the physical environment, participants generally agreed that they felt more comfortable working in partnership in home-based services, with a more relaxed environment, less time pressure and potentially less scrutiny

from managers and other colleagues than in residential or outpatient settings. Home visiting services provide the opportunity for practitioners to take time to build relationships with families without the pressure typical of clinics or residential units, where multiple clients or busy waiting rooms add stress.

[A home visit] gives you a lot more latitude because you've got a lot more time. So, very consciously, particularly in a clinic setting, I had to really think about my step-by-step and think about the timing and the clock and to be able to get all the writing in and the checks done. I mean there's obviously physical and clinical work to be done within that as well. So yeah, I found that inordinately difficult.

Clinical Nurse 1

I feel here [outpatient clinic] sometimes you still have [the organisation's] agenda over you and sometimes it's your pace that you've got to set, not so much the client's pace. Home visiting was a good way to practise it too

Clinical Nurse 10

Another participant noted that the time pressure inherent in the universal home visiting program (as distinct from other outreach services) did not facilitate building strong relationships despite being in the client's own home:

Sometimes there's not a lot of difference. It depends, but definitely in the home they're in their home environment – they're more relaxed. Again down here – universal home visiting is that you get in, you do all your paperwork and you get out and that's that and that might be the only home visit they get, whereas previously where I've worked we sort of had three appointments to get all their booking work done so you got to know the family a lot better.

Manager 1

A few participants identified the scope for utilising FPM in in-patient, even acute, settings, especially where there was ongoing contact with clients (eg in NIC units, or in paediatric in-patient care of chronic conditions)

There's so many things they need to learn. So it's really working with them to give them the skills to do that, to manage it, to become confident in looking after those things. That's why I think that it does have a place in the acute care setting ... I think there's other people, like DoCS workers and physios, who have long-term relationships, OTs, speech pathologists, all those people that – people don't always see that. But they work with families for a long time as well.

Facilitator 2

You could go to an A&E in hospital and meet this doctor once in your life and still feel that you were respected by them and that they took the time to hear what you were saying. I don't think those things have to be mutually exclusive.

Facilitator 3

Participants identified that learning to draw on parents' expertise and to work with parents' existing skills constituted an essential outcome, in particular, focusing on parental strengths rather than deficits. At times, putting the FPM to work was challenging for the participants when working with parents who are reluctant or unused to working in partnership. Embracing the FPM as a practice framework has enabled the participants to acknowledge improvements in their ability to provide nursing care and to work more effectively with parents by consolidating skills and in many instances extending their nursing skills. Finally, the participants highlighted the need to step away from a more hierarchical expert model when working with parents and use their expertise in new and innovative ways that created better outcomes for parents and their young children.



Theme 3: SUSTAINABILITY

THEME 3: SUSTAINABILITY

SUSTAINING THE FAMILY PARTNERSHIP MODEL

Sustaining innovation is a complex and difficult issue that occupies a central place within the health reform and health service redesign literatures. It is a central concern for governments and health service providers seeking to produce and embed change. This section reports on how the issue and challenge of sustaining the FPM was viewed and experienced by participants.

The discussion of this theme is organised into four sections.

- ***Practice – a process of continuous learning***
- ***Supervision – a valued learning opportunity – what’s happening on the ground and what might be possible***
- ***The role of individual practitioners and peers***
- ***The importance of management and organisation developments***

PRACTICE – A PROCESS OF CONTINUOUS LEARNING

One of the most consistent themes discussed by participants was about the importance of ongoing learning opportunities.

The value of ongoing learning was most often raised with reference to refresher courses, formal follow-up or in-service education, and opportunities for reviewing the principles of the model and for discussion with peers who had been using the FPM. It was often seen as an organisational or managerial responsibility to provide such opportunities, and/or to release staff for external courses. For the most part, however, access to ongoing learning or external learning opportunities was described as being dependant on particular management champions rather than embedded as part of organisational practice.

Some participants thought that FPM updates should become a regular part of CFH practice, as had other practice-related topics such as immunisation and OH&S. Underpinning these

comments was a view that practice was a developmental process, dynamic and continually evolving, with formal training constituting a first step only.

Participants consistently noted a general absence of follow-up, and the threat this posed to the further development and sustainability of a new form of practice, in this case the FPM. They regularly indicated concern about falling back into previous models of practice.

Against this backdrop, some participants discussed the need for individual responsibility in engaging further with the FPM, eg through current publications and conferences. Others made up for lack of formal learning opportunities in their organisations by meeting informally, although these meetings tended to be sporadic and were hard to arrange in time-pressed environments.

Calling attention to it [the FPM] every now and then will re-spark it in people, because it can die very easily and nurses particularly can easily go back to just the advice-giving mode.

Clinical Nurse 1

They need to have something that actually jolts them to say, yeah I’m actually working in that model... how do you go about doing that when you’ve got this conflict between so much clinical time and so much administrative time and so much education time?

Manager 2

They do the course, and they go back to work. There’s none, there’s nothing.

Clinical Supervisor 3

It’s like a reunion, people come back to have a refresher course, to look at the model and bring any queries or problems that they’ve had... they found it useful because some of the participants told me that they tend to forget some of the framework.

Facilitator 4

SUPERVISION – A VALUED LEARNING OPPORTUNITY – WHAT’S HAPPENING ON THE GROUND AND WHAT MIGHT BE POSSIBLE

The need for and lack of regular supervision, in particular, supervision modelled on the FPM, was a constant point of discussion in relation to practice development and practice sustainability.

Supervision was identified as one of the most important and potentially accessible opportunities for ongoing learning.

Many participants discussed clinical supervision as a means of supporting FPM practice post-training, embedding it in practice and sustaining it in the long term. It is also important to note that supervision, whilst generally recognised as important, was not viewed in a unitary way (see later discussion).

Despite the common notion that supervision is or could be valuable in sustaining FPM in practice, the opportunity to access supervision was not guaranteed in the two Australian settings. Plunket, however, promoted a very different and systematic approach to training and supervision whereby existing and new clinical staff are trained in skills using material that draws heavily on FPM principles, with the great majority of clinical supervisors having completed FPM training and being expected to use it in their day-to-day work of providing clinical supervision and ongoing support to staff.

Participants viewed supervision as something that needed to be organised, provided or made available ‘from above’. Participants commented on supervision being very different in different organisations and, at times, very different in different practice settings within an organisation.

Some participants highlighted management mediation in terms of whether or not supervision was mandatory, and the fact that strong managerial support, direction or formal release could make it easier for nurses to find or make time in their busy schedules. Some nurses described themselves as feeling dependent on managers for the opportunity to participate in supervision, as opposed to supervision being a

mandatory part of organisational practice. This dependency was further exacerbated with managers who were perceived as not being supportive of supervision.

Supervision was not something that was encouraged by management at all.

Clinical Nurse 4

[Where I was previously] supervision was acceptable, I’m saying I guess it’s been for a long time was accepted by more people as the norm, whereas down here it’s still being forward a bit I think ... not really understanding what the benefit of it [is].

Manager 1

I’ve had no supervision at all since I’ve come ... my name was never put down for – I mean, nobody ever put me forward, so that’s something I’ve never had.

Clinical Nurse 8

Even when supervision was available, many participants described feeling unable to attend clinical supervision meetings because they were simply too busy. Without clear support or direction from management, nurses felt unable to justify or feel comfortable leaving the clinical shopfloor for something that could be perceived as a luxury. Others explained how the scheduling of supervision (particularly when done in groups) made almost impossible to attend, given rosters, especially for shift workers and part-time staff. Some participants mentioned organisational efforts to make access to supervision more flexible.

There’s a lot of pressure on these people. They’ve got more work; they’ve got very high caseloads without being asked to take on new things all the time. Supervision’s a bit of a luxury for them I think.

Clinical Supervisor 1

I don’t think the organisation’s saying you can’t have supervision. I think people are just not accessing or making the time to have it.

Facilitator 5

While the majority of participants valued supervision, some noted that not all their colleagues shared this view. They referred to some reluctance and a suspicion that supervision is about checking up on individuals and about individuals admitting their inadequacy, rather than supervision being seen as normal. Conversely, some participants noted some experienced staff did not feel they needed supervision, and that it was irrelevant to their practice.

There's a lot of people I talk to in my work who haven't ever had supervision. They all think it's checking on what they do, their actual practical work... That comes out all the time when people have never got any knowledge of supervision.

Clinical Nurse 4

I think even the nurses too don't see it as valuable so they don't make the time.

Manager 1

They've had me tell them week after week 'don't forget I'm here and you can ring me' and they've still got a perception that that's not a possibility... I did say 'you're very welcome to contact me, that's part of my job and I'm really happy to see people'... But nobody has.

Clinical Supervisor 1

So it's finding different people on different days to be able to attend supervision, and judgement, but the people that need supervision don't attend it.

Clinical Nurse 7

Participants typically referred to supervision as a space in which FPM can be discussed in one of two ways.

- Supervision exists and provides a formal structure for supporting ongoing FPM eg families can be discussed with supervisors, making reference to the model - FPM is named.
- Supervision exists as a space for sustaining FPM, but without it being named or discussed explicitly and

without the idea of partnership being foregrounded.

That's actually come up through supervision, when we discussed that, in working with colleagues when things have come up and we think 'okay, let's take it back to working in partnership and how we can relook at it'.

Clinical Nurse 10

So if someone brings up a family with complex issues that they wanted to discuss, whilst nobody is saying 'oh let's think of it as in partnership', I just think the ideas that come up would be along those principles anyway, so that is still using the partnership approach, even though no-one would be defining it as that at the time.

Clinical Nurse 2

Some supervisors felt it was up to nurses to raise the FPM – if they didn't mention it or suggest thinking about a case in that way, then it wouldn't come up – or that it was not pursued in supervision sessions. Some participants cited the absence of 'supervision for partnership', implying perhaps that this would be separate from other forms of supervision – more clinically based, or more about professional capacity rather than family partnership.

Often I will talk about how are you going with family partnership? But it doesn't seem to lead anywhere, doesn't seem to be something that people want to work on.

Clinical Supervisor 1

While many participants discussed the importance of supervision for the development of FPM, they also discussed supervision in its broader context, that is a mechanism for developing professional practice more broadly: help with complex cases (including case review), emotional support, being listened to about work and reflecting on practice. At times supervision was spoken of as a chance to air frustrations with work conditions and satisfaction more generally, offering clinicians a 'voice', with supervisors sometimes construed as go-betweens who could influence management. However, other views

were also evident, with participants explicitly stating that supervision should not (as it did at times) become a 'general bitch session'. Whilst not always what they would have liked, many participants focused on supervision for what it could offer - reflection and debriefing, conveyed through words like 'nourishing' and 'growth'.

Some participants saw supervision utilising the principles of the FPM as being a powerful way to model and learn about partnership practice. The adoption of the FPM as a way of delivering supervision was regarded by many participants as crucial to good supervision and to the sustainability of the FPM. Participants from Plunket noted that the principles of the FPM were being adopted as a conceptual framework for supervision in their organisation.

THE ROLE OF INDIVIDUAL PRACTITIONERS AND PEERS

The majority of participants referred to the importance of peers in sustaining FPM. They gave vivid accounts of how informal peer relations helped them bring FPM to life in their daily practices, for example, sharing experiences day-to-day, informal debriefs, tea-break chat, email or phone discussions, diffusing stressful situations, bouncing ideas off one another, informal case reviews. Sometimes participants explicitly characterised such interactions as occurring within a FPM framework – non-judgemental, listening actively, respecting each other's constructs, and challenging each other. Sometimes peer interactions were facilitated by organisations through semi-formal peer supervision arrangements, teamwork structures, or through sending colleagues to FPM training sessions jointly, which tended to generate mutual support over time.

It's fabulous. Like everyone debriefs all the time. It works very well. It's a very supportive place to work here, amongst your colleagues.

Clinical Nurse 9

But just that I have this close relationship with my colleague because we work in a small room together. We would always bounce the situations off each other and

say, 'oh, well, if we had spoken about specific skills or qualities of the helper, we would say this is what happened to me today'.

Clinical Nurse 3

However, participants also gave accounts of where this was not happening. Some rural nurses had no peers. Others worked in organisations where no or few other staff had done the training. Some described colleagues as passionately against the model: either peers who felt that 'you can't teach an old dog new tricks', or those from other disciplines (allied health or hospital doctors being examples of groups characterised as working in other models). In some cases nurses described difficulties working with peers when the organisation as a whole didn't fit with FPM – as when one joined an institution that was at the time still very focused on babies rather than mothers in documentation, outcomes reporting etc.

It's what lets down a lot of the programs being really taken up. Because ... if you don't try and get everybody on board at the same time so that everyone's talking about it and starting to practice ... which certainly I think didn't happen in our organisation. It's taken a long time to get everybody trained.

Facilitator 5

I'm not sure that it's really fair to send just one person. It's not the sort of training that you just go, you find out and you tell everyone else about it. It doesn't feel like enough. It feels like there needs to be more than one person. The need to be [with] people who can talk to each other about what comes up and who can be analytical together about the way that they're working in light of what they've learned.

Facilitator 3

One organisation, Plunket, made a strategic decision to include different agencies within the FPM training courses it co-ordinated. This has had a specific impact on the nature of FPM experience in the New Zealand context.

Participants (including some from the NSW organisations) mentioned the value of building relationships with colleagues in other organisations and agencies when a training group contained a cross-section of participants. They also highlighted the value to clients of this approach.

So because of the different range of people that were on the course that had some real benefits because you got to network with people in the community, find out about what they were doing, the kind of issues that they might have in their roles - if they chose to talk about those... So that was kind of interesting to hear what, how other people interact with clients. So it was good having a variety I think.

Clinical Nurse 5

The group I was in there was, I think, about ten of us and they came from very varied backgrounds, which was good because I enjoyed the different perspectives people had from other fields besides nursing. Certainly, most of them, I think, were in community health in some way, shape or form.

Clinical Nurse 7

The benefit is for client I think. Once again it's giving us a tool to actually really look at working collaboratively and working together and all those nice words that sometimes everybody has the intent but unless you do actually - I just think it facilitates that in them ... In particular that in smaller towns too, you'll have a lot of these people that work with the same families.

Facilitator 3

In addition to the importance of peers, participants also conveyed a sense of their personal role in sustaining FPM. Some saw themselves as 'carriers' of the FPM, demonstrating the model through their practices. Their work in sustaining the FPM took various forms: writing their own reflective journal; personal reflections; reading relevant materials

and resisting the temptation to go back into expert models. Many suggested that sustainability was not about maintaining the status quo, but about evolving and growing in their partnership practice and experience, learning about how to adapt and implement it, trying it out, and gradually getting better at it.

I still think it takes a while. It's not something, you can't just go into the training and then walk out and know family partnership. You've got to actually live it.

Clinical Supervisor 4

It was just a change of being, I suppose.

Clinical Nurse 1

Closely related to the issue of individual practitioner responsibility, was a discussion of 'autonomy'; that is the autonomy of the nurse to determine how best to practice. At times this was discussed in terms of nurses having control over scheduling client meetings (duration, frequency). At other times autonomy was discussed more as challenging certain pre-determined ways of practising and allocating time, for example, running over time (because clinicians were discussing a matter important to a client), resisting other demands placed on them ('that's not important, I'm not doing that'). Two nurses mentioned 'giving themselves permission' to change, and to try new things in their practice.

I think one of the things that I've gained was actually I felt very comfortable to make changes and gave myself permission that this was okay without having anyone really - maybe there was a slight challenge there, but I discussed those issues when I talked about the importance of me as number one. Looking after myself to look after my clients. We did discuss that.

Clinical Nurse 4

It is important to note that such comments were not disregarding of organisational requirements and policies; rather, they pointed to the inevitable tension experienced by both nurses and managers in responding to policy and workload requirements while also developing family-centred rather than organisation-centred

responses to complex family situations. These tensions were well recognised by managers participating in the research.

THE IMPORTANCE OF MANAGEMENT AND ORGANISATION DEVELOPMENTS

Participants offered diverse comments about what was occurring in their organisations and the impact on the development and sustainability of the FPM post-training. In particular, they identified the understanding and actions of managers as critical to the future of the FPM. Overall, these comments point to the immense importance of organisational life – policies, procedures, information systems etc - to the sustainability of new approaches.

The role of management

In many instances nurses looked to their managers for leadership, but often found it lacking regarding FPM. Managers were viewed as being required to drive FPM forward (based on an understanding of its elements and values), to ensure organisational structures were in place and, more broadly, to take the lead in embedding the FPM into the culture of the organisation. Recognising that training on its own is not enough, participants viewed managers as required to provide (or at least release staff for) supervision and ongoing education. Managers could make a concrete difference through allocation of caseloads (giving time to work in partnership), monitoring of staff stress and wellbeing, and by sheltering them from the 'stats'.

Participants suggested that managers should understand where nurses are coming from, understand the model, and what is required to implement this new form of practice. Many suggested that the way to achieve this is for managers to participate in the FPM training, as a way of ensuring that the organisation's approach to the FPM was both bottom-up and top-down. They recognised that management, like clinical practice, could be dictatorial and a barrier to improving practice / sustaining FPM, or based on a partnership approach, demonstrating effective listening, empathy and an acknowledgement of mutual strengths.

Participants associated the management culture with the culture of the organisation (the former has the power to influence the latter).

Where I work is very supportive about those things and they [managers] try really hard to lead by example as well

Clinical Nurse 3

There's people further up that want to sustain it but we still haven't come around to who's going to drive it ... we need somebody to actually drive it.

Manager 2

I think you need your managers to have done the course... It's got to be coming from the top down before you can really expect the staff to be embracing it and using it well with clients ... to embed anything in then we have to put in extra work after the training's done.

Facilitator 5

I do think it is ensuring that the area managers and clinical leaders do receive or have an opportunity to participate in the Family Partnership training so they understand the shifts that people are maybe trying to make in their practice.

Manager 3

You need to motivate the people at the top first, because if you haven't got them embracing it the message is not coming down the right way ... if they value it, when you're making changes outside the normal scope of practices, they're understanding that and being more supportive of it so you are not breaking down the barriers.

Clinical Supervisor 4

Capacity – the practical side of things

Several participants commented that capacity - financial and/or practical support - is crucial to sustaining FPM, for example, in supporting nurses post-training, and in securing the future of FPM by ensuring all staff can be trained. It was noted that while it is easy for organisations to 'be supportive', it is less easy if this involves funding.

In very practical terms, participants saw support as being demonstrated in a variety of ways, such as, paying for training or releasing staff to attend training, providing administrative / secretarial support, and devoting existing staff time to coordination and leadership roles relating to partnership. Support for both training and post-training were seen as crucial.

[Facilitator: What do you see is the future of Family Partnership in a service setting like yours?] I guess it really depends on money, doesn't it? It does. That would be the number one thing.

Clinical Nurse 3

There's no drive [after training] they say 'Look we've funded it, we got people to come out there to train. We've trained people to train facilitators, we've funded all of that.' But there's no way to sustain that. So if you want to sustain it you have to keep putting money there to sustain it and you have to see it's a priority.

Manager 2

Information and communication technology (ICT)

Participants gave a strong sense that ICT / computerisation affected partnership practice, most commonly in regard to recent introductions of computerised note taking, record keeping or data management. For some practitioners ICT itself presented a challenge, even among those who regarded themselves as more generally computer literate, arising from problems associated with specific software, the extra time required to enter information onto computers, or increased requirements for information. More rarely, a lack of computers (hardware) was deemed to hinder practice. Many participants referred to making real time notes on computers as an intrusion in nurse-client interaction, both during face-to-face contact, and due to the consequent reduction in time available for clients.

There is a particular program that is going to be introduced into our area, and I think like any new program it's going to take time from the clients.

Clinical Nurse 1

I think you can't do a Family Partnership Model and have that trusting relationship when you've got your face in a computer and the client's sitting in the chair. That's what it's about and that's why I don't actually type up while they're talking to me.

Clinical Nurse 4

Yes, computerisation will make it difficult ... Yep, the interference of technology into taking note of psychosocial issues that are actually happening for families and being with the families.

Manager 2

Documentation requirements and their impact on a partnership approach

Some participants experienced the requirement to produce particular kinds of documentation as a problem when this structured the interactions between nurse and family in ways that did not allow for the development of a parent centred focus. However, in other situations, documentary practices were seen as supporting the FPM, eg where protocols had been changed to involve clients much more actively (eg developing goals jointly with the nurse), where clinical notes systems changed to incorporate a mother file in addition to the existing child file, reflecting the FPM focus on parents, or when changes allowed nurses to document particular pieces of information that they felt were relevant given their FPM-informed interactions and judgements.

You often get the families themselves [who] just look as though you've got two heads when you're getting the history and saying 'do you drink or do you smoke?' and all they're worried about is they haven't had a decent night's sleep for six months and they're ready to kill someone.

Manager 4

Once upon a time we would write 'mother's not compliant, and mother's not following through' but now we'd be writing 'mum needs a lot more support when she's settling her baby'. It's just so different.

Clinical Nurse 9

Organisational policy and culture

Several participants referred to organisational policies and culture and how these impacted on partnership practice. Examples included the introduction of Care Pathways as a part of a model of care, changes in clinical guidelines (both in practices and language used), and shifts from baby- to mother-centred care and from nurse/expert-centred models to approaches that were more strongly shaped by clients' perceptions and needs, all of which support a FPM approach.

A few participants made comments about wider state and national policy, pointing to a good fit between some of these and the FPM, such as a more client-centred approach to clinical hand-over (as recommended by the Garling Report); an emphasis on parental evaluation in the NSW Government Blue Book (Personal Health Record); wider shifts towards a more participatory culture / policy around health (even if not specifically FPM), leading to changes in parents' expectations; anticipated changes in nurses' contractual arrangements; and forthcoming national registration and clinical skills assessment policies. One nurse commented that FPM seemed to lack the support of clear organisational guidelines that were associated with evaluating quality in other areas of practice, such as domestic violence or depression.

When we start the admission we get her to sign a little consent form, it's saying – she's consenting to work in partnership with the staff ... So every time at the early stage of doing the admission it brings you back – yourself as the nurse – to that ...

Clinical Nurse 9

Like immunisation – it has to be seen to be that important.

Clinical Nurse 1

In a broad way, many participants talked about the culture (the overall ethos, value base and directions) of the organisation in which they worked and how this culture was or was not aligned to the FPM. Participants presented a complex picture of the organisational cultures of which they were a part. Change was a central feature of these descriptions. For example, changes in the ways that colleagues were expected to interact, changes in the language used, or a new emphasis on parent-focused approaches to care. Many spoke of palpable shifts associated with embedding the FPM – 'we're doing FPM now' – the use of 'we', perhaps, signalling a sense that for many participants a partnership approach was being experienced as a shared organisational practice. Although most comments referring to cultural change were positive, some identified barriers to sustainability, eg the ways that measures of success are identified, the way that funding is determined with its strong focus on the 'baby' rather than the family.

I think it's really hard for us at [an organisational level] because the baby is the client. We're funded for the baby but they want us to change our practice to a family-centred approach, but we're really restricted administratively and medical records wise about the service provision we can provide.

Clinical Nurse 7

People seem to listen to each other a bit better ... With their colleagues and again particularly in meetings where you see most of that kind of interaction between people. They spend a little bit more time listening to what another person has said, respecting their point of view, trying to understand their point of view better.

Facilitator 3

For me the whole workplace changed, the structure of how we were doing everything and putting out their models of care ... [before] we didn't really talk about her goals each day ... whereas now we've got Care Pathways which are all about the

mum, so the mum has goals that she wants to achieve for herself separately to what she wants to achieve for her baby.

Clinical Nurse 9

[Discussing conversations with colleagues in another section of the organisation]

'What? You do a discharge summary for every mother?' 'Yep, because I'm seeing the mother, I'm working with the mother. I'm not doing anything with the baby, she is'. So that, to me was a more significant shift because now when I look through all the notes I can see that most of them [mothers] are getting a discharge summary.

Clinical Nurse 7

This final theme of sustainability raises numerous important issues that need to be considered by organisations if they are to sustain and embed the use of the FPM for engaging and working with parents. Plunket's success in implementing the FPM into their organisational practices was possibly due to a more systematic approach to implementation, whereas the two NSW based organisations appeared to have been more ad hoc in the implementation and support of the FPM. The timing of the FPM implementation was significant: NSW Health introduced the model in 2004 at a time of major change of Area Health Service structures. Regardless of timing, however, participants identified several sustainability issues as crucial: manager leadership and support in changing organisational culture; access to effective clinical supervision; and ongoing education.

CONCLUSION

This research set out to investigate how three CFH services, two located Australia and one in New Zealand, have implemented a significantly new approach to early childhood health service provision, the Family Partnership Model. In particular, the research aimed to develop new understandings about how knowledge of and experience with the FPM was developed beyond an initial training experience; how the model was adapted to specific practice contexts (the three participating services); and how a partnership approach to practice was supported and sustained within the three organisations. In doing this, the findings of the research have addressed significant knowledge gaps within the area of the FPM and, additionally, have made a significant contribution to a broader literature on practice innovation, its successful implementation and its sustainability. Other publications and presentations from this research have explored some of these themes in greater depth (see Appendix A).

Whilst the scope of the research was limited and particular, a focus on the FPM as it was being applied within three practice contexts, the semi-structured interviews with individuals and focus groups produced a number of well-defined and consistent themes. In this section, we summarise these themes and explore the challenges and implications they pose for health professionals, for health service provider organisations, for health professional education and, critically, for clients.

THE IMPORTANCE OF REFLECTION – A LITTLE LEARNING GOES A LONG WAY

Participants highlighted the importance and impact of the training experience, in particular, how opportunities for reflection allowed them to engage with and take stock of their practice in ways that the busy demands of daily activity do not allow. Consequently, many participants recognised the need for and possibility of improvement, even when they were already utilising the FPM. For some, the training experience was transformative. These comments reflect a well-developed literature and research

base on the importance of review and reflection and its role in creating the conditions and momentum for ongoing learning and quality improvement. One of the strongest and most consistent messages communicated by participants was about the importance of, and need for, regular opportunities to reflect and learn.

RETHINKING PROFESSIONAL PRACTICE – PRACTICE AS A DYNAMIC AND DEVELOPING ACHIEVEMENT

Developing more effective and sustainable health services requires careful consideration about professional practice, professional learning and the conditions required for the achievement of successful health service redesign. Participants provided many insights about these complex matters.

Whilst effective professional practice and practice change are often thought about in static terms, that is with a focus on attaining a particular competence after which practice is consistently effective, participants identified a very different view. They presented practice as something that is dynamic, relational – developed between the participants involved – and continually evolving. Participants consistently talked about the challenge of developing their practice in response to the particular circumstances of an individual family and, importantly, in a process of learning with and from the family. That is, working in partnership.

The implications and possibilities of seeing practice in this way are, we think, profound. They pose new challenges for how we think about effective practice, practice capability, learning and change; and, in terms of where most learning takes place, require far more attention on the possibilities for learning and development in the workplace.

THE NEED TO KEEP PRACTICE EVOLVING

The need to keep learning alive and evolving within a busy workplace is also critical. Participants recognised that developing new approaches to practice was not a once-and-for-all achievement that was completed and ready to go

at the end of a five-day training experience. On the contrary, many participants saw the training, as powerful as it was, as being the first stage of something that needed to be further resourced and supported, through ongoing opportunities for learning and reflection. Participants consistently identified two strategies as central to addressing this challenge – follow-up training and supervision. More than any other strategies, regular training and supervision were identified as the most important ways in which organisations could invest in and ensure professional development and continuing quality improvement. Ideally, participants felt that supervision modelled on the FPM would produce the greatest benefit. However, they recognised that supervision that operated with a strong commitment to review and reflection was well able to facilitate professional learning, provide support and enable service improvement.

A MORE ACTIVE ROLE FOR CLIENTS – A POSITIVE APPRAISAL BUT FURTHER RESEARCH IS NEEDED

Participants' discussions about their use and experience of a partnership approach in their day-to-day work with families were important and illuminating. Whilst there is a global policy push toward developing new and active forms of partnership with clients, there are few accounts of how this is achieved, how the partnership is experienced, and what can be learned.

Significantly, participants perceived that a partnership approach allowed and supported a far more active contribution from clients. They also reported a 'freeing-up' of health professionals to work with clients in a more holistic and situated way. Participants felt more able to be relevant: to engage with their clients in ways that focused attention on the clients' concerns rather than the priorities of the service provider. For the most part, participants saw the outcome of a partnership approach in very positive terms, as enabling the development of increased parenting confidence and capability in clients and gave numerous examples of such developments.

Some qualifications are needed, however. Firstly, the study was not an evaluation, but reported on the *perceptions* of a group of health professionals. To make definitive statements about impact and outcomes would require a very different kind of study. Secondly, it was also clear that a partnership approach requires clients to be prepared to participate differently – more actively. Yet participants reported that some clients found difficulty with the changed expectations that were required of a partnership approach. Similarly, some participants discussed professional colleagues who resisted a change in their approach to practice. Part of the practice development challenge for health professionals was the need for greater exposure to what a partnership approach could and could not offer, and how 'old' and 'new' practices might be worked together. Many participants discussed still finding their way with a new approach.

WHAT DOES A PARTNERSHIP MODEL MEAN FOR THE ROLE AND EXPERTISE OF HEALTH PROFESSIONALS?

One issue well described in the literature and discussed by some participants, was the concern that taking on a partnership approach would diminish the role and expertise of the health professional, constraining health professionals from utilising their expert knowledge and judgement while accommodating their clients' needs. Many participants commented that this was not what they had experienced. On the contrary, they noted that adopting a partnership approach was not an alternative to being the expert; rather, their experience was that it required new kinds of knowledge and capability, thus extending the repertoire of their practice skills. Many participants felt they were still learning how to blend partnership and more interventionist approaches, particularly in cases when the health professional perceived a situation of risk for a child.

SUSTAINING CHANGE – WHAT IS REQUIRED?

Not surprisingly, the question of the sustainability of innovation was a central topic of comment. Sustaining innovation or, more frequently the

failure to sustain innovation, is a central issue in the health service redesign literature. It is also a central issue for governments and health service providers seeking to produce and embed change. Participants provided important insights into these issues. They presented the need for a range of interconnected strategies that would support and further develop innovation, what could be termed the 'conditions for sustainability'. A number of these strategies are identified above – especially systematic learning opportunities and supervision incorporating review and reflection.

They also discussed four other matters identified as critical to sustainability.

Firstly, the importance of how management positioned itself in relation to the FPM or, more broadly, to innovation, was identified as critical to whether innovation was likely to become embedded. Whilst some participants reported receiving strong support from a senior managers, participants considered that sustainability was more likely to be influenced by systematic and organisation-wide support and enabling. Such support was discussed frequently in terms of ensuring that supervision and training opportunities existed and that staff were enabled to take advantage of them. Participants often felt unable to utilise supervision even when it did exist if there was not sufficient front-line cover. A number of participants suggested that management should attend a FPM training session as a means of orientation to the approach.

Secondly, the importance of peer support was a strongly developed theme. In the absence of formal supervision and/or training, the support of colleagues who were working with a partnership approach was identified as making an immense

difference. Participants gave many examples of corridor or lunchroom discussions with colleagues that kept learning alive and practice developing.

Thirdly, a number of participants discussed the contribution they each could make to the development of their own practice, such as searching out training opportunities. Whilst this was identified as one part of the development and sustainability process, participants noted that self-directed activity was much more likely to ensure sustainability if it were one part of a range of organisationally-supported development initiatives.

One final issue discussed by many participants related to the fit between different practice settings and the FPM approach. Most typically, participants identified that some practice settings, in particular, home visiting rather than centre-based care, fitted better with the FPM requirements. Some participants identified that practising in line with FPM principles required autonomy and more time than was currently available. This view was not held universally. Other participants indicated the FPM was more time-efficient and effective as by using this approach, professionals could get to the heart of families' concerns with greater speed.

Related to this theme of fit, some participants identified other aspects of the changing context of practice in general. Two examples of this were the introduction of computers for clinical record keeping and the requirement for professionals to administer various at-risk protocols. Such developments were seen as reshaping practice, in particular, limiting flexibility regardless of the practice setting.

REFERENCES

- Avon Premature Infant Project (1998) Randomised trial of parental support for families with very preterm children. *Archives of Disease in Childhood - Fetal Neonatal Edition*, 79, F4-F11.
- Barlow J, Davis H, McIntosh E, Jarrett P, Mockford C & Stewart-Brown S (2007) Role of home visiting in improving parenting and health in families at risk of abuse and neglect: results of a multicentre randomised control trial and economic evaluation. *Archives of Disease in Childhood*, 92, 229-233
- Bidmead C & Cowley S (2005) Evaluating family partnership training in health visitor practice. *Community Practitioner*, 78, 239-245.
- Bidmead C, Davis H & Day C (2002) Partnership working: what does it really mean? *Community Practitioner*, 75, 256-259.
- Bovaird T (2007) Beyond Engagement and Participation: User and Community Co-production of Public Services. *Public Administration Review*, 67(5), 846-860.
- Bowlby J (1988) *A secure base: clinical application of attachment theory*. London: Routledge.
- Council of Australian Governments (2009) *Protecting Children is Everyone's Business: National framework for protecting Australia's Children 2009-2020*. Canberra: Commonwealth of Australia.
- Crawford P & Brown B (2009) Mental health communication between service users and professionals: disseminating practice-congruent research. *The Mental Health Review*, 14, 31-39.
- Davis H & Day C (2010) *Working in partnership: the Family Partnership Model*. London: Pearson.
- Davis H, Day C & Bidmead C (2002) *Working in Partnership with Parents: The Parent Adviser Model*. London: The Psychological Corporation.
- Davis C, Day C, Bidmead C, MacGrath M & Ellis M (2007) *Current Family Partnership Model*. London: South London and Maudsley NHS Foundation Trust. Available online from <http://www.cpcs.org.uk/uploads/downloads/family%20partnership%20model/Current%20FPM%20Framework.pdf> (accessed 7 March 2012).
- Davis H, Dusoir T, Papadopoulou K, Dimitrakaki C, Cox A, Ispanovic-Radojkovic V, Puura K, Vizacou S, Paradisiotou A, Rudic N, Chisholm B, Leontiou F, Mantymaa M, Radosavljev J, Riga E, Day C & Tamminen T (2005) Child and family outcomes of the European Early Promotion project. *The International Journal of Mental Health Promotion*, 7, 63-81.
- Davis H & Fallowfield L (1991) *Counselling and communication in health care*. London: Wiley.
- Davis H & Meltzer L (2007) *Working with Partners in Partnership*. London: Department for Education & Skills, Department of Health.
- Davis H & Spurr P (1998) Parent counselling: an evaluation of a community child mental health service. *Journal of Child Psychology and Psychiatry*, 39, 365-376.
- Davis H, Spurr P, Cox A, Lynch M, Von Roenne A & Hahn K (1997) A description and evaluation of a community child mental health service. *Clinical Child Psychology and Psychiatry*, 2, 221-238.
- Donald T & Jureidini J (2004) Parenting capacity. *Child Abuse Review*, 13, 5-17.
- Dunston R, Lee A, Boud D, Brodie P & Chiarella M (2009) Co-production and health system reform – from re-imagining to re-making. *The Australian Journal of Public Administration*, 68(1), 39-52.
- Elkan R, Blair M & Robinson J J A (2000) Evidence-based practice and health visiting: the need for theoretical underpinnings for evaluation. *Journal of Advanced Nursing*, 31, 1316-1323.
- Engeström Y, Miettinen R and Punamäki R (eds) (1999) *Perspectives on Activity Theory*. Cambridge: Cambridge University Press.

Farrall E & Arney F (2010) Harnessing 'resilience' when working with children and families. In: Arney F & Scott D (eds.) *Working with Vulnerable families: a partnership approach*. Melbourne: Cambridge University Press, pp. 45-69.

Fowler C & Rossiter C (2007) *NSW Health Families First Statewide Education Project: Health Home Visiting, Integrated Perinatal and Infant Care, Family Partnerships*. Unpublished, Tresillian Family Care Centres.

Government of Victoria, Department of Human Services (2010) *Supporting parents, supporting children: a Victorian early parenting strategy*. Melbourne: Victorian Government.

Head B & Redmond G (2011) Making prevention work in human services for children and youth. *Australian Review of Public Affairs* 10, 5-22. http://www.australianreview.net/journal/v10/n1/head_redmond.pdf

Jackiewicz S (2004) *Evaluation of Family Partnerships Training in Western Australia 2001-2003*. Perth: Family Partnership Training Program Consultative Group.

Keatinge D, Fowler C & Brigg, C (2008) Evaluating the Family Partnership Model (FPM) program and implementation in practice in New South Wales, Australia. *Australian Journal of Advanced Nursing*, 25(2), 28-35.

Kelly GA (1955) *The psychology of personal constructs*. New York, WW Norton.

Kirkpatrick S, Barlow J, Stewart-Brown S & Davis H (2007) Working in partnership: user perceptions of intensive home visiting. *Child Abuse Review*, 16, 32-46.

Layou-Lignos E, Tsiantis J, Hilton D, Rudic N, Puura K, Paradisiotou A, Ispanovic-Radojkovic V, Roberts R, Hadjipanayi Y, Dejan R, Mantymaa M & Tamminen T (2005) Training for primary health care practitioners. *The International Journal of Mental Health*, 7, 41-53.

National Public Health Partnership (2005) *Healthy Children – Strengthening Promotion and Prevention Across Australia. National Public Health Strategic Framework for Children 2005-2008*. Melbourne: NPHP.

Newman J (2001) *Modernising Governance: New Labour, Policy and Society*. Thousand Oaks: Sage.

NSW Department of Health (2009) *NSW Health/Families NSW Supporting Families Early Package – SAFE START Strategic Policy*. North Sydney: NSW Department of Health.

Papadopoulou K, Dimitrakaki C, Davis H, Tsiantis J, Dusoir T, Paradisiotou A, Vizacou S, Roberts R, Chisholm B, Puura K, Mantymaa M, Tamminen T, Rudic N, Radosavljev J & Miladinovic T (2005) The effects of the European Early Promotion Project training on primary health care professionals. *The International Journal of Mental Health*, 7, 54-62.

Rogers C (1959) A theory of therapy, personality and interpersonal relationships as developed in the client centred framework. In: Koch S (ed) *Psychology: A study of a science*, Vol. 3. New York, McGraw-Hill, pp 184-256.

Schatzki, T R (2001) Practice Theory, in T R Schatzki, K Knorr-Cetina & E von Savigny (eds), *The Practice Turn in Contemporary Theory*. London and New York: Routledge, 1-35.

APPENDIX A: OUTPUTS FROM THIS STUDY

PUBLICATIONS

Fowler C, Rossiter C, Bigsby M, Hopwood N, Lee A, Dunston, R (forthcoming) Working in partnership with parents: the experience and challenge of practice innovation. Accepted to *Journal of Clinical Nursing*, June 2012.

Hopwood N, Fowler C, Lee A, Rossiter C & Bigsby M. Sustaining Partnership Practice in Child and Family Nursing: a case study of practice architectures. To be submitted for publication.

Rossiter C, Fowler C, Hopwood N, Lee A, Dunston R (2011). Working in Partnership with Vulnerable Families: the experience of Child and Family Health practitioners. *Australian Journal of Primary Health* 17(4) 378-383, doi.org/10.1071/PY11056.

CONFERENCE PRESENTATIONS

Fowler C. *More than Being Nice*. Presented at the NSW Child & Family Health Nurses Association (in partnership with Tresillian Family Care Centres and Karitane) Conference, Sydney, June 2010.

Fowler C, Dunston R, Bigsby M. *Family Partnership Model: Developments and Innovations* Workshop with Dr Crispin Day. Sydney, 30 July 2010.

Hopwood N, Rossiter C, Lee A & Dunston R. *Supporting Children and Families through sustained partnership: the Family Partnership Model in Australia and New Zealand*. Presented to The Annual Meeting of the American Educational Research Association, New Orleans, 8-12 April 2011.

Hopwood N, Fowler C, Rossiter C, Dunston R & Lee A. *Sustaining family partnership in organisations: lessons from practice*. Presented at the 10th International Family Nursing Conference, Kyoto, 25-27 June 2011.

APPENDIX B: QUESTIONNAIRE FOR INTERVIEWS

This questionnaire was used for direct service staff (clinical nurses). The questionnaires for Managers, Facilitators and Supervisors were slightly different, with wording reflecting their specific roles, but focused on the same issues and content.

Setting the scene: brief introduction for direct service staff

As you know from the briefing and the information sheet, we are interested to learn about what has happened for staff who have completed the FPM training and brought the FPM approach into their workplace and into their practice.

QUESTIONS

Information gathering - position and role

- What is your position and role within the organisation?
- How long have you been in this position?
- How long have you been practicing as a - whatever professional designation – nurse, doctor, social worker etc?

The training

1. When did you do the FPM training?
2. How did you come to do the training?
3. Can you tell me about the training you did?

Returning to the workplace, organisational and self-support

4. Can you tell me what it was like to return to your workplace and to your patient/client (whatever term is used) practice after the FPM training?
5. In terms of your workplace, can you describe anything that assisted you to utilise and further develop what you learned in the FPM training?
6. Can you also describe what has been less helpful or made this more difficult?
7. We are interested to know about how well you feel your organisation has been

actively involved in supporting and assisting you to use and develop what you learned in the FPM training?

8. In particular, we are interested to know whether and how supervision and/or consultation have been used to support you in using and developing a FPM approach, and how has this been?
9. We have so far focused on how your organisation and your colleagues have, or have not, supported you in the development of a FPM approach, are there ways in which you have supported yourself in maintaining and learning more about this approach?

Practice development and practice change

10. We are interested in what ways you have found the FPM approach different from your previous approach to practice. We recognise that for some practitioners the FPM approach may be very different, for others, it may be less so. Can you tell us how it is for you?
11. As you work to develop a FPM approach, are there particular issues/challenges that are grappling with?
12. We are interested to know how your clients have responded to the FPM approach and if the way they have responded has encouraged you in your use of this approach?

Conclusion: overview questions – support and the future of the FPM

In concluding, we would like to ask you two summary questions.

13. Thinking back across your experience of using a new model of practice, from what you have experienced and learned, what are the most important ways in which organisations can support staff who are developing new approaches to practice?
14. What do you see for the future of Family Partnership in a service setting like your own?
15. Is there anything else you would like to comment on?

APPENDIX C: RESEARCH TEAM

UNIVERSITY OF TECHNOLOGY, SYDNEY

- Professor Alison Lee, Director, Centre for Research in Learning & Change
- Professor Cathrine Fowler, Tresillian Professor of Child and Family Health, Faculty of Nursing Midwifery & Health
- Associate Professor Roger Dunston, Centre for Research in Learning & Change
- Associate Professor Jo McKenzie, Director, Institute for Interactive Media & Learning
- Dr Nick Hopwood, Chancellor's Post-Doctoral Research Fellow, Centre for Research in Learning & Change
- Chris Rossiter, Research Assistant, Centre for Research in Learning & Change

ROYAL NEW ZEALAND PLUNKET SOCIETY

- Marg Bigsby, National Family Partnership Leader
- Dr Joy Bickley Asher, Researcher
- Trinie Moore, Researcher
- Angela Baldwin, Chief Operating Officer

RESEARCH PARTNERS

- Dr Crispin Day, Centre for Parent & Child Support and Child & Adolescent Mental Health Service Research Unit, South London & Maudsley NHS Foundation Trust, UK
- Professor Graham Vimpani, Clinical Chair, Kaleidoscope Hunter Children's Health Network and Head of the Discipline of Paediatrics & Child Health, University of Newcastle
- David Hannaford, General Manager, Tresillian Family Care Centres