Working in Partnership with Vulnerable Families: the experience of Child and Family Health practitioners

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Family circumstances in infancy are persistent and powerful determinants of children’s physical and mental health, influencing inequalities that trace from childhood through to adulthood. While the social factors that perpetuate patterns of inequality are more complex than can be addressed through single interventions, child and family health (CFH) services represent crucial sites where trajectories of inequality can be disrupted. In particular, approaches that foster opportunities for practitioner-parent engagement that challenge traditional hierarchical health care practice, such as the Family Partnership Model (FPM), are recommended as ways of addressing disadvantage.

Little is known about how practitioners implement models of working in partnership with families and, consequently, there is a gap in understanding how best to develop and sustain these new CFH practices. This paper reports a research project that investigates 25 health professionals’ experiences of working within a FPM framework, with vulnerable families. Through discussion of four key themes – redefining expertise, changing practices, establishing new relationships with parents and the complexities of partnership practice – the paper offers first-hand accounts of reframing practices that recognise the needs, skills and expertise of parents and thus contribute to empowerment of families.

KEYWORDS
Child and family health, partnership practice, Family Partnership Model.

INTRODUCTION
Family circumstances in early infancy are powerful determinants of children’s physical and mental health, educational performance and subsequent economic and social achievement (Maggi et al 2010). Longitudinal studies have demonstrated the negative health and developmental effects of socio-economic inequality and disadvantage as experienced and played out in family circumstances characterized by relationship breakdowns, ineffective parenting and disruptions in secure attachment between young children and parents. In this article we refer to such families as vulnerable. For many vulnerable families, the negative effects of such disruptions can be traced across generations (Halfon et al 2010; Stanley et al 2005).

Early access to responsive health, education and community services can support and enable parents to mitigate the effects of family disruptions and strengthen conditions that Harnett and Dawe (2008) refer to as ‘protective’. Effective parenting and secure attachment are identified as vital in creating the protective conditions associated with mental, social and developmental health (Maggi et al 2010; Center on the Developing Child 2010).

In policy terms, recognition of the positive outcomes of delivering responsive, skillfully designed health and community services as early as possible, underpins international consensus and substantial government investment in early intervention services in child and family health (CFH) (e.g. Victorian Government 2010, NSW Health 2009).

Recently, governments and health service providers have shown considerable interest in ‘partnership’ models of care. The move towards new more substantial partnerships between
providers and recipients as more effective means of generating positive health outcomes and sustainable health services is now a global phenomenon and strongly developed within Australian policy discourse (Dunston et al 2009). The ‘partnership turn’ is particularly evident in the design and delivery of primary health and CFH services. Partnership models intend to build confidence, capacity and resilience (Davis et al 2002) and have resulted in positive outcomes for families; enhanced quality and experience of care (Roudebush et al 2006), and improved indicators of mental health and well-being (e.g. Davis and Meltzer 2007; Olds 2006).

Partnership models are typically differentiated from conventional CFH approaches, and broader health practice, which emphasise the directive input of an ‘expert’ health professional enacted within a strongly hierarchic relationship with families. Research with vulnerable families indicates that expert-based hierarchical approaches often fail to engage those parents who may need these services most (Arney et al 2010). Conventional service provision is often based on deficit models that ignore the strengths, capabilities and context-specific expertise of parents. Such approaches highlight parental inadequacy and, consequently, fail to capitalise on the health- and resilience-building possibilities of the relationship between service providers and recipients (Stanley et al 2005; Scott 2010; Davis et al 2002; Puckering 2004).

Whilst the health reform discourse regularly advocates for partnership-based models and their potential outcomes, partnership approaches have rarely been examined. Little research has tracked, documented and analyzed: how partnership approaches are implemented across different service settings, and particularly with vulnerable families; how they are experienced; and critically, how they impact. These major gaps in understanding constitute, we believe, a significant risk for governments investing in partnership initiatives and for provider organisations making complex resource allocation decisions.

This research

This article reports on a pilot study for a larger program of research aimed at developing knowledge about how partnership models are implemented and experienced across various settings providing services for vulnerable families. It explores the experiences of 25 health professionals implementing one specific partnership approach, the Family Partnership Model (FPM). In particular it addresses the question of how the FPM is used to maximize engagement with vulnerable families and promote beneficial outcomes for parents and children over time.

Using thematic content analysis we identified four representative and overlapping themes discussed below. Together, the participants’ narrative accounts identify the significant challenge, complexity and possibilities of the FPM approach, particularly with vulnerable families.

This pilot study involved a relatively small number of health professionals. It thus explored their experiences of implementing partnership practice, rather than evaluating the FPM or identifying its outcomes from clients’ perspectives.

The Family Partnership Model

The FPM was developed in Britain, by the Centre for Parent & Child Support (www.cpcs.org.uk), as an innovative approach to health interventions for families with young children. It aims to support parents by involving them as partners in their children’s care, ‘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). The model provides a clear framework for partnership practice, specifying: (i) a staged helping process, centred on identifying parents’ goals, exploring strategies, evaluating outcomes and negotiating further steps; (ii) helper qualities, skills and behaviours that facilitate respectful and collaborative interactions (e.g. empathy, unconditional positive regard for parent strengths); (iii) a theoretical basis for understanding parenting and parent/child relationships (drawing on attachment theory and personal construct psychology). FPM explicitly recognises practitioners’ expertise, and their role in challenging parents, but constructs this expertise as one of multiple sets of knowledge and skills relevant to parenting issues (others relate to parents and their social support networks). The FPM foundation course, attended by all respondents, consists of 10 half-day training sessions.
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FPM locates agency for change in the relationship between the parents, health professionals and services. It aims to build on parents’ strengths, linking them more effectively with social supports, providing a strong base for responding to current problems and modelling ways to approach future parenting difficulties (Davis et al 2002).

Evidence suggests that the FPM improves physical and psycho-social outcomes for families, and better equips parents to cope with challenges (summarized in Davis and Meltzer 2007). In Australia, a small body of survey-based research (e.g. Keatinge et al 2008) focuses largely on FPM implementation and practitioners’ perceptions of its strengths. It indicates that FPM has the capacity to engage parents who feel alienated by traditional CFH service approaches, by working collaboratively and respectfully to foster their strengths and resilience.

METHOD

A qualitative approach was selected, given the pilot study’s exploratory nature. Data were generated from interviews and focus groups with 25 FPM-trained health professionals from three CFH organisations in Australia and New Zealand. Three authors conducted the Australian interviews/focus groups; the other two authors collaborated with them for data analysis and report writing. One author did not participate in fieldwork because of her close relationship with one of the organisations.

Participants were all female and 22 were nurses (the remainder were a social worker, a doctor and an educator). Their roles included nurse managers (five), clinical supervisors (five), FPM trainers (five), and clinicians (ten) working in CFH services, providing home visiting, clinic-based and inpatient care. They agreed to participate in the study after attending an information session by researchers, and receiving written information. Participation was voluntary and participants provided written consent to be interviewed and audio-recorded. The study received approval from university and health service Human Research Ethics Committees. The semi-structured interview framework addressed different clinical roles. After initial analysis the focus groups reviewed and clarified findings with interviewees at each of the five settings (two at each Australian organisation). Participants discussed their experiences of FPM training, adapting their practice to a partnership approach, and the implementation and sustainability of FPM within their organisations.

Participants were self-selected to the study and were typically FPM champions. While possibly limiting critique, this proved valuable in eliciting insights into the FPM’s impact and potential benefits for vulnerable families.

DATA ANALYSIS

Transcripts of the interviews and focus groups were imported into MAXqda qualitative data analysis software. The research team developed themes and categories which were elaborated through a critical analysis of key concepts from FPM literature, including the concept of partnership itself (canvassing the operational ways participants reported their understandings and enactments of this key term), adaptation, expertise, relationship, power, equality, sustainability and change. The inductive possibilities of working directly with transcribed data concurrently with codes allowed for an open flexible interrogation of unexpected concepts and patterns emerging from the data. Thus, following Srivastava and Hopwood (2009), the analytic process was shaped both by the conceptual framework (what did we want to know?) and the data (what were the data telling us?). The software indicated the spread of particular themes across the data, or their concentration in particular contexts.

This paper focuses on participants’ reports of working in partnership, articulated through accounts of their practical experiences implementing a new model of practice and developing new concepts of expertise. Four main themes clustered around this main focus: redefining expertise, changing practice, forming new relationships with parents and the complexities of partnership practice.

RESULTS

1 Several participants fitted multiple categories eg four supervisors were also clinical nurses.
This section presents data related to these four key overlapping themes, exploring participants’ experiences of partnership in practice. The extracts were selected as representative of the themes, providing succinct or telling statements of the issues, especially in working with vulnerable families. All come from interviews, but they also reflect focus group discussions.

Redefining expertise
Respondents frequently related their understandings of working in partnership by contrasting it to ‘traditional’ healthcare practice. Many portrayed the negative consequences of hierarchical approaches, typified as follows:

I just see it so much in the health profession of – not only nurses but medical people and everything – being very direct and judgemental of the most needy people. I find it quite a challenge in my work - the lack of empathy and very judgemental comments and approaches to people’s needs. (Clinical Nurse 4)

This nurse articulates an issue at the heart of the relationship between CFH services and vulnerable families: how those most dependent on services for support because they lack potentially beneficial networks, frequently experience services as judgemental and lacking in empathy.

Many respondents acknowledged clients’ distress at services characterized by a didactic approach, and revealed their awareness of how families often take away an unintended consequence of the interaction – that is, a sense of being judged as failing and incompetent.

In the past women have said ‘I went to that child and family health nurse and she said I was doing everything wrong’, which is what the mothers say. When in fact the child and family health nurse would have been giving them advice [but] that’s what the mother perceived. They walk out with this sense of failure ... Nobody says ‘you’re doing it all wrong’, but the mothers perceive that they’re doing it all wrong when they’re given advice without being asked for it. (Clinical Nurse 1)

This account indicates the delicate relations of power and knowledge, experienced in terms of failure by parents if care is provided in a hierarchical manner. Several clinicians reported their sense that vulnerable women are likely to avoid health professionals whose words and actions compound their own sense of inadequacy and distress.

CFH practitioners draw on significant professional knowledge and skill in order to work effectively with families. Participants frequently identified that working in partnership does not involve abandoning this expertise – on the contrary, they often described additional expertise, a relational expertise and an attention to the parent’s capability. Several respondents discussed the value of a strengths-based approach, illustrated by this manager’s account of the benefits of a nurse acknowledging a client’s strengths and efforts:

She [nurse] was talking about the strength she could see in this young mum [an unsupported teenage parent] - her commitment to her baby, the fact that she was so sleep-deprived she could barely see straight – and to actually ... work together to find a way that she actually got some space to get some sleep. Then the mum made some decisions about what she needed to do for her and her baby to cope in the long-term and what agency support she was going to accept and what ones were okay for a 16-year-old mum to accept ... 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.’ (Clinical Supervisor 5)

This commentary exemplifies how attention to the mother’s strengths and a relational sensibility as to what was possible in the moment, may well have made the difference between the stressed young mother retreating from the service or, as she did, seeking to re-engage.

Changing practices
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The interviews made visible changes in how practitioners understood and sought to enact a partnership approach. Participants detailed how FPM training had inspired new ways of working with families, frequently contrasting this with their previous practice. Most described a different approach, endeavouring to work more collaboratively with clients rather than seeing their role as dispensing expert information. Many commented on the importance of ‘listening more attentively’, contrasted with ‘jumping in’ with solutions. Working gradually, building trust and inviting clients’ solutions, as opposed to the clinician ‘fixing it’ was often highlighted, as was learning to consider clients’ individual world-views and values and to use this understanding to design each intervention.

In an example of changing practices, a clinician discussed sleep management, a typical concern of CFH services. She illustrates the shift by trying to encourage parents to set the agenda rather than responding ‘by the book’:

They [parents] brought up their issue, which related to sleep management, and that’s pretty much all we spoke about today. And I did an assessment of the child as well, but that’s all we spoke about because that’s all that was important for them today. Whereas if I had not done that, if I had come in, asked about everything that I would ask about, and only left that question until the last five minutes, we might not have been able to cover all the things that we covered today. So I think they went away feeling that they’d had all their questions, they had some strategies that they might like to try, all that kind of stuff. So I think they went away really happy. (Clinical Nurse 9)

This example of multi-tasking in the interaction with parents is, we think, of considerable interest. Engaging with the focus identified by the parents, the nurse was able to meet their specific information needs but at the same time was able to attend to the child’s situation (an assessment of the child). The nurse contrasts what occurred with her sense of what might have been a brief and prescribed interaction if she had not chosen to be led by the parent. Respondents frequently identified opening up new interactive possibilities by using a partnership orientation.

Several respondents addressed the issue of generating trust with clients. While most talked about less contentious aspects of CFH practice, one participant discussed using a partnership approach to a concern about child safety:

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 7)

In contrast to a didactic mode she may have used in the past, this nurse describes how the partnership approach can open a way for securing both a longer-term engagement with the client and potentially significant changes in parenting attitudes and resources. She demonstrates her expertise in making complex child protection judgments. This incident, and many others recounted by respondents, demonstrates the immense shift in their CFH practice. Many described a large-scale cultural change, taking them out of their comfort zones and often challenging years of experience.

Establishing new relationships with parents

Participants recognised the potential of their role as primary health workers in engaging clients in a fruitful relationship, and the importance of their initial contact. They accounted for the improved client engagement and greater potential for new service relationships in terms of rapport, trust, honesty and mutual respect. They identified these qualities as particularly important when working with vulnerable families. In exploring how these principles translated into practice, participants all noted the impact of their personal approach with clients and offered many examples of working in new ways with families, often in complex situations. The two following transcripts highlight the nurses acknowledging the significance of their initial contact with vulnerable clients:
After working in the country with very high-risk families, it was just of enormous benefit to be kind, supportive, reassuring as much as one possibly could, you know, with the exception of significant child protection concerns. Because if they came back again that was a triumph. It wasn’t a success, it wasn’t a relationship, it was a triumph. It was gold. Wow, she’s back, if I can engage her we’re going to make some long term progress. (Clinical Nurse 1)

Here, the nurse demonstrates that she prioritises opportunities for longer-term engagement. Similarly, developing appropriate forms of engagement means adapting times, places and patterns of activity to undo prior alienating experiences, facilitating continued engagement with vulnerable clients:

Some of them 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 7)

These accounts focus on promoting more enduring, open relationships with health professionals for clients who are vulnerable and may doubt their own capacity.

Participants emphasised how acknowledging parents' skills and knowledge could boost self-efficacy, enhance infant/parental attachment and encourage parents to set goals and work towards resolving their own problems. They further reported how these new practices require complex skills and restraint to implement partnership effectively and to facilitate the shift from advice-giving to the co-production of workable strategies. The extract below sums up what several respondents discussed about demeanour, body language and sensitive communication:

Family partnership is so much about you know, your body language and your words and how you use them and even your tone of voice, and ... it’s about thinking and listening to the family and listening to what they’re saying, reflecting on what they’re saying, putting it back to them so: ‘Is that clear?’ so they’re clear about whether what they’ve said is what they mean or could they use something else. Whereas a typical medical sort of thing is ‘well you do this, you do that and that’s how you do it and I’ll see you next week’ ... it’s more authoritarian I guess, whereas partnerships is really working with the family. (Manager 1)

This manager explains how skills acquired through FPM training can be adapted to nurses' interactions with clients, contrasted with the authoritarian approach of providing a set formula regardless of clients’ specific needs or circumstances.

Complexities of Partnership Practice
Throughout the interviews and focus groups ran a thread recognising the complexity and challenges, as well as the manifest benefits, of working in partnership with clients. Some participants acknowledged the difficulty of sustaining the skill and energy necessary to explore issues thoroughly, especially when clients were reluctant to work collaboratively. This was particularly true of vulnerable clients who may sometimes appear less articulate and less motivated than others. The following extracts typify frequently-cited difficulties:

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. (Clinical Nurse 10)

It [working in partnership] definitely is a skill because it is much easier to just come in and go ‘do A, B, C and D’ and it doesn’t take as much time either. I can see why it can be difficult and why people fall back on other ways. (FPM Trainer 2)

These respondents acknowledge the difficulty of changing practice and adapting their intervention to clients’ social circumstances, which require time, energy and ‘art’. It also highlights
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the impact of some families’ previous experiences with health services, leading them to expect to be told what to do and reinforcing their perceived inferior position in exchanges with health professionals.

Some respondents struggled with the process of ‘challenging’ clients, a skill identified by the FPM authors to help parents change, especially when the clinician considers that the parents’ perspectives on their problem may be blocking their openness to possible strategies. They propose that challenging is not necessarily judgmental but, conducted skillfully, can increase the range of options by providing additional information or alternative constructions of the situation. ‘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, subtle process requiring particular attention to ensure that parents do not feel criticised or diminished.

Some participants discussed developing skills to challenge parents effectively, especially confronting the common view that the CFH nurse will ‘fix’ problems. One nurse describes the result of challenging this view:

> It is rare – most people are really well mannered and 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 Nurse1)

This account illustrates several elements of working in partnership: communicating carefully; respecting parents’ views; appreciating their perspective on the nurse’s role; and embracing health care and parenting education as a ‘journey’ rather than a one-off intervention. It also highlights how the nurse has overcome her own ‘default mode’ of stepping in and solving clients’ problems which may yield short-term results but has no lasting impact on the parents’ learning or their sense of efficacy or control. Some families may have minimal experience of ‘solving their own problems’. However, if they perceive the exchange as valuable, rather than alienating or humiliating, they may be inclined to maintain connection and benefit from CFH services.

DISCUSSION

This study has identified key themes in health professionals’ experience of implementing FPM approaches. In particular, the practitioners describe incorporating FPM principles into their daily practice, changing their notions of expertise, their actions and relationships with clients. They outline its potential for working positively with vulnerable families, reducing the rigid unrealistic approach of traditional health models and enhancing confident parenting and secure attachment. It can enable practitioners to grow professionally and to be more mature and skilful in using their knowledge, cognisant of context and parental capacity. However, these accounts also address the difficulty of changing practice and sustaining that change with clients from all backgrounds.

The literature has demonstrated that intervening early – through universal CFH services – is important to the life chances of children by promoting effective parenting and parent-child attachment. Our investigation has provided insights into the potential of partnership approaches to deliver CFH services in a way that renders them more sensitive and acceptable to vulnerable families. We have drawn on participants’ accounts of putting partnership into practice to argue that changing the relational nature of health services from traditional hierarchies of expertise towards partnership has the potential to enhance such protective factors for vulnerable families accessing CFH services.

The study has clear limitations, given the small number respondents who were self-selected and typically FPM advocates. Our conclusions are further constrained by including only health professionals rather than consumers. However, we propose further ethnographic research to examine practices and relationships in greater detail and from multiple perspectives. This preliminary study has, nonetheless, raised important questions for further exploration, which is timely...
given the extensive changes within CFH services and the increasing adoption of FPM into organisational policies, protocols and culture. It emphasises the model’s potential in service delivery, especially when working with vulnerable families where the risk of perpetuating inter-generational parenting problems is significant.

It is important to include the clients of CFH services in future research, not only to observe their interactions with practitioners, but to explore their accounts of shifting power relationships between health providers and consumers, the extent of their involvement in decision-making, and the perceived outcomes of new forms of practice.

In particular, the issue of challenging parents (discussed above) suggests that practitioners are aware of the complex implications of collaborating with families. Partnership practice, certainly at this stage of its development, relies on practitioners’ willingness to engage and involve clients. The complexity of the relationship at the heart of FPM is that health professionals own the capacity to open up space for more agency for parents. The professional controls the choice between working with clients in a way that affirms the clients’ sense of competence and engagement, or one that confirms their alienation from the health system. Effective partnership, according to the model, requires a commitment to move beyond the pleasantries of empathy and respect, and calls for specific knowledge and expert practice (Davis et al 2002). This suggests that CFH practice could be further investigated in terms of forms and degrees of partnership and of how services and individuals operate along this continuum. This in turn could help identify whether and how practice differentiates among clients according to their circumstances.

Finally, this study has investigated partnership at a specific time in the development of FPM practice in Australia and New Zealand. Given its potential for assisting vulnerable families at an early stage and for enhancing protective factors, it is essential to explore the way in which FPM can be sustained, both within CFH organisations and the practices of individual health professionals.

REFERENCES


