

Evaluating the Family Partnership Model (FPM) program and implementation in practice in New South Wales, Australia

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KEY WORDS

family partnership model, program evaluation, child and family health, relationship

ABSTRACT

Objective

This study investigates participants' experiences of implementing and educating colleagues in the Family Partnership Model (FPM).

Design

Qualitative research approaches using content analysis.

Setting

NSW child and family health services.

Subjects

Seven child and family health professionals.

Intervention

Implementation of the FPM facilitators education program to develop the competence of participants as FPM facilitators.

Main Outcome

Findings from this study identify that the FPM built on and extended existing knowledge and was relevant and useful to clinical practice. Further, the FPM's value is evident in participants' positive comments about it and their ability to successfully implement it in their practice and educate and encourage colleagues to do the same.

Conclusions

The study has identified that the sustainability of FPM program and implementation depends on adequate support for practitioners/facilitators, and the commitment of resources to this process overall.

INTRODUCTION

The importance of promoting positive family and community experiences for young children during the earliest years of childhood has been confirmed by growing evidence from a diverse array of disciplines (Heckman 2006; McCain and Mustard 1999; Karoly et al 1998). In recent years health professionals have recognised that a critical factor underpinning successful interventions with parents of young children is their capacity to promote and support a positive parent-child relationship through a partnership approach (Fowler et al 2002). This shift in approach from the more prescriptive expert model of interaction to a partnership model is well supported by research findings and reflections on clinical practice (Gottlieb and Feeley 2005; Day and Davis 2003; Graybeal 2001).

On the basis of this evidence about the importance of the early childhood years, the New South Wales (NSW) Government introduced its Families First Initiative in 1998, to support parents and enhance their parenting skills before parenting challenges developed into problems resulting in significant family dysfunction (The Office of Children and Young People 1999). The emphasis on nurse home visiting for parents with newborns in this initiative made it timely that education in a model such as the Parent Advisor Model (termed the Family Partnership Model (FPM) in Australia) be made available to the State's health professionals, particularly child and family health nurses. This model emphasises the need to adopt a facilitative role when assisting parents and enabling them to extend their problem solving abilities, self-esteem, self-efficacy and interactions with their children, thereby fostering parental development and well-being (Davis et al 2002a). The NSW Health Department had demonstrated significant commitment to supporting families by allocating funds to the education component of the FPM, in particular for child and family health nurses and midwives.

Issues relating to staff education in the FPM, implementing this model, and evaluating both

processes, were discussed during planning meetings and considered essential to ensuring the translation of the model into the context of NSW Child and Family Health Services. This paper's researchers and authors were members of this committee and obtained a grant to conduct an evaluation study of the first FPM facilitators' education program offered to 16 community child health professionals in NSW to investigate their experiences of implementing the FPM in their practice and educating colleagues in this model. This paper will briefly describe the FPM and report on the qualitative component of this 18 month follow up study of the outcome of the first FPM facilitators' education program within NSW.

LITERATURE REVIEW

Early intervention programs have been identified as a crucial component in assisting to improve the health and life chances of children who are identified as 'at risk' (Heckman 2006). For example McCain and Mustard (1999) and Karoly et al (1998) identified the critical nature of stimulating interaction between adults and children for brain development. Further, McCain and Mustard's (1999) research highlighted the lasting impact of the quality of children's experiences on the shaping of brain cell connections, found to be vital in a child's attainment of developmental milestones. Nevertheless, Wilson (2002) raises concerns that to focus only on the importance of brain development and parenting will alienate many families unless there is a shift from the negative approaches to working with parents and systems change occurs to reduce such risk factors such as poverty and lack of access to services.

As this and other evidence on early intervention has been disseminated, governments have taken notice developing new policies and supporting initiatives. Numerous international programs have sought to provide early intervention for families and their young children who have been identified as 'vulnerable' or at 'high risk'. These programs include the Head Start program (Fish 2002; Karoly et al 1998; Zigler and Muenchow 1992) and Elmira Antenatal/Preschool program (Fish 2002; Olds et al 1997; Olds et al 1986)

in the USA and the English Sure Start (Department for Education and Skills 2004; National Evaluation of Sure Start 2004).

A foundation premise for many of these early intervention parenting programs is the use of a partnership model to identify, recognise, and use parent strengths (Astride-Stirling et al 2001; Graybeal 2001). One such model is the FPM that has been implemented by nurses in the United Kingdom (Bidmead and Cowley 2005) and Australia. Kemp et al (2005) in her review of the competencies required for sustained nurse home visiting found that the nurse needed the ability to sustain long-term relationships with his/her clients. The challenge for these nurses lay in maintaining a belief in the parent's strengths and abilities, and negotiating and problem-solving rather than imposing priorities and solutions (Kemp et al 2005).

THE STUDY

The study was conducted in two stages. Stage 1 was a quantitative survey of participants experience and learning in an FPM facilitators' education program and is not reported here but was used to inform the development of the Stage 2 18-month follow up study. This paper reports on Stage 2.

Aim

The aim of the study was to explore the experience of implementing the FPM facilitators' education program from the perspective of child and family health professionals, the majority being nurses.

METHODOLOGY

This follow up study conducted 18 months following completion of the facilitators' education program had two components. The first was a follow-up survey of participants (n=7 completed surveys). The second component was the completion of reports about participants' experiences of the FPM implementation.

This paper focuses on the qualitative findings from the follow up component of the study at 18 months, while also presenting findings relating to the yes/no options associated with some qualitative questions.

Participants

A committee convened to facilitate the introduction of the FPM in NSW selected a multidisciplinary group to participate in the first facilitators' education program. This process resulted in a multidisciplinary group of 16 participants from NSW Area Health Services committed to implementing the FPM. The participants were required to participate in the facilitators' education program and commit to implementing the model in their workplace.

The 16 participants comprising two social workers, a medical doctor and 13 senior clinical Community Child and Family Health nurses, completed the study's Stage 1 pre and post program surveys in October 2002 prior to the commencement of this study. In order to recruit participants for the follow up study, an information letter and consent form was posted to each of the 16 facilitator program participants. Seven of the original 16 facilitator program participants consented to participate in the follow up study.

Ethical considerations

Ethics clearance for the study was obtained from the appropriate university and health service committees. Participation in the study was voluntary and consent comprised written consent following receipt of an information letter detailing the study methods.

Data collection

A copy of the follow up survey was forwarded to participants prior to the research assistant (RA) administering it by telephone. This enabled participants to review the questions prior to responding to them. One participant completed and returned her survey before it could be administered by telephone.

When posting the follow up survey for participants to review, the RA also included a form titled 'My experience relating to the Family Partnership Model' on which participants were asked to document their experiences of implementing the FPM. The provision of a stamped addressed envelope enabled the return of this form. Responses on completed forms were analysed and are presented in the findings section of this report.

Both the follow up data collection tools allowed the research team to capture data that enabled an overall picture of facilitator program participants' experiences of implementing the FPM in their workplaces.

Data analysis

Qualitative content analysis was used to structure qualitative data emerging from the follow up qualitative questions. This process involved reading and re-reading each open ended question to develop themes which emerged from participants' responses (Brink and Wood 1994). A number of responses to the qualitative questions reflected more than one theme. Frequencies were analysed in yes/no responses associated with some qualitative questions in the

follow up survey. Four 'my experience...' forms were returned and qualitative content analysis was used to analyse data emerging from these responses.

FINDINGS

The study's findings are presented in two parts; findings from the follow up survey, and findings from participants' experiences of implementing the FPM in their workplaces. Findings are identified according to the themes (identified in italics) detected in data, with each theme (where one could be identified) being illustrated by an example of one or more quotations. Frequencies identified in yes/no responses sought in association with some qualitative questions in the follow up survey are identified in figure 1 alongside the questions to which they relate.

Figure 1: Stage 2 survey questions and findings in yes/no responses

Question No.	Questions
Q.1	Has the Family Partnership Model required you to change your preferred communication style which you use with families who have young children? Yes: 4; No: 2; Comment only (Co): 1
Q.2	Does the Family Partnership Model challenge you in any way? Yes: 5; Yes and No*:1; Co: 1
Q.3	Do you think that there have been any changes in your practice or the way you think about your practice (or both) since you attended the FPM facilitator training in October 2002? Yes: 5; No: 1; Co: 1
Q.4	What support (if any) have you received to assist you to implement the FPM into your practice? (see qualitative responses in text below)
Q.5	What other support mechanisms would have assisted you to implement the FPM into your practice? (see qualitative responses in text below)
Q.6	Do you consider that you have implemented the FPM in your practice? Yes: 5; Co: 2
Q.7	Do you think this has impacted on your working relationships with families with whom you work? Yes: 4; Co: 3
Q.8	Have you developed any new professional qualities since you attended the FPM facilitators program in October, 2002? Yes: 1; 'I suppose': 4; Co: 2
Q.9	Are there any additional professional qualities or skills that you need to develop and/or enhance in order to implement or utilise the FPM? Yes: 3; No: 3; Co: 1
Q.10	Has the FPM model enabled you to enhance your communication with colleagues? Yes: 6; No: 1
Q.11	Have you educated any of your colleagues in the FPM since you attended the FPM facilitators program in October 2002? Yes: 7
Q.12	Are there any other comments you would like to make about the FPM or its impact on your practice with the families for whom you provide care? (see qualitative responses in text below)

*On occasions participants adjusted the 'yes/no' choices

Findings from the follow up survey

The follow up telephone survey identified the experiences of the participants since completion of the facilitators program. Survey questions and participants' responses to the findings from the yes/no options associated with these questions are identified in figure 1.

The first of these questions revealed that rather than changing their preferred communication style the experience of implementing the FPM had *Affirmed/reinforced/refreshed existing communication styles*: the title of the first theme emerging from responses. One participant's response that: "As a mental health nurse I already work in partnership with my clients but the course revisited the model for me and re-affirmed the importance of working in this way", illustrates this theme. The second theme: *Changes in communication style*, revealed these changes not only related to communication with parents but also with colleagues. For example one respondent said: "...at times when tension is high or you're dealing with a difficult colleague, you can find yourself being defensive and attacking or undermining so you need to pull back and work in a respectful manner with colleagues".

When asked whether the FPM challenged respondents in any ways, participants generally agreed that the model did challenge them and several described how it: *Challenged attitudes and behaviours*, the theme emerging from responses. For example, one respondent identified how: "It (the FPM) challenges you to work in that model with the clients and requires you to change everything that you do to fit the model. It's also a challenge to apply the model to other parts of my working life, where it's a new concept".

Along with these challenges most participants identified that the FPM had resulted in: *Changes in Practice*. Illustrating this theme one participant responded: "I am much more reflective. I feel I communicate more clearly and get more results". While most participants identified that, in terms of support to implement the FPM, they had experienced: *Supportive management*, some noted this applied only to some managers and not others.

However in responses to the question about what support would have assisted participants in implement the FPM two themes were detectable in responses: *Clinical Supervision and Peer Consultation*. Most participants nevertheless identified that they perceived they had managed to implement the model in their practice since completing the facilitators program although they held diverse views about how the model had impacted on their working relationship with families.

Some participants appeared cautious about whether they had developed new professional qualities since attending the facilitators program, with the theme emerging from participants' responses to the question relating to this topic revealing that this development had largely: *Increased knowledge of 'training'/group skills*. Reflecting this theme one respondent commented: "I've become more skilled as a trainer. I'm much more skilled at running training programs. I've realized that I don't have to come in as the expert ... the groups run more smoothly in this way".

The survey found that all participants had implemented the FPM program for their colleagues since undertaking the facilitators program and concluding comments provided by four survey respondents were all positive, including that: "It's a good model, and I know it works, so I'm quite enthusiastic about it and sharing it with others...".

Findings from 'My experience with the FPM' forms

Four completed forms were returned, one of which largely comprised details of the number of colleagues educated in the FPM. Figure two identifies the key themes that emerged from the responses documented by facilitators' program participants on these forms.

Three of the study's participants suggested that the FPM, both the education program relating to it and the implementation of the model in practice, had been challenging, rewarding, valuable and/or refreshing. Participants' positive comments included that the model had enhanced the skills of colleagues whom they had educated in the FPM since attending the

facilitators program, and impacted positively on these colleagues' practice.

Another participant commented that: "The power and impact of the (FPM) training should not be underestimated and therefore the integrity needs to be upheld", with other participants attributing changes in approaches to staff and colleagues, as well as practice changes, to the FPM program.

On a less positive note, participants identified the significant time commitment required to organise and implement the FPM education program for colleagues. However, participants also noted that many of these colleagues had voiced a dislike for 'homework' relating to the FPM education program,

as well as feelings of being 'deskilled' during the program's initial phases. Some participants highlighted that this commitment related to the lengthy period required for colleagues to be away from their workplace to attend the FPM education programs and the difficulty in ensuring they could be released from their usual workload. Others identified that the "organisational logistics (for conducting the education) were time consuming", especially given this had to be achieved as an extension of participants' existing roles. Some participants also identified that facilitating these education programs was "...draining and required the opportunity to debrief after each day with a co-facilitator".

Figure 2: Themes identified in completed 'My Experience with FPM' forms

- 1: Participants' (in the facilitators program) experiences with the course.
- 2: Comments from study participants' colleagues relating to FPM education courses they subsequently conducted in their work context.
- 3: Changes in staff/practice attributed to FPM.
- 4: Application of the FPM in practice.
- 5: Time consuming element in educating others and in organisation of FPM education programs.
- 6: Negative aspects of the course/providing FPM education programs.

DISCUSSION

Findings from this study indicated that the FPM provides a tool for working with parents in a facilitative role, and more especially, that it provides them with a problem management framework based on a strong conception of partnership, and skills to put such a framework into operation (Barlow et al 2003).

The follow up survey conducted 18 months after the initial facilitators program was completed, yielded responses about affirmation and consolidation of participants' practice with parents. For example, six of the seven participants in the survey identified that the FPM had enhanced their communication style, indicating this had become more open and of a 'listening' nature, reflecting some of the FPM goals. In addition, most participants identified the FPM as challenging to themselves, and their practice. Interestingly in this follow up survey there were 12 mentions of changes in practice or the

way participants think about their practice. These changes included positive changes in relationships with families and/or colleagues and in communication with both. From these findings it appears that while immediate responses to the facilitators program largely revealed that participants perceived this to have built on existing skills, implementation of the FPM, and facilitating the education of others in the FPM, appears, as Davis and Rushton (1991) found, to have resulted in positive changes in practice. Nevertheless, the finding in this study that the FPM had had a positive impact on peer relationships appears not to have been previously identified.

Despite varying levels of support from management, five of the seven respondents to the follow up survey perceived they had implemented the FPM model in their practice, and one 'thought' that she had achieved this. A further feature of the responses was that although support so far received had

enabled participants to educate others in the model, as facilitators of this education they had received little or no support, and hence their emphasis on their need for Clinical Supervision, preferably from someone familiar with the FPM model. Davis and Spurr (1998) also identify the need for regular supervision of those educated in the FPM and working in specialist contexts. It is suggested as a result of the study reported here that findings reveal this need to be so important, that although participants had achieved educating a large number of colleagues in the FPM, this is unlikely to continue if support for these facilitators is not forthcoming.

Participants who completed a 'My experience...' form revealed some difficulties experienced by those who participants had educated in the FPM, including that they found the 'homework' related to this irksome, and that, given difficulties in achieving staff release to attend the program and the extensive distances some had to travel to obtain it, the program needed to be condensed and delivered over a shorter time frame.

The follow up survey and the 'My experience...', descriptions all concluded with several very positive comments about the FPM. These included that this model should be integral to the practice of health professionals working with families and children, and that the FPM is "the only way to go" and that "it's a good model, and I know it works..."

CONCLUSION

Although limitations of this study included that it evaluated only 7 participants' experiences of educating others in the model and implementing the model in practice, the opportunity to survey these participants 18 months following this initial education program enabled an evaluation of its impact in relation to each of these factors over the longer term. Findings from this study identify that participants found the FPM built on and extended their existing knowledge and was relevant and useful to their practice. Further, the FPM's value is evident in participants' positive comments about it and their ability to successfully implement it in their

practice and educate and encourage colleagues to do the same.

Nevertheless, the study also identified that the sustainability of the FPM program and implementation depends on adequate support for practitioners/facilitators, and the commitment of resources to this process overall. Despite this, the study's recommendations include that the FPM be endorsed as a framework for health professionals practice with families and children, and that education about the FPM be made available to all professionals engaged in health care delivery to this group of clients.

Since the study's completion significant progress has been made in implementing its recommendation in that NSW Health has adopted the FPM as a component of the core skills required for child and family health nurses working in this State, and education in the model is ongoing for these nurses.

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