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Title: Challenges faced by young mothers with a care history and views of stakeholders about the potential for Group Family Nurse Partnership (gFNP) to support their needs

(short title: Views on gFNP for mothers who were looked after)

Abstract:

Women with experience of being 'looked after' are more likely than their peers to become young mothers. There has been limited research investigating support for their needs. This study, embedded in a randomised trial of Group Family Nurse Partnership (gFNP), involved interviews with young mothers with care experience, Family Nurses delivering group gFNP, and health and social care professionals. This first qualitative study to explore the views of these varied stakeholders found consensus regarding young mothers' social isolation and lack of trusting relationships but diversity in views about the potential of gFNP to meet their needs.

Introduction

Looked after children (LAC) are at increased risk of a range of adverse outcomes compared with children not looked after but with similar socio-economic backgrounds (Viner and Taylor 2005; Sebba and others 2015). These include educational underachievement (Rees 2013), mental and physical ill health (Simkiss 2013; Zlotnick and others 2012), poor sexual health (Carpenter and others 2001), early and/or unplanned pregnancy (Hobcraft 1998; Vinnerljung and Sallnäs 2008), homelessness (Evans 1996), and sexual exploitation (Jay 2014).

Looked after children may 'graduate out' of care into adulthood prematurely, often into early pregnancy (Dworsky and Courtney 2010; Boonstra 2011), without a stable relationship or supportive family (Botchway and others 2014; Stein and Munro 2008). Recent estimates suggest that 22% of young women leaving care become teenage mothers (National Audit Office 2015) while the under-18 conception rate in England and Wales was 2.3% in 2014 (ONS 2016). Mothers who are care leavers are at increased risk of parenting problems (Dowdney and others 1985; Quinton and others 1984; Botchway and others 2014) and unstable housing arrangements. Their children may be taken into care, leading some women to avoid involvement with services (Chase and others 2006; Maxwell 2011; Connolly and others 2012).

More research is needed into interventions to support these women and their children during the perinatal period. There is evidence from the US that the Nurse Family Partnership programme - introduced in the UK in 2007 as the Family Nurse Partnership (FNP) - reduces the risk of child neglect and abuse (MacMillan and others 2009). The FNP programme comprises nurse home-visiting from pregnancy until children are two years old, and is offered to first time teenage mothers, of whom a substantial minority may have a looked after history (Barnes and others 2008). Group FNP (gFNP) was developed to provide similar support in a group context to parents not eligible for FNP (i.e. expectant mothers aged under 20 with at least one live birth, or 20–24 with no live births and with low educational qualifications) (Griffiths 2016). Groups are facilitated by two specially trained Family Nurses (FNs). The programme offers an FNP-based curriculum, providing routine antenatal care and infant checks according to National Institute for Health and Care

Excellence (NICE) and Healthy Child Programme guidelines. Groups run from the first trimester of pregnancy until infants are 12 months, with a target of 14 sessions during pregnancy and 30 in infancy (Barnes and Stuart 2016).

The current study was an embedded qualitative component of First Steps, a multi-site randomised parallel-group trial of gFNP in England. Further details of the trial are in the protocol (Barnes and others 2013).

Aims and objectives

The aim of the LAC study was to explore stakeholders' views about, and experience of, gFNP for women with care experience.

Specific objectives were to conduct interviews with:

- a) Women participating in First Steps who were/had been in care;
- b) FNs delivering the gFNP programme who had at least one mother or one father with a care background allocated to a group they facilitated;
- c) Health and social care professionals working with looked after children and/or care leavers in the seven First Steps areas.

Methods

Participants and procedures

Participants included in the study were: mothers participating in the First Steps trial (who had/had not been allocated to receive gFNP), FNs delivering gFNP, and health and social care professionals whose work focussed on looked after young women (see Table 1). All research participants were provided with written study information and given the opportunity to ask questions before giving informed consent.

They were recruited as follows:

- a) *Mothers*: Trial participants identified as having care experience were asked for consent for their contact details to be passed to researchers conducting the LAC study. If they agreed, a researcher telephoned them, provided information about the study and, if consent was given, arranged an interview. All gave written consent to participate.

Six of the 137 (4.3%) women interviewed for First Steps when their children were six months old (three allocated to gFNP and three to usual care) reported having care experience. One was lost to follow-up in the trial, one declined to participate in the LAC study and four agreed to be contacted. Of these, three participated in an interview (one allocated to gFNP and two to usual care).

Face-to-face interviews with mothers were conducted between July and September 2015 and lasted between 40 and 60 minutes. Participants were given a £20 voucher to recognise their contribution to the study.

- b) *Family Nurses*: Ten FNs in four research sites where at least one woman or one man with a care background had participated in a group were invited to take part in an interview.

All ten FNs were interviewed - three FNs in two sites, and two in two sites. All were group interviews conducted by telephone between October and December 2015 and lasted about an hour.

- c) *Other professionals*: We approached each health service and local authority in the trial's seven areas to identify health and social care professionals working with looked after children and/or care leavers. We then contacted each named individual by telephone and/or email and invited them to participate in an interview.

Fourteen people were identified and contacted (one from health services and one from social services in each area). Thirteen agreed to take part on their own behalf and, in some cases, on behalf of colleagues. As it was not possible to arrange two interviews, eleven were carried out (with health staff in five areas and social services staff in six).

Interviews took place between September and November 2015. Practitioners were: two designated nurses and two named nurses for LAC, a clinical nurse specialist for children in care, two advanced social work practitioners working with LAC and care leavers, three managers of social work teams working with LAC and/or care leavers, a commissioner of LAC services and six personal advisors to care leavers. None of those interviewed was familiar with gFNP although all were aware of FNP.

Eight interviews were conducted by telephone with individuals. Three interviews were conducted face-to-face at workplaces. Of these, one was with an individual and one with two participants. The third was a group interview with a team of five personal advisors to care leavers and their manager. Interviews lasted between 25 to 90 minutes.

Measures

Semi-structured interview schedules were developed for the study:

For mothers topics included: experience of care; feelings about pregnancy; experience (if any) of gFNP; experience of maternity and health visiting services; and views on the particular health service needs of mothers with a care background.

For FNs Interview topics included: experience of working with those with a care background who participated in gFNP and the possible impact of gFNP.

Practitioner interview topics included: perceptions about why young women with experience of care are more likely than peers to have an early pregnancy; challenges facing these women when they become pregnant/parents; the needs of this group and how they might be met; the availability and adequacy of local services; participants' knowledge of and views about FNP and gFNP; potential challenges for women with a looked after history taking part in gFNP; the role of gFNP in service provision; and views on whether FNP or gFNP should be offered to all pregnant young women with a looked after history.

Data analysis

All but one of the interviews was audio recorded, transcribed verbatim and anonymised.

All transcripts were read by at least two authors. After familiarisation with the transcripts, data were analysed on *a priori* themes drawn from the interview schedules using the Framework approach (Ritchie and Lewis 2003). Given the different interview schedules used for different groups of participants (mothers, FNs and health/social care professionals), we conducted data analysis for each group separately and then drew together common themes from the groups which were refined and developed following team discussion. Some themes, such as mothers' experience of social isolation and care leavers' common antipathy to social services, were found in the majority of accounts, while the three groups of research

participants had different views on, for example, the potential of gFNP to meet the needs of young mothers with care experience.

Quotes are accompanied by a brief description of the participant. Professional participants are also identified by a number indicating the anonymised area where they work. Mothers are not identified by number because of the small number interviewed and the potential for identification.

Ethical approval

The First Steps trial was approved by the NRES Committee South West – Frenchay (reference 13/SW/00860) in May 2013. Approval for the LAC study was given in November 2014 (Amendment 6).

Results

Early motherhood

Responses from health and social care professionals about why women with care experience are more likely to have an early pregnancy can be categorised into two broad areas: life events related to women's childhood experiences - removal from their birth families and resulting experience of care - and the associated desire to create a family of their own. Lack of strong familial and social networks were said to be associated with early sexual debut and a potential for involvement in exploitative relationships, as well as with immaturity regarding contraceptive use. Disrupted education, resulting from changes of placement, may mean young people miss sex and relationships education and so are poorly informed about reproductive processes. One participant explained:

'Some don't even understand the actual biology of getting pregnant so they think it'll never happen to me.' (Nurse for Looked After Children 1)

Practitioners viewed women's personal vulnerabilities, along with financial insecurity, unsettled living arrangements and, in some cases, harmful relationships, as contributing to a desire for a baby to love and be loved by.

It's something to call their own, isn't it, it's their own For a lot of them it's the first time they've ever had anything that belongs to them; the parents have gone, different foster parents, ..different social workers and stuff like that.

Whereas having a baby it's there, it's yours, you've got to look after it and, yeah, definitely your own.' (Personal Advisor 2)

Some participants thought that, even though pregnancy may not be planned, early parenthood may be a norm in young women's social circles and, given the absence of alternatives, could be seen as a positive choice. One of the mothers interviewed, who had her baby when she was 23, supported this viewpoint:

'All my friends, like, they all had kids so, like, I was the last one out of all of us to have a child.' (mother)

Challenges faced by young mothers

Participants outlined challenges faced by young mothers. Moving from foster or residential care to living independently is in itself challenging for an 18-year-old; having a baby to care for is an enormous additional responsibility. Young women are likely to be short of money and may lack budgeting and housekeeping skills. They may have competing priorities on their time - managing welfare benefits, meeting with professionals, attending college, working or applying for jobs - and may not have the maturity to make prudent decisions. Care leavers continue to be supported by a personal advisor but their level of social support is reduced and regular health checks no longer provided. Unless they are offered FNP or live in an area where there is a continuity model of maternity care, contact and therefore opportunities to build relationships with professionals in midwifery and health visiting, may be limited.

Professionals noted the isolation experienced by mothers with a looked after background, particularly if they have moved away from the area where they were in care.

'A lot of the time, ...they tend to become a bit of a prisoner in their own home. A lot of the young girls that I work with find it quite hard to make connections with other young girls - they can be quite catty. So to go into like a Sure Start centre and to be vulnerable is quite difficult for them.' (Personal Advisor 3)

The mothers interviewed also mentioned isolation. All had separated from their babies' fathers and lived alone with their children and only one had regular contact with birth or

foster parents. One mother, who had been prescribed anti-depressants, described her isolation:

'I felt like after I'd had [baby] I was very isolated, so I felt like it was just me and her in these four walls.' (mother)

Despite social isolation, young mothers with a looked after background may be wary of seeking professional support because of their own experiences. Several professionals talked about mothers' reluctance to request help, especially from social services, in case this could be seen as admitting failure as a parent. As one personal advisor (2) put it, their 'ultimate fear' is that their baby may be removed and placed in care. One of the mothers who had been in care because of her father's violence, and who had spent time in a women's refuge as a result of her partner's ill treatment, acknowledged this fear and her resolve to keep her child:

'I just knew, no matter what, nothing was going to take him away from me.'
(mother)

Those in most need of support may be least likely to engage with services. Professionals talked about having to develop creative strategies to work effectively with them. Young people 'who are difficult, challenging, oppositional' (Leaving Care Team Manager 4) with emotional and/or mental health problems were said to be less likely to seek support.

The high thresholds of need for social services provision may also mean that support for young parents is not prioritised; services may be so stretched that those entitled to support may receive a minimum.

Young people's own experiences of being parented may have been detrimental to their development. Their lack of positive parental role models may mean they have little understanding of the physical and developmental needs of babies. Some of those interviewed believed that young women may inadvertently put their babies at risk:

'They may want to keep the baby safe but they can't stay away from the people that could cause the baby harm.' (Clinical Specialist for Children in Care 3)

However, despite the numerous challenges faced by mothers with a care history, professionals cited examples of individuals who had overcome multiple difficulties.

'Not all young people who get pregnant don't cope or aren't good parents. We've got some really sensible young parents who are very motivated and very successful... doing university and having children.' (Leaving Care Team Manager 4)

Many of the professionals interviewed noted the diversity of young women's experience of care, their personalities and the circumstances of their becoming mothers, concluding that generalisations could not be made about their experiences or their needs.

Maternity and health visiting services

The three young women interviewed reported having seen different health care personnel during their pregnancy, the birth and in their baby's early weeks, and so lacked the opportunity to develop rapport with any individual professional.

Antenatal care was described by one health practitioner as 'very scanty' (Clinical Specialist for Children in Care 3). A personal advisor from the same area felt strongly that midwives should visit vulnerable mothers at home before delivery in order to build trusting relationships and to check that they were prepared for the birth. Specialist services such as midwives with expertise in working with young mothers were reported to be facing cuts due to tightening budgets.

Two mothers talked about lack of breastfeeding support:

'...it was like I was an inconvenience to the hospital for asking for help for [baby] to latch on and in the end I gave up. And I wish I hadn't given up but I didn't get the right support from the hospital.' (mother)

Personal advisors working with care leavers talked about developing and maintaining links with health professionals, including FNs, and supporting young mothers by signposting them to services, linking them with professionals, accompanying them to appointments and even acting as birth partners. In two areas, plans were being developed to meet the particular needs of looked after children and care leavers when they become parents as a gap in services existed. However, support services for parents with young children were reported to be facing funding cuts and, in one area, local voluntary sector schemes (such as mother and toddler groups) had disappeared because of lack of funding.

The potential benefits and disadvantages of gFNP to mothers who are in care or care leavers

Social services and health professionals were universally positive about one-to-one home-based FNP and its role in supporting young mothers with a care background although none had experience of gFNP.

'We have had some real success stories with our looked after children where they've become parents themselves and gone on to successfully parent the children and I think how that's been successful is because of the input with the FNP ...any of the ones who've gone through our FNP would sing their praises really.' (Nurse for Looked After Children 1)

However, it was acknowledged that attending a group made up of strangers in a new environment could be challenging for any young person and that preparation would make attendance more acceptable. Professionals tended to think that the potential benefit of gFNP to looked after children and care leavers would depend on personalities and preferences. Those mothers who were motivated and confident would be more likely to be interested in participating in group activities whereas others might feel intimidated and stigmatised in a group setting because of their background.

'It might either work really well or not at all. And it would just depend on the kind of personality of each of the young women... And... whether they wanted to engage with peers or, because some really do, some really don't...' (Named Nurse for Looked After Children 5)

'I think particularly for the young people we work with, there'd be no point just sending them an appointment saying, oh, you can just come to this group because the likelihood is they wouldn't go. There'd have to be preparation.' (Advanced Practitioner, Leaving Care Service 7)

The views of two of the mothers (not allocated to gFNP) illustrate the different preferences. One would not have wanted to be a member of a group:

'I don't like being around too many people.' (mother)

The other thought:

'...if I could have met other mums similar to my age and made... a network of friends with other babies, I think it would have benefited me and [baby].'

(mother)

The third mother interviewed, who had attended a group during her pregnancy, reported enjoying the experience but could no longer attend when she was re-housed in another area.

FNs, however, were positive about the potential of gFNP to support those with a care background. They believed that the diversity of backgrounds and circumstances of those attending groups meant that those with a care background would not be singled out. The 'nurturing' gFNP approach encourages peer learning and support from all participants, which may be particularly empowering for women who have been in a care. They suggested that participating in a group builds confidence and that individual women become skilled at particular aspects of caring for a baby and can model behaviour and advise others.

'...we noticed that, specifically with one client, ..., that she lacked a lot of confidence when she first came and we observed how that confidence grew. So it's kind of being accepted, you know, that acceptance and, yeah, you're sharing ideas, you're all new to it but she had a lot to share and was an expert in weaning at one point, wasn't she, yeah it was brilliant for her confidence.' (FN 5)

Interviews with mothers suggest that they lacked confidence and skills in socialising their children. One said that, because of lack of contact with other children, her child was 'clingy' and did not like group activities. Another was concerned about her child's aggressive behaviour.

FNs thought that attending a group could help to address the social isolation often experienced by young mothers. They gave examples of the sustained nature of the social networks developed by groups. Some members remained in contact beyond the gFNP programme, setting up group Facebook pages and supporting each other's learning about parenting by posting questions and suggesting solutions, while also meeting socially.

Some FNs thought that the group model could be more effective and powerful than one-to-one FNP because of this opportunity for group interaction and shared problem solving. The empathic nature of established groups was described by FNs, explaining how members

responded to individuals when they shared their concerns within the group. They saw the group setting as an opportunity for those attending to have time to concentrate on being a parent.

'I don't think looked after mums need anything different in terms of adding anything specific into the group because all they want to do, they want to be part of something that's taking them away from the everyday things they're having to go through.' (FN 4)

The fact that everyone is treated in the same way was seen by FNs as a positive aspect of gFNP for mothers with a care background.

'...they wouldn't necessarily want to be getting preferential treatment because they're looked after. They just want to get what everyone else is getting within the group... the group's an opportunity to be that sort of normal person like everybody else...' (FN 4)

This also applied to a father who had been in care and attended gFNP sessions.

'He didn't particularly talk about his childhood but I think he liked the support that he got from attending group... just that there were other dads there as well.'
(FN 1)

It was suggested by some social services professionals that a 'hybrid' model of FNP could be developed which would encompass both one-to-one and group sessions. FNs reported that gFNP members have the opportunity to talk to them privately at the end of a session and are encouraged to get in touch between sessions if they want to discuss anything including issues that they do not want shared with the group. However, it was felt that it was not possible to develop the same close relationships with mothers as in one-to-one FNP.

'You don't get to know them as well as you do your one-to-ones because you don't see them in the home environment all the time and we don't have those one-to-one, intimate conversations about feelings and such like.' (FN 1)

Some support was articulated among health and social services professionals for group-based provision tailored to meet the needs of young parents with a care background although interview participants were equivocal about the potential benefits. Some thought

that a special group could provide a 'safe place' in which members could find mutual support while others believed that they would benefit from a group drawn from the wider community.

'...having other people, not only people from the care system but other young women who are young and pregnant and... I think the support they get and learning from role modelling from other young parents who have come from a different background is...absolutely hugely beneficial to them, to be honest... they do tend to stick with people that they have known from the care system and I think it would be beneficial for them to have that wider experience.' (FN 6)

Discussion

This qualitative study, embedded in a randomised trial of gFNP, was designed to explore the challenges faced by women with care experience in pregnancy and early parenthood and to assess the potential of gFNP to meet their needs through the perspectives of a range of informants. These included mothers, FNs delivering the programme and health and social care practitioners from the seven local authority areas across England where the trial took place.

The findings of this study are consistent with wider evidence highlighting the vulnerability of young mothers with a care history, and the importance of supporting them in their transition to adulthood and parenthood (Hall and Hall 2007). Practitioners who work with care leavers testified to the impact of financial insecurity, unsettled living arrangements and social isolation, which may have been exacerbated by recent years of austerity (Hastings 2015; Cann and Lawson 2016). One common perception was that early parenthood, even if unplanned, offered young women whose family life had been disrupted a child to love and be loved by. This is consistent with other studies, which found that feelings of loneliness, rejection, stigma and being unable to trust others may contribute to early parenthood (Knight and others 2006). However, gaining the valued identity and status associated with motherhood could also involve the loss of other identities as students or unencumbered young people (Pryce and Samuels 2010).

Our findings also correspond with those of others (Rolfe 2008; Birtwell and others 2015) in suggesting that, despite personal vulnerabilities and structural challenges, motherhood can be a positive experience for this group of women. Research has found that, for them, becoming a mother presented an opportunity 'to set right the wrong of their past' (Maxwell and others 2011) in terms of their own family history and to stabilise their lifestyle and circumstances (Connolly and others 2012). Having a child was, for many, the first time they could develop a relationship offering a sense of permanency in a family in which 'their value and membership could not be questioned' (Pryce and Samuels 2010). Parenthood can foster a new sense of responsibility and purpose (Barn and Mantovani 2007) and provide a measure of agency and control lacking in other aspects of their lives (Rolfe 2008). In contrast to their childhood experiences, young mothers hoped to be 'ideal' parents although the reality was found to be challenging and sometimes overwhelmingly demanding, raising self-

doubt about their competence (Maxwell and others 2011). The perinatal period would appear to be an important window of opportunity to support women with a care history to succeed as parents.

There was consensus among participants in the current study that care leavers are in need of additional support during pregnancy and postnatally, and that maternity and health visiting services may not be equipped to provide the level of support required. Social isolation was commonly mentioned as was the importance of developing trusting relationships given the lack of family support and the mistrust these young women might have for professionals.

Close relationships lie at the heart of both FNP and gFNP. Those interviewed expressed a range of views regarding the relative benefits of individual and group models for women with a care history. FNs who had first-hand experience of delivering gFNP thought that the group model provided women with opportunities to build confidence and develop child-raising skills with peers from a range of backgrounds and with whom they could develop ongoing relationships. However, health and social care practitioners, who tended to focus on the difficulties these women face in social situations, were less positive. Group FNP was perceived by some as unlikely to provide women with the same opportunity as one-to-one FNP to develop a close and trusting relationship with a practitioner. One suggestion was that a hybrid model of FNP and gFNP might provide this vulnerable group with the benefits of both types of provision.

These contrasting views were reflected by two of the participating mothers, one of whom felt that she would not like to join a group, while the second felt that a group would have allowed her to develop a network of friends with similar experiences. Although none of the health and social care professionals and only one of the mothers who took part in an interview had experience of either delivering or receiving gFNP, their perspectives represent potential problems in terms of recruiting women with a care history into gFNP. They also highlight the importance of choice and preference particularly for young vulnerable women.

Strengths and limitations of the study

The credibility of this research is indicated by the use of in-depth data collection methods with a range of participants. However, this was a small study and, of only six trial

participants identified as having a care history, it was only possible to interview three. The limited number of young mothers who had been looked after and who also took part in gFNP had an impact on the numbers of FNs with direct experience of facilitating groups whose membership included those with care experience. Moreover, the other professionals we interviewed, while familiar with the challenges facing looked after children and all familiar with FNP, had little or no knowledge of gFNP.

Conclusions

This is the first study to have used qualitative interviews to explore a range of stakeholders' views about the needs of pregnant women with a care history and their thoughts about a group-based version of FNP in meeting these. We found consensus among informants regarding the vulnerability of looked after children and care leavers when they become mothers highlighting their social isolation and lack of trusting relationships.

While there was also consensus that FNP is a valuable resource in meeting the specific needs of parents who had been in care, there were divergent views about whether these would be best met by an individual or group-based version of FNP, with some suggesting the potential benefits of a (hypothetical) hybrid programme involving both one-to-one and group sessions. We recommend further research – including longitudinal studies - on the needs of young mothers with care experience from their own perspectives while acknowledging that recruitment of such a sample may be challenging.

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