Guidelines for the Applicants of the open call “Implementation of the Model for Home Visits and Provision of Early Intervention Services” under the Programme “Health” of the European Economic Area Financial Mechanism 2014-2021

Annex 1

**DESCRIPTION OF THE MODEL FOR HOME VISITS AND PROVISION OF EARLY INTERVENTION SERVICES**

The need to provide care and love to one's children comes naturally and is self-explanatory for the majority of parents. However, number of families are facing various difficulties, seldom originating in the presence of external circumstances that have a negative impact towards the relationship between family members. Parents face difficulties trying to overcome the rising problems, neglecting outside help. Often, the aforementioned parents refrain from seeking professional help. Comprehensive and harmonious development of a child is only possible within a loving, happy, nurturing and understanding family that is able to take care and provide for their child.

Maltreatment of children is one of the problems within the area of public health. Based on the data of the World Health Organization (WHO), three out of four children, from 2 to 4 years old, are experiencing physical punishments or psychological violence form their parents or legal guardians on a regular basis 1. One out of five women and one out thirteen men state that they have been subject to sexual abuse in their childhood. Children that have been subject to violence and neglect are more likely to express violent behaviour in their adulthood[[1]](#footnote-1).

Maltreatment of children is linked to physical injuries, growth retardation, obesity, unrest, depression, post-traumatic stress disorder and long-term impacts, such as: development retardation, lack of social and educational skills.

Children that have experienced maltreatment in their infancy, childhood and teenage years are more likely to partake in use of alcohol, drugs, criminal activities, irresponsible sexual activities and violence, as well as experience mental problems and chronic illnesses in their adulthood years. Maltreatment of children has various negative consequences on the daily functioning and development of children, i.e., consequences that become highlighted during the adulthood years of the aforementioned children causing negative and lasting social impact towards the society, such as: reduction in family functions, inactivity within the labour market, lack of social skills.

Formation of a favourable and nurturing environment for infants and children is regarded as one of the best possible investments. Number of studies reveal that the earlier we undertake on such an investment, the more benefits we will reap in the future.2, 3. Economists in USA have calculated that an investment of just 1 dollar into the programme “Nursing: family partnership” give back future returns that are five times higher than the initial investment.

The prenatal period is the most suitable time to take on the formation of favourable and nurturing environment for infants as well as the family. By providing prenatal services, we realise the number of challenges women are faced during pregnancy and following the birth of the child. In order to successfully complete this decisive period, young women need to receive care and thoughtful advice.

Article 19 of the United Nations Convention on the Rights of the Child states that: “States shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child”.

Despite the spread of maltreatment of children, many of the implemented programmes are only offering secondary prevention services instead of supporting the primary prevention of maltreatment of children. “Nurse-Family Partnership Programme” is a programme based on scientific evidence gathered during the provision of primary preventions services towards families in need.

## “Nurse-Family Partnership Programme” and theoretical reasoning

The “Nurse-Family Partnership Programme” was founded by the Prof. David Olds (USA) in order to ease the consequences for young women giving birth and their children in vulnerable socials groups. The aim of the programme is to reduce the known risk factors that can cause negative birth consequences, social divide, neglect and abuse of children. To support responsible care of vulnerable children and to reduce the number of unwanted cases by educating and giving guidance for the parents on the development of their children, parent-child relations and formation of said relations.

“Nurse-Family Partnership Programme” is a structured and intense programme employing professional and trained family nurses to provide home visits. The programme encompasses 64 home-visits (14 visits during the prenatal period, 28 visits during the period following the birth of the child and until the child reaches the age of 12 months old, as well as 22 visits until the child reaches the age of 2 years old). The following subjects are covered during the visits: personal and environmental health, future life perspectives, role of a mother within the life of the child, family and friends, accessibility to healthcare and social services.

The aforementioned programme is based on three theoretical perspectives. They are as follows: First: Human Ecology Theory explaining that the care provided by parents have a significant impact on the development of the child and the development of the child through the relation of people and their surroundings2. Second: Bandura's self-efficacy theory explaining that people are able to learn a number of key aspects just by supervising the behaviour of others and constructing behavioural patterns. Bandura explains that the communication patterns of a child are built based on the supervision of the behaviour of other people. The child learns the most just by studying the behaviour of one of the parents of the same gender. Learning by studying takes less time and it is one of the most important survival and development factors[[2]](#footnote-2). Third: Attachment theory explaining that every child possesses the need to attach themselves to one of their main guardians in order to receive continuous care[[3]](#footnote-3).

Conceptual model of the “Nurse-Family Partnership Programme” explains how each element works and supports the development of health of mothers and their children. The Aim of the programme: to control the risk factors and implement safeguards within all three key aspect areas: prenatal health linked to behaviour; safe and responsible care of children; responsible parenthood. The aforementioned preventive programme has a direct relation to better pregnancy results, better child health and development results, as well as economic independence of families.

The present programme employs a scientifically justified nursing model where nurses provide home visits for first time parents, families having reduced income and their children. Each nurse supervises from 25 to 30 clients. Nurses enrolled within the “Nurse-Family Partnership Programme” work with vulnerable families within the confines of their homes where they are respected and feel safe. Development of sustainable and long-term therapeutic relations is key for achieving the aims of the programme. Nurses enrolled within the “Nurse-Family Partnership Programme” work with each client by providing most of their attention to the physical and mental state of the mother, development of the health of the child, environmental health, lifestyle improvement, including planning and participation in work and school life, as well as use of community resources in order to achieve economic independence. Long-term implementation of the programme allows for the evaluation of the short-term and long-term impact of the programme towards the society and individuals. Based on the data of the *Lancet* magazine (2008), we are able to state that, to this day, there are only two scientifically justified programmes (one of them being the “Nurse-Family Partnership Programme”) effectively reducing the maltreatment of children through the promotion of the social responsibility of young mothers and sustainable statistical promotion of the life quality and social welfare of the family and the children within.

Currently, the “Nurse-Family Partnership Programme” is being implemented within USA, United Kingdom, Australia, Canada, Scotland, Northern Ireland, Norway and Bulgaria. The aforementioned countries boast efficiency ratings that are directly correlated to the duration of the programme, counted from the date of the implementation of the aforementioned programme.

### Model methodology

Even though, nurses and midwives are trained to provide care for children and women under strict clinic guidelines, they lack training for provision of primary aid aimed at the identification of possible risk factors and to take preventive actions as early as possible in order to control and mitigate the possible negative consequences towards the physical and mental health of mothers and children as much as possible.

Home visits and provision of early intervention services, as well as the generalized implementation methodology are established within the model based on theoretical expertise, scientific research results, good practice and expertise. Model for home visits and provision of early intervention services provides 5 necessary components during the provision of early intervention services towards families. The aforementioned components have been divided among the three following areas: Provision of care (My health; My child); Decision-making and support (Caring for a child); Social and community resources (My family and friends; My home).

### Evaluation of service provision within municipalities

The model for home visits and provision of early intervention services shall be evaluated within the institution operating in various municipalities of the Republic of Lithuania and selected by way of an open call. The aforementioned institutions shall implement the model for home visits and provision of early intervention services through ongoing projects.

**Phase 1: Selection of service providers**

The services of the model for home visits and provisions of early intervention services shall be rendered by nurses/midwives of selected institutions operating in various municipalities of the Republic of Lithuania. The aforementioned specialists shall be compliant with the following requirements:

 - Bachelor's degree in health sciences (or equivalent) and a professional qualification of general practice nurse/advance practice nurse/midwife;

- Valid professional qualification licence of general practice nurse/advance practice nurse/midwife;

- Work experience > 3 years;

- Ability to communicate with patients;

- Valid driving licence, Category B.

The specialists shall be selected by way of a motivational interview during which their ability to communicate, motivation to work with representatives of a target group and sense of empathy shall be evaluated. It is aimed to select at least 30 community nurses/general practice nurses/advance practice nurses/midwives from the selected Project Promoters during the open call.

**Phase 2: Training of service providers**

Prior to the start of the service provision, all of the community nurses/general practice nurses/advance practice nurses/midwives must have undergone and completed the Postgraduate Study Programme. The duration of the aforementioned programme is 63 hours (participation in training programmes (excluding mission expenses) shall be compensated by the Lithuanian University of Health and Sciences organizing the aforementioned training). Aim of the programme: to help the specialists providing home visits acquire the “soft” competencies required for the provision of primary intervention services for families subject to risk factors. The aforementioned Postgraduate Study Programme has been prepared in accordance with the Human ecology theory, Attachment Theory and Self-efficacy theory, as well as good practice of foreign countries in implementing the “Nurse-Family Partnership Programme”.

**Phase 3: Provision of services within municipalities**

Following the completion of the aforementioned Postgraduate Study Programme, the specialists providing home visits shall be employed at the Primary Health Centres (PHC) operating within the aforementioned municipalities. Following the analysis of the information of the Primary Health Care Facilities (PHCF) on registered persons, the specialists providing home visits shall select families that meet the criteria for the inclusion to receipt the services of the implemented model.

The services shall be rendered towards women and families that are subject to inclusion criteria and who are willing to participate within the project. Criteria for women:

- Pregnant women (up to 22 weeks pregnant) (priority: first time mothers, young mothers < 21 years of age and older women > 40 years of age).

- Pregnant women (up to 22 weeks pregnant) subject to social risk environments and/or subject to at least one of the following risk factors:

- Smoking;

- Consumption of alcohol;

- Lack of social skills;

- Socially unacceptable behaviour;

- Unsafe social environment;

- History of criminal experience;

- Mental disorder conditions and other illnesses;

- Lack of parenting skills;

- Poor family/couple relationship;

- Close relationship violence;

- Lack of attachment to an already existing child;

- Poor living conditions;

- Low self-esteem;

- Low mental resilience;

- Maltreatment of an already existing child;

- History of unwanted pregnancies.

Each specialist providing home visits shall oversee at least 25 families (recommended workload for a single specialist – one full time position). The specialist providing home visits shall make 14 home visits during the pregnancy period; 28 home visits following the birth of a child and until the child reaches the age of 12 months old; 22 visits during the period from the child becoming 13 months old and until the child reaches the age of 24 months old. During each visit, the specialist shall gather the necessary information in accordance with the pre-prepared checklist for each visit and evaluate the changes in family behaviour, home environment, as well as distinguish the area that the family is lacking in the most. The specialists shall evaluate the following three areas: Provision of care (My health; My child); Decision-making and support (Caring for a child); Social and community resources (My family and friends; My home).

The implementation of the model for home visits and provision of early intervention services within the municipalities of the Republic of Lithuania shall take on intervention measures that shall change the behaviour of the woman/family from subject to risk factors to a behaviour that is less subject to risk factors to a behaviour not subject to risk factors shall be used. Use of the aforementioned measures shall increase the model output indicators established within the project (see. Section: Model output).

Intervention measures to be applied:

* Intensive care by a home visit specialist.
* Consultation and education of families within the following areas: Provision of care; Decision-making and support; Social and community resources.
* Behaviour change through the use of consultation and motivation measures.

### Functions, responsibility and accountability of the home visit specialist

During home visits, the home visit specialist shall provide the individual health care services as described within the following Decree of Ministry of Health of Lithuania: MN 57:2011 Job description of community nurse: Rights, duties, competency and responsibility; MN 28:2019 Job description of General practice nurse: Rights, duties, competency and responsibility; MN 40:2014 Job description of midwife: Rights, duties, competency and responsibility.

**Additional functions of the home visit specialist:**

* Identification of pregnant women (up to 22 weeks of pregnancy) registered at PHCF.
* Identification of risk factors within a family of pregnant women (up to 22 weeks of pregnancy).
* Inclusion of families within the programme.
* Evaluation of the situation of families receiving early intervention service in accordance to the established visiting plan, supervision of changes and application of suitable intervention measures in accordance with the evaluation results.
* Referral of mother/families (if required) to appropriate specialists (e.g., family doctor, psychologists, social worker, etc.).
* Regular meetings for provision of feedback with coordinating authorities.
* Regular evaluation of the situation, drafting and submission of an evaluation analysis every 6 months towards the coordinating authorities.
* Publication of services, searching and inclusion of new clients.

**Responsibilities of the home visit specialist:**

* Formation of an environment ensuring respect towards the values, customs and spiritual beliefs of an individual during the provision of the services.
* Confidentiality of personal information and the right to dissemination of aforementioned information in accordance to their professional expertise.
* Communication with colleagues: nurses, doctors, social workers, psychologists and representatives of other areas subject to the well-being of public health.



**Participating families**

Functions: participation within the programme, cooperation with the home visit specialist

**Municipal Social Services Department**

Functions: cooperation with PHFC; home visit specialists; NGO taking care of families subject to increased needs in exchanging on data and Child Protection Rights Services.

**PHCF**

Functions: participation during the model implementation, creating of job position for HVS; cooperation with Social Services Department in exchanging on data on families with increased needs.

**Home visit specialist (HVS)**

Workplace: PHCF

Functions: provision of individual health care services as established within the MN. Provision of additional services as established within the model description.

 *MN – Medical norm*

*NGO – Non-governmental organisation*

Figure 2. Position of the home visit specialist within the health care and social service sector.

Following the completion of the project, the home visit specialists shall become mentors for newly selected home visit specialists. Practice teacher (mentor): nurse or midwife working within the same PHCF, having completed the Postgraduate Study Programme for Home Visit Specialists and having no less than 2 years of working experience within the family visiting programme.

Mentors shall train the newly selected home visit specialists in accordance to the training programme prepared under the Benner model where the skills are passed on by the acquired expertise. The programme shall provide the necessary expertise and knowledge by going through five competency and skill levels: ranging from novice and going all the way to expert[[4]](#footnote-4) (Fig. 2).

Teacher (mentor) shall partake with the newly selected and trained specialists in supervision and meetings for sharing of feedback during which the arisen challenges and measures for overcoming the aforementioned challenges shall be discussed and adopted.

Having regards to the statements of the Benner's Theory, by understanding of a specific situation and reflection on the aforementioned situation, the specialist is able to adopt the appropriate expertise according to the needs of the patient/client/presence/time and conditions that lead to the development of clinical expertise and competence. By acquiring additional experience, the specialists are able to better organize the provision of care, resolve problems, identify the needs of the patients, integrate different problem solving methodologies in to their professional life and communicate more efficiently. A presumption may be made that by going through the levels of the aforementioned model, the specialist develops their competence, skills, and in this way, ensures the safety of the patients, as well as the quality of the provided services.

**Phase 4: Service monitoring**

Project Team (Lithuanian University of Health and Sciences) shall arrange 18 meetings for supervision and provision of feedback for each home visit specialist. Meetings for supervision and provision of feedback shall take place once a month, starting from the date of the inclusion of a woman/family within the model and until the child reaches the age of 1 year old. Afterwards, the meetings for the supervision and provision of feedback shall take place once every three months.

The Project Promoter (Lithuanian University of Health and Sciences) are planning to visit families included within the programme and conducting personal interviews with aforementioned families in order to evaluate the acceptance, quality and personal benefit towards the woman/family of the provided services. The families shall be selected at random within each municipality. Only families accepting to partake in individual interviews shall be subject for the inclusion within the programme.

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## V. MODEL OUTPUT

The aim following the implementation of the model for home visits and provision of early intervention services shall be to promote the short-term[[5]](#footnote-5) and long-term[[6]](#footnote-6) indicators highlighting the social well-being and health of the mother and children.

**Short-term health and social well-being indicators:**

* Increase in number of breastfed new-borns (infants, children);
* Increase in number of vaccinated children (< 6 months);
* Reduction in number of smoking pregnant women;
* Reduction in number of women subject to an increased arterial blood pressure;
* Reduction in number of second pregnancy prior to the existing child reaching the age of 2 years old;
* Reduction in number of visits to hospitals following accidents, choking hazards and poisoning of children younger than 2 years old;
* Improvement in new-born, infant children physical development up to 2 years old;
* Improvement in parents abilities to care for their children within a safe environment;
* Improvement in emotional connection between children and parents.

**Long-term health and social well-being indicators:**

* Reduction in number of families subject to social risks due to lack of skills for taking care of their children by the end of the year to 100000/pers.;
* Reduction in number of hospitalization due to traumatic experiences (up to the age of 2 years old);
* Increase in women involvement within the labour market;
* Decrease in women delinquency.

## MODEL SUSTAINABILITY

In order to avoid fragmentation of rendered services and ensure achievement of the increase of short-term and long-term health and social well-being indicators, the provision of services by the home visit specialists should be maintained following the completion of the project implementation and should be rendered along routine healthcare services within municipalities. A funding mechanism shall be required in order to ensure the sustainability of the provision of the services.

1. <https://www.who.int/news-room/fact-sheets/detail/child-maltreatment>

2 - Harriet L. MacMillan and others, “Interventions to Prevent Child Maltreatment and Associated Impairment,” The Lancet 373 no. 9659 (2009): 250-266.

3- David L. Olds and others, “Home Visiting by Paraprofessionals and by Nurses: A Randomized, Controlled Trial,” Pediatrics 110, no. 3 (2002): 486-496. [↑](#footnote-ref-1)
2. Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84*(2), 191–215. [↑](#footnote-ref-2)
3. [Bowlby](https://www.amazon.com/John-Bowlby/e/B001HCUQTK/ref%3Ddp_byline_cont_book_1) J. Attachment and Loss.Basic Books, New York, 1969. [↑](#footnote-ref-3)
4. Benner P. From novice to expert: Excellence and power in clinical nursing practice. Menlo Park: Addison Wesley, 1984;13-34 [↑](#footnote-ref-4)
5. Achievable during the model implementation period [↑](#footnote-ref-5)
6. Achievable within 5 years following the completion of the model implementation [↑](#footnote-ref-6)