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ORIGINAL ARTICLE

Strength-based approaches: a realist evaluation of implementation in maternity services in Scotland

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Abstract

Aim Strength-based approaches draw on patients' strengths and perspectives to partner with them in their own care, recovery and problem solving. The effectiveness of strength-based approaches to address complex health problems has a growing evidence base leading to its incorporation within universal services in many countries. However, practitioners' understanding of implementation of strength-based approaches, such as how to agenda match, set goals and revise plans within universal services are under-researched. Maternity services are a key point of access to health services and women's experiences of them have consequences for families' future willingness to engage with public health provision. This study researched strength-based components of children's services policy, Getting It Right For Every Child, in maternity care in Scotland.

Subject and methods Complex interventions, such as this policy, requires a methodology that captures complex dynamics. Consequently a realist-evaluation-informed case-study approach was adopted across three contrasting health boards comprised of: (1) interviews with women receiving maternity care with heightened risk profiles, (2) a sample of maternity care professionals responsible for implementing the policy and (3) document analysis of policy guidance and training materials.

Results Whilst midwives reported adopting more open approaches to raising sensitive issues with women, many midwives were unfamiliar with strength-based approaches and were not drawing upon them, in contrast to a perception amongst managers that training and implementation was common.

Conclusion These findings suggest implementation of strength-based approaches within universal services require further attention to training and embedding culture change.

Keywords Midwives · Service user views · Program evaluation · Strength-based approach · Complex interventions · Getting it right for every child

> "I haven't had training to deal with some of these sensitive situations. I'm drawing on my experience as a mother, as a grandmother, as a human being."
> (midwife HB1)

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Introduction: scaling up strength-based approaches for every child in Scotland

Strength-based approaches draw on patients' strengths and perspectives to partner with them in their own care, recovery and problem solving. These approaches have been developing an international evidence base since the early 1980's, with work in Australia (Davis and Spurr 1998) and the US (Olds et al. 1986) developing along similar but distinct lines. Key to them is forming empathetic partnerships with patients. As Day points out, "The most consistent predictors of successful health care engagement and outcomes are the interpersonal qualities and skills of practitioners (and) the characteristics of the relationship and therapeutic alliance (2013: 4)."

Motivational Interviewing is a key component of strength-based approaches, such as Nurse Family Partnership programs

rolled out across multiple sites in the United States and at varying stages of trial across the UK (Beam et al. 2010; Ormston et al. 2014). Motivational interviewing focuses on evoking and strengthening the client's own verbalised motivations for change as part of an empathetic, person-centred communication stance (Miller and Rose 2009, p. 258). A broader conception of clinical empathy is widely advocated as being a core skill required for quality health care (WHO 2010). Integrated services policy, in seeking to put families and children at the centre and provide continuity of care across services, also highlights the importance of partnership skills (Audit Commission 2012; Cheetham et al. 2017). Scotland's integration policy for children's services, Getting It Right For Every Child (GIRFEC), builds upon this same evidence base. However, there is a lack of literature about how these concepts are percolating into wider practice beyond targeted programs and the degree to which a skilled understanding of empathy is embedded in practice.

Wand et al. (2010), in examining the advantages of realist evaluation, point out that the control mechanisms of randomised controlled trials prohibit learning about the effectiveness of approaches within wider implementation, where controlled conditions are no longer maintained and more real-life, messy factors interact. Ferlie and Shortell (2001) concur with Olds et al. (2003) that several factors affect the implementation of a particular treatment, when scaling up randomised controlled trial interventions to standard practice across a health system, at multiple levels of the practice context such as the level of client-clinician interaction, provider organisation management, and service-system-sector-coordination levels. In this study, we explore the implementation of strength-based approaches across maternity care services in NHS Scotland and begin to shed light on the challenges for wider uptake of these approaches with a particular emphasis on the client-clinician interaction level.

The Refreshed Framework for Maternity Care (The Maternity Services Action Group 2011) has GIRFEC as an integral approach to improving maternal and infant health and is supported by a number of Scottish Government guidance documents (Stradling et al. 2009) that stress the importance of strength-based approaches. However, this policy is challenging to established practice. As Vincent et al. (2010) point out, this entails a shift from a 'sequential' model of joint working to a 'parallel collaboration' model, with increased emphasis on shared frameworks for assessing wellbeing and engaging with families to support their children's wellbeing.

This integrated approach involves the adoption of an accessible practice model and agreement across services on how to engage families using this practice model. As such, it constitutes a complex intervention, that is, an intervention with several interacting components. In order to be successful, complex interventions require different aspects of a change program to be successfully coordinated.

Realist evaluation (Pawson and Tilley 1997) compares an intervention's program theory (how steps within policy are meant to effect change) with how program steps play out in reality across different contexts. Realist evaluation is particularly suited to examining complex interventions as it examines the complex inter-relations amongst contexts of implementation, the specific program steps as they are interpreted and enacted within each context, the mechanisms which these steps trigger (changes in attitudes, resources, and approaches) and the extent to which these inter-related factors lead to both intended outcomes (benefits, such as improvement in delivery of services and improved health outcomes for women and children) and unintended outcomes (disadvantages such as increased expense, resistance or disengagement; Wand et al. 2010; Befani et al. 2007). The inter-related components of a program are referred to in the literature as context mechanism outcome (CMO) configurations (Pawson and Tilley 1997). It is important to note that unintended outcomes produced at early points of program implementation may constitute important aspects of the context for future program steps triggering more exacerbated unintended outcomes at subsequent service provision points. As Day illustrates:

> A mother who has repeated experiences of feeling let down by others is likely to be more sensitive to and more likely to interpret actions of a nurse as being signs that she too is unreliable or untrustworthy. As a consequence, the mother may be more guarded and cautious towards the child and family nurse (Day 2013; p. 5).

Understanding these dynamics within GIRFEC implementation at an early stage provides important formative evaluative feedback, as they have done in other health interventions (Befani et al. 2007; Cheetham et al. 2017). Taken together, such studies can inform integrated strength-based policy implementation across the wider health policy landscape. In this article we examine two particular program steps in light of the policy context in order to probe what mechanisms they effect. The program steps as illustrated in Fig. 1 are: (1) the coordination of implementation of policy with professionals in other sectors and (2) the introduction of the policy tools and approach to patients. These program steps are anticipated to trigger a cluster of mechanisms.

Step 1 is intended to trigger the mechanisms of increased understanding and trust across professional sectors leading to more effective working and better intervention strategies. Step 2 is intended to encourage better rapport and engagement between practitioner and patients leading to patients' increased efficacy in supporting their children's wellbeing outcomes (Stradling et al. 2009). A dynamic that often confounds change programs is divergence of interpretation of key concepts (Greenhalgh et al. 2009). This study focuses particular analytic attention on possible divergence of interpretation of

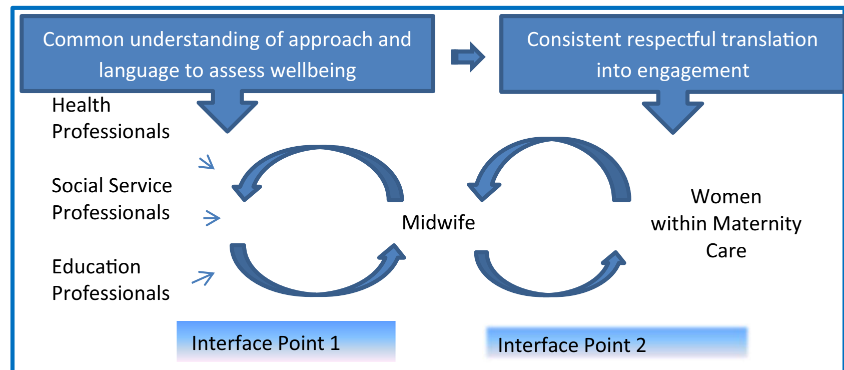

Fig. 1 Interface points within GIRFEC implementation into maternity services)

strength-based approaches within GIRFEC at the level of front line delivery.

Divergence in practitioners' understanding of strength-based approaches when engaging families in the wellbeing assessment could result in the semblance of implementation consistency, thus concealing divergent practice. Divergent practice can lead to diverging mechanisms producing markedly different outcomes.

Within social services, there are a number of models for integrating service users' involvement in services that are premised upon strength-based approaches (IRISS 2011). However, within the literature there is a lack of clarity across differing services about what strength-based approaches mean and how practitioners facilitate them (Stradling et al. 2009). There are some similarities between social service approaches and those within health services but also important differences (IRISS 2011; Glasgow Centre for Population Health 2011), for instance, between appreciative inquiry-based service planning within social care (IRISS 2011) and the agenda matching approach within Family Nurse Partnership approaches (Ormston et al. 2014). Concerns have been raised about the lack of clarity about terminology and the degree to which training and support for these approaches has been available (Audit Commission 2012; Cheetham et al. 2017). Follow through on training has been identified in the wider literature as a barrier to full implementation of strength-based approaches (Fowler et al. 2012; Porr et al. 2012).

The confusion and lack of ready identification of strength-based tools is of particular concern if one considers the literature on motivational interviewing (MI). The literature cautions that training in MI to be clinically effective requires a sustained training and development approach. Early studies comparing different training models for MI found that in one-off training workshops:

> . . . clinicians (thought) that they had acquired MI skilfulness, but their actual practice did not change enough to make any difference to their clients. . . Two common learning aids seemed good candidates for improving training: progressive individual feedback on performance, and personal follow-up coaching. . . . A practical challenge in convinced training clinicians in MI, then, is to help them persist in behaviour change past an initial workshop exposure that may erroneously convince them that they have already learned the method. (Miller and Rose 2009, pp. 9–10)

Crucially, part of MI is allowing the patient to develop motivation to change before moving on to the strategizing phase of the interview. This requires particular skill to assess. Where this transition is rushed, MI does not deliver significantly higher returns on investment. The one key factor in both the training and implementation of MI and, arguably, any strength-based approach, is appropriate pace of intervention. Day's (2013) work in developing the Family Partnership Model in Australia corroborates these findings, arguing implementation requires not only skill development but commitment and courage to implement these skills in practice.

Methodology: realist evaluation and strength-based conversations

In this study it was, therefore, important to adopt a methodology that 'sounded midwives out' about the strategies for implementing a strength-based approach (interface point one) and the degree to which they were drawing upon a strength-based approach with women in their care (interface point two). As implementation was at different phases in the three health boards where research was conducted, we applied a realist evaluation approach particularly suited to formative evaluation where mechanisms were beginning to emerge.

Sampling

Three case study sites were purposively sampled from Scottish health boards at varying stages of implementation. The sampling strategy also insured that a range of socio-economic and geographic (urban, rural, remote) contexts were included in the study. This meant that in each setting the total

number of participants involved varied so that sampling a representative number of those involved also varied. The recruitment strategy in each health authority was developed in consultation with lead practitioners to minimise service disruption, target a purposive sample and contribute to the health boards' on-going development and formative evaluation. Respondents were recruited to give their views on GIRFEC implementation in a manner that conformed to ethical protocols. The scope of data collection was constrained by the time available for completion of this study; however, the views of the following key informants were collected:

- Three senior policy makers within Scottish Government
- Three midwives with senior management responsibility for GIRFEC policy within maternity services
- Two NHS Child Protection Advisors
- Three midwives responsible for GIRFEC implementation training within their health board areas
- Five specialist midwives with responsibility for women with alcohol and substance misuse issues
- Twenty-two community midwives implementing GIRFEC across standard maternity provision
- Two maternity care assistants
- One obstetrician
- Fifteen women currently accessing maternity services, thirteen identified as having some risk of poorer pregnancy outcomes

Contextual factors within study sample

Realist evaluation entails careful consideration of the context in which mechanisms are enacted. In terms of policy context for this study all three health boards were functioning within recent national changes to maternity services. For several years a standardised women's hand held record had been rolled out across maternity services with the intent of increasing women's active engagement in their own maternity care. The most recent version had widened the scope of wellbeing indicators assessed and introduced GIRFEC terminology. Evidence of the degree to which the record facilitates a strength-based approach with women or increases their engagement is inconclusive (Entwistle et al. 2011). Maternity services in Scotland within the last 5 years had also implemented a care pathway that increased midwives' responsibility by giving them lead professional status for all women with normal pregnancy indicators. Just prior to the study, child protection practice across Scotland had been extended to work with families on an unborn child, where risks were assessed as likely to impact upon that child. This change in policy gave added impetus for social work departments to work with and consult midwives as part of pre-birth meetings to discuss concerns with parents (Scottish Government 2010).

Further, there were important policy context differences amongst the boards. Health Board One (HB1) had taken a pathfinder role within developing GIRFEC policy. Some localities within it had been working on implementation for 5 years and, thus, training and implementation were much further advanced than in the other two boards studied. Health Board Two (HB2) had received Scottish Government moneys to develop learning materials for implementation and had been working at implementation for 2 years, trialling implementation strategies, developing policy change champions and delivering training. At the time of research, the process of training midwives and initial implementation across community midwifery teams was only a few months underway. Health Board Three (HB3) had implemented the policy on more of an ad hoc basis.

In terms of socio-economic contexts, there were also important contrasts and similarities. In HB2 and HB3 there were concentrated areas of high unemployment and social exclusion to a greater degree than in HB1. HB1, as well as serving urban areas, had a large rural service area that increased difficulties in terms of access and travel required for service delivery. Impacting implementation in HB1 was women's sense of high visibility within small communities, which created particular concerns for midwives exploring sensitive issues. In contrast, HB3 had centralised services. The large caseloads and lack of midwives embedded in localities in HB3 generated a sense of anonymity that midwives perceived as a barrier to establishing rapport with women in time-pressured contexts.

Realist evaluation interviews

Within each site individual and group, interviews were conducted with key informants who had been involved in implementing GIRFEC by the project research fellow between March and June of 2012. All respondents agreed to take part without offer of payment. A unique interview schedule was used for each type of respondent. Interviews with those key to managing implementation within maternity services probed how they understood the tools and approaches and how they strategized about implementing them into their practices. Interviews engaged practitioners in a conceptual refinement process where the meanings of key concepts and the implicit criteria for assessing their application to work practice were explored (Pawson and Tilley 1997). Practitioners were prompted to expand on the explanations of their choices. Related topics of how fit for purpose these tools were, and crucially how they effected change, were also explored. In interviews with women receiving maternity care, we asked them to evaluate the service they were receiving and the approach that practitioners adopted to discussing their wellbeing with them.

Analysis

All interviews were audio recorded and transcribed and checked for accuracy by comparing the transcript with the sound file. To protect participants' anonymity, all names were removed from the transcripts. Each participant was assigned a code consisting of a health board code (hb#), a letter abbreviation signifying role and a unique numerical identifier. Data analysis utilising the realist evaluation framework (Pawson and Tilley 1997) was carried out by the research fellow with rigour achieved via secondary coding by the principle investigator and respondent validation. Initially data was coded for each of the proposed CMO configurations (mechanism, outcome, and context) separately for each site. Cross comparisons were then made.

Reflexivity was integrated into the study in the following manner. As researchers, we brought complementary perspectives and research expertise to the task of analysis and reflection in a cyclical fashion over three iterations of data collection broadly coinciding with work in each of the three health boards. Each analysis review was used to guide subsequent hypothesis refinement within the remaining health boards. Hypothesis refinement is an important aspect of realist evaluation where program theory as intended is compared to program theory as implemented (Greenhalgh et al. 2009). Transcripts were reread several times to ensure familiarity with the data. The research fellow produced an initial hierarchical coding framework that was based on concepts relating to the aims of the research and issues prioritised within interviews. Overarching codes corresponding to the identified steps within implementation were correlated with a substrata of codes that corresponded to information about the mechanisms effected by the implementation steps. The overarching codes corresponded to questions asked within interviews. The substrata of codes depended on what implementation steps and mechanisms respondents indicated in their responses, rather than being suggested by the interviewer, as this may have pre-empted the terminology and range of mechanisms they identified themselves. Coding included practitioner perceptions, intentions and strategies in reference to different aspects of implementation (building rapport, gaining consent to share information, assessing wellbeing, record keeping, interagency working) and their observations on success of implementation and barriers to this in terms of mechanisms facilitated and where possible, outcomes. This conceptual framework was reviewed first between the research fellow and primary investigator at the three intervals indicated above and then within a workshop with the Scottish Midwifery Research Collaboration, who provided comparative insights from other relevant studies.

Respondent validation was assessed through a summarising and feedback process at the close of each interview and by focus groups with midwives that reviewed an interim draft of research findings. This enabled findings to be validated and further explored. They also provided important benefit for practitioners who engaged reflexively in the discussion and identified possible strategies to overcome challenges highlighted in the draft.

We took several steps to ensure findings were robust and trustworthy. These were testing findings with respondents, continually interacting with the data throughout the analysis, and checking the data carefully for disconfirming cases and other possible interpretations of data.

Findings on interface point one: common understanding of approach and language to assess wellbeing amongst professionals

Managers and health policymakers' views

At a strategic level managers and health policy makers indicated that the primary vehicle for increasing the efficacy of joint working was through initial training to implement the program. In HB2 this was augmented by developing a team of implementation champions and through phased roll out of the approach. This consisted of midwives trialling the approach with a few women on their caseload and reviewing this with their locality champion before full implementation. Managers were of the view that midwives should be familiar with strength or asset-based approaches through motivational interviewing (MI) techniques they had received training for previously in relation to smoking cessation and drug and alcohol reduction interventions (NHS Health Scotland 2010). These views were consistent across all health boards.

Professionals working alongside midwives views

Child protection advisors, whose role is to liaise between health and social work sectors in HB1, where the intervention had the longest track record, reported that the program step of increased time working together, for example, when social workers, health visitors, and midwives made joint visits to families, contributed to better work relationships and increased trust across different sectors of children's services. Developing planned pre-birth consultation processes with parents identified as at risk of poorer outcomes also improved communication and trust amongst professionals of different services. The strong emphasis on using a framework of common assessment language was also reported as being very helpful.

As GIRFEC is meant to be implemented by all health professionals, it was important to gain the views of obstetricians involved in maternity care. This proved possible in only one instance. The obstetrician interviewed in HB1 indicated that they would leave, "that side of things," to the midwives, citing

lack of time and caseload pressures as prohibiting capacity to develop a strength-based approach with patients. Although it is inadvisable to draw conclusions from one response, this attitude was consistent with concerns raised by midwives in the wider literature about doctors' lack of commitment to holistic care (Cheyne et al. 2013).

Midwives views

Midwives identified the following factors as contributing to important improvements to working with other sectors, particularly in child protection cases which required joint work with social work professionals:

- Joint training with other sectors
- Shadowing practitioners in other sectors, primarily social work
- Joint working to develop materials to implement the program

Midwives who had worked within specialised multi-professional teams compared the universal implementation of GIRFEC to their prior experience in specialised services. They expressed the view that universal implementation of GIRFEC could overcome drawbacks of specialist multi-professional teams. Joint working of specialist teams of a few practitioners in each sector was seen as a drawback to building up wider links between sectors as a whole, as it precluded the skill development for the workforce as a whole that those few involved in specialist teams for high-risk cases were developing.

The one area of interprofessional communication that raised concerns for midwives was in the area of training to implement strength-based approaches. There were important discrepancies between managers' perception of what training had entailed and midwives recall of their experience of training. When midwives were asked if they were familiar with strength-based approaches from training in Alcohol Brief Intervention (NHS Health Scotland 2010), midwives in all areas did not associate this training with supportive or strength-based approaches but recounted that this training focussed on accurately assessing units of alcohol intake-based on women's anecdotal recall of drinking activity. They emphasised that training was about technical assessment rather than communication skills. Many midwives seemed unfamiliar with the term strength-based approach itself. When a description of the approach was described, some midwives reported that they had had some training over 10 years ago in approaches like this in relation to blood-borne viruses. Training for routine inquiry into domestic violence was also seen as relevant. Several midwives felt more training and information about these crucial aspects of how to implement GIRFEC should be available. As one midwife in the HB1 reflected on her practice:

> HB1MW 6: I haven't had training to deal with some of these sensitive situations. I'm drawing on my experience as a mother, as a grandmother, as a human being. But we can be singing from a slightly different hymn sheet depending on life experience. We could do with more training in this area.

The discrepancy between managers' views on efficacy of training and midwives' recall of it suggests that prior programme implementation may not have reinforced training to the degree required, a concern that wider literature also raises (Olds et al. 2003; Fowler et al. 2012).

Findings on interface point 2: consistent respectful translation of assessment language into engagement with women accessing maternity care

Views of midwives implementing GIRFEC

Considering context

A crucial contextual aspect that differs across health boards is temporal. Scheduling pressures in urban settings limits the time midwives feel they can take with each woman they see, with some midwives stressing that more than 2 min taken to explore a concern in one appointment jeopardises the rest of the clinic's schedule. Whereas in rural settings, time pressures were not raised as urgently.

Variance in access to IT is another contextual factor that impinged on program steps. Development of the wellbeing assessment with parents and communicating with other professionals who may need to contribute support to the assessment were reported as being problematic on wards where several midwives on shift had access to only one laptop amongst them, in contrast to other community settings where each member of staff had their own dedicated computer.

Another key contextual factor the midwives highlighted was that of proximity to other services. Midwives co-located with other services highlighted the importance of this in developing interprofessional working and were more positive and confident about achieving better outcomes for families. In illustrating why this was so, midwives related narratives of informal discussions that build relationships and understanding that could be more effectively drawn up in crisis situations with families. Midwives in health boards that had recently been restructured away from community-based co-location of services towards more centralised single service provision raised concerns that this would diminish their capacity to

achieve many of the GIRFEC outcomes. These differences in context influenced how program steps were interpreted and enacted, and the degree to which they were attempted. Turning now to look at the communication between midwives and women, midwives described themselves as drawing upon strategies developed over a period of time through conferring with colleagues in order to address sensitive issues with women and gain their cooperation. Within these embedded practices there were differences in how midwives would broach topics, the degree of openness about assessment language they would use and the extent to which they would involve parents in planning, as is illustrated in the examination of quotes from midwives in the following.

Engagement strategies

Although positive about the benefits that GIRFEC policy could mean for families, midwives interviewed for the study expressed contrasting views about what this meant for how they engaged with families. The significance of the change in policy is encapsulated by how a HB2 midwife characterises common attitudes amongst midwives prior to the introduction of GIRFEC:

> HB2MW2: Because I think in the past a lot of the time you thought, if I don't ask, I'll not know about that problem, then we won't have to deal with it, or passing the buck to social work. Hopefully that'll stop.

Whilst these remarks indicate an awareness that families may be better served if concerns or problems are not presumed to be the responsibility of another service, the remark also indicates that broaching sensitive topics has been avoided in the past. Further analysis of views reveals a contrast in views about how to go about opening up such topics. In particular, midwives indicated different views about the extent to which they would be explicit with women about the new policy and the increased degree to which social factors that impact on wellbeing were being assessed. Some midwives saw this assessment as something which would be a positive opportunity to involve women:

> HB2M1: It's about involving women more in their wellbeing.

As a midwife in HB3 remarked, "partnership working means partnership working right from the start", an important component of that being honesty about information sharing. Other midwives indicated a reluctance to make assessment explicit. When asked if they used the GIRFEC indicators (safe, healthy, achieving, nurtured, active, respected, responsible and included) as a basis to talk about wellbeing, some midwives indicated that they would not explicitly do so:

> HB2MW5: I don't think we would necessarily have to say, "Right, now, we're looking for respected." No, I would just say "Have you got all your baby's equipment? Have you got the cot?" So that's respecting the baby as an individual that needs his own place to sleep. We wouldn't say, "are you responsible?" but we would know in our head that it is responsible.

Although the assessment framework was expressly developed to use more accessible language than previous policy discourse, this midwife conveys a sense that to use the language of the common assessment framework would, nevertheless, come across as judgemental or intrusive. Rather than the assessment being seen as something the midwife and woman could do in a positive joint process, there is a degree of surreptitiousness to the strategy this midwife indicates she would take.

Another midwife also indicated she downplays the assessment aspect within talking through wellbeing and care with women. As she described the approach she would take, she does indicate she would make it a shared activity:

> HB2 MW3: Basically what I say to mums is during their pregnancy jointly we'll look at what they're doing with their lifestyle to ensure they're as well as they can be during the pregnancy and also to make sure that during the pregnancy their baby is healthy and that afterward that they have the capability to be able to provide the best for their baby. It's finding a balance so mums actually understand what you'll be doing with them during their pregnancy.

As this midwife talked about her approach she used gestures to indicate she would sit beside the woman with the wellbeing assessment open in front of them so that they could decide together what will be written. This is an experienced midwife who has worked specifically with high-risk mothers over a number of years. There are a number of ways this prior experience may inform this relaxed, open approach. This midwife talks further about 'sounding out' women to find the language she is comfortable with and finding ways to make a bridge to the wellbeing assessment:

> HB2 MW3: We had to find a way to put it in mum's language so that she understood what these wellbeing indicators and assessments mean for her and her baby. I don't use the word assessment because that can put a barrier up right away. Once you've done that initial consultation, depending on their understanding of it, you break it down. There isn't one sentence that fits for all

of them; you need to be able to adapt to your individual mums.
Both of these midwives indicate they in a sense are scaffolding transitions into a process they assess women will be unfamiliar, and possibly uncomfortable with. Within adhering to the goals of the process they modify their use of the assessment language.

This approach contrasts to the experience of implementation that another midwife depicts when she describes writing an assessment-based plan prior to meeting with the patient rather than doing it with them:

> HB1MW6: I think part of the additional workload, too, in it is that this antenatal plan is something which they're going to read and they have to agree to, so it takes time to think about how you're going to word something that somebody's going to be happy with as well. I find this is one of my more stressful things to sit and write . . . because you're just thinking 'will they take umbrage to me writing this?' you know 'will this annoy them to see it in black and white, their strengths and their pressures?'

Rather than a shared open process, this midwife indicated the assessment is something she has to complete as a separate task done at a computer rather than with the woman in the appointment. This positions the patient very differently than the more open approach narrated in the preceding and shuts down the patient's decision-making and engagement potential. Crucially, it precludes a motivational interviewing process.

This same midwife (HB1MW6) reported that families were resistant to any assessment process and the introduction of any level of increased support or intervention. While some families may be more cautious about what they disclose once they are made aware that needs and risks are being assessed, midwives who described taking a more open approach reasoned that trust can be built that includes rather than skirts around difficult topics. Another midwife in HB1 describes the longer-term benefit that results from the open approach:

> HB1MW3: Once it is out in the open they can relax a little. Once they know support is there to help the child stay, they trust us a little bit more. We were worried there would be a backlash from parents, but most have been very good. It means we are more realistic with parents and in the end it's easier for parents because they aren't hit with a sudden crisis once the baby is born.

This midwife shared an example of an antenatal plan in which the mother had added her own comments. This proved to be a vehicle to express her concerns as part of an on-going working relationship with those providing support. The midwife went on to reflect that the process of developing an ante natal plan had allayed perhaps outdated views of child protection as overly interventionist that the woman had at the outset.

Another midwife's description of how she implemented the use of the plan emphasises the active role a woman can play within it:

> HB1MW11: The reason behind the plan is support; it's the carrot and not the stick. It's done sitting down and working through it with the woman. A mother can get so caught up in whatever is going on that doing the plan actually gives them the opportunity to sit down. And it does give them a chance to gain some insight. The penny drops or something and they can see this is not the best way to behave or whatever it is that is the problem. It helps them look at what support they can call on, whatever the issue, and it's not just pressures. It's helping them look at strengths. It's taking a balanced look. . . Every family is unique and you are trying to find out about that particular family, that particular woman.

These differing accounts of implementation indicate a wide range of approaches from ones which do not draw upon strength-based approaches at all, to others moving towards a more open working relationship, to ones that look to empower the woman as an important decision maker. In reference to the analytic question set out at the beginning of the article, this kind of variance is likely to lead to a wide variance in outcomes, some of them counterproductive.

Views of women receiving maternity services

In relating the views of women receiving maternity services, it is important to bear in mind the demographic spread of those interviewed as reported in Table 1. Overall women were positive about the care they received; however, differences in approach to their care were apparent in their responses. Women without increased risks expressed the view that more attention should be given to families other than those identified as at greatest risk, a view echoed by another recent study of parents' views:

> HB1W4: They need to spread it (attention) around, they should give their focus to every family rather than just focus on one and not another. And if there are concerns, they should take their time rather than just jump in before they know the full story.

The views of women who are at increased risk of poor health outcomes also emphasised that if child protection is being considered this should be a gradual rather than an abrupt

Table 1 Demographic information on women participating in study

Maternity care in:	HB1	HB2	HB3	Total
Women participating	6	5	4	15
Parity				
Primiparous (first child)	2	1	3	6
Multiparous (at least one previous child)	4	4		9
Age				
< 20	1	1	4	6
20–35	2	2		4
> 35	3	2		5

process and should begin by informing and consulting with parents about concerns.

Younger mums who were interviewed indicated a number of ways in which they hoped midwives would be more open with them and allow them greater participation and choice. All six teenage women who participated in the study were very clear that if there were concerns that meant social worker involvement might be sought, they would want to know about this earlier rather than later. As one commented:

> HB3W1: I would be really upset if I was sent to the social work. I'd want someone to explain to me.

Women in their teens reported that it would be helpful to have more information early on about the process as a whole and indicated it is helpful to have support to ask questions, as they may be afraid that their questions are silly or out of place. As one young woman remarked, who had a concern that she was afraid to bring up, (HB3W1), "I wouldn't want to tell them their job". This particular woman had problem solving and planning that she wanted to do but was not confident such an approach would be welcome by those providing care. Another woman receiving care for the birth of her second child also expressed a need for more support:

> HB3W2: I feel as if I've hardly seen anybody really and they've not really offered me the same things as the last time.
> Researcher: Right…
> HB3W2: Aye, you know how, like, the way, like, in your first time they'll explain, like, breastfeeding and all that, but they don't do that this time, so they must, like, assume... I remember from the last time, but, obviously, I can't remember from the last time (laugh). It was ages ago.

This woman's reflections suggest there is much less support provided for second time mothers and questions the assumptions this may be based upon. This same woman, in common with the other women under 20 expressed a reluctance to go to parenting classes. As she had experience of one of them, she identified what had made her uncomfortable about them:

> HB3W2: you sit there and you want to fall asleep it's that boring. . . .it's like you sit in a circle and then they get up one by one to make a bottle and stuff like that and it's rubbish. . . There's, like, a class, like, all of them watch you doing it, and when I first done it I didn't know how to do it and I was doing it wrong and it was embarrassing so I wouldn't go back to it.

Rather than building on existing strengths and experience, the format of this class for this young woman exposed her lack of confidence in a very public way. It draws attention to what can result when strength-based approaches are applied in a piecemeal way, perhaps only within specialist services, as was the practice in this health board, rather than consistently across the service as a whole. Whilst this is the experience of one woman within the study, it resonates with findings (Beake et al. 2010) in a study of maternity care in England that also reports that inconsistency of information contributed to women's negative perceptions of care.

Returning to the theme of openness or covertness of approach midwives took to broaching assessment of sensitive issues, five women interviewed in HB2 in contrast to the women interviewed in the other health boards reported that they were surprised at the thoroughness of the questions midwives asked. Those with previous experience of maternity services marked this as a change from previous practice. Women were quick to clarify that they did not find this intrusive and thought that inquiries were conducted in a sensitive and supportive manner. They saw clear benefits to this approach in some cases spurring them to think about factors impacting upon their pregnancy that they had not previously considered. Where there were concerns or problems that women were dealing with, they felt midwives had helped them to problem solve, given them appropriate information and helped them access other services.

As one woman related, she was aware of the assessment midwives are doing:

> HA2W1: I think their job is to observe. As nice as they are, I think from the minute you walk in they're observing you and that's part of their job because they maybe see something you don't see.
> I do think if they are friendly in nature and you talk to someone you will let things slip. They would pick up on something you've said in another conversation about something else and would maybe be able to bring it round to bring more of the situation out.

This description of practice suggests this woman understands that there can be a slightly covert aspect to assessment or that there is more to appointments than is made overtly apparent. This indicates that there is awareness of this culture of caution around sensitive issues, at least in some cases, on the part of both clients and clinicians.

Discussion

Main findings of the study

Implementation strategy variations

In stepping back to review what the views shared by all respondents tell us, it is important to look at the inter-relation of context mechanism outcome configurations (Pawson and Tilley 1997). The views of midwives and women in the preceding indicated that there are a wide range of interpretations of strength-based approaches within maternity care. Unlike the more technical aspects of practice, the skills that strength-based approaches entail: building rapport, encouraging motivation, mutual goal setting, are complex and nuanced tasks that cannot be prescriptively taught. Whilst the qualities (being caring, flexible, supportive) of a skilled practitioner are easy to list, translating these abstract nouns into embodied strategies and modes of practice is more difficult to capture or evaluate. It is this aspect of implementation around which there are the most tensions and ambiguity. This nuance makes it more difficult for managers to assess the impact of training. The midwives quoted have very different ways of talking through how they relate to women. They narrate very different interaction strategies that they employ with women. The degree to which midwives understood and used strength-based approaches varied and as a result the degree to which implementation included this approach, particularly with women at risk of poorer outcomes, also varied. These differences occur within as well as across health boards. It is also important to note there were similarities in approach by midwives in very different contexts.

A better predictor of mechanism variation was midwives exposure to previous program steps in other change programs. The factors that contributed to this variation are many. Those that the study was able to identify are midwives prior learning and experience. Midwives with training for and experience in delivering specialist services were better equipped to adapt to strength-based approaches. As Greenhalgh et al. (2009) point out, mechanisms are dependent on the transfer of sets of ideas. Across services, as a whole, training was not the enabler, it was assumed to be by managers and did not effectively transfer the required set of ideas that managers believed it had. Particular packages of training seemed more effective when followed by supervision and joint working cultures of specialist multi-agency working. Here, it is important to return to the findings of Miller and Rose (2009) that identify progressive individual feedback on performance, and personal follow-up coaching as important strategies to ensure training becomes embedded in practice. The development of GIRFEC Champions in HB2 potentially could involve employing these steps; however, at the time of research, the extent of the role of champions was still under revision. As with training itself, the use of champions is limited by time constraints. Further study examining in depth the role of champions and other embedment strategies would be worthwhile.

Health policy in Scotland is increasingly highlighting the centrality of strength-based approaches. This study along with others (Segaar et al. 2007) indicates that existing practitioners are at very different places and will require different approaches and levels of support to developing strength-based skills. Identifying this gap in capacity to take up strength-based approaches provides focus for further research in more detail on the role strength-based approaches can play in an overall program of patient-centred service integration.

Considering possible outcomes

Whether training and follow through to reinforce training can address the variance in skills that threaten GIRFEC implementation is uncertain. As one midwife observed much depends on initial attempts at change convincing midwives that the benefits are worth the investment and risk that change requires. In other words, the lessons midwives themselves identified from early implementation are a key factor motivating longer-term implementation. Privatisation of services and the fracturing and scaling back of services that this would entail are possible threats to program implementation.

What is already known

As stated in the introduction there is robust evidence of the efficacy of strength-based approaches within the controlled conditions of targeted programmes (Olds et al. 2003; Beam et al. 2010). There is also evidence that realist evaluation can provide important insights to the efficacy of complex health interventions or programmes of service change (Pawson and Tilley 1997; Greenhalgh et al. 2009).

What this study adds

Our study is an example of how small-scale research can both highlight the importance of nuances of embodied practice and compare these to the theory of change upon which the programme is premised. Bringing together different perspectives about how crucial junctures within an implementation strategy contribute to the emerging patterns resulting from the quality and sequencing of the components moves beyond the

reporting of micro-products without examining their relation to each other. As such, the study provides beneficial information for formative evaluation. The patterns identified also suggest the usefulness of extending this evaluation approach to include other services such as sexual health, addiction, and early year's services. This would extend insight into how different services for women and families at higher risk of poorer outcomes are developing common policy commitments such as GIRFEC. If the integration of services advocated across the global health landscape (WHO 2010) is to result in better working practices that yield important savings this kind of joined up evaluation requires attention.

Limits of study

Whilst this study draws on an impressive number of perspectives for a qualitative study, it is important to reflect on the limits of the study. In the preceding, we indicate emergent patterns but cannot make claims about the prevalence of these across the health sector as a whole, rather we have generated a robust enough hypothesis to test at a larger scale. We have highlighted the richness of detail participants conveyed about their implementation strategies that the research approach helped elicit. This does provide valuable insight into how these practitioners think through their implementation and in some cases how this transfers into an embodiment of practice. However, the time limits of the research prohibited deeper investigation of both affective and embodied aspects of implementation that longer engagement with participants could have afforded such as studies on empathy (Gair 2012). As such, the study occupies a medial space within the research field. As Westhues et al. have observed:

> Often complex studies don't attempt any kind of broad analytic integration. Instead, they produce a number of "microproducts" that, though united around a set of common themes, do not form a synthetic whole (Westhues et al. 2008).

Westhues et al. make this observation as argument for a large-scale participatory study that involved a survey component that gave them access to a quantitative perspective. Consequently their study design enabled data collection over a greater level of scale than the one here reported. In common with their research and Cheetham et al. (2017), we drew on iterative stages of interpretation that involved consulting with key stakeholders through focus group analysis, specifically meetings with midwives within HB2 and with the Scottish Midwifery Research Collaborative in a negotiated collective process of analysis that provided a range of perspectives, tested findings against experience and brought differing theoretical lenses to the analysis. Whilst Westhues et al. (2008) study was used to develop a new framework of action, our study was used to provide formative evaluation of implementation of a major national policy program at a key point in its development. It is also worth noting that it would have been helpful to engage a wider range of stakeholders, such as social workers and health visitors to gain their perspectives on inter-professional working with midwives. Another limitation is the exclusion of men from the study, a crucial group whose perspectives are important to consider. As screening for domestic violence protocols dictate that women be seen by themselves at appointments, using appointment surgeries as the recruitment point precluded the possibility of recruiting men to the study.

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Compliance with ethical standards Ethical approval for the study was granted by the School Research Ethics Committee, Department of Nursing and Midwifery, Stirling University. As the study was designated a service evaluation, it was waived from ethics approval by by the Southeast Scotland Research Ethics Service NHS and granted clinical quality approval by NHS Highlands, Lanarkshire and Glasgow Boards. The research governance procedures of the Department of Nursing and Midwifery and Research Ethics Committee, University of Stirling were followed. In particular, all potential research participants were provided with information about the study including a summary of interview questions. Participants were asked for written consent for the interview to be conducted and recorded and were given the option of discontinuing recording or the interview itself at any point should they wish to. Participants were informed they could withdraw from the study at any time and that any information they had contributed would be expunged from the study. The safety of interview spaces was co-assessed by researcher and GIRFEC lead in each health board.

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