# National Nursing
## RESEARCH UNIT

**Why Health Visiting? A review of the literature about key health visitor interventions, processes and outcomes for children and families.**
**(Department of Health Policy Research Programme, ref. 016 0058)**

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# Contents

 Appendix 1: Health Visitor / Parent Relationships: a qualitative analysis.......................................................see separate document

Appendix 2: Medline broad search

Appendix 3: UK Empirical Literature..............see separate document

Appendix 4: Literature Considered but Not Included for Review ...............................................................see separate document

Appendix 5: Multidisciplinary risk assessment in child protection....... ...............................................................see separate document

# Executive summary

## Background

This literature review was commissioned to support the *Health Visitor Implementation Plan* 2011-2015: *A Call to Action* (Department of Health 2011). That document sets out plans to increase the number of health visitors employed by around 50% (4200 additional health visitors by 2015), to mobilise the profession and to align delivery systems with new NHS architecture and local government children's services (including Sure Start Children's Centres). The *Implementation Plan* describes how the new health visiting service should include delivery of the existing Healthy Child Programme (HCP) and integrate with services for children, families, mental health and public health. Such a large undertaking brings in its wake a number of research questions, and we engaged with policy customers through the Policy Research Programme to create and refine the key questions for this review. In particular, despite a raft of reviews about early interventions, parenting support and home visiting, there has been limited research attention to the specific impact of health visiting practice, including whether or not it makes a difference in terms of outcomes for families to have services and programmes delivered by a health visitor or other staff member.

## Study Aims

The overarching question for the review was:

- **What are the key components of health visitor interventions and relationships between the current health visiting service, its processes and outcomes for children and families?**

The *Health Visitor Implementation Plan* sets out four levels of service delivery for health visitors, along with a description of how they contribute to the protection of children. Detailed review questions identified at the start of the process were summarised in a series of core questions aligned with each level, and presented with the key findings below.

## Methods

This scoping study incorporated a narrative review of the research about health visiting practice, to distil information from diverse forms of evidence. We chose three different approaches to searching the literature because of the broad and unwieldy nature of the task and the widely dispersed literature.

1. A broad general search of databases covering a range of subject areas like nursing, health, social science, and psychology revealed several thousand papers. Focusing on publications after 2004 - selecting this date as a cut off in view of the significance of *Every Child Matters* (HM Treasury 2003) and related policy in transforming children services - reduced this to 593 papers about health visiting. We read all the abstracts and identified 49 papers reporting empirical work from the UK and countries that have services similar to health visiting. These were read and reviewed in full.

2. A more structured search focused on 15 key topics of interest to health visitors derived from the HCP, such as breast-feeding, non-accidental injury and parenting support. More than 3000 papers were screened and 318 abstracts read, before finally including 218 empirical papers from Ireland and the UK, giving a total of 267 papers.

3. To ensure we captured arguments from some of the seminal work on health visiting published prior to 2004, the health visitors on our team each reviewed another list of 272 papers generated from our initial broad search results, (i.e., before concentrating on the post-2004 papers, as described above, under search 1), with additions from secondary references and curricular material from health visitor education programmes. They identified influential or seminal publications considered crucial to any serious examination of health visiting issues, which yielded a further 81 papers.

A total of 348 papers were included in the final review (49 from search 1 and 218 from search 2 as described above, plus 81 from search 3). We read all the 348 included papers in full and, whilst we formed judgements about the quality of the research, study quality *per se* was not an inclusion or exclusion criteria. Rather the amount and quality of the information about health visiting practice was our main reason for inclusion, which was often unrelated to the quality of the research. In some instances (for example) we excluded trials where the research was high quality, but the papers mentioned health visitors only as potential referral agents with no details about health visiting practice. Other included papers would not meet current research quality standards, but had useful and relevant detail about health visiting practice. Detailed tables of all included papers, and all those read but excluded, are collated into appendices, to serve as a

resource for future researchers. Each team member took the lead in reading and analysing key areas, working with at least one other team member to discuss and cross-check impressions, analyses and writing. Overarching impressions were discussed across the team at regular intervals before pulling together the final report (Cowley, Whittaker, Grigulis et al 2012), which was jointly authored by all team members.

## Key Findings

The findings are reported in five findings chapters (Chapters 3-7), which each correspond to the service descriptors in the *Health Visitor Implementation Plan.*

### Community

This service level is about building and using capacity to improve health outcomes and leading the HCP for a population. The core question is:

- **What is the health visiting orientation to practice, and how is this represented in service organisation?**

*Health visiting service organisation*

In exploring how health visitors help **build community strengths**, we found some evidence about how their services are organised and fit with the wider community provision, including traditional approaches and some documented changes. Improvements in uptake and access to services are reported from health visitors working with a traditional caseload, extending their remit through community/public health activities, as well as from those who prefer to focus on community development activities without retaining responsibility for traditional one-to-one/family work. This literature includes a number of small project descriptions, which report the ways in which health visitors can contribute to the wider services, and various suggestions for organising services to build community strengths.

Some studies explored the impact of **multi-agency work and team composition** and culture on service users, and we were able to identify some positive examples, but little evidence that the studies had engaged with wider research about organisational culture. Factors determining the fit of health visiting services with other community and children's services include the way in which the teams are organised and supported by the employing organisation, but we found little evidence about how service innovations and change affected client outcomes.

*The contribution of health visiting to children's health and well-being*

We identified health visitors' **'orientation to practice'** through a thematic analysis comparing older (mainly qualitative and descriptive evidence) and more recent research (including some more evaluative studies) about health visiting, which indicates considerable continuity in the basic values and skills for practice. This exercise gave us confidence that older literature is still relevant to current practice, although different organisational contexts need taking into account.

We identified that an improved fit between provision and uptake of the service may be achieved through a health visiting orientation to practice that guides delivery of health visiting across the whole service spectrum, which:

1. Is salutogenic (health-creating), which involves being proactive, identifying and building strengths and resources (personal and situational) and being solution-focused.

2. Demonstrates a positive regard for others (human valuing), through keeping the person in mind and shifting (the health visitors') focus to align with client needs, recognising the potential for unmet need, actively seeking out potential strengths, maintaining hope.

3.  Recognises the person-in-situation (human ecology), through assessing and acting as a continuing process, always taking account of the individual and their personal and situational circumstances, whether acting in the client's space, the community or the workplace.

In turn, these concepts and ways of working can - potentially - be instrumental in enhancing uptake and use by understanding more about a **'service journey'** followed by service users. The unsolicited, proactive and health promoting focus of health visiting means that services need, particularly in the early phases of pregnancy and having a new baby, to reach out to parents who have not initially requested a service. To get to know the parent, the health visitor needs to first gain access to family, by attuning, listening and observing the situation, which in turn allows the parent to get to know the health visitor. Ideally, then, a range of activities including assessing and intervening, ongoing availability, reciprocal exchange and collaborative interaction leads to a situation in which the parent understands and has confidence in the service, is able to express needs and accept referrals or initiate further contact as required.

We drew on some classic studies to unravel these processes, but much of the research was qualitative and descriptive, without a link to child and family outcomes. Also, we identified a

number of papers highlighting service approaches and practice that failed to achieve the ideals summarised here. On the other hand, a number of other papers included evaluative research showing positive outcomes achieved by using health visitors as intervention agents, without explaining the detailed processes involved. Throughout the report, we highlight places where elements of the service journey and health visitors' orientation to practice contribute to particular outcomes.

## Universal

The Universal service for all families involves working with midwives, building strong relationships in pregnancy and early weeks and planning future contacts with families, as well as leading the HCP for families with children under the age of 5. Here, the core question is:

- **What are the key components of health visiting practice and how are they reflected in implementing the 'new service vision' and HCP?**

*Components of health visiting practice*

The 'health visiting orientation to practice' (described above) appears to influence the way health visitors work in any situation, but is particularly evident in delivery of the Universal service, which then operates as a gateway to other levels of provision. Three core practices appear to operate together in delivering the Universal service:

1. the health visitor-client relationship,

2. health visitor home visiting and

3. health visitor needs assessment.

Research about these three components of practice describes similar skills and attributes, and cross-references the other two, indicating that they operate as a single process. **Health visitor-client relationships** are mentioned in much of the research as a mechanism or key way of working, which is considered especially important in enabling uptake by families who sometimes find services hard to access. We drew on some current research that integrated qualitative data from interviews with parents and health visitors with insights from the literature, as a prelude to developing an instrument to measure the health visitor-client relationship. The analysis identified different stages of relationship formation and working that could both potentially contribute to positive outcomes, and the planned instrument will enable such hypotheses to be tested in future.

The key processes involved in relationship-formation often proceed in tandem with **home visiting** and we found evidence in several trials to suggest that these approaches may help to promote more relaxed mothering and better use of services. We clarify approaches to **health visitor needs assessment** described in research, explaining that assessment appears to be a continuing process, rather than occurring as a single event; it is also intimately bound up with home visiting and the professional-client relationship. The main skills and knowledge required for making these assessments and professional judgements are identified in the research, and include highly developed interpersonal skills, empathy, application of knowledge and observation.

We identified two key approaches that support the integrated approach to health visiting work, each acknowledged in the HCP. The Family Partnership Model (FPM) (Davis & Day 2010) has proven effectiveness and beneficial outcomes, particularly when used with promotional interviewing techniques (Puura, Davis, Mantymaa et al. 2005a). The Solihull Approach offers benefits as well, having positive pilot study evaluations and a strong theoretical base that is helpful and compatible with health visiting, (Douglas & Brennan 2004; Bateson, Delaney et al 2008).

*Key aspects of Universal provision*

There is interest in improving the extent to which health visitors engage and **work with fathers**. We found various resources designed to enhance practice including a pilot questionnaire that aimed to improve communication with fathers in practice, but limited evidence about the effect of health visitors' work in this field.

Similarly, there is wide acknowledgement that health visitors have an important role in **supporting breastfeeding**, particularly its continuation; but in this field there is somewhat more research. Specifically training health visitors in breast-feeding support has been shown to be effective in improving breast feeding rates. Both technical knowledge and emotional support are required, and there is some suggestion that, when combined with knowledge of the 'person-in-situation' and non-judgemental approaches, these can be effective in enabling mothers who start (usually with support from midwives) to continue breastfeeding.

The research about preventing **unintentional injuries** is somewhat mixed, again drawing attention to the need for additional training for health visitors in this area and barriers to promoting

home safety. Evidence suggests health visitors tend to focus on a micro/individual level, rather than on the broader public health level, although the latter may be more effective in the long term. One trial of safety consultations or free safety equipment showed some changes in families' safety practices, but not to the recorded number of accidents. Peer educators seemed to be more acceptable and effective to mothers, and they were also welcomed by the health visitors who trained and supervised them.

Most health visitors appear to adopt a 'parent-centred' approach in informing and supporting decisions about **immunisations,** in order to achieve a balance between their public health role (to promote uptake and herd immunity) and that of providing (non-judgemental) support to parents. Again, the need for additional training was raised by the research, as were barriers to successful practice. As with breast feeding, health visitors were aware of a tension between an expectation that they would promote the 'approved line,' yet were anxious that this might undermine the trust and relationship upon which acceptance of health advice seems to depend.

## Universal Plus

Universal Plus services are offered to any family that may need them, including packages of care that the health visitor may provide, or arrange through delegation or referral, intervening early to prevent problems developing or worsening. The core question is:

- **What is the health visiting contribution to leading and delivering services where families need support or help with specific issues?**

*Commonly arising concerns needing Universal Plus provision*

We examined evidence about how health visitors deal with **post-natal depression (PND**), as a key mental health issue with known effects on infants as well as mothers. This was one of the most widely researched areas, although our review reflected the findings of an earlier review in suggesting that the evidence of effectiveness of health visitor interventions for post-natal depression was limited, with many studies having methodological or reporting limitations. More recent evidence shows achievement of positive health outcomes through training health visitors to identify depressive symptoms in mothers and provide psychologically oriented support through home visiting (Morrell, Slade, Warner et al 2009). This resulted in statistically significant improvements for women with all levels of risk as predicted at 6 weeks post-partum including, in a later analysis of data, improved prevention amongst women who initially appeared to be low-risk. The ability to reach all women and form a health visitor-client relationship, combined with the

additional sensitivity and knowledge gained from the PND-specific training, was the presumed reason for this universal prevention (Brugha, Morrell, Slade & Walters 2011).

There were surprisingly few studies about the health visiting role in **nutrition and obesity prevention**, particularly in the first year of life, despite parents reporting that they turn to health visitors more frequently than other professionals for advice on weaning. Studies focused on the need for a clear knowledge base and careful communication, particularly because of the strong cultural and family impact on weaning, and sensitivity about obesity, where health visitors may feel inhibited in raising issues of risk. This draws attention once more to the need for health visitor-client relationships along with awareness and use of an ecological approach and the non-judgemental orientation implicit in 'human valuing.'

We found more papers about **support for parents and parenting support**, but overall they offered limited insight into health visiting practice, being a collection of disparate studies that vary in methodology and quality with little conclusive evidence of service outcomes. There was some evidence that programmes helped parents of children with behavioural disorders, and there were promising outcomes from additionally-trained health visitors providing focused help for early identified sleep and behaviour difficulties. Additional training also helped when parents were able to access health visitors working within a specialist field and team (Attention Deficit Hyperactivity Disorder), which reduced childrens' problematic symptoms and improve maternal well-being (Sonuga-Barke et al 2001)  although that success was not carried forward when health visitors tried to implement the same approach whilst holding a generic caseload.

As well as specialist health visiting, we found evidence that health visitors enabled timely **access to other services**, through initial case-finding (for example, of pervasive developmental disorder, and young children with mental health needs), then referring them to appropriate services. Other literature documented the way health visitors enabled parents to access Sure Start Local Programmes and general or specialist parenting programmes.

*Specialisation, skillmix and health visitor team organisation*

We also identified that **skillmix** teams appear to have been widely implemented within health visitor services. Some project descriptions identified reduced stress where staff shortages had been relieved by the introduction of junior staff, including community nursery nurses or staff nurses who were then enabled to access health visitor education themselves, an approach that

minimised tension in the team. There were very few studies that identified the process of planned delegation to a junior team member because she or he had appropriate skills and could relieve the health visitors' time. Lines of accountability appeared clearest when they had been carefully considered ahead of time, but the most frequently reported approach to delegation involved pragmatically using team members interchangeably, which led to concerns about missed opportunities for health promotion and potentially reduced service quality. Indeed some papers challenged the idea that dilute skillmix reduced stress, because of the additional supervisory load and difficulty in maintaining quality of services. There was also concern about vulnerability, where local women were employed as support workers. One large survey of mothers found a preference for retaining a relationship with one health visitor rather than a team, even if advice was consistent across team (Russell 2008). However, reported studies focused mainly on implementation and change processes rather than child and family outcomes.

## Universal Partnership Plus

Universal Partnership Plus provides additional services for vulnerable families requiring ongoing additional support for a range of special needs arising from social disadvantage or disability. The core question is:

- **What is the health visiting contribution to provision for vulnerable families and groups, or those with complex needs, who need continuing support?**

*'Seldom-heard' populations*

We carried out a wide search for evidence about how health visitors work with **seldom heard** populations, identifying a small number of publications about insecurely housed and travelling communities, asylum seekers and refugees. These studies do not form a coherent whole but rather mirror the fragmented nature of the literature on health visiting noted throughout the study. Descriptive studies identified the complexity and skill required to work successfully with families, such as **asylum-seeking families** who have no recourse to public funds or rights to receive health, housing or social care. This leaves the health visitor as the sole provider of care to very vulnerable children and families who may 'go underground' at any time, to avoid identification by immigration officials.

We found very little research about health visitors' work with people with learning difficulties or with **insecurely housed families.** However, survey evidence gathered from hostel-dwelling families identified that they knew their health visitor and how to make contact, generally valuing

the provision and using it to avoid inappropriate use of emergency services. Whilst limited in amount, the evidence about health visitors' work with this very disadvantaged population underlined the level of knowledge and skill needed.

*Black and Minority ethnic groups and cultural competence*

Cultural sensitivity and awareness of the complex nature of their lives is a fundamental requirement for all families facing disadvantage or with complex needs, and we found research that emphasised the importance of such understanding, before families feel able to trust services. Most of the evidence about **cultural competence** was elicited from research concerning health visitors' work with **black and minority ethnic (BME) groups**. There was evidence that some health visitors felt ill-equipped to practice in a culturally-competent way. Also, one study about implementation of a Trust-wide policy espousing equity identified that the plans did not translate into practice, because of lack of clarity and education for staff. Other studies mirror the concerns of many health visitors (e.g. finding it difficult to manage limited resources in balancing attention to the baby with attention to the mother) and policymakers (e.g. developing cost-effective culturally sensitive systems of support), but found that BME mothers were particularly affected.

*Domestic violence*

The literature on **domestic violence** provides examples of how health visitors can enable families to express their needs, in particular, in relation to disclosure and the subsequent referral of families to appropriate services (Baccus, Bewley & Mezey 2003). Reasons for underreporting include women being fearful of losing their children or feeling that they have nothing to gain from their disclosure, often linked to a lack of trust for health visitors or others. Evidence of enhanced disclosure came from one area that included routine questions about domestic violence, with other studies emphasising the importance of privacy and trust gained through home visiting and established relationships (Peckover 2003a, Hester & Westmarland 2005).

*Evidence-based home visiting programmes*

The HCP and *Implementation Plan* both emphasise the importance of **evidence-based home-visiting programmes** for vulnerable families. The Family Nurse Partnership programme is implemented separately but alongside the health visiting service for first-time teenage mothers, so lay somewhat outside our remit. However, other home visiting programmes were identified, which provide evidence that health visitors are able to implement such programmes with fidelity. The type and quality of the studies varied, with two external evaluations, one non-randomised

longitudinal comparison study, one cluster randomised trial and two RCTs (Emond, Pollock, Deave et al 2002, Austerberry, Wiggins, Turner & Oakley 2004, Puura, Davis, Cox et al 2005, Shute and Judge 2005, Barlow, Davies et al 2007a, Kemp, Harris, McMahon et al 2011). Each of the programmes achieved some significant benefits in key areas, along with other beneficial changes that were not statistically significant or identified only in qualitative work. These include mothers having a more relaxed experience of parenting, being able to use health services appropriately (with reduced use of emergency or GP care), more sensitive mother-child interactions and improvements to the home environment.

## Child Protection

The contribution to child protection is about ensuring that appropriate health visiting services form part of the high intensity multi agency services for families where there are safeguarding and child protection concerns. The core question is:

- **What is the role and contribution of health visitors to child protection and safeguarding?**

Most of the preventive work carried out by health visitors includes an element of **safeguarding,** which is a broad concept encompassing emotional and physical safety as well as protection from harm. Their key role in terms of **child protection** lies in identifying (or 'case-finding') children who are, or who are at risk of, experiencing significant harm and initiating formal safeguarding procedures by involving colleagues from social care or the criminal justice system, as necessary. Once other services are engaged, health visitors maintain contact and a relationship with the children and family, to continue their preventive health role.

*Health visitors' role and risk assessment*

We reviewed a number of papers about how **health visitors assess risk** in families, including identification of high risk and low protective situations. Research aimed at identifying future significant harm to children has shown it cannot reliably be predicted in advance, and attempts at identifying suitable screening instruments have failed to achieve the required levels of specificity or sensitivity. Longitudinal research showed that health visitor screening for risk factors in a single post-natal assessment did not help to accurately identify those families who would go on to maltreat a child (Browne, 1995b; Dixon, Browne, Hamilton-Giachritsis et al 2009), so repeated contacts, preferably through home visiting as part of the Universal service, is required. This is

particularly because Serious Case Reviews identify that very young children are most vulnerable to significant maltreatment, including death.

Studies about health visitors' professional judgements showed that they tend to **prioritise families** on their caseload according to key risk factors, but also took into account family strengths and context. This is a dynamic and multi-factorial process, which requires repeated reassessments and awareness of the whole context ('person-in-situation') taking into account information and knowledge of individual families, factual knowledge of child health, as well as about theories of child development, attachment and family functioning (Appleton and Cowley 2008a,b). Some studies identified that Trusts have often implemented some form of **structured assessment** protocols or guidance in an attempt to standardise this process, but by and large these are unhelpful, in that they do not improve identification of risk, but inhibit relationship-formation and trust, thereby reducing access by the families who need services the most.

*Health visitors' role in child protection*

Much of the evidence about health visitors' work to **modify risks** to children and families comes from the home visiting programmes detailed under the 'Universal Partnership Plus' service level, supporting maternal sensitivity and engagement with services. There is also evidence about universal education programmes that highlight the risk to infants of brain damage from shaking and head injury, although this was cited in a narrative review of ways that health visitors could help, and no outcomes are reported (Coles and Collins 2007).

Reports about health visitors' work where there is a **child protection plan** tend to emphasise the amount of time taken, proportionate to that for the rest of the families, with some qualitative work noting that the interface between health visitors and social workers changes according to thresholds operated to manage workloads. This may lead to health visitors being the sole worker involved with high-risk families, which is reported to be the cause of high levels of anxiety and concern, about both the child at risk (who is not in receipt of appropriate social care) and of other families for whom the health visitor is responsible, who receive a correspondingly lower share of time. Continuing to provide a non-stigmatising universal service in cases where families are involved with multi agency child protection plans requires both a supportive relationship and a surveillance component, which can be a difficult professional and ethical balancing act, requiring a high level of knowledge and skill.

## Conclusions

This large scoping review incorporated a narrative study about the key components of health visitor interventions, within the context of the *Health Visitor Implementation Plan*, and relationships between the current health visiting service, its processes and outcomes for children and families. The **broad and unwieldy** nature of the task and the literature meant that we needed to sacrifice depth in some areas, and whilst we incorporated three different and complementary search strategies to maximise coverage, we cannot be sure that we have identified all potentially relevant research. We took the decision to exclude grey literature, non-empirical papers and overseas studies for pragmatic (time and relevance) reasons, but recognise the **limitations** this places on our findings. The health visiting literature that we identified is widely dispersed and does not form a coherent body of research, although there are some examples of papers that are well integrated to other research programmes, such as those about post-natal depression, parenting support and early interventions/home visiting. Across the board, papers with the strongest methodological base often told us least about health visiting practice, whilst many in-depth expositions about how health visitors work reported no outcomes.

In general, the research is characterised by small-scale, single studies, (i.e., one-off, not part of a programme of research), often under-theorised or forming part of masters or doctoral work that is not then followed up to create a convincing body of work. We identified a surprising **paucity of research** in key areas of interest for health visitors, notably within early nutrition and obesity prevention, speech and language development, engaging 'seldom heard' populations, child protection/complex needs (except in terms of needs assessment and prioritisation) and skillmix, teamwork or other organisational arrangements. Studies that we found tend to lack integration with wider bodies of research in the field, so there is no opportunity to benefit from that expertise. Having said all that, there is a consistency in the findings of studies, whether large or small, across some important key areas:

- There is evidence of **beneficial outcomes** from health visiting practice, albeit in specific areas such as prevention, identification and treatment of post-natal depression and parenting support by specialist health visitors or through structured home visiting visiting/early intervention programmes. There is a need to be realistic about the extent of change that should be expected from health visiting interventions for families living in complex situations, but equally there is a need to acknowledge that apparently small changes (such as more relaxed mothering, improved mother-child interactions or early identification of post-natal depression) can translate into large benefits, either later in an

infant's life, or through improved parental confidence in services, leading to their better use.

- There is a consistency across thirty years of research, including classic studies and more recent topic-specific evaluations, about approaches to health visiting practice that have been valued across the board. These include aspects of the **health visiting 'orientation to practice,'** described as salutogenic (health-creating), involving a sense of 'human valuing' (accepting people on their own terms and in their culture) and working with people within their own situation or context (human ecology). These find expression through a **triad of core practices**, being home visiting, health visitor-client relationship and needs assessments, which all operate together as a single process. We argue that this unique combination, with its focus on health rather than illness, sets health visiting apart from other workers in health and social care, making them the most appropriate workers to deliver the Healthy Child Programme. When applied in practice as intended, these apparently separate components combine to enhance and clarify the **'service journey'** for parents/families, enabling them to access and use health visiting services and, through them, be better placed to reach other services. This is of particular importance for families who may otherwise find services hard to reach or access.

- We also identified **contradictions** in the literature, where competing expectations on health visitors can create tensions that appear under-acknowledged. Examples include **organisational arrangements** (whether from dilute skillmix or lack of time in the working day) that inhibit the flexible working identified as central to enabling more vulnerable families from entering the 'service journey' and accessing provision, or prevent operation of the unified relationship-assessment-visit processes that enable the human valuing and respect. All these components have been identified as essential across areas where sensitive practice is needed, such as for excluded populations, disclosure of domestic violence, prevention of obesity and more. **Public health imperatives,** likewise, may create tensions, where health visitors are required to promote behaviours (like breast feeding or immunisations) that may be essential in their own right, yet which require time, skill and sensitivity when working with parents who may hold views that run counter to the recommendations. Whilst coping with (for health visitors) or facing (for parents) these **ethical and practical ambiguities** has been the subject of some of the earlier health visiting literature and is of wider research interest, we did not find any recent studies or intelligence to inform progress or even debate in this field.

- A key theme running through almost every area of research that we studied, is the need for health visitors to be better prepared in terms of specific **education and training**. This may be partly an artefact due to the need for those delivering interventions for trials to be

well prepared in order to maximise outcomes (so they are giving trial-specific preparation), but the need for more information, better developed skills and greater knowledge and information was expressed in studies that engaged health visitors and service users as participants. The ubiquity of this theme suggests there is a particular need for **improved initial preparation** of health visitors and, particularly, for **more continuing professional development** opportunities.

In conclusion, analysing and collating the literature for the report was a complex process, partly because of the extent to which each topic (identified from the HCP) and service level (identified in the *Implementation Plan*) crossed boundaries and was interconnected across other areas of research. We reviewed the literature about the way health visiting services are (or should be) set up as part of the Community, so they can then be delivered effectively through the Universal provision. Evidence from those two levels formed an essential basis for all the subsequent literature, which consistently referred back to the importance of the Universal service and key ways of working identified (and described above) as a basis for the specific areas of practice and, most importantly, for those parents and population groups with continuing and complex vulnerabilities and needs. Sub-divisions and separate descriptors are helpful for specifying elements of the service and topics of interest, but there is evidence of multiple interconnections across different levels, priorities and approaches to practice. This suggests that approaches to health visiting practice embedded within **the Universal level form an essential cornerstone of the entire service.**

## Recommendations arising from the review

Recommendations arising from the whole review are ordered according to who is best placed to implement them – four are identified that need additional input from policy to enable them to happen, so they are included again under that heading.

### Recommendations for research and researchers

- Researchers in this field should ensure the term 'health visitor' is used in the title, abstract or key words of publications, to enable more effective searches in future
- Greater collaboration is needed to embed research about health visiting within wider bodies of research to strengthen it academically and enable researchers from other fields to understand better the contribution and context in which health visiting takes place.

- Research should be carried out urgently to evaluate the safety, quality and acceptability to service users of different skillmix and team working (e.g. corporate teams) arrangements in practice.

- The academic infrastructure for health visiting needs specific support and action to enable it to develop from its current very low base.

## Recommendation for service

- Evidence about the multiple interconnections across different levels, priorities and approaches to practice indicates that the health visiting service should be planned and organised as a single, holistic form of provision, centred around the Universal service.

- Organisational arrangements need to take account of the interlinked nature of the 'triad of core practices,' so that health visitors charged with needs assessment have the opportunity to form relationships and undertake home visits.

- Evidence based approaches (including the associated education and training) for post-natal depression, parenting support and early intervention/home visiting for disadvantaged families should be implemented as part of the Universal Plus and Universal Partnership Plus levels of service delivery, including the Healthy Child Programme.

- Commissioners should write service targets (Key Performance Indicators) and commission services in a way that acknowledges the need for health visiting flexibility in meeting parents' perceived needs.

## Recommendations for education

- Recruitment and preparation of student health visitors, and continuing professional development, should take account of the values, skills and attitudes embedded in the health visiting 'orientation to practice,' and to develop the capabilities required for the triad of core practices.

- Educationalists should enable health visitors to recognise and work with ethical and practical tensions in practice, arising from contradictory expectations.

- Consideration should be given to the changes needed to current health visitor education, to enable all the necessary content to be encompassed within initial qualifying programmes.

- A planned period of continuing professional development should be introduced, following initial qualification as a health visitor.

## Recommendations for policy

- Consideration should be given to how best to formalise use of the titles 'health visitor' and 'health visiting' to avoid confusion in future.

- The academic infrastructure for health visiting needs specific support and action to enable it to develop from its current very low base.

- Evidence about the multiple interconnections across different levels, priorities and approaches to practice indicates that the health visiting service should be planned and organised as a single, holistic form of provision, centred around the Universal service.

- Consideration should be given to the changes needed to current health visitor education, to enable all the necessary content to be encompassed within initial qualifying programmes.

- A planned period of continuing professional development should be introduced, following initial qualification as a health visitor.

# Glossary of terms

| | |
|---|---|
| ADHD | Attention Deficit Hyperactivity Disorder |
| ASSIA | Applied Social Sciences Index and Abstract |
| | An indexing and abstracting tool covering the fields of health, social services, psychology, sociology, economics, politics, race relations and education |
| BSc | Bachelor of Science |
| CAF | Common Assessment Framework |
| | A shared assessment tool for use across all children's services and all local areas in England |
| CINAHL | Cumulative Index to Nursing and Allied Health Literature |
| | A nursing and allied health research database |
| CPHVA | Community Practitioners' and Health Visitors' Association |
| | A professional organisation for health visitors, school nurses, nursery nurses and other community nurses working in primary care |
| DCSF | Department for Children, Schools and Families |
| | A department of the UK government (between 2007 and 2010) responsible for issues affecting people in England up to the age of 19, including child protection and education. Replaced by the Department for Education in 2010 |
| DfES | Department for Education and Skills |
| | A UK government department (2001 and 2007) responsible for the education system and children's services in England |
| DH | Department of Health |
| ECM | Every Child Matters |
| | A set of policy initiatives and development programmes, launched in 2003, for children's services in the UK |
| EMPOWER | Empowering Parents to Prevent Obesity at Weaning |
| | A programme designed to prevent obesity at weaning |
| EPDS | Edinburgh Postnatal Depression Scale |
| | A self-report instrument that screens for depression |
| EPPI | Evidence for Policy and Practice Information and Co-ordinating Centre |
| | Part of the Social Science Research Unit at the Institute of Education, University of London |
| ESRC | Economic and Social Research Council |
| FNP | Family Nurse Partnership |
| | Intensive home visiting programme for first-time teenage parents developed in USA, where it is known as Nurse Family Partnership. Implemented in England since 2007 |
| FPM | Family Partnership Model |
| | Formerly known as the 'Parent Advisor Approach,' FPM is an explicit model of the helping process that takes into account of relationships between supervisor-trainer, parent-helper and parent-child. |

| | |
|---|---|
| GP | General Practitioner |
| HCP | Healthy Child Programme<br>Department of Health/Department for Education programme which focuses on a progressive universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. |
| HSW | Health Support Worker |
| HV | Health Visitor |
| IYP | Incredible Years Programme<br>A home-based parenting programme |
| MECSH | Maternal and Early Childhood Sustained Home Visiting programme<br>Australian programme of home and community based support delivered by (their equivalent to) health visitors, which is beginning to be used in England. |
| MeSH | Medical Subject Headings<br>Controlled vocabulary for the purpose of indexing journal articles and books in the life sciences |
| MMR | Measles, Mumps and Rubella combined vaccination |
| NHS | National Health Service |
| NICE | National Institute for Health and Clinical Excellence<br>Develops evidence-based guidelines on the most effective ways to diagnose, treat and prevent disease and ill health |
| NMC | Nursing and Midwifery Council<br>The nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland and the Islands |
| PCT | Primary Care Trust |
| PoNDER | The PoNDER trial<br>Post-Natal Depression Economic Evaluation and Randomised controlled trial |
| PT | Practice Teacher<br>Supports and supervises trainee health visitors. |
| RCT | Randomised Control Trial |
| RtP | Return to Practice |
| SCPHN | Specialist Community Public Health Nursing<br>Part of the NMC register that contains health visiting as one area of practice |
| SIDS | Sudden Infant Death Syndrome |
| TAC | Team around the Child<br>A range of different professionals, including health visitors and social workers, who work together to develop care plans for children with additional needs |
| WHO | World Health Organisation |

# Chapter 1: Introduction

## Background to study

Over the last two decades, there has been an exponential increase in scientific understanding about early child development. This new knowledge includes neurophysiology, the interplay of genetic inheritance and environment (Center on the Developing Child at Harvard University, 2010; Shonkoff & Phillips, 2000), and evidence confirming the crucial influence that pregnancy and the early years have on the child's future life course and health inequalities (Irwin, Siddiqi, & Hertzman, 2007; Marmot et al., 2010). In turn, this has laid the foundation for a parallel increase in understanding about which health promotion and preventive activities are most likely to help, and where the strongest evidence lies (Center on the Developing Child at Harvard University, 2007a, 2007b).

These developments have excited much interest in British policy, leading to initiatives such as Sure Start (Belsky, Melhuish, Barnes, Leyland, & Romaniuk, 2006), Starting Well in Scotland (Killoran Ross, de Caestecker, Sinclair, & Lakey, 2005) and the Family Nurse Partnership programme in England (Olds, 2006), which were all policy initiatives designed to bring best evidence into practice. The Healthy Child Programme (HCP) (Department of Health and Department for Children Schools and Families, 2009a), offered to all pregnant women, their pre-school children and families, was developed and expanded by drawing on a large review of reviews of the most effective approaches (Barlow, Schrader MacMillan, Kirkpatrick et al., 2008). A number of policy reviews and reports have continued to highlight the importance of the early years (Allen, 2011; Field, 2010; Tickell, 2011). Overall, there was a large expansion in funds devoted to children's services in the first decade of this century, although the total spend on health visiting services declined (Audit Commission, 2010), see Table 1.1.

There has been no corresponding rise in research about the way that health visitors carry out their work. Elkan, Kendrick, Hewitt et al (2000) carried out a large systematic review of 'domiciliary health visiting,' which drew evidence mainly from home visiting programmes carried out in the USA, where service provision differs greatly from the UK. Their study included a selective review of British literature, drawing together a large amount of material from higher degree theses about the process and outcome of home visiting, but they did not consider other aspects or elements of health visiting. Elkan et al recommended an increase in research

focusing on process as well as outcomes, along with studies comparing home visiting programmes delivered by either health visitors or non-professionals; neither of these have been carried out. Their work was included in a more recent review of reviews of ante-natal and post-natal home visiting programmes (Bull, McCormick, Swann and Mulvihill 2004), but once more the authors focused largely on studies carried out overseas, with no additional focus upon health visiting practice.  The review of reviews carried out by Barlow, Schrader MacMillan, Kirkpatrick et al (2008) to inform the revised Healthy Child Programme (HCP) (Department of Health and Department for Children Schools and Families, 2009a), identified which health-led parenting interventions in pregnancy and the early years would be most suitable and effective. Drawing on this evidence, the HCP emphasises the importance of having staff with appropriate skills to deliver the recommended approaches and interventions, so health visitors are expected to lead delivery of the HCP. However, none of these reviews have considered evidence to show specifically what difference health visitors make, or addressed the issue of linking different forms of professional practice to outcomes.

**Table 1.1: Children's Services - Revenue costs 1999-2011**

Source:  Audit Commission (2010) Giving Children a Healthy Start

| Funding | 1999/2000 – 2001/02 £millions (actual) | 2002/03 – 2004/05 £millions (actual) | 2005/06 – 2007/08 £millions (actual) | 2008/09 – 2010/11 £millions (estimated) |
|---|---|---|---|---|
| Sure Start Local Programmes | 141 | 840 | 1074 | 838 |
| Children's Centres | 0 | 13 | 656 | 2205 |
| Health visitors | 965 | 965 | 900 | 840 |
| Totals | 1106 | 1818 | 2630 | 3883 |

An expansion in NHS nursing and midwifery staff under the Labour government (1997-2010) was not matched by a growth in the number of health visitors, either (NHS Information Centre for Health and Social Care, 2011), and when the new Coalition government came to power in May 2010, they made a firm policy commitment to increase the number of health visitors by 4200, by 2015, see Figure 1. Such a large increase in staff is a considerable undertaking, and the '*Health Visitor Implementation Plan* 2011-2015: a Call to Action' (Department of Health, 2011) was developed over the following year, to recruit health visitors and ensure effective service delivery with three key workstreams:

1. Growing the workforce
2. Professional mobilisation
3. Aligning delivery systems

**Figure 1:  Actual changes in Nursing, Midwifery and Health Visitor workforce 2000-2010 with changes in live birth rate, and anticipated growth in health visitor workforce to 2015**

Source (with thanks) Dave Munday Unite/CPHVA
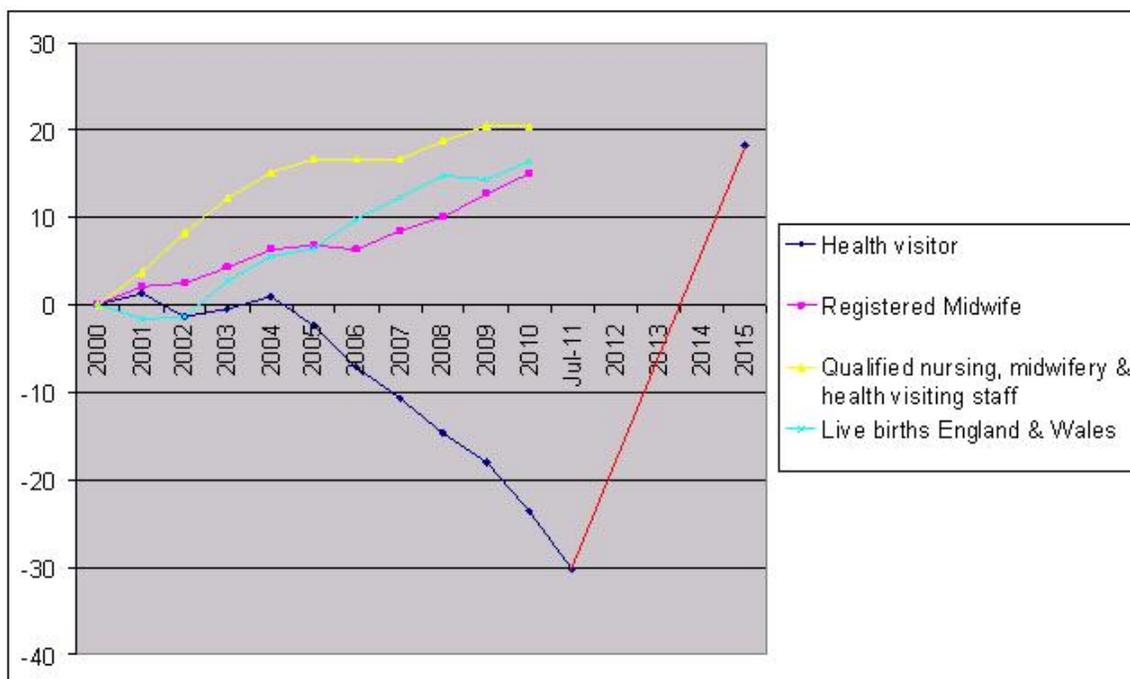


Along with the *Implementation Plan*, the Department of Health published a 'new service vision' (Department of Health, 2010a), setting out expectations of how the service will look, once all the additional staff are in place, and describing the different levels of service to be offered to families, known as the 'family offer'. The new service vision provides a useful framework through which to report this research study, which was commissioned to support the *'Health Visitor Implementation*

*Plan: a Call to Action,'* by carrying out a scoping study and narrative review of the literature about health visiting practice. Many possible research questions arose in the development of the implementation plan and new service vision (Department of Health, 2010a, 2011), and in the evolution of this project, which are detailed below. Most of this review underpins the 'professional mobilisation' work stream within the *Implementation Plan*, specifically the wish (Department of Health, 2010a) to promote learning, development and spreading of good practice and to support high quality professional practice, including the model of practice for effective health visiting and clinical supervision.

## Health Visiting

Health visiting is a 'contested' profession and field of practice, which is to say that, whilst there is broad agreement about the phenomenon, there are continuing debates about its nature, form and purpose, and which terminology is most appropriate in describing it. Internationally, and even across the four countries of the UK there are different government policies about child and family health and wellbeing, and competing opinions about how services are best organised and delivered, including which sector or discipline should be responsible for the provision. This has implications for the transferability of approaches and literature from other countries in this review, which examines the evidence base regarding delivery of care by health visitors and its relationship to outcomes for families.

This project was commissioned following the decision to increase the number of health visitors by some 50%, reversing an earlier fall in the size of the workforce (see Figure 1). This policy is in line with an increasing consensus that child protection, development and welfare should be seen as a public health concern, and therefore be part of the health sector (Gilbert, Kemp, Thoburn et al., 2009; Irwin, Siddiqi & Hertzman 2007), with health visitors seen as being in a position to deliver effective service provision because of their non-stigmatising approach (Conservative Research Department, 2009; Family and Parenting Institute (FPI), 2007). They have the benefit of working across the health and social care divide, making prevention and intervention relevant to individual families within their immediate family environment, their community or neighbourhood and their wider social world (Department of Health and Department for Children Schools and Families, 2009a). However, there has been a large expansion in the children's workforce as children's services have developed (see Table 1.1), with increasing provision across the sector, influencing and potentially enhancing the health of children. This draws attention to the need to understand how the delivery and organisation of health visiting services affects uptake of the different components of the Healthy Child Programme and family offer in the 'new service

vision', and how the revised provision fits and adds value to children's services and primary care in general.

Long-standing debates about the relative importance of a universal or targeted approach for preventing child abuse or reducing health inequalities (Barlow & Stewart-Brown, 2003; Graham & Kelly, 2004; Marmot, Allen, Goldblatt et al., 2010) have been reflected in changing priorities for the heath visiting service over time (Elkan, Robinson, Williams, & Blair, 2001; Greenway, Dieppe, Entwistle, & Meulen, 2008; Peckover, 2011). This has led to a very different shape of provision in each of the four UK countries following devolution (Hoskins, 2009), and the opportunity to recruit and employ more than 4,000 new health visitors applies only to England. It is important for Government and policy makers to understand how to best utilise and deploy these new (or returning) workers to maximise value to the nation, and to child and public health in particular.

There is a continuing dialogue about the nature and position of health visiting as a form of practice, a service or a profession. It is not the purpose of this study to unravel these tangled debates, many of which have recurred throughout the 150-year history of health visiting, but they provide a background to this research. Health visiting began in the Victorian philanthropic public health movement, gradually moving from the voluntary sector into local government by the end of the nineteenth century and becoming established as a state-sponsored profession and service following the Notification of Births Acts of 1907 and 1915. Through the twentieth century health visiting became increasingly entwined with nursing and midwifery, although it was regulated as a distinct profession until 2004.

This history has led to a situation in which the term 'health visitor' means different things to different people. For some, it is a professional title, describing a person who holds the qualification regardless of which job they are doing. For others, it is a job title, referring to the caseload work with mothers, fathers and their infants and pre-school children described in the 'new service vision' (Department of Health, 2010a). In the second formulation, papers describing work carried out by a qualified health visitor may be hard to identify if, for example, they are described as 'therapists' (e.g. Sonuga-Barke, Thompson, Abikoff, Klein, & Brotman, 2006) or 'nurses' (Taylor, Lauder, Moy, & Corlett, 2009) carrying out work that is not part of the core caseload work of a health visitor. Alternatively, reflecting the first view described above, the term 'health visiting' has traditionally been used to describe the practice of health visitors, much as nurses do 'nursing' or teachers do 'teaching' (Cowley, 1995b). It may also be used as an adjective, for instance to describe services led by a health visitor and, by extension, activities

carried out by anyone in that team or working with them, much as health care assistants may be described as doing 'nursing' or 'physiotherapy' according to who supervises them (Cowley, 2002).

This blurring of roles and terminology means there is need for information about specific health visiting skills, to show where alternatives will not suffice. This study is concerned with reviewing the evidence on health visitors' practice in the current service and what makes this work effective, so we endeavour to make clear where we refer to health visitors or other colleagues in members of the health visiting team. We use the terms 'health visiting workforce' or 'health visiting services' inclusively, as in the NHS Operating Framework for England (Department of Health, 2010b, page 25) which describes public health services for children under five as 'health visiting services, including the leadership and delivery of the Healthy Child Programme for under 5's (working closely with NHS services such as maternity services and with children's social care); health promotion and prevention interventions by the multi-professional team and the Family Nurse Partnership'.

## Current policy for health visiting

This review is not primarily about seeking general evidence of effectiveness to improve child health, since that is well covered in the Government's Healthy Child Programme (HCP). The HCP is set out in three main documents, of which two (Department of Health and Department for Children Schools and Families, 2009a,b) refer to pre-school children and name health visitors as the lead professionals in implementing the policy. The HCP is based on evidence drawn from a range of sources, including that from Hall & Elliman (2006), Barlow et al (2008), various forms of NICE guidance and advice from a team of experts who meet regularly to ensure the content remains up to date and relevant. The HCP is intended to provide guidance to everyone who works with children in the health and children's sector, so (as identified above) it includes some information about the skills and knowledge required to implement it. It is not specifically intended to inform organisational procedures or deployment of staff, but the health visiting role was stressed to counter wide variations in the way the former 'child health promotion programme' was commissioned and implemented (Lowe, 2007). The HCP policy remains in place following the change of government in 2010, and is an integral part of the new service vision set out as part of the *Health Visitor Implementation Plan* (Department of Health, 2011).

The 'new service vision' (Department of Health, 2010a) was published in the run-up to the publication of the *Health Visitor Implementation Plan*. It was used to inform the final model

described in the *Implementation Plan*, as shown in Figures 2 and 3, and the language varies slightly between the two documents. The service vision was developed through a series of discussion workshops with health visitors, so it has wide currency with practitioners and gives a great deal of detail about practice, but did not explicitly include research evidence. The new service vision document is aspirational, describing the intention for services once a full complement of health visitors has been restored and health visitor education re-energised. Likewise, the review team recognise that the practice literature may not reflect current practice or service organisation, but the evidence was examined for insights into how the health visiting could and should be delivered in line with the *Implementation Plan*, in order to contribute to improved outcomes for children and families.

**Figure 1.2:  Model of service provision from Health Visitor Implementation Plan**



**Figure 1.3:  The New Service Vision**
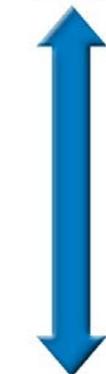
The new service is to include five levels of provision, which are each linked to a series of questions, which are listed below. The results of the review are reported in a separate chapter for each level, following the methodology chapter.

**1. Interactions at a community level:** building capacity and using that capacity to improve health outcomes and leading the HCP for a population.

This level of provision raises questions about how the health visiting service fits with the wider community public health service and in understanding the principles that guide health visiting through the whole service spectrum. We need to discover what is known about how health visitors practice in the current service, including forms of team organisation and skillmix issues and what skillmix models are required to deliver outcomes in priority areas. We are interested to find out how different forms of health visiting service delivery and organisation affect uptake of the different components of the HCP and 'new service vision.' Key questions are:

- How does the health visiting service fit with the wider community public health service?
- What are the principles that guide health visiting through the whole service spectrum?
- What is the evidence about different workforce models in health visiting, and how do they influence effectiveness and service delivery?
- How do different forms of health visiting service delivery and organisation affect uptake of the different components of the 'new service vision,' particularly by users who find services hard to reach?

**2. Universal services for all families:** working with midwives, building strong relationships in pregnancy and early weeks and planning future contacts with families. Leading the HCP for families with children under the age of 5.

There are questions about how health visitors practice in the current service, and about what makes the work effective, particularly in terms of how and in what ways it benefits families in terms of outcomes. The nature of the health visitor-client relationship needs to be clarified, along with evidence for any therapeutic aspects of this or other aspects of the work of health visitors. Identifying the different elements of the health visitor-client relationship to examine the nature and extent of the evidence base about the impact of these on child and family life. Also, the universal service is intended to enable health visitors to identify families with high risk and low protective factors, through their approaches to needs assessment. A review of the evidence is needed to establish the different ways of considering practice, which suggest that the universal service may

operate as a form of prevention in its own right (the 'health visiting intervention') or, alternatively, only as a mechanism for identifying families who need more support/referral to other services. A clearer understanding of health visiting skills, particularly in respect of relational skills/relationship forming, health visitor needs assessment and professional judgement, would help to identify the relevance and importance of these, and how the different forms of practice influence the experiences of health visiting service users. Key questions are:

- What is the evidence about current health visitors' practice and what makes this work effective?
- What is known about how health visitors deliver the universal level of the 'new service vision'?
- How and in what ways does this work benefit families in terms of outcomes?
- What is known about specific health visiting skills?
- What is the nature of the health visitor-client relationship?
- Identify the different elements of the health visitor-client relationship and provide an evidence-base for the impact of these on child and family life.

**3. Universal plus services** are additional services that any family may need some of the time, for example care packages for maternal mental health, parenting support and baby/toddler sleep problem, where the health visitor may provide, delegate or refer, intervening early to prevent problems developing or worsening.

To understand how and in what ways this form of health visiting work benefits families in terms of outcomes, first we need to identify what is known about how health visitors implement the universal plus level and whether it enables families who need more support to access the services they need. That would identify the evidence base regarding delivery of care by health visitors and its relationship to outcomes for families, and any different workforce models required to deliver outcomes in priority areas in health visiting. The evidence about skillmix in health visiting needs to be examined, perhaps through models used in other fields, to see how the different skillmix models influence effectiveness and service delivery. Given the diversity of service provision, identifying the components of safe and effective delegation or referral pathways will help to inform skillmix models. Key questions are:

- How and in what ways does the Universal Plus level of health visiting work benefit families in terms of outcomes?
- Does the health visiting service enable families who need more support to access other services?  How?
- What is the evidence about safe and effective delegation or referral pathways, to inform skillmix models?

**4. Universal partnership plus services** provide additional services for vulnerable families requiring ongoing additional support for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health problems or substance misuse.

As with the other levels of provision, we need to understand what is known about how health visitors implement the universal partnership plus level of the new service vision. Whilst health visitors may identify families with high risk and low protective factors through needs assessment carried out through the universal service, there is a particular need to understand how this form of practice enables the most vulnerable families to express their needs and decide how they might best be met. Key questions are:

- What is known about how health visitors implement the Universal Partnership Plus level of the new service vision?
- What is known about how different programmes or projects influence health visitors' responses to the higher needs of vulnerable families?
- What is known about how health visitors work with families living with domestic violence?

**5. The contribution to child protection** makes sure the appropriate health visiting services form part of the high intensity multi agency services for families where there are safeguarding and child protection concerns.

This is not a level of service provision, as it operates across the whole of health visiting, but we have followed the *Implementation Plan* format in including a separate chapter about child protection and safeguarding. Safeguarding is a major part of health visiting practice across the entire proactive and preventive service, but the 'sharp end' of child protection is extremely important in its own right. A description of the knowledge, skills and values required for child protection practice, including dealing with interpersonal violence in families, would help to explain how and when these are specific to health visiting and how they complement alternatives across health and social care. In turn, this would clarify what is known about how health visitors contribute to safeguarding and child protection. Key questions are:

- What is known about how health visitors contribute to safeguarding and child protection?
- How do health visitors identify families with high risk and low protective factors?
- What are the knowledge, skills and values required by health visitors to implement child protection practice?

In carrying out the literature review, we recognise that the service vision explains the multiple layers of health visiting which, in practice, are often intertwined and appear inseparable. As an example, a health visitor meeting an expectant mother for the first time as part of the universal service, may conclude with her that she is highly vulnerable and in need of the additional provision available through the local children's centre, which is part of the community level. At the same time, the health visitor might offer or arrange some additional provision to meet some specific needs, which would be described under the universal plus or universal partnership plus service levels. Health visitors were designated as having an overall 'lead role' (Department of Health and Department for Children Schools and Families, 2009a) in the HCP and in Sure Start Children's Centres (Department of Health, 2011) because of their presumed ability to shift from one level to another, reaching professional judgements and decisions that incorporate and balance multiple aspects of the client need and service context, which is likely to be unique to each situation and locality. In the literature, there are also multiple overlapping elements, and whilst they have been separated out for the sake of clarity, we acknowledge the integrated nature of the role and function.

# Chapter 2: METHODS AND METHODOLOGY

## Background to study

The task facing this review team was formidable by any standards. The aim was to carry out a scoping study, incorporating a narrative review of the research, about health visiting practice: a task that has not, as far as we are aware, been attempted before. The study developed as a result of a current policy plan to enhance the number of health visitors in practice by around 50% between 2011 and 2015 (Department of Health, 2011), and an accompanying desire to ensure that this increase results in improvements in practice and health outcomes for children and families. The policy itself has developed as a result of the increased evidence about the importance of the early years, (e.g. Shonkoff & Phillips 2000; Center on the Developing Child at Harvard University 2010) and about what helps or hinders children's healthy development and wellbeing (e.g. Barlow, et al, 2008; Hall & Elliman, 2006). Evidence about the value of health promotion interventions tends to be generic, relevant to everyone working with children, and is continually reviewed for purposes of updating the Healthy Child Programme (Department of Health and Department for Children Schools and Families, 2009a). We avoided replicating this focus on the outcomes and effectiveness of programmes or approaches, although our quest to identify information about the particular effect to be expected from deploying a health visitor or health visiting service (instead of another staff member or form of provision) inevitably led us to some of the same literature.

Since this form of synthesis of health visiting practice has not been attempted before, we aimed to distil from diverse forms of evidence information that was specific to the practice of health visitors, which would help us to identify their skills, knowledge and capacities, how these are applied and what difference they make to children and families receiving them. Although we began with very broad search criteria, as explained below, we eventually focused on empirical work from the UK, excluding other forms of literature. Our review shows that the current emphasis in the health visitor research arena focuses on the evaluation of outcomes determined by national policies, such as the Healthy Child Programme, or by local service commissioners who determine priorities, and the more interpersonal and relational qualities of health visiting practice appear to be still valued. In addition, we show that professional judgement and a high level of knowledge about child and family health continue to be a priority for service users. The changes occurring over time in the research literature appear to reflect the changing social and professional situation of health visitors. Whilst much of the earlier qualitative literature describes the health visitor in

more 'autonomous generalist' terms, the later literature places health visitors within the context of modern health technology evaluation, usually providing specific additional training for health visitors delivering experimental interventions. However, this review reveals that there are significant gaps in the research, with a host of small, one-off projects and studies either failing to meet contemporary levels of rigour or lacking the detail needed to clarify how health visitors work.

The report sets out findings in five chapters, each corresponding to one of the 'levels' of service 'offer' to families set out in the *Health Visitor Implementation Plan* (as detailed in Chapter 1 and explained further below). Our decision to stay close to the structure of the *Plan* enabled us to focus the review whilst dealing with a large and unwieldy amount of literature. However, this decision tied us to assumptions about the benefits of health visiting and way the services are delivered – some of which are not as clear-cut in practice, or in the literature, as in the policy document.  In addition, we collated tables summarising details of all the literature reviewed, showing both the eventually included empirical literature and those papers that we considered but excluded from the final review.  These are included as appendices to the main report and provide a form of 'knowledge support' as described by Mays, Pope and Popay (2005), in that they offer an accessible overview of the entire literature reviewed.

In this chapter we detail the methods used for this review, focusing on the steps taken and the decision processes behind these. The rationale for our chosen method (broad-ranging scoping review) is discussed throughout this chapter. In summary, a broad-ranging scoping review was chosen as we felt it was the most appropriate method to capture the vast and dispersed evidence base on health visiting, which spans various subject areas, including child health, nursing, and psychology. Given the disparate literature base, a scoping review would enable us to use a criteria based on relevance, as opposed to the quality of the studies (Poth and Ross 2009). In addition, because of the broad inclusion criteria used in scoping reviews and the process of discussing recurrent themes with experts in the area, the importance of locating review findings in their context could be prioritised (ibid).

## Methods

The broad and unwieldy nature of the task affected our choice of methods and presented us with a number of methodological challenges. We were clear about the policy context for our project, which currently assumes that health visiting is a 'good thing' in itself, hence the decision to expand the workforce. However, translating this clarity into well-defined research questions proved thorny. We aimed to strike a balance in bringing our attention to policy concerns together with a need to produce a review that would be of value for the research community. We hope to

have achieved this by generating a document that clearly delineates the policy, practice, education, bringing research scepticism to our analysis of the literature and its implications.

We examined a number of papers about review methods, bearing in mind the broad and unstructured nature of the literature and the need for an approach that would enable us to focus the review as it developed.  We considered this to be a scoping study, in the form described by Poth and Ross (2009), in that:

- The criteria for exclusion and inclusion are not based on quality of the studies, but on relevance.

- It is exploratory, so all results from all studies on a topic are included.

- Data from the included studies are charted; themes and key issues are identified.

- Themes are discussed with experts and stakeholders in the topic area, to give context to the findings.

Citing McColl (2007), they also note the flexibility of the scoping review to either guide the selection of studies by identifying the concepts or to search and allow the inclusion criteria to arise from the data itself is unique.  Further, our study incorporates a narrative review, in that (as described by National Institute for Health Research (NIHR) cited by Levac, Colquhoun and O'Brien (2010)) it includes clarification of working definitions and conceptual boundaries of a topic area, developed in the form of systematic overview of the literature but specifically excluding a traditional systematic review in their definition, to determine a frame of reference. However, we worked systematically, by stating our aims and review questions, identifying inclusion criteria, searching for studies, screening studies and judging the weight of (relevant) evidence for our review and synthesizing, for which further details are given below.

We noted that many more recent methods papers referred back to the papers by Arksey and O'Malley (2005) or Dixon-Woods, Agarwal, Jones, et al (2005), with the former being particularly helpful for our purposes.  Our study broadly followed the five steps set out by Arksey & O'Malley (2005), which are (1) identifying the research question; (2) identifying relevant studies; (3) study selection; (4) charting the data, collating, summarizing and (5) reporting the results. However, along with Levac, Colquhoun & O'Brien (2010) and Valaitis (2012), we found the process was far more iterative and collaborative than linear. It involved exploring, complementing, and re-working tentative early questions (generated with a focus on the fast-moving policy context of health visiting) into sound research questions before we could orient the identification, selection, and

review of published work on health visiting. Figure 2.1 shows how the study progressed, with an iterative first stage to clarify the research questions, after which two parallel, slightly different but still iterative, approaches were used to identify and select relevant studies, before bringing the literature together as a whole.

**Figure 2.1:  Stages of Review, after Arksey and O'Malley (2005) and Levac et al (2010)**

Stage 1

Establish Team and Orientation

Broad Search

Refine Questions and Framework

Stage 2

Revise Review Strategy and Framework

Structured Topic-based Searches

Scope HV-Focused Research

Stages 3 & 4

Study Selection

Study Selection

Further Refine Framework

Review and Analyse

Review and Analyse

Stage 5

Collating and Summarizing

Report Findings
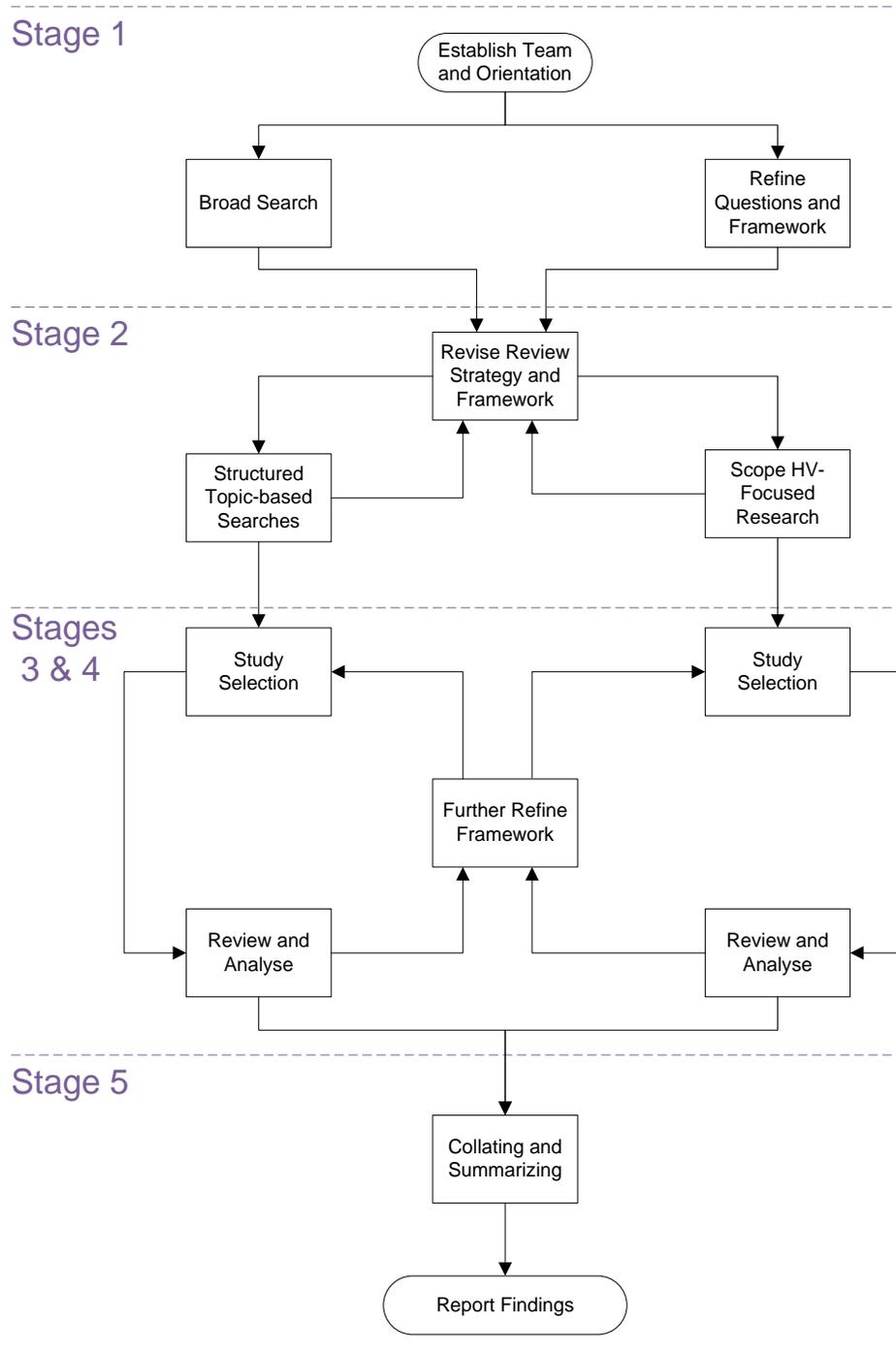
## Research questions

The research questions and framework needed to be refined throughout the review, and therefore we describe this process here before presenting the details of each stage. We continually revisited the policy to focus attention on the initial purpose of the study, using the service levels detailed in the *Health Visitor Implementation Plan* to logically organise our review and to generate a core question for each level of the 'family offer' as follows:

The overarching question for the whole review is: **What are the key components of health visitor interventions and relationships between the current health visiting service, its processes and outcomes for children and families?**

1. Interactions at **community level**: there are questions about how the health visiting service fits with the wider community public health service and in understanding the principles that guide health visiting through the whole service spectrum, so we asked: **What is the health visiting orientation to practice, and how is this represented in service organisation?**

2. **Universal services** for all families: there are questions about which forms of practice are central to the entire provision by health visitors. Our question became: **What are the key components of health visiting practice and how are they reflected in implementing the 'new service vision' and Healthy Child Programme?**

3. **Universal plus services** are additional services that any family may need some of the time. To identify what is known about how health visitors implement this level of service, we asked: **What is the health visiting contribution to leading and delivering services where families need support with specific issues?'**

4. **Universal partnership plus services** provide sustained additional services for vulnerable families. The core question for this level is: **What is the health visiting contribution to provision for vulnerable families and groups, or those with complex needs, who need continuing support?**

5. Health visiting contributes to **child protection** by being part of the high intensity, multi agency services for families where there are safeguarding and child protection concerns. We asked: **What is the role and contribution of health visitors to child protection and safeguarding?**

## Stage 1a:  Establish Team and Orientation

Our research team consisted of six people in the first instance, including researchers with health visiting as well as social science backgrounds (SC, KW, MM, SD, AG and JM). Later, subject specialists were identified in two key fields. One was a specialist in child protection (HW), who contributed key writing and analysis of this tranche of literature, as well as aiding the final analysis and pulling together the report. The second (CB) contributed key writing - included as Appendix 1 - about the health visitor-parent relationship, encompassing new empirical work as well as a review of the literature on this topic. Finally, EM joined the team and made a major contribution in sorting and editing the mass of literature into tables for Appendices 2 and 3.

Scoping the literature began with initial orientation meetings, to identify key contextual policies and map the main phases of research about health visiting, i.e. early research from the 1970s and 1980s (largely research monographs, initially descriptive, moving towards theorising and evaluation); qualitative research about health visiting practice from the- 1980s and early 1990s (including classic grounded theory, conversation analysis studies); health visitor-specific studies from mid-1990s onwards (including evaluations of interventions delivered by health visitors); research informing health visitor policy and practice to the present day (including reviews that inform the Healthy Child Programme and relevant NICE guidance). The broad searches involved in this initial orientation process allowed us to take account of the wider research context when deciding how to approach more recent literature about health visiting practice.

The team met at regular intervals throughout, to discuss the characteristics and complexities of the literature and to plan the next steps of the review. Whilst concurring with Valaitis et al (2012) that subject expertise is essential, we also regarded the varied backgrounds of team colleagues as a strength, bringing the ability to highlight and question taken-for-granted positions and discipline-specific perspectives. Also, an advisory group was established to provide guidance and advice through the review process, which included researchers and practitioners in health visiting, child health, psychology, nursing, primary care and user engagement.

As we were conscious of the need to build in processes to offset possible unconscious bias from the start, involving team colleagues who were very familiar with the health visiting literature was very beneficial. It enabled a speedy review of titles identified through the searches, being able (for example) to say immediately which pieces were empirical or not, whether they were UK based and whether they were considered important. This led to considerable discussion within the team

about what constituted 'important' and/or seminal and why papers were regarded as such: the frequency with which they were cited within the literature and usefulness for teaching student health visitors were two key markers. Another was the influence it had had on academic thinking in the field, and what were once new or novel ideas at publication were now accepted as a given. We were concerned to avoid personal biases and preferences, and found the presence of team members who were new to the field, and willing to challenge and question assumptions of the health visitor members was a considerable advantage in achieving this aim. In a further check, having initially generated lists, we then individually marked our preferred key papers, before cross checking and finding considerable agreement. We then checked our views and opinions with advisory group members to ensure we were not omitting other key papers or including inappropriate work, but we have no way of knowing whether a different research team would have made different choices.

## Stage 1b: Initial Questions and Broad Searches

Our searches became progressively more focused, eventually, being limited to empirical work carried out in the UK and Ireland only. However, at this early stage, we had broad research questions, formulated at a time when the policy for the *Health Visitor Implementation Plan* and new service vision were still being developed. Accordingly, we used a broad search strategy to draw out and identify the main trends within the health visiting research literature in English. We searched several databases using generic terms, for example home visit* and health visit* (the '*' wildcard allowing us to search simultaneously for health visit-s, health visit-or, health visit-ing). As part of this broad search we also included (where relevant to the database) Medical Subject Headings (MeSH); public health nursing, community health nursing and home visiting. An example search is included as Appendix 2, which illustrates the use of both free-text and MeSH terms, combining the facets for health visitor and home visit. The databases we chose covered a range of subject areas including nursing, health, social science, and psychology:

- Through the OVID interface we were able to access the following databases: Medline, Embase, British Nursing Index and Archive, Psychinfo" (covering the main biomedical journals);
- Cumulative Index to Nursing and Allied Health Literature (CINAHL), excluding Medline (covering the nursing and allied health literature);
- Applied Social Sciences Index and Abstracts (ASSIA) (covering health, social services, psychology, sociology, economics, politics, race relations and education);

- Web of Knowledge and its sub database Web of Science (for more general science literature).

We compared the search results of the four databases, checking for repetition. The overlap in search results proved minimal, therefore we felt it necessary to continue searching all of the databases to enhance comprehensiveness. Our early searches (including all countries at this stage) returned very large number of records (in the order of several thousands) we therefore resolved to:

1) limit the timeframe to 2004-2011 (in view of the significance of Every Child Matters 2003) and related policy in transforming children services);

2) only include studies carried out in countries with public health nursing roles comparable to health visitor roles in the UK;

3) reorganise the searches according to topic areas derived from the Healthy Child Programme.

The health visitor experts on the team screened the records generated through these broad searches, to highlight publications considered crucial to any serious critical examination of health visiting issues. These searches highlighted the disjointed and fragmented character of much health visiting research, prompting us to adopt a more structured and organised approach to searching the literature, as summarised in Table 2.1. These search strategies were intended to balance the need to keep the number of papers to manageable proportions, whilst ensuring we obtained the most significant and relevant literature.  We did not have the time or resource to cover grey literature or the vast number of potentially relevant overseas literature. Some critical commentary papers provided helpful context and useful ideas, but did not form part of the review *per se*; likewise, we omitted service development papers and any focusing purely on instrument development or audit.  Only a small number of surveys with national coverage were included, again largely to provide context for the findings overall.

**Table 2.1: Three approaches used to search the literature**

| Stage 1b<br>Broad searches | | Stage 2a<br>Structured topic-based searches | | Stage 2b<br>Influential and seminal publications | |
|---|---|---|---|---|---|
| **Language:** English | | | | | |
| Provisionally included abstracts<br><br>N=593 | Reviewed in full<br><br>**N= 49** | Provisionally included abstracts<br><br>N= 318 | Reviewed in full<br><br>**N = 218** | Provisionally included abstracts<br><br>N=272 | Reviewed in full<br><br>**N= 81** |
| **Date of publication:**<br><br>2004-2011 | **Date of publication:**<br><br>2004-2011 | **Date of publication:**<br><br>2004-2011 | **Date of publication:**<br><br>2004-2011 | **Date of publication:**<br><br>any | **Date of publication:**<br><br>any |
| **Country:**<br><br>UK, Ireland, Sweden, Norway, Finland, Denmark, USA, Australia, New Zealand, International review | **Country:**<br><br>UK, Ireland, Sweden, Norway, Finland, Denmark, USA, Australia, New Zealand, International review | **Country:**<br><br>UK, Ireland, Sweden, Norway, Finland, Denmark, USA, Australia, New Zealand, International review | **Country:**<br><br>UK and Ireland | **Country:**<br><br>Any (main focus on UK and Ireland) | **Country:**<br><br>Any(main focus on UK and Ireland) |
| **Publication type:**<br><br>review; empirical research; discussion paper | **Publication type:**<br><br>review; empirical research; discussion paper | **Publication type:**<br><br>review; empirical research; discussion paper | **Publication type:**<br><br>review; empirical research | **Publication type:**<br><br>empirical and seminal non-empirical; from early searches, reference lists, and curricular material | **Publication type:**<br><br>empirical and seminal non-empirical |
| | **Purposeful sampling**<br><br>particularly influential, historically relevant, or crucial to accurate contextualisation | | **Grading:**<br><br>papers graded as 'definitely relevant' only (see page 48) | | **Purposeful sampling**<br><br>particularly influential, historically relevant, or crucial to accurate contextualisation |

## Stage 2a. Revised review strategy: Structured topic-based searches

The Healthy Child Programme (Department of Health and Department for Children Schools and Families, 2009b) is an embedded part of the *Health Visitor Implementation Plan* and new service vision. It focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. Drawing upon it we identified the following topics on which we based our structured searches: accident prevention; alcohol and drug abuse; breastfeeding, nutrition and obesity; child protection; detection and management of maternal post-natal depression; domestic violence; father involvement; homelessness and travelling communities; learning difficulties; parenting; seldom heard groups; speech and language issues. In addition, we also searched for research exploring skillmix issues that could guide our way into themes of service organisation and team working. This topic based search was a sub-set of the broad search and was primarily used as a means to categorise and organise the large literature base.

As we used this second approach as a sub-set of the broad search we searched the same databases used for our broad searches (CINAHL, ASSIA, Ovid, Web of Knowledge). We decided against searching for Medical Subject Headings (MeSH) after the broad searches had indicated that the standard cataloguing terms used by databases e.g. Medline, reflected terminology appropriate to medicine and the American health services rather than reflecting language used to describe the UK health visitor role. Instead we opted for more specific search terms (using wild cards for inclusiveness) for each topic, and drawing on the extensive subject expertise within the team to ensure a wide number of possible terms were used for the different literatures. For example, to identify articles on health visiting approaches to post-natal depression, we searched for the following terms with the specified Boolean operators (AND, NOT, OR): (post*natal depress* OR peri*natal depress* OR maternal depress*) AND (health visit* OR home visit*). In particular, with regard to the latter terms, we considered it important to extend our searches to 'home visiting' more broadly. Although this strategy yielded a higher number of spurious records, it also ensured that we identified studies referring to home visiting as part of public health nursing (with or without reference to the formal title of Specialist Community Public Health Nurse for health visitors).

## Stage 2b. Revised review strategy:  Scoping the health visitor-focused literature for influential and seminal publications

Issues of depth versus comprehensiveness are acknowledged as problematic features of scoping studies (Levac et al, 2010). We were aware from our initial orientation of a number of seminal and other papers that focused in-depth on specific aspects of health visiting practice, including organisation, process and outcomes, which we call 'health visitor-focused literature.' It became clear from both the initial broad and the later structured searches that, in order to contextualise our closer analysis of the topic-based literature, we would need to find a meaningful way to incorporate this specific health visiting literature in our report, especially if the work was published prior to 2004 and therefore not identified through our structured searches.

Expert input was sought in order to ensure that our searching and reviewing strategies were sound and that we were not overlooking important literature or neglecting crucial questions. This input took various forms. In the first instance we drew upon the different types of expertise available within the team and arranged regular meetings to discuss the characteristics and complexities of the literature identified through our different field-specific perspectives. Secondly, we discussed our strategies and plans with the advisory group that supports the Health Visiting Research Programme, which includes researchers and practitioners in health visiting, child health, nursing, primary care and user engagement.

Finally, it became clear from both the unstructured and the structured searches that, in order to contextualise our closer analysis of the literature, we would need to find a meaningful way to incorporate in our report some of the central arguments of the seminal work on health visiting published prior to 2004 and therefore not identified through our database searches. The health visitors on our team therefore each reviewed the list of 272 papers generated from our initial broad search results, secondary references and curricular material from health visitor education programmes. They produced a set of publications that they considered crucial to any serious critical examination of health visiting issues. First, they made individual selection, then discussed their choices in order to jointly produce a set of key publications, then checked papers with health visitor experts on the advisory group prior to bringing 81 papers into our final review. In general, there was more agreement about which papers to include, than how to describe them – the term 'seminal' seemed too strong for some papers that seemed, nevertheless, to be influential in that they were well known and much-cited by health visitors and used frequently for health visitor education. The use of 'theoretical' or 'selective' sampling is well established in qualitative research and it appears to be widely used in mixed

methods literature reviews (Dixon-Woods, Agarwal, Jones & Sutton, 2005, Poth and Ross 2009). Using this approach enabled us to contextualise and extend the analysis in a way that is discussed further under Stage 4.

## Stage 3. Study selection

Throughout, the various aspects of the review were iterative, interactive, dynamic and recursive rather than fixed procedures to be accomplished in a pre-defined sequence (Dixon-Woods et al, 2006), with none of the stages being very clearly delineated. Indeed, as in the experience reported by Levac et al (2010), Stages 3 and 4 (study selection and extraction of data) largely merged into one, as shown in Figure 2.1, but they are reported separately for clarity.

We described earlier how the selection of health visitor-focused papers was guided by expert input and team discussion. However, we required a systematic approach to accurately establish the relevance to the overarching research question of the papers identified through the topic-based searches. These searches yielded over 3,000 records, which we sorted manually to eliminate all spurious records. The list generated through this process included 565 annotated references, from which we provisionally selected 318 for further review. We discussed and established a labelling framework to prioritise our reading and reviewing of these publications. For easy labelling and managing of the abstracts we imported the annotated references into NVivo (version 8; QSR International) and used this text analysis software to assign to each abstract a set of relevant labels. This included three levels of priority:

- definite relevance (from the abstract, the article seemed to present a detailed description of the role of the health visitor[1] or particularly relevant to the discussion of health visitors' contribution to public health for other reasons);
- low relevance (from the abstract the paper did not seem to offer detail on the role of the health visitor or it dealt with some contextual aspect of health visiting which did not address our research question);
- no relevance (on closer examination, the abstract made little reference to health visiting).

We also agreed to label each abstract according to: country (including an 'international/review' and a 'not clear from abstract' option) and type of study (e.g. empirical, quantitative; empirical, qualitative; review; unclear from abstract; etc.). The papers which we had labelled 'unclear from abstract' referred to those papers where we

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[1] Or other relevant health professional title when the study was not based in the UK, e.g. Public Health Nurse in Ireland.

couldn't easily determine to what extent health visitors were discussed. These papers were examined in the first instance by team members familiar with the literature to assess whether their content was clear, and if they should be included in the review. After this stage, if there was any ambiguity about the relevance of the abstract the full text was retrieved and the full content was checked and assessed for relevance.

Early reading of the full-text of the articles proceeded in parallel with ongoing searching. We initially planned to review research carried out in the UK as well as in countries with comparable or relevant public health nursing roles (see Table 2.1) and to include discussion papers alongside empirical research and review papers. However, due to the volume of literature that our various search strategies identified, we resolved to narrow our scope and focus on the published work that was strictly relevant to the UK policy context – i.e. empirical research carried out in the UK and review papers. A very few other papers were included for context or other exceptional, specific reasons. In summary, through the various strategies, we brought into our full-text review stage two lists of publications: one health visitor-focused list, including 49 relevant records from the early searches and 81 'key' health visiting texts identified by our subject experts (130 in total); and one including 218 records from our topic-based searches.

## Stage 4. Reviewing and analysing

Our aim was to examine the literature with a view to presenting a critical review of the evidence for the specific contribution that health visitors make to community public health and children's and families' health and wellbeing. Each team member was responsible for reviewing various sets of papers, which were generated according to the main topic and central argument presented in the abstract. For ease of sharing and comparison, essential information from the studies was recorded in two tables including: aims of the paper; setting and country; relevance to research question and comments/implications (for example for policy and practice). – See Appendix 3: Empirical Literature (included) and Appendix 4, Literature Considered but Not Included for Review

We carefully assessed the methodological strength of all the publications we reviewed in full, but did not base any early inclusion/exclusion criteria on the methodological robustness of the record under consideration. Instead, if a paper contained a lot of information about health visitors' contributions to children's health, team members used a thematic approach looking for common themes between each topic group and across the topic areas. When a paper did not contain prevalent themes relevant to the

overarching research question, it was examined for other useful contextual or supplementary information. Taking a closer look at rigorous and robust studies as well as studies that were methodologically weaker or problematic helped us to gather a richer picture of the research landscape in the area of health visiting. Within the text of the findings, we discuss the methodological rigour of the paper (or papers) included because we felt there was something useful about health visiting practice, rather than because of the high research quality.

Also, an in-depth thematic analysis was completed on a selection of the health visiting focused literature, comparing concepts and themes from earlier (pre-2000) key papers with later ones, to assess whether there had been changes in the basic approaches to practice over time. Although this started as a limited exercise, not including the 'topic-focused studies (search 2), in the end it covered most of the papers retrieved. It served the planned purpose, showing consistency across time, which was considered important in determining the continued relevance (or not) of the health visitor-focused papers (searches 1 and 3). It also helped to clarify theoretical and conceptual constructs used to explain health visiting practice, bringing new insights to the descriptions in the Community and Universal chapters. It also led to the theoretical sampling of more papers as the analysis progressed, by following up references and citations from the initial list and from hand searching reference lists. These papers were included in the numbers cited at stage 3.

## Stage 5. Collating and summarising

The planned structure for the report of this review was progressively refined throughout the stages of the review and mirrored the levels of the new service vision. The interconnected nature of practice across the five levels was reflected in the research, so that some pragmatic decisions were needed about where to report different aspects of the literature. In some instances, we chose to report a topic-focused group of papers (e.g. parenting, safeguarding and child protection) all together, explaining the links to the different levels in the one that seemed most relevant, even though those topics were mentioned across all levels.

As an example, although we found no papers that explicitly described health visiting practice as contributing to outcomes, a number of early intervention/home visiting trials were identified that used health visitors to carry out the programme. A study by Dixon-Woods, Sutton, Shaw et al (2007) showed only slight agreement across three methods of appraisal and whilst structured approaches to assessing the quality of research made reviewers more explicit about their decision-making, they did not increase agreement above unprompted judgements. We were primarily interested in the extent to which

papers informed our knowledge about health visiting practice rather than (as described above, page 40) replicating research about outcomes and effectiveness of programmes undertaken for the Healthy Child Programme.  In view of this, at least two team members read each paper and used unprompted judgements to comment on the quality in the text where the papers are reported, but decisions about inclusion or not continued to be informed primarily by the extent to which the papers had something to say about the way in which health visitors practice.

This group of papers (about outcomes) was as varied in quality as all the others, but collectively they contributed to the depth of our understanding of how health visitors practice in delivering these programmes.  Also, they made up a discrete section about this form of service delivery, so they are reported together in a section in the 'Universal Partnership Plus' chapter.  However, they also shed light on forms of practice that are relevant to other service levels, so information drawn from them is also reported in other chapters. In another example, literature guiding wider service organisation seemed relevant to the chapter about working across the 'community level', whilst guiding health visiting team dynamics and delegation seemed more linked to delivering defined packages of care for the universal plus level.

It became increasingly clear that a number of separate bodies of research provided partial answers to our research question. The heterogeneity of the research literature pertinent to health visiting practice is not surprising given the diverse nature of health visitor work. However, by the end of the study, we were able to bring together the research we had identified through the structured, topic-focused search with the literature that started out by describing the organisation and practice of health visiting. By examining both sources of literature together, we could identify the **key components of health visitor interventions and relationships between the current health visiting service, its processes and outcomes for children and families.**

## Strengths and weaknesses

Our scoping study and narrative review of health visiting research aims to be current and immediately relevant to evolving policy concerns, but at the same time it does not overlook the broader context and historical insights of less recent work in the field. In examining the literature and reporting our findings, the multiplicity and diversity of disciplinary and research backgrounds within the team proved an important asset. Although this diversity made the process of thoroughly discussing searching criteria and reviewing strategies and analytical themes - both within the team and with external advisors - lengthier, it also contributed to considerably enrich the critical discussion of findings that we present in this report. Also, we present (in Appendices 3 and 4) the whole body of literature reviewed, collated in tables under the headings to summarise all

the literature we found in each field, and to show which papers were included and which not. We hope this will help to contribute to the transparency of our study, in that colleagues can review our decisions for themselves, and that the Appendices will form a useful reference resource and starting point so that future researchers in this field avoid the need to start completely from scratch, as we did. Further, we hope the analysis we expound in the following chapters confirms the observation by the Evidence for Policy and Practice Information and Co-ordinating (EPPI) Centre that "reviews are likely to be more relevant and of a higher quality if they are informed by advice from people with a range of experiences, in terms of both the topic and methodology" (2007, p. 6).

This review aimed to address a very specific policy need in the context of the expansion and enhancement of health visiting services that the Department of Health set out in the *Health Visitor Implementation Plan 2011-2015* (Department of Health, 2011). In view of this, we managed our time and resources with a view to ensuring that the funnelling process of distilling literature would thoroughly address our overarching question. We approached our searches with an open-minded stance and were prepared to review a broad range of evidence in order to capture what is already known and understood about health visiting. Where we had to narrow our scope, this was due to pragmatic reasons and to the gradual refocusing of the research questions.

For our less structured and topic-based searches we chose a relatively narrow time frame – papers published between 2004 and 2011. Given the policy relevance of this report, it was important for us to focus primarily on health visiting as it has been practised in recent years. We therefore prioritised searching the literature published after the call for radical transformation of children services that was announced by Every Child Matters (Department for Education and Skills, 2004) and enshrined in law with the Children Act (2004). Nevertheless, as anticipated earlier, we ensured that we also drew upon historically important and/or pioneering research to adequately contextualise our findings and to be able to outline analytical themes that have deeper roots in earlier health visiting scholarship. We suggest that the inclusion of key studies of health visiting pre-dating 2004 allowed the examination of what is feasible for health visitors to practise in optimal conditions. It also exposed important discussions of health visiting practice in sub-optimal conditions, i.e. when staff numbers are low and time is limited, or when educational preparation has been narrowed, or skills underdeveloped.

The review identified a key selection of trials, mentioned above, where health visitors were used to deliver programmes, and which highlighted particular outcomes for parents and children.  However, we found no studies that directly evaluated delivery by health visitors in comparison with other professionals or different staff, and we did not attempt to replicate the systematic reviews carried out for the Healthy Child Programme.

Accordingly, although we emphasise the importance of modest outcomes where they are shown, we are ourselves modest about the extent to which this review can provide direct evidence of outcomes. We have inferred and made what we hope are logical links across a very broad and widely-dispersed body of knowledge, to show what is feasible and important in the field and what can be expected from particular forms of health visiting practice and service organisation, and we conclude by making recommendations for further research to fill the gaps that we identified.

Indeed, we are confident that the gaps this report identifies in the published health visiting literature are very real ones, even though we acknowledge that we cannot guarantee to have found all the relevant studies. Also, we do not attempt to explain or understand in depth the shortcomings of the existing research that we did find. Rather, we draw attention to gaps in the literature with a view to highlighting important areas for future research. We do not review here the policy documents and 'grey' literature that so profoundly shape the way in which health visitor education and practice have evolved and continue to evolve, as this would fall outside the remit of our study. However, we signal the importance for health visiting research to allow for critical analytical approaches to this literature in order to better understand the discourses that shape health visiting structures and practice, and the public's understandings of the service.

# CHAPTER 3:  COMMUNITY SERVICES

## New service vision:  Community level

Families are advised that: 'Your community has a range of services, including Sure Start services and the services families and communities provide for themselves. Health visitors work to develop these and make sure you know about them' (Department of Health, 2011). Further details in the new service vision Department of Health (2010a) suggests that, amongst other things: health visitors play a lead role in improving health outcomes by applying the principles that guide health visiting through the whole service spectrum. In addition, they support and encourage others - such as health trainers, community nurses and allied health professionals - to be 'health promoting practitioners' and build community strengths and capacity to generate local responses from local people to the health issues that matter to them.

These assertions about how health visitors operate at the community level raise a series of key questions for our analysis of health visiting:

- How does the health visiting service fit with the wider community public health service?
- What are the principles that guide health visiting through the whole service spectrum?
- What is the evidence about different workforce models in health visiting, and how do they influence effectiveness and service delivery?
- How do different forms of health visiting service delivery and organisation affect uptake of the different components of the 'new service vision,' particularly by users who find services hard to reach?

The core question for this service level is:

**What is the health visiting orientation to practice, and how is this represented in service organisation?**

This chapter is divided, broadly speaking, into two main areas. First, we looked for evidence about how health visiting services are organised and fit with the wider community provision, including the traditional approaches and some documented changes. This literature includes a number of small project descriptions, which report the ways in which health visitors can contribute to the wider services, as well as a variety of suggestions for organising services to meet community health needs. Also in this first

section we look at what is known about the values, intentions and principles that inform health visiting practice, and link this to the mechanisms required for service users to be enabled to access health visiting provision at community level. We found minimal evidence of directly attributable outcomes from health visitors' practice, or from the way services are organised. However, a picture emerged which suggests that health visitors could make a positive difference if their practice and service is organised to suit parents' needs. In the second half of the chapter we illustrate how the health visitors' contribution to family health at the Community and Universal level can be mapped onto the 'service journey' followed by service users. This second part of the chapter draws on an analysis of a wide range of research to unravel and explain how this can - potentially - be instrumental in enhancing uptake and use through this service journey. We discuss the 'service journey' here as this provides a useful mapping tool to make sense of a vast amount of research. It also revealed a way of conceptualising health visitors' particular 'orientation to practice' and health visitor-client interactions, which will help the reader to navigate through the aspects of health visiting examined in the following chapters. Also we signal briefly how the health visiting literature helps to shed light on some prominent aspects of health visitors' skills and practice reported in later chapters, particularly for delivery of Universal services detailed in Chapter 4.

## Health visiting service organisation

### Background

Historically, health visiting services were delivered through local government until 1974, when they were absorbed (along with other public health, school nursing and community midwifery services) into the NHS. After that, health visitors began to be attached or aligned to general practices (and General Practitioners; GPs), deriving their caseload of expectant and new mothers and their pre-school children from the GP's list. The practice of working within a geographical locality or area and in conjunction with community midwives was never completely discarded, but became increasingly variable across the country. With the help of the Nursing and Midwifery Council (NMC), which distributed questionnaires to a sample of health visitor registrants, Cowley, Caan, Dowling, & Weir (2007) surveyed 1459 health visitors (46% response rate), of which 980 (including some in specialist posts) described themselves as holding responsibility for a caseload of clients. Of these, 73% (682) derived their caseloads directly from a GP list, whilst 7% (64) worked geographically. Others included systems of client self-referral, or used a mixture of approaches. The same survey showed that 60% (582) held sole responsibility for their caseload, whilst 35% worked in some form of team or corporate caseload

system. Most health visitors had some form of skillmix team or other workers to whom they could delegate or refer; only 27% (269) had nobody to whom they could delegate work.

A move towards greater variation in health visiting team makeup was signalled in a review of the role of health visitors, Facing the Future (Lowe, 2007), which noted the continuing debates and tensions between the need to collaborate with local Sure Start Children's Centres at the same time as continuing to liaise closely with GP practices. The need for health visitors to continue leading skillmix teams is reiterated in the more recent *Implementation Plan: A Call to Action* (Department of Health, 2011) with an emphasis on working across early years settings to ensure local delivery of the Healthy Child Programme Department of Health and Department for Children Schools and Families, 2009a,b). We did not identify any research that directly compared the different ways of working, but there are a number of individual studies and descriptive papers that offer useful detail about the attempts to enhance the 'public health role' of health visitors, including community development activities, and a wider literature about service organisation across primary and community services, of which some is directly relevant to working with Sure Start Children's Centres. In this chapter we review the literature examining different forms of service organisation, whilst more detail about skillmix and the benefits and challenges it presents is provided in Chapter 5.

## The evidence from the literature

### Building community strengths

A key part of the 'family offer' at the Community level involves health visitors helping to build community strengths and capacity to generate local responses from local people to the health issues that matter to them (Department of Health, 2010b). This is the central purpose of community development activities or, at times, of focused initiatives or circumscribed projects. We found examples of both types of activity in the literature, but these examples often consisted of small, one-off project reports or descriptive papers offering personal narratives (e.g. Grant 2005a, Harrison, Parker & Honey, 2005; Smy, 2004; Stuteley, 2002).

Forester (2004) identifies the difficulties in locating information about how health visiting services might be organised to deliver a community development oriented service. In noting longstanding debates about this issue, Forester (2004) highlights the challenge for health visitors of simultaneously managing a caseload *and* community development responsibilities. In some healthcare trusts, delivering community based activities might

be regarded as peripheral to core practice, which means that health visitors often prioritise individual caseload work (Carr, 2005b), especially where there is a connection to safeguarding functions (Worncast & Smith, 2010). A supportive management structure and additional help provided through support roles, access to tailored post-registration training, or specialised posts that afford more autonomy, appear important but are not always available (Cameron & Christie, 2007; Goodman-Brown & Appleton, 2004; Hogg & Hanley, 2008; Parker & Kirk, 2006; Smith, 2004). The health visitor survey carried out by Cowley et al (2007) (described above) indicated that in the mid-2000s child protection activities and one-to-one client work dominated health visitors' practice, thus providing some corroboration to the possibility that organisational structures were unsupportive of community activities. In view of this, we suggest that the explicit inclusion of a Community level of practice in the new service vision may be particularly helpful to practitioners who have previously felt constrained by service systems, allowing them to legitimately give time to community engagement activities.

In reporting the perspectives of 11 health visitors who had incorporated community development practices into their role, Forester (2004) also highlights that relationships developed within the community were used as a means of identifying agendas that were important to the community. The caseload provided a legitimate gateway into the community, enabling health visitors to familiarise themselves with existing networks. There was reference to trying to achieve power-sharing through partnerships, where the health visitor listened to community members, going to places where they were and entering their space. Through such relationships the health visitor was in a position to mediate between communities and the health service agenda. When there was a mismatch between the local/national policy and what the community felt was a priority, health visitors adopted the role of advocates in order to present the case of the community to local planners. To achieve this they concluded that practice should be organised on a basis that suited the community as opposed to the service provider, and therefore geographical workload allocation and location within the community was preferred to GP attachment.

Community development work is described by Drennan et al (2007) as an area of practice where health visitors have demonstrated entrepreneurial action, creating benefits for the wider community and the employing organisation. In the examples identified, the authors note that often additional funding, competitively sought from outside the NHS, was required for emerging projects. The health visitors taking the lead for innovative work were sometimes employed in clinical specialist roles or were encouraged to use their professional autonomy, for example, to re-organise their service to improve availability for a particular population group with greater needs. Such examples demonstrate the scope for health visiting to reach those more marginalized in

society and who might ordinarily find services hard to reach, such as those who experience a learning disability (Harrison & Berry, 2006), who have insecure housing (Jenkins & Parylo, 2011), who are seeking asylum (Feldman, 2006), or who experience an addiction difficulty (Smith & Gibbs, 2007). Chapter 6 includes more information about activities directed at these groups.

Where community activity is developed as part of generic practice, it is now commonplace to find the health visitor role being supplemented by other practitioners or paraprofessionals who have existing links with the community. For example, in the Starting Well project in Glasgow (which is reviewed in detail in Chapter 6), health support workers were recruited to work alongside health visitors (Mackenzie, 2006) and in Wales, Smith et al (2007) investigated the role of the health support worker in Sure Start, where the intention was to supplement the role of the health visitor. In other cases, link workers were employed to help bridge cultural gaps between professional care providers and culturally diverse communities. Smith & Randhawa (2004) report the results of a study using link workers in Luton where the link workers had been routinely employed for interpreting services and regularly used by health visitors. In Lincolnshire, Burton (2011) reports the use of assistant practitioners under the supervision of the health visitor to deliver on a range of priorities detailed within the local children and young people's plan. In Bradford health visitors have worked with local mothers to deliver a childcare course within schools (Harrison et al, 2005).

## Multi-agency work and team composition

The edited book by Pugh and Duffy (2010) describes models of service organisation that can prove useful when exploring health visitor work with key partners such as Sure Start Children's Centres. Within this edited collection, the Brighton and Hove model detailed by Hawker (2010) provides an example of a fully integrated service for children and families achieved through a process of structural change. Here, an impressive number of local authority and NHS staff are brought together under a single organisation with services re-designed into three area-based multidisciplinary teams. Each one of these teams comprises four sub-teams, led by professionals mirroring the central functions of the sub-team: health visitors lead the Early Years sub-teams; educational psychologists the School and Community Support; social workers the Safeguarding; and youth workers the Integrated Youth Support sub-teams. This is reported to have created a well co-ordinated service that ensures every family with a newborn is known to a Children's Centre and has a personalised family health plan developed with health visitor guidance. Importantly, the sub-teams all work to the same organisational boundaries and operational head, thus the strong lines of communication between different practitioners

and families can be maintained as needs change and when support beyond community level and universal provision is required.

Similar in principle to the Brighton and Hove model is the Health Co-ordination approach developed in East Lancashire. A realistic evaluation exercise of this approach provided empirical data on the context for practice, operating mechanisms and service outcomes of health co-ordination (Whittaker, Mace, Murphy, Carter, & Tudor-Edwards, 2011; Whittaker & Robinson, 2011). In East Lancashire a health co-ordinator was allocated to each district to link child health, Children's Centre and local government services. The role evolved from earlier health visitor practice within Sure Start programmes and was directed by a single health visitor service manager. The evaluation exercise highlighted health co-ordinators as a key human resource, able to use expertise to work collegially with partners and to implement solution focused action. Democratic leadership and mindfulness of locally determined community strategies set the context for a whole-system approach to delivering services, which led to the creation of new or revised workstreams integrated across a range of partners and addressing, for example, child dental health needs or preparation for parenthood. This approach supported positive co-operation between separately employed health visitor teams and Children's Centre staff. The Brighton and Hove and Lancashire experiences suggest that, by working more closely with other agencies (especially Sure Start Children's Centres) through either referring to (Byrne, Holland & Jerzembek, 2010; Hutchings et al, 2007) or co-facilitating parent education/support programmes (Clarkson & de Plessis, 2011; Grant, 2005b; Hutchings, et al, 2007; Roberts, 2012), health visitors can play a greater part in the community and support more positive service experiences for clients (Cox, 2008). What appears to be missing from the literature is any explicit evaluation of outcomes from the different organisational approaches.

Focusing more closely on teamwork and team composition, a themed issue of the *Educational & Child Psychology* journal (2006, volume 23, issue 4) explores 'Psychological perspectives in multi-agency working' and includes two papers involving health visitors as well as other health, education and social care professionals. In one of these papers, Hymans (2006) explores what constitutes successful working, and uses Q-sort methodology[2] to question a wide range of professionals from multi-agency teams (54 participants). The resulting analysis indicates the value placed by professionals on the availability of clear strategy, processes, opportunity for participation, partnership and leadership in multi-agency work. In the other paper, Watson (2006) develops a questionnaire from existing literature and asks 52 professionals working in multi-agency co-located teams about features enabling effective working. Factors found to be

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[2] a methodology based on 'statement sorting' that allows the researcher to analyse the data and obtain key 'factors' around which there is significant agreement between participants.

important to multi-agency co-located teams concerned sharing a clear vision, service objectives and an understanding of each other's roles and responsibilities. Participants in this study also commented on the importance of service evaluation and on the challenges it often posed, stating that external help with this was desirable. Watson recommends adopting more flexible, multi-method evaluation strategies; specific facilitation approaches to developing shared objectives; and joint training as an opportunity for team members to develop a deeper understanding of roles and dynamics. Sharing learning in participatory appraisal methods was identified as a helpful means to achieving this deeper understanding within the East Lancashire experience (Whittaker, et al, 2011). Similarly, Grant (2005a, b) demonstrates the benefits of using community participatory appraisal to develop a shared professional and lay understanding of local health needs.

Grounding our thinking around team working further, Bell et al (2010) provide a very illustrative example of transition from a traditional model of multi-disciplinary working to one of trans-disciplinary practice at a child development centre. Services provided by the centre's early intervention team were offered when children experienced developmental delay or suffered from disabilities. The progressive transformation of this service from specialty-based approaches to assessment and intervention towards joint, trans-disciplinary strategies for referral, assessment, and intervention produced a highly significant increase in attendance and reduction in waiting times, alongside an inevitable but well-managed increase in caseload. The development at this particular centre saw therapist, medical, health visitor, psychology and nursery nurse expertise being brought together in complementary fashion; this emphasised the value and maximised use of the skills of different practitioners that had a positive bearing on each part of the client journey.

In addition to the different forms of multi-agency working, there is a growing variation in the types of skillmix or team working implemented within the health visiting service. The benefits and challenges of skillmix are considered in Chapter 5 (where we discuss the Universal Plus level of 'family offer'), but we mention here some of its general aspects. Drawing on evidence from their review of reviews of research into skillmix change, Sibbald et al (2004) explain that the cost-effectiveness of the system as a whole will only improve if benefits of the new activities outweigh the benefits of the old activities that have been transferred elsewhere. This suggests that changes need to be 'actively managed' to facilitate movement in job roles and a 'positive human resource management culture' seems important for maximising strengths from newly formed skillmix teams (Adams, Lugsden, Chase, Arber & Bond, 2000). In environments in which planning was enabled, nurses could identify developmental opportunities from skillmix, which supported enhanced motivation and authority. Likewise service benefits arose

when nurses took greater responsibility for personal development and supported efficiency practices.

An insight into the impact of the management culture and the importance of 'getting this right' in health visiting is found in research revealing that practitioners will mirror controlling management practices in their interactions with clients (Mitcheson & Cowley, 2003). Similarly evidence suggests that where practice is didactic and rule-bound, using guidelines and assessment checklists without tailoring delivery, the result is an instructional approach that does not seem specific to the individuals' needs or circumstances (Cowley, Mitcheson & Houston, 2004; Houston & Cowley, 2002; Mitcheson & Cowley, 2003). More detail about these studies is included in Chapter 7.

There is a raft of one-off, individual projects where the health visitor has been a key service provider (Bryans, Cornish, & McIntosh, 2009; Cameron & Christie, 2007; Drennan & Joseph, 2005; Forester, 2004; Grant, 2005a,b; Hillen, 2004; Kirkpatrick, Barlow, Stewart-Brown & Davis, 2007; Ling & Luker, 2000; McIntosh & Shute, 2007; Wilson, Barbour, Graham et al, 2008a; Wilson, Furnivall, Barbour et al, 2008b; Worth & Hogg, 2000) These reports offer some insight into different ways of working (insights that are explored below and in later chapters), but the projects they describe have not been taken forward in a concerted way, even where local successes were reported.

## The contribution of health visiting to children's health and wellbeing

One thing we noticed throughout the organisational literature was a paucity of guidance or consideration about what *specifically* health visitors brought to the team or interagency activity, apart from another 'pair of hands'. This led us to explore further what forms of practice need to be preserved or considered as services are transformed, i.e. health visitors' particular 'orientation to practice'. In order to be able to articulate clearly what this orientation consists of, we consider first the academic literature that sheds light on the contribution of health visiting to children's health and wellbeing.

## Health Visiting Orientation to Practice

Research focusing on what health visitors do has been conducted over three decades. It charts the story of health visiting over time and because evidence is derived from different contextual circumstances present in different time periods, it suffers from being fragmented. The evidence drawn from earlier decades shows the contribution 'that has been' and thereby what is feasible with a given set of circumstances. It follows that newer evidence more closely reflects contemporary circumstances, although the new service vision and the current health service reforms mean that the landscape for professional practice is evolving again.

However, this more recent literature examines health visiting practice directed at particular health needs, indicating how health visitors can contribute to delivery of the Healthy Child Programme (Department of Health and Department for Children Schools and Families, 2009a,b) and support progress towards achieving health outcomes related to, for example: child behaviour (Bateson, Delaney & Pybus, 2008; Hutchings et al, 2007; Merrifield, 2005; Stewart-Brown et al, 2004); dental registration (Shute & Judge, 2005); parent-child interaction (Puura, Davis, Mäntymaa et al, 2005b); home safety practices (Kendrick, Mulvaney, & Watson, 2009); post-natal depression  (Morrell et al, 2009); childhood obesity (Barlow et al, 2010b) and identifying children with developmental disorders (Bell et al, 2010; Chakrabarti & Fombonne, 2005). In many instances these studies report enhanced service provision for specific needs and it is not known whether there are commonalities in the various modes of additional training and models of clinical supervision. Therefore, this more recent but rather fragmented body of evidence does not provide a comprehensive understanding of the specific contribution of

the health visitor; rarely does it explain how outcomes are achieved and whether results can be achieved as part of generic service provision.

The body of literature that provides greater insight in the organisation and practice of health visiting dates back to the late 1980s and can be aggregated into three types of evidence: early grounded theory studies of health visitor practice; detailed examinations of client experiences of health visitor services completed as research degrees (Doctoral and Masters level), and studies reporting on individual projects/service developments where the health visitor had been a key service provider.

The grounded theory studies were published from the late 1980s to mid-1990s and focused on examining the health visitor-client relationship (Chalmers, 1992, 1994; Chalmers & Luker, 1991; Cowley, 1991, 1995a, 1995b; de la Cuesta, 1993, 1994a, 1994b; Kendall, 1993; Luker & Chalmers, 1989; Luker & Chalmers, 1990; Pearson, 1991). This body of work is particularly useful as it began to expose the detail of ordinary practice and to make health visitor work that occurs in the privacy of the home setting more visible. The work by Chalmers and de la Cuesta set out a trajectory for practice, providing examples of steps and processes that are geared towards 'persuading[3]' clients to accept health messages and actions. A limitation of these studies is that they do this from a professional perspective, involving only health visitor practitioners as research participants. This gap was addressed by Pearson (1991), who interviewed both clients and health visitors, and to some extent by Cowley (1991; 1995a,b) who, in addition to interviewing informal groups of health visitors, also gained observation data on practitioner-client interactions in baby clinics, audio recordings of home visits, and (in a separate study) follow-up interviews with the main carer (mostly mothers) in families (Cowley & Billings, 1999). Similarly Kendall (1993) collected data through observation of health visitor-client interactions, but also interviewed the health visitor and client separately following the observed interactions. More recent studies offering direct evidence of health visitor practice have also involved clients as participants, usefully offering a picture of generic contemporary practice either in ordinary circumstances (Appleton & Cowley, 2008a,b; Bryans, 2005; Hanafin & Cowley, 2006; Ling & Luker, 2000; Plews, Bryar & Closs, 2005; Worth & Hogg, 2000) or as part of a special public health project (Bryans et al, 2009; McIntosh & Shute, 2007)

The papers reporting earlier evidence of health visitor practice (published prior to 1999) were specifically analysed for content explaining 'what a health visitor did to provide a service'. This process was informed by Miles and Huberman's (1994) approach to data

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[3] We discuss de la Cuesta's use of language below, but note that 'verbal persuasion' is one element of social learning theory (Bandura 1982). Positive verbal persuasion (praise, support, encouragement) is said to help to support the development of self-efficacy, whereas 'negative verbal persuasion' (criticism, judgements, undermining) is said to adversely affect it.

analysis involving reduction, display and verification. Each paper was read to highlight sections of study results and code these using key terms. This reduced body of evidence was then displayed in a table logging key terms, descriptions of practice and the reporting authors. The key terms were then sequenced to mirror the typical order of activity, suggesting a mechanism by which potential clients might enter and use the health visiting service – the service journey. The descriptions of practice were then grouped to identify categories and overall themes (illustrated in Table 3.1), which were then verified through discussion with a small number of health visitor academics and with literature published since 2000.

**Table 3.1  Content analysis of literature showing the orientation to practice**

| The Orientation to Practice | | Health Visitor Actions - Older Evidence (≤1999) | Health Visitor Actions - Newer Evidence (≥ 2000) |
|---|---|---|---|
| **Creating health: salutogenic approach** | Pro-active | ➔Seek out (Luker & Chalmers 1990; Cowley 1991; Chalmers 1992)<br><br>➔Providing information for health education purposes (Foster & Mayall 1990; Chalmers 1992; Plews, 1998)<br><br>➔Offer follow-up (Collinson & Cowley 1998a)<br><br>➔Confronting client to bring an issue 'face-to-face' (Chalmers 1994)<br><br>➔Understanding the fine balance between seeking to educate about health and respect client choice (Cowley 1991) | ➔Health visitors with additional training in family partnership model and motivational interviewing, with access to regular clinical supervision, found to be more knowledgeable and self-efficacious about their role as 'helpers' for families with identified vulnerability risks (Papadopoulou et al, 2005)<br><br>➔Provide information/advice without obligation to accept (McIntosh & Shute 2007)<br><br>➔Professional honesty to prompt health action (Brocklehurst et al, 2004; Kirkpatrick et al, 2007)<br><br>➔Able to act on judgement: to instigate early referral to specialised expertise (Chakrabarti & Fombonne 2005) to safeguard the interest of children (Barlow et al. 2007a) to take opportunistic action to reduce family stress (Orford, Templeton, Patel, Velleman, & Copello, 2007b, p. 122). |
| | Identify resources (personal and situational) | ➔Build on strengths – check out existing expertise (Collinson & Cowley 1998a)<br><br>➔Negotiating an important feature of getting to know and becoming known to help understand the resources available to client (Cowley 1991)<br><br>➔Assesses needs by treating health as a process that draws on personal and situational resources (Cowley 1995a; Cowley & Billings 1999) | ➔For families with children vulnerable to poor psycho-social development use interactions to develop personal resources, such as parental confidence, (McIntosh & Shute 2007), a sense of being 'listened to' and faith in services  (Davis et al, 2005) and situational resource for child in the form of improved parent-child interaction (Puura  et al, 2005b).<br><br>➔Delivers community parenting programme, with access to regular clinical supervision, to provide resource for parental learning and skills development (Sonuga-Barke et al, 2001; Stewart-Brown et al, 2004; Hutchings et al, 2007)<br><br>➔Linking clients to one another (Hanafin & Cowley, 2006) or to community projects or services (Chakrabarti & Fombonne, 2005; Drennan & Joseph, 2005; Byrne et al, 2010) |
| | Solution focused | ➔In the absence of available resources effort goes towards creating new resources specific to needs (de la Cuesta 1994a; Cowley 1995a)<br><br>➔Identifies those who can benefit from referral to expert help (Godfrey 1995) | ➔Work with others to support availability and delivery of additional community resources; parenting programme provision (Whittaker & Cornthwaite, 2000); Hillen, 2004; Stewart-Brown et al, 2004; Bateson et al, 2008; Whittaker & Cowley, 2012); sleep behaviour clinic (Merrifield 2005); obesity prevention (Barlow et al, 2010); breastfeeding education (Clarkson & de Plessis, 2011); support for relatives of those with addiction problems (Orford, Templeton, Patel, Copello & Velleman, 2007a); community development initiatives (Stuteley, 2002; Forester, 2004; Grant, 2005b); additional child mental health expertise (Craig & Power, 2010); outreach to homeless families (Jenkins & Parylo, 2011) or those with refugee status (Drennan & Joseph, 2005) |

| | | | |
|---|---|---|---|
| **Value the person: 'to keep in mind'** | Shift focus to align with client | →Respecting client priorities to achieve consonance (Cowley, 1991) and focus on what is important to client (Chalmers, 1992)<br>→Waiting for right time – growing trust (de la Cuesta, 1994b)<br>→Need to consider the child development trajectory (Pearson, 1991) | →Reflexive practitioner pursues issues raised by client & checks their perspective (Bryans 2005)<br>→Gauging what, how and when to say something to pitch information at the right moment when the client is ready (Appleton & Cowley 2008b; Bryans et al, 2009)<br>→Listening to offer support specific to client need (Turner et al, 2010)<br>→Being available helped clients feel 'cared for' (Plews et al, 2005; Orford et al, 2007a) |
| | Recognises potential for unmet need | →Offering everyone a certain level of service (Cowley, 1991)<br>→Hidden/unacknowledged need (Collinson & Cowley, 1998a)<br>→Keep trying - not giving up on families (Luker & Chalmers, 1990; Chalmers & Luker, 1991; Chalmers, 1994)<br>→Providing advice/information as reassurance to support ongoing parenting (Plews, 1998) | →Concern that judgements made too early may misdirect care (Appleton & Cowley, 2008a) and miss later developing needs (Cowley 1995b, Wilson, Thompson, McConnachie & Wilson, 2011; Wright, Jeffrey, Ross, Wallis & Wood, 2009)<br>→Assessment requires time investment for cumulative picture of the person to be developed (McIntosh & Shute, 2007; Wilson et al, 2008a)<br>→Providing support and recognising needs during transition (Plews et al, 2005) or substantial parental distress from seemingly benign difficulties such as infant crying (Long & Johnson, 2001)<br>→increased support offering better service satisfaction and less reliance on emergency care (Christie & Bunting, 2011) |
| **Value the person: 'to keep in mind'** | Seeking out potential strengths – maintain hope | →Respect and value client expertise (Collinson & Cowley, 1998a)<br>→attention to communication skills that emphasise partnership (Chalmers, 1992)<br>→Dialogue/partnership style (Foster & Mayall, 1990)<br>→refer and retain - continuing relationship even when referred to additional service (Collinson & Cowley, 1998a) | →Demonstrating partnership communication techniques to support growth in the client behaviours (Patterson et al, 2005; Puura et al, 2005a; Kirkpatrick et al, 2007; Orford et al, 2007a)<br>→Refer and retain - continuing relationship even when referred to additional service (Chakrabarti & Fombonne, 2005; Halpin & Nugent, 2006; Bryans et al, 2009) |
| | | | |
| **Person-in-situation (human ecology)** | Assessing and | Acting in the client's space:<br>→home visiting (de la Cuesta, 1994b)<br><br>→Observing to improve real knowledge of client's situation (Cowley, 1991) | →Additionally trained health visitors can more accurately determine need for intensive parenting home support (Papadopoulou et al, 2005)<br>→Intensive home support has assisted mothers in feeling less anxious about their child's development and has impacted on their reliance on health services (Wiggins et al, 2004; Knapp et al, 2005)<br>→Reflexive approach balances maternal and infant needs, keeps mother in mind (Bryans, 2005) and |

| | | | recognises contribution of 'significant others' as resource (Bryans et al, 2009) |
|---|---|---|---|
| acting (intervening) constant feature and continuing process, taking account of the individual and their personal and situational circumstances. | →Attunement to client situation – intuition (Chalmers, 1992) recognising when situation 'not quite right' – acknowledges this (Chalmers, 1993)<br><br>→Being aware of hidden and unacknowledged need (Collinson & Cowley, 1998b) | | →Reading the whole situation to gauge what is happening to know what to say, how and when (Plews et al, 2005; Appleton & Cowley, 2008a), tuning in to client (Plews et al, 2005) and their situation (Ling & Luker, 2000; Wilson et al, 2008a; Bryans et al, 2009)<br>→Health visitors additionally trained in listening and with ongoing access to psychologist's expertise, helped stimulate awareness and 'unlock issues' for women with postnatal depression, assisting their sense of ability to manage their condition (Turner et al, 2010) |
| | Acting in the community to:<br>→facilitate groups, liaise with other groups/agencies marketing service. Making best use of 3rd parties to help 'pave the way' (Luker & Chalmers, 1990)<br>→know the community to be able to make appropriate referral (Luker & Chalmers, 1989)<br>→mediate between client and agency, described as 'working up the agency' (Luker & Chalmers, 1989; Chalmers, 1993) | | →Mediate between client and agency (Brocklehurst et al, 2004; Bryans et al, 2009)<br>→With appropriate training improved clarity of public health role and connection between family and community work (Parker & Kirk, 2006)<br>→Enabling client to access service that they would otherwise have resisted (Shute & Judge, 2005; Kirkpatrick et al, 2007)<br>→Ability to keep community resources in mind when working in role combining caseload and community development work (Forester, 2004)<br>→Desire to deliver public health practice in wider community if have sufficient support from managers and organisation (Smith, 2004; Goodman-Brown & Appleton, 2004; Hogg & Hanley, 2008) |
| | Acting in the workplace to:<br>→manage workload, working within limits to safeguard self and client (Pearson, 1991)<br>→keep trying, using organisational system to legitimise contact renewal and open fresh opportunity for searching for needs and stimulate awareness (Chalmers, 1992)<br>→work around the official system of prescribed visiting/core programme to deliver service fitting client needs (Cowley, 1995b) | | →Use personal autonomy in workplace, drawing on own specialist expertise to assess and make referrals or deliver interventions when organisational system permits (Sonuga-Barke et al, 2001; Mitcheson & Cowley 2003; Chakrabarti & Fombonne, 2005; Papadopoulou et al, 2005; Hutchings et al, 2007; Wilson et al, 2011; Condon, 2011)<br>→Access workplace clinical supervision to safeguard practice and quality of care when working intensively with families (Barlow et al, 2003; Turner et al, 2010)<br>→Demonstrate entrepreneurial action/influence policy (Stuteley, 2002) |

Overall, our analysis of this literature suggests that, where organisational circumstances support the delivery of a service that is based on a health visitor-client service journey which has the potential to move across a whole service spectrum depending on need and family situation, the health visitor should - at least in theory - be in a position to: be proactive, responsive to needs, flexible, well timed, solution focused, non-judgemental, resource aware, attuned to situations, persistent, and facilitative; use helpful communication; support a parent's sense of competence; and draw on different forms of knowledge to assess and intervene to promote health simultaneously. The orientation to practice identified through this analysis is characterised by: (i) a salutogenic (health creating) approach, (ii) a positive regard for all persons and (iii) an understanding of the person-in-situation (human ecology). We propose that these concepts signify health visitors' fundamental orientation to practice, which has the potential to promote access and service use. In view of the relevance of health visitors' orientation to practice in their daily work within the Universal level of service provision, we illustrate in more detail the core skills and attributes needed to turn this orientation into practice in Chapter 4.

In the remainder of this chapter, we turn our attention to the health visitor-client service journey we mentioned a little earlier. In reviewing the historically very important body of literature on the contribution to children's health, we developed a model to illustrate the mechanisms by which potential clients might enter and use the health visiting service – the service journey. This model proved useful in mapping and making sense of the themes that this literature discussed. We describe it here as fundamental to the Community and Universal levels of service provision, and the basis for the additional care packages of Universal Plus and Universal Partnership Plus levels.

## The service journey

This service journey has been mapped out and illustrated drawing upon the body of qualitative research conducted over the last 25 years by health visitor academics examining professional practice. It is a tool to summarise and map the contribution of health visitors to children and family health at different points in time. It suggests that the contribution made by a health visitor has the potential to be wide ranging, long lasting and - through connecting with other community resources - central to the availability of a continuum of support (Christie, Poulton & Bunting, 2008), which is important in helping the passage through a major life transition (Deave, Johnson & Ingram, 2008). Of course, this contribution will vary depending on the orientation of the practitioner and the organisational system and circumstances in which she/he is operating. Also, much of the literature that contributes to outlining the service journey we describe here points to 'ideal' forms of health visiting practice, illustrating how health visiting could and should work. In examining the features of good practice that this work illustrates, we acknowledge also that the conditions of practice in specific services may

be far from mirroring the good practice we discuss. In illustrating the service journey we use the key words detailed in the text boxes of Figure 3.1 to indicate important features of this experience and we report them *italicised* in the text for easy reference.

The journey, which varies in intensity over time, commences as an *unsolicited* experience where the health visitor, uninvited, seeks out the client who is either about to be or has recently become a parent (Chalmers, 1992; Collinson & Cowley, 1998a; Cowley, 1995b; Luker & Chalmers, 1990). It is unlikely that they have formed a relationship at this stage, although if the health visitor has engaged in other activities in the wider community, they may have met previously or third parties may have passed on information to indicate the health visitor's reputation (Forester, 2004; Luker & Chalmers, 1990), or have obtained prior information at the 'pre-contactual phase' of engagement (Hanafin & Cowley, 2006). The initial stages are concerned with each *becoming known* to one another, with the health visitor seeking *entry* into the client's situation (physical and personal) and the client determining how far to *allow access* to their life. As part of this they engage in a *reciprocal exchange* (Chalmers, 1992) to share information and thereby achieve a *collaborative interaction* (de la Cuesta, 1994b). In an ideal service journey this would be a core feature that runs alongside the interwoven action of *assessing and intervening,* which starts at the first contact and occurs on a repeated basis, made possible by the *ongoing availability* of the routine service from pregnancy to 5 years (Appleton & Cowley, 2008a).

If the client shows some resistance to becoming known, it is likely that the health visitor will to some extent market her/him self by *negotiating* or by participating in *fringe work* (de la Cuesta, 1993; de la Cuesta, 1994a). This includes activities that are commonly peripheral to the core role, but are an investment for *re-entry* because through this action, including negotiating and advocating for the client (McIntosh & Shute, 2007), the health visitor communicates recognition of the client's felt need and demonstrates that the relationship can be of longer term value (Collinson & Cowley, 1998a; de la Cuesta, 1993).

**Figure 3.1: The service journey conceptualised**

Intervening – providing information, positive verbal persuasion/praise, modelling, social support, community networking, mediating, advocating, developing and facilitating community groups

Getting to know

Attune

Re-entry

Fringe work

Assess situation – listen, observe & talk

Gain entry

Starts as unsolicited contact

Allow access

Engage

Accept fringe activities

Feel valued

Health visitor becomes

Identify referral need

Provide information

Confront

Shift focus

Hold case - listening

Mediate

Support introductions to help source

Follow-up

Attune

Routine service

Reprioritise workload to meet new needs

Negotiates

Interweaving assessing & intervening

Ongoing availability

Reciprocal exchange – Collaborative interaction

Ends – care transfers

Health activities

New awareness

Open up – share

Using community resources

Accept referral

Feel kept in mind

Initiate contact - expresses need seeks help

Open up

Confidence improves – need less help

Move

**Key**    = Relationship of varying intensity over time    = Health visitor activities    = Parent activities

73

Repeated contacts are important for health visitors to develop a true understanding of the client situation (Appleton & Cowley, 2008b; Chalmers, 1994; McIntosh & Shute, 2007; Pettit, 2008; Wilson, et al, 2008a) and changing client needs as the family evolves (Pearson, 1991). Sensitive communication used within visits, allows the health visitor to *attune* to the client's situation and be ready to *shift the focus* of the visit to match pressing needs (Appleton & Cowley, 2008a; Chalmers, 1992; Cowley, 1991, 1995c). Use of *listening, observing and talking* skills helps the client engage with the service and makes it possible to *open up* the discussion to expose issues that may be troubling the client (Appleton & Cowley, 2008b; Chalmers, 1992; Houston & Cowley, 2002; Long & Johnson, 2001; McIntosh & Shute, 2007; Pritchard, 2005). When the relationship is based on trust and respect, this helps clients *feel valued* (Collinson & Cowley, 1998a). Importantly this process of communication is used to both *assess* and respond to need, by helping the client develop a *new awareness* and understanding of their own situation (Appleton & Cowley, 2008a; Chalmers, 1993; Cowley, 1991). Where necessary, it can prepare the ground for making a *referral* that the client may otherwise have rejected (Cowley, 1991; Kirkpatrick, et al., 2007; Luker & Chalmers, 1989).

If the health visitor is unsuccessful in opening up discussion about an issue that is considered important (such as in child protection), she/he may find it necessary to directly *confront* and 'to bring face-to-face' an issue that the client has been avoiding (Chalmers, 1994, p. 175). In working towards confronting an issue the health visitor may need to adjust the frequency and intensity of contact carefully to ensure she/he acts at the right moment to achieve a successful result - e.g. the client engaging in alternative behaviours or accepting additional support (Appleton & Cowley, 2008b; Chalmers, 1994; McIntosh & Shute, 2007).

The health visitors will draw on their local and professional knowledge to *provide information,* making links with local resources and the client's existing community networks when seeking to raise *awareness* and facilitate *health enhancing activities* (Appleton & Cowley, 2008b; Bryans, et al, 2009; Cowley, 1991, 1995a; Cowley & Billings, 1999; Luker & Chalmers, 1989). If resources are inadequate, this might cause them to limit health awareness-raising action to avoid creating client demands that cannot be met (Chalmers, 1993; Pearson, 1991). Alternatively, health visitors can seek to influence the availability of local resources by creating new ones (Cowley, 1995a; de la Cuesta, 1994a), sometimes by encouraging people to develop their own capacities and support systems as *resources for health* (Cowley & Billings, 1999), or perhaps develop services such as new youth facilities to meet needs identified in a community survey (Grant, 2005a,b), and accessible forms of health care to combat social exclusion in people with learning difficulties (Harrison & Berry, 2006). In doing so, the health visitors aim to work within limits of a situation, to safeguard themselves and the client, and to manage effectively their own workload. Long waiting lists or limited specialist help may mean that the health visitor has to continue to hold the case (Wilson et al, 2008), or consider offering listening visits whilst waiting for availability of additional expertise or community resource (Cody, 1999). In some instances the health visitor will *mediate* between the client and a third party (Bryans et al, 2009) and when the client *accepts referral,* the health visitor can *support introductions to the other source of help*

(Kirkpatrick et al, 2007; Luker & Chalmers, 1989). After identifying needs and resources, *follow-up* can be offered, which helps the client feel that they are being *kept in mind* (Hanafin & Cowley, 2006; Worth & Hogg, 2000).

The enduring consequence of an effective relationship formed over earlier repeated contact is that if later new difficulties arise, clients can *initiate contact* and request help (Hanafin & Cowley, 2006; Pearson, 1991). In seeking to offer a quality service the health visitors (organisational systems permitting) may *reprioritise their workload* to offer additional help at times when clients experience greatest need (Appleton & Cowley, 2008a; Hanafin & Cowley, 2006). During episodes of contact the health visitor uses *verbal persuasion* skills to help the client recognise their own existing expertise and feel more *confident* about their actions and future abilities (Collinson & Cowley, 1998a; McIntosh & Shute, 2007; Plews et al, 2005). With confidence growing, the two can *negotiate* a change in pattern of contact and prepare for ending the health visitor service journey (Chalmers, 1992) and transfer to other services, such as school health.

As we mentioned briefly at the beginning of this section, evidence supporting the various components of this service journey helps us to delineate the characteristics of good health visiting practice across the service. It is, perhaps, particularly important at the Universal level, so Chapter 4 gives more information about how the three central concepts and their component parts (Table 3.1), identified as forming part of health visiting orientation to practice and forming the 'service journey' (Figure 3.1), are implemented. Other evidence also illustrates the flaws in practice where health visitors have missed client cues and so have not been well attuned to client need or have not demonstrated helpful communication (Cowley, 1991; Cowley & Houston, 2003; Kendall, 1993; Mitcheson & Cowley, 2003; Pearson, 1991). This applied to perceived insufficiency in advice-giving (Pearson, 1991) and hasty communication if the health visitor moves swiftly to advice-giving before exploring the client's perspective (Foster & Mayall, 1990; Kendall, 1993). A danger with this is that whilst there may be some common thinking about the difficult things in parenting, the importance and priority of these difficulties can differ for health visitors and parents (Bloomfield et al, 2005). Moving straight to advice-giving without reading client cues or purposively seeking clarification of their understanding risks damaging future opportunities for health promotion as clients can feel as though they are being dictated to and misunderstood when presented with unsolicited advice (Bloor & McIntosh, 1990; Foster & Mayall, 1990; Kirkpatrick et al, 2007; McIntosh & Shute, 2007). This may be perceived as being judgemental or as 'negative verbal persuasion' (Bandura, 1982), which has the potential to undermine self-efficacy, even though 'positive verbal persuasion' (praise, encouragement, support) can help it to develop. Although in this report we focus on the ways in which health visitors can and indeed do contribute to children and family health, these examples remind us that, even where organisational systems are positive, poor individual practice may inhibit achievement of the desired outcomes in practice.

## Conclusions

### Summary of findings

Questions for this chapter reflected the description of the Community level of service, as being about building and using capacity to improve health outcomes.

**Question: How does the health visiting service fit with the wider community public health service?**

- A range of examples showed the health visiting service having a good fit with other community public health services, with some reports of improved uptake and access and some evidence about how health visitors help build community strengths.

- Factors determining this fit include the way in which the teams are organised and supported by the employing organisation.

- Evidence for outcomes from different models of health visiting and service organisation is limited, although there are reported descriptions of service/team experiences.

**Question:  What is the evidence about different workforce models in health visiting, and how do they influence effectiveness and service delivery?**

- Some studies explored the impact of **multi-agency work and team composition** and culture on service users, and we were able to identify some positive examples, but little evidence that the studies had engaged with wider research about organisational culture.

- Where a collaborative culture is grown and practitioner systems are put in place to allow practitioners to know and understand each other's roles and develop a shared philosophy for practice, it is suggested that greater partnership work across the community can be achieved

**Question: What are the principles that guide health visiting through the whole service spectrum?**

- An improved fit between provision and uptake of the service may be achieved through a health visiting orientation to practice that guides delivery of health visiting across the whole service spectrum and which is:
  - salutogenic (health-creating),
  - demonstrates a positive regard for others (human valuing) and
  - recognises the person-in-situation (human ecology)
- We describe a worked-through model showing how these concepts potentially influence the

'service journey,' making it more or less likely that service users will be able to access and take up appropriate services.

- This is a hypothesis that has emerged from our analysis, which needs testing in research.

## Discussion

The core summarising question for this chapter asked ***"What is the health visiting orientation to practice, and how is this represented in service organisation?"*** To answer this, we focused on research drawn from both older and more recent qualitative and evaluative studies about how health visiting practice is delivered. We did not find research about the widely debated issue of whether health visiting services are best attached to general practice or based in local geographic areas, but some of the community-based papers made cogent arguments about the need for locality working, particularly for users who may find services hard to reach. A picture emerged, which suggests that health visitors could make a positive difference if their practice and service is organised to suit parents' needs. We described the health visiting 'orientation to practice' and a worked-through model showing how these potentially influence the 'service journey,' making it more or less likely that service users will be able to access and take up appropriate services.

We included some classic literature in our analysis, but much of the research used to unravel these health visiting processes was qualitative and descriptive, without a link to child and family outcomes. Also, we identified a number of papers highlighting service approaches and practice that failed to achieve the ideals proposed and reported more a negative picture. On the other hand, a number of other papers included evaluative research showing positive outcomes achieved by using health visitors as intervention agents, without explaining the detailed processes involved. Throughout the rest of this report, we highlight places where elements of the service journey and health visiting orientation to practice contribute to particular outcomes.

Finally, we were conscious that not all health messages are straightforward and positive, and if not delivered with appropriate sensitivity and knowledge, may be imposing 'approved' ways of parenting or of working that are not culturally acceptable: this message recurred through much of the literature. We highlighted the use of the term 'persuasion' in this chapter, which may be viewed negatively or positively, and may also raise some ethical concerns, because practitioners may be imposing 'approved' health messages or ones that (despite being officially sanctioned) are not culturally acceptable or not straightforward. Tensions arising for service users and practitioners were a recurring feature to which we return throughout the report.

# CHAPTER 4: UNIVERSAL SERVICE

## New service vision: Universal services

The Universal level of service is seen as the pivot and centre-piece of health visitor provision and, using the terminology of the 'family offer', families are advised that 'universal services from your health visitor and team provide the Healthy Child Programme to ensure a healthy start for your children and family (for example, immunisation, health and development checks), support for parents and access to a range of community services/resources.' The universal contact and provision is believed to provide a non-stigmatising approach, offering a broad reach for delivery of the Healthy Child Programme through the health visitor-client relationship. Key questions are:

- What is the evidence about current health visitors' practice and what makes this work effective?
- What is known about how health visitors deliver the universal level of the 'new service vision'?
- How and in what ways does this work benefit families in terms of outcomes?
- What is known about specific health visiting skills?
- What is the nature of the health visitor-client relationship?
- Identify the different elements of the health visitor-client relationship and provide an evidence-base for the impact of these on child and family life.

The core question for this service level is:

> **What are the key components of health visiting practice and how are they reflected in implementing the 'new service vision' and Healthy Child Programme?**

In Chapter 3 we discussed the contribution of health visitors to children and family health. We explained an analysis of the literature that revealed the fundamental orientation to practice of health visitors, resting on a salutogenic (health-creating) approach, on demonstrating a positive regard (human valuing) for all clients/people and on work strategies that take their situation into account: human ecology. To put this orientation into practice, health visitors need specific knowledge, skills, attributes, and capabilities. In this chapter we examine these concepts in more detail. Then, to illustrate their implementation in practice, we draw attention to three aspects of this orientation to practice that emerged from the academic literature as particularly important to the provision of Universal services: health visitor-client relationships, home visiting, and the assessment of health needs. We then begin to zoom in on key aspects of health visiting practice at the Universal level of provision and focus on reviewing the research studies that examine the contribution of health visitors

to working with fathers; supporting breastfeeding; preventing unintentional injuries; and promoting immunisation.

## Health visitors' orientation to practice

### The salutogenic approach to health visiting, valuing the person and human ecology

Literature spanning thirty years describes the salutogenic approach of the health visitor, with pro-activity being a key facet. Early studies of health visiting describe how health visitors *seek out* health needs and act to address the health needs identified by the families they work with (Chalmers 1992) (Chalmers, 1992; Cowley, 1991; Luker & Chalmers, 1990). The capacity of the health visitor to work pro-actively, especially in relation to identifying and addressing situations of risk for individual children has also been described (Appleton & Cowley, 2008a; Ling & Luker, 2000). In addition to pro-activity, salutogenesis is also characterised by the ability to help families identify their personal and situational resources in order to build on these and to maximise the opportunities for health gain (Cowley 1995a, Collinson & Cowley, 1998a,b). Early studies (Cowley 1991, Collinson & Cowley, 1998a, and Cowley & Billings, 1999) have described how this might be achieved through building on pre-existing family strengths, helping families to identify and then use the resources available to them. More recent studies (McIntosh & Shute, 2007) illustrate how this might occur within the context of one local neighbourhood and community or in the course of delivering a community parenting programme (Sonuga-Barke et al, 2001; Stewart-Brown et al, 2004).

Family life is experienced not in isolation but rather within the physical, emotional and social context of the family home, the local community, neighbourhood and larger social group. Bronfenbrenner's (1979) ecological model of health is frequently used within the clinical field of child and family health as a means of understanding how influences from each of these spheres have an impact on a family's health experience and health expectations. Within Bronfenbrenner's model the child and parents are at the centre of several concentric circles, which – moving from the inner to the outer circle - represent the immediate family home, the extended family, the neighbourhood or community, and the greater social world.

Research exploring the work of health visitors at different levels in Bronfenbrenner's model has focused on the context of the family home, i.e. the inner sphere of the model (Christie, Poulton & Bunting, 2008), as well as on the broader spheres of the human ecological system (McIntosh & Shute 2007). Christie et al (2008) explored parental views of health visiting and suggested that health visitors could, through their inter-personal interventions, help to change the situation or the context in which a particular health behaviour was experienced and thereby enhance outcomes for both parents and child. A health visitor might not, for example, be able to stop a baby from crying but could help the parent to respond to the crying in a particular manner, thus helping parents to manage the emotional and social context of the home more constructively.

McIntosh & Shute (2007) described health visiting interventions delivered within the Scottish Starting Well project, a programme of intensive home visiting aimed at influencing relationships between parents and local communities, neighbourhoods and the greater social world (see also Chapter 6). Several key benefits were achieved through the Starting Well combination of intensive home visiting and strengthening of access to community resources: increased confidence in child care and in using local resources; reduced anxiety about specific child care needs such as feeding and nutrition; increased knowledge and competence in parenting practices; reduced isolation and advocacy for those experiencing housing, financial or family social problems. McIntosh and Shute suggest these benefits were the result of complex health visitor led interventions including different forms of information giving, modelling of mother/infant communication, tactful questioning of maternal decision making, praising achievement and encouragement of successful parenting practices. Drawing on experience from the Starting Well project, Bryans, Cornish & McIntosh (2009) recommend more explicit use of Bronfenbrenner's (1979) ecological model of health within health visiting.

A salutogenic approach to health visiting and an understanding of family circumstances in their broader context, in line with the ecology model, underpin the orientation to practice of health visitors. This orientation translates into working practices that shape health visitors' interactions with families and structure the type of support they are able to provide. From the health visiting literature we examined, three forms of practice appeared to encapsulate particularly well a salutogenic, human-valuing and ecology-minded orientation to health visiting: cultivating health visitor-client relationships; visiting families in their home; and skilfully assessing health needs. We consider these forms of practice and the literature exploring them here, as they are central to the effective delivery of Universal services.

## Core practices: cultivating health visitors-client relationships

As illustrated in the discussion of the 'service journey' in Chapter 3, most families do not ask for their first home visit by a health visitor but rather receive this as part of a programme of health care which is provided for all families (Cowley, Mitcheson & Houston 2004). Many families may be ambivalent, at least initially, about the health promoting interventions offered by the health visitor and especially those interventions that call into question firmly held health beliefs and practices.

Faced with the dual challenge of gaining access to the private space of the home and to the psychological space of the family's health beliefs and health practices, health visitors have developed patterns of communication, skills and professional qualities which are core skills of health visiting practice. Chalmers' & Luker's (1991) analysis of interviews with 45 experienced health visitors aimed to identify the context for interaction and the patterns of communication, which from the perspective of the health visitors, contributed to their success in promoting family health. Frequent home visiting, addressing expressed need and demonstrating the qualities of respect and genuine concern for the

family's welfare were, for the health visitors in this study, the building blocks of relationship formation. The home environment was identified as the optimum place in which the relationship formation and identification of needs could happen. In the home environment families were much more likely to 'open up' and to disclose longstanding problems (for example, family histories of abuse or domestic violence) (Chalmers & Luker 1991, Dixon, Browne, & Hamilton-Giachritsis, 2005).

Cowley (1995b) developed this theme by describing the unpredictable, risk laden and sometimes threatening nature of situations encountered by health visitors within the home environment. Her analysis of data from interviews with health visitors and observation of consultations with families illustrates how participants in this study described 'making time' for the distressed individual, expressing sympathy and conveying compassion and concern for their plight as significant aspects of their practice. Cowley argues that health visitors in her study communicated not only human comfort and consolation but also containment of the presenting difficulties, and that through their display of human empathy they built relationships with families that were based on mutual trust and respect. Their effective communication not only prevented escalation of the distress but also provided the foundation for a relationship, which could be health enhancing for the individual involved and health promoting for their family. This suggests that the relationship between the health visitor and the families with whom she/he works may not only be the mechanism for effective delivery of health promoting programmes, but also therapeutic in itself.

The therapeutic aspect of health visiting has been given a clear expression within the professional literature describing the 'Solihull approach' (Whitehead & Douglas, 2005; Bateson & Delaney 2008; Douglas, 2010). The Solihull approach is a theoretical model of therapeutic communication used by health visitors supported by a resource pack and specific training. Health visitors facilitate parental understanding of emotional containment and reciprocity in communication as a means to childhood behaviour management. Within the Solihull approach, the parent is helped to access their parenting skills, learning how to experience the emotions of their child without being overwhelmed by them. It is based on the theory that parental containment of the child's emotion, facilitated by the health visitor, eventually enables the child to manage their own emotions. The health visitor, using the Solihull approach, uses his/her own interaction with the family to model containment and empathy, which is then believed to help shape childhood behaviour patterns. A small pilot evaluation with 13 families showed promising outcomes within 2-3 visits (Douglas & Brennan, 2004). Mothers' anxiety levels reduced and they were better able to cope with common children's behaviour problems, which were perceived to improve, and health visitors appeared able to identify more serious difficulties, such as attachment problems, more readily.

Research is also currently being carried out to develop measures of the health visitor-client relationship that would make it feasible to test hypotheses about their therapeutic value (Bidmead, 2013, see Appendix 1). Using data obtained from video-stimulated recall interviews with 6 health visitor/parent dyads and subsequent discussions of these with a group of 7 health visitors and 4

parents, Bidmead identifies stages of relationship formation (introduction, putting at ease, eliciting expectations, giving information about role, establishing ground rules) and relationship working (explanation, establishing understanding and clarification, negotiating aims and goals, planning a strategy, implementing and reviewing) each of which contribute to a therapeutic health visiting interaction. Bidmead also identifies features that reflect the health visitor orientation to practice concepts of 'keeping in mind' and elements of human valuing, which are reciprocity between the family and the health visitor, a non-judgemental approach to the difficulties of family life, reliability and ability to give sound advice, and willingness to 'reach out' to all families and 'not give up' on any family as key to enabling health visitor-client relationships and effective health visiting. Practical aspects of service provision - e.g. having one health visitor over an extended period of time and receiving visits at home - were also identified by both parents and health visitors as contributing to a successful therapeutic relationship. In addition, certain professional and personal health visitor characteristics and skills - e.g. knowledge and experience, empathy and understanding, availability and approachability, honest and genuineness and respect, trust in the parent, caring and the motivation to help, friendliness and a sense of humour - were described by parents as supporting the relationship between health visitor and family (further detail on Bidmead's research is provided in Appendix 1).

## Core practices: Visiting families in their home

In the health visiting literature 'home visiting' was identified as a fundamental aspect of service provision. Through a questionnaire survey to health visitors (detailed in Chapter 3), Cowley, Caan, Dowling and Weir (2007) found that home visiting was central to the delivery of health promotion for families with young infants, with contacts mainly concerning families with babies aged under one year. Analysis of responses to the survey found the number of home visits offered to families served as a descriptor for the health visiting service as a whole; they described the diminution of the health visiting service in the years preceding the study and linked this directly to the number of health visitor home contacts.

In a randomised controlled trial involving 731 mothers of babies born in one year, Austerberry, Wiggins, Turner & Oakley (2004) investigated the impact of differential patterns of home visiting on family health outcomes. The study is reviewed more fully in Chapter 6, but the key issue here is the clear preference for home visiting shown, through randomising participants to one of three groups. Mothers in Group 1 received a new birth visit and planned monthly visits from a 'support' health visitor (who was trained to offer social support only; she could respond to requests for health information, but not raise issues herself) during the infant's first year of life. Mothers in Group 2 were offered access to a Community Support Group and mothers in Group 3 (which served as a control) received one post-natal visit from a health visitor. Only 19% of the Group 2 mothers allocated to community group support (which included telephone helpline, drop-in sessions and home visiting on request) took up the offer, whereas of the Group 1 women offered home based monthly 'support health visiting' visits

for a year, 94% stayed with the programme. For mothers in Group 1, levels of service satisfaction were higher, maternal anxiety lower, contact with the GP was reduced and there was a better uptake of NHS services than for those in Group 3. In terms of maternal depression, child injury and maternal smoking, however, no significant difference between the groups was identified.

Home visiting is generally popular with families from all walks of life, and health visitors have long appreciated the non-stigmatising approach of offering this service to everyone as part of a universal service (Elkan, Kendrick, Hewitt et al, 2000). However, Christie & Bunting (2011) were unable to identify many immediate benefits to the 'low-risk' mothers offered weekly home visits when their infants were between two and six weeks old. In their study, maternal self-assessments of parenting, including the ability to deal with baby's crying, sleeping patterns, physical health and feeding needs, showed no significant difference at either 8 weeks or 7 month follow up between mothers who were in the intervention group and received weekly home visits (n=136) and those who were in the control group and received only one (n=159). This paper is reviewed more fully in Chapter 5.

Christie and Bunting's findings resonate with earlier evidence discussed by Bull, McCormick, Swann, & Mulvihill, (2004) in their review of (nine) reviews of home visiting, including one focused specifically upon health visitor 'domiciliary visiting' (Elkan, et al, 2000). This review of reviews identified that programmes of home visiting could be effective in improving parenting and parental management of child behaviour problems, promoting the cognitive development of vulnerable infants, reducing accidental injury, detecting post-natal depression and improving breastfeeding rates if they were of medium to long term duration. Drawing on four of the reviews examined and cited in their review (Olds et al, 1994, 1997; Ciliska et al, 1996 and Macleod & Nelson 2000), Bull et al suggest that home visiting should begin pre-natally or at the birth and continue for at least six months and up to 12 months after the infant's birth (2004). Bull et al (2004) and Elkan et al (2000) found that the most successful home visiting programmes are, in addition to being of medium to long term duration, multi-focused and targeted on the needs of vulnerable families. With these provisos about the evidence supporting this method of service delivery, particularly for more vulnerable mothers, we review the main programmes in Chapter 6. One aspect of the Universal provision is to identify those mothers who would benefit from such programmes, those who may need a more circumscribed intervention (explained in Chapter 5) and those whose needs will be met by the universal service.

## Core practices: Assessing health needs

Needs identification and understanding the concept of need from the family's perspective have been described as a central pre-requisite to gaining access to the family's physical private space (the home) and also to building trust and to relationship formation. Needs identification and attempts to meet identified needs may symbolise the good intent and efficacy of the health visitor. The following

section considers the literature describing the process and efficacy of health visitor health needs assessment and identifies the relationship between this and professional judgement in health visiting.

The 'search for health needs' was first described as a key principle of health visiting practice 35 years ago (Council for the Education and Training of Health Visitors 1977). Assessment of need is still a core component of health visiting practice and an educational requirement for qualification (Nursing and Midwifery Council 2004). A number of studies have described the general process of health needs assessment and identified its key features. Chalmers (1993) argued that the health visiting service was often predicated on health visitor assessments of family responsiveness to offers of support and of the family's 'worthiness' to receive a service in terms of suitability to gain from health visiting: a form of prioritising. Other scholars have identified the on-going nature of health visitor assessments (Collinson & Cowley 1998a, Appleton & Cowley 2008a, McIntosh & Shute 2007; Wilson et al, 2008a) and the different fields of knowledge used by health visitors to deal with the complexity and uncertainty of family life (Cowley 1995b, Appleton & Cowley 2008b).

The evidence describes the way that health visitors use finely honed professional judgement skills when assessing the needs of children and families, particularly when assessing vulnerability and in order to prioritise and plan future contacts (Appleton, 1995, 1999; Barlow & Calam, 2011; Brocklehurst, Barlow, Kirkpatrick, Davis, & Stewart-Brown, 2004; Newland & Cowley, 2003; Williams, 1997). In a large empirical study incorporating both interview data from parents (n = 53) and health visitors (n = 15), and observational data obtained on home visits (n=56), Appleton and Cowley (2008a) describe how professional judgements in health visiting are composite or 'holistic' and multi-factorial, as they are based on a complex mix of different decisions and judgements supported by evidence from various sources (Appleton & Cowley 2008a). Assessment of need was typically 'on-going' and initial assessments were often followed by re-assessments, especially in complex family situations. Health visitors in this study were typically wary of over-reliance on initial assessments, in a manner that resonates with Eileen Munro's subsequent (2009) warning of the dangers that can ensue if workers are reluctant to review initial impressions of a family even when evidence confounding those impressions is forthcoming.

Appleton & Cowley (2008b) have also illustrated how health visitors' professional judgement and assessments are based upon complex and sophisticated knowledge. Combining a factual knowledge of child health and development with an understanding of social norms and an intuitive awareness of parenting practices, the health visitors in Appleton & Cowley's (2008b) study developed a heightened sensitivity to cues given consciously or unconsciously by parents as to their child's well being. Health visitors described how information, which was either seen or heard, was sometimes accompanied by a sense of personal unease. This combination of external stimuli and internal response was described as a 'gut feeling,' the importance of which was recognised, although so too was the importance of

giving this credence by searching out confirmatory information and submitting the gut feeling to scrutiny and examination. In an earlier ethnographic study, offering a rich description of the work of 16 health visitors working in the north-west of England, Ling and Luker (2000) described a similar phenomena which they referred to as 'intuitive awareness' or as 'empathy… honed by experience' (p. 575). Both Ling & Luker (2000) and Appleton & Cowley (2008b) have described how health visitors use 'intuitive awareness' to retrieve relevant, but not always immediately apparent, information on risk and vulnerability, to form a sound professional judgement based on that information once retrieved, to initiate interventions and to make appropriate referrals to other agencies. The resultant sequence of actions (information retrieval, forming a professional judgement, initiation of intervention and referral) means health visitors are well placed to identify need, then prevent the escalation of risk to individual children within the family home and potential child protection concerns.

The inadequacies of many 'formal' health needs assessment tools, in particular, their insubstantial evidence base, have also been identified (Cowley & Houston 2003; Houston & Cowley 2002; Mitcheson & Cowley 2003). These papers are considered further in Chapter 7, since the tools intended to guide prioritisation and predict risk of child maltreatment, an ambitious aim. It is not feasible to validate an instrument that can reliably predict future need for health visiting support because of its breadth and the changing nature of family life (Cowley & Houston 2004). However, some structured assessment tools, which focus on specific issues such as the Edinburgh Post-natal Depression Scale or parent relationship problems (Simons, Reynolds & Morison, 2001), can greatly enhance the service health visitors offer to families, when validated and used for their intended screening purpose. Alternatively, there is evidence of the value of using cartoons (Glover, 2001) or other trigger tools to open and focus discussion about sensitive issues.

## Core practices: an integrated approach

Whilst relationship formation, visiting parents at home and assessing their health needs have all been researched as separate processes, it appears that all three core practices are interconnected and operate together in delivering the Universal service rather than independently. Research about each core practice describes similar skills and attributes, and cross-references the other two in explaining how they operate. One approach that appears to typify this is the 'Family Partnership Model' (FPM) (Davis & Day 2010), a goal-orientated, relational model of partnership practice, which uses a form of helping process that begins with establishing a relationship with parents, then explores issues in their family context and life situation ('assessment'), clarifying and enabling understanding before setting aims or goals and planning strategies, then implementing them and finally reviewing the effects. The Early European Promotion Project (Davis & Tsiantis, 2005), which is reviewed in Chapter 6, is a longitudinal comparative study.  Health visitors trained in FPM and 'promotional interviewing,' (now referred to as the use of 'Antenatal/Postnatal Promotional Guides') carried out a universal ante-natal and post-natal home visit, resulting in greater satisfaction with the service and statistically improved

interaction between mothers and their children and the home environment.

In a second example, Bryans (2005) carried out a simulation study of 15 health visitors to unravel the expertise involved in working with clients at home. As well as the video-recorded simulated visits, the study involved post-visit interviews with the health visitors and observation of 'real life' visits to validate the authenticity of findings. The study revealed one approach to practice that involved immediately pursuing issue raised by the mother and explicitly acknowledging her feelings, giving 'tailored' context-specific advice and explicitly and consistently seeking the mother's perspective. Where health visitors were client focused in this way, it was more likely that the mother (client) would raises new issues, ask questions and freely volunteer new information (thus helping assessment), responding actively and positively to health visitor suggestions and advice (thus affirming a developing relationship). Where health visitors used a question-response format, failed to acknowledge clients' views explicitly or gave information that was not specifically tailored, the client was more likely to respond neutrally or negatively to health visitors' advice and information, so the home visit did not help assessment or relationship-building.

Overall, the skills, attributes and knowledge needed in the triad of approaches (relationship formation, visiting parents at home and assessing their health needs) appear to be mirrored across health visiting practice at the Universal level, and include:

- Ability to engage in respectful, meaningful communication with families (Chalmers & Luker, 1991; Douglas & Brennan, 2004; Bryans, 2005; Davis & Day, 2010)
- Empathy and respect for individual families and the context of their lives (Appleton & Cowley 2008a; Bidmead 2013/Appendix 1)
- Ability to demonstrate caring (Cowley, 1991) and genuine concern (Chalmers & Luker, 1991)
- Retrieval of information through a variety of sources
    - e.g. discussion and observation (Appleton & Cowley, 2008a),
    - knowledgeable observation in the home/home visiting (Christie, Poulton & Bunting, 2008)
    - awareness of wider situation/context (McIntosh & Shute, 2007)
- Combining different levels of information and knowledge  (e.g. information on individual families, factual knowledge of child health, knowledge of theories of child development, attachment and family functioning) (Appleton & Cowley, 2008a, Bidmead 2013/Appendix 1))
- Tempering instinct and gut feelings through critical reflection and consideration of information from a variety of sources (Ling & Luker; 2000; Appleton & Cowley, 2008a)
- Willingness to assess and re-assess (Appleton & Cowley, 2008a)
- Formation of a complex professional judgement of familial risk and vulnerability vs. strength and resilience (Appleton & Cowley, 2008b)

- Using interpersonal interventions and skills to help change the situation or context (Cowley, 1995b; Christie, Poulton & Bunting, 2008)

There appears to be considerable consistency about the nature of skills and knowledge that are needed across health visiting practice, and in all cases the professional, field-specific knowledge is viewed as important. Next, we looked at specific areas of practice.

## Evidence from specific areas of practice

### Working with fathers

The importance of proactively involving fathers in the care and support of a child's early years – from pregnancy throughout the childhood years – is consistently emphasised in the Healthy Child Programme (Department of Health, Department of Children, Schools and Families 2009a, 2009b). In particular, the Programme stresses the significance of the father's contribution for the child's healthy psychosocial development in the first five years of life, independent of the marital status and living arrangements of the child's parents (2009a). The document points out that too often health care services for children demonstrate a focus on mothers and children accompanied by a worrying lack of engagement with fathers and their needs. The programme aims to address this shortfall in care and provides clear direction for 'good practice for engaging fathers in the HCP' (2009a, p.26).

Health visitors were traditionally known as the 'mothers' friend' (Davies, 1988) and so the professional challenge of engaging with fathers and academic scrutiny of this is relatively new. From our exploration of the recent literature on health visiting, we concluded that research has yet to catch up with the call for renewed attention to, and more consistent engagement with, fathers' involvement in the early years of a child's life. Examples of engagement and investigation of the usefulness of this are, however, emerging within the professional health visiting literature. For example, Greening's (2006) pilot study of a structured questionnaire designed to promote communication between health visitors and fathers is one example of a health visitor taking action to address the lack of research and resources to support men's mental health and well-being in their experience of parenthood.

We also identified recent, broader work discussing more structured approaches to thinking about fathers and fathers' involvement in parenting and child's health. Examples of this type of work are the reports by the Fatherhood Institute (2008, 2011), the Joseph Rowntree Foundation (Salway, Chowbey & Clarke, 2009), and the University of Birmingham (Williams & Hewison, 2009; Williams, Hewison, Stewart, Liles & Wildman, 2012). Although this work refers to the specific role of health visitors only in passing (e.g. Williams & Hewison, 2009 mention the unlikelihood of active engagement of African Caribbean men in conversations with health visitors), these reports offer some very useful data supporting the involvement of fathers before, during and after birth, and proposes practical

recommendations such as providing more information for fathers about the statutory services which are available for their support and respecting fathers' commitment (Salway, et al, 2009) both to providing material resources for their children and to developing intimacy between father and child. In this way recommendations for best practice in the increased engagement of fathers are clearly available for incorporation into the universal level of the family offer and *Implementation Plan*.

## Support for breastfeeding

In contrast to the paucity of evidence linking health visitors to work with fathers, health visitors' support for infant feeding has been well documented. Promoting best practice in infant feeding and, in particular, supporting breastfeeding has become a public health priority for the UK government (Department of Health, Department of Children Schools and Families 2009a), and has long been recognised as a core component of health visiting practice. However, compared to other European countries, current UK breastfeeding rates are not high. The issue does not appear to be lack of initiation - Hamlyn 2002 (cited in Marshall et al, 2007) explains that 70% of women in the UK begin to breastfeed - rather it is the lack of breastfeeding continuation. Hamlyn notes that after 2 months only 28% of women are exclusively breastfeeding. Whilst there have been recent improvements, the pattern remains similar, with the 2010 UK Infant Feeding Survey showing a somewhat higher initial breastfeeding rate (81% ever breastfed), falling to 55% at six weeks and just 34% at six months (McAndrew,Thompson, Fellows et al 2012).  The literature suggests several reasons for this including: the changing role of women's participation in the labour market meaning that they may not be physically able to breastfeed exclusively (Kosmala-Anderson & Wallace, 2006 cited in Marshall et al, 2007) as well as the physical and emotional challenges associated with breastfeeding. Shakespeare et al (2004) conducted in-depth qualitative interviews with 39 post-natal women within Oxford City Primary Group area and found that difficulties with breastfeeding, such as associated pain and its time consuming nature, were common and caused emotional distress. Emotional challenges also relate to the social, emotional and cultural meaning of breastfeeding (Marshall et al 2007), which can make breastfeeding a 'moral imperative'. In particular, the cultural link between failure to breastfeed and being a bad mother (Murphy, 2003; Schmied & Barclay 1999, cited in Shakespeare et al, 2004) can fuel anxiety and esteem issues in the mother.

Skilled support for breastfeeding women has been shown to increase breastfeeding duration (Renfrew et al, 2005 cited in Spencer et al, 2010; Sikorski et al, 2003). Health visitors in particular are thought to be well positioned to support mothers with breastfeeding because of their continued and active engagement with mothers after childbirth (Cairney, Alder & Barbour, 2006). Although there is currently little evaluation of health visitors' impact on breastfeeding (Renfrew et al, 2005), there are indications within the literature illustrating why health visitors are suited to the role of supporting the initiation and continuation of breastfeeding. This support can be both technical and emotional. Technical support was identified as being of 'paramount importance to women' (pg. 2152) by a qualitative study of 22 in-depth interviews and 158 interactions between breastfeeding women and

midwives or health visitors in a PCT in the north of England (Marshall et al, 2007). Marshall et al found that health professionals (including health visitors) were able to provide not only the necessarily technical expertise but were also able to carry out emotional work, for example reassuring women about their breastfeeding.

Within the scope of emotional support, improving women's' confidence around breastfeeding appears to be key. In her ethnographic study of new mothers in an English maternity ward, Dykes (2005b) describes how women saw gaining confidence in breastfeeding as a primary goal in ensuring effective feeding of their baby. Similarly, Marshall et al (2007) reported that women wanted reassurance that they were doing the right thing when breastfeeding, and that it was important to have the support of health professionals even if they were just there to say 'you are doing well, keep going' (p. 2154). A particular concern of women was that they were not producing enough milk. It was with regard to this that the skilled and sensitive practice of health visiting in weighing infants and in helping mothers interpret their infant's weight was identified as particularly important. Monitoring the weight of all infants, especially breast feeders, is a skilled practice. Deciding upon when to weigh an infant interpreting the correct meaning of the resultant weight and conveying this sensitively to the parent is a key component of the health visiting role and one which can provide consistent and appropriate support for breastfeeding. Spencer et al (2010) explain how a number of studies have suggested that a failure to provide such support is one possible reason behind early cessation of breastfeeding.

Health visitor's understanding of the contextual influences on family health has been described elsewhere (Christie, Poulton & Bunting, 2008). In the field of breastfeeding Marshall et al (2007) found in their research study with mothers and health professionals, that one solution did not 'fit all' and that it was important for health professionals to gather knowledge on women's contextual circumstances so that that could provide tailored support to the woman. They identified that this is what health visitors were doing, they were considering each woman's individual circumstances and combining different sources of knowledge, including clinical and personal experience to make their support the most appropriate for the individual woman (Marshall, Renfrew & Godfrey, 2006). The non-judgemental approach of health visitors, which is one part of the respect for all persons identified in Chapter 3, was also identified as being an important part of breastfeeding support. However, the qualitative study of Shakespeare et al (2004) showed that whilst women found midwives to be non-judgemental and encouraging, health visitors were described by some participants as bossy, inaccessible and judgemental. Training may be one way of overcoming judgemental attitudes and improving continuation rates in general.

In their qualitative study of health visitors and breastfeeding effectiveness in Glasgow, Scotland, Tappin et al (2006) found that infants who were breastfed at the first visit were significantly more likely to be fed infant formula by the second visit if the health visitors had no training on breastfeeding in the

previous two years (although the authors do not discuss reasons behind this finding, i.e. what was it about the training that 'made the difference'). The call for improved training is also reflected in the findings of Simmons (2002a,b) who in her qualitative study of interviews with midwives, health visitors and breastfeeding mothers in a single NHS trust in England, found that inconsistent advice about breastfeeding from health professionals can have persistent disadvantages. Simmons argues that the large proportion of women who discontinue breastfeeding are doing so at a time when involvement from health professionals such as health visitors is at its highest, suggesting that the type and quality of health professional involvement may be inadequate.

One reason why there is little evidence on the impact of health visitors on initiation rates is that in reality, health visitors may have little involvement with women at the stage when breastfeeding initiation would be expected to take place i.e. after birth, in a hospital setting (or ante-natally, when decision-making takes place). For most women, their first days of breastfeeding commence in an institutional setting of the hospital (Dykes, 2005a), where the midwife would typically be the key contact for the woman. Carlisle (2008 cited in Spencer et al, 2010) explains how some health visitors have assumed that breastfeeding promotion and education is part of the remit of the midwife. However, the literature calls for coordinated, extended support from both the midwife and health visitor to be provided to the mother. Hoddinott et al (2009) show that professional support interventions which extend through pregnancy to after birth are more effective than those concentrated in a shorter period, i.e. with the midwife in the hospital. This suggests that the involvement of health visitors early on is important to support breastfeeding continuation, especially in light of the statistic presented by Bolling et al (2005 cited by Hoddinott et al, 2009) that in an infant feeding survey 17% of women had stopped breastfeeding by the time they come into contact with the health visitor for the first time at 7-14 days after birth. An appropriate time for health visitors to become involved could be soon after women leave hospital. Marshall et al (2007) show women feel particularly vulnerable in terms of breastfeeding confidence when moving from the hospital to their home. Whilst health visitors may have missed the critical 'initiation window', if they can get to the mothers in time, there is significant scope for health visitors to improve breastfeeding continuation rates especially as the support health visitors offer is within the context of the home, the neighbourhood and the community.

Support in the community has certainly been linked to improved breastfeeding rates. Hoddinott et al (2006) in their breastfeeding intervention study in Scotland showed that women who received ante-natal, birth and post-natal care from community midwife-led units were more likely to be breastfeeding at 2 weeks compared to women who received some or all care in district maternity units, which suggests that the community component is important for supporting women (although the authors do not make this link themselves). Dykes (2005b) takes this one step further and maintains that the hospital environment may not be the most suitable place for women to commence breastfeeding given its 'factory-like' nature. High levels of activity in hospitals may provide an additional reason for

this assertion, as in a study of 297 women expecting their first baby in Scotland, Cairney et al (2006) found that midwives (with the exception of community midwives) were seen as giving less support on infant feeding than doctors or health visitors. This was attributed to infrastructure issues and constraints that hospital midwives faced. In summary health visitors are well placed to support breastfeeding because of their work within the family home, neighbourhood and community and their ability to offer interventions which address need at each of these levels (Christie & Poulton, 2008; McIntosh & Shute, 2007).

## Unintentional injury

Unintentional injury, often occurring in the home, is a leading cause of death in children in the UK (British Medical Association, 2001 cited in Watson et al, 2005). This suggests that it is important to identify ways to reduce levels of injury in children, especially in the home environment (Watson et al 2005). The literature presents the case that health professionals are well positioned to play an important role in injury prevention, through home safety counselling, to safety equipment provision (Watson et al, 2005, 2007). Because of their work with families, health visitors appear to be particularly well placed to work on injury prevention in the home, an assertion supported by various studies including Marsh et al (1995) and (Hayes 1996) (cited in Watson et al, 2007) which additionally report that health visitors have a positive attitude to and an interest in injury prevention activities.

However, despite this, at present there is little evidence that primary care teams in the UK can be effective in reducing injuries (Watson, Kendrick, Coupland & Futers, 2007, p. 2). Woods et al (2004) adds that little is known about whether trained health professionals can influence behaviour change and the adoption of safety practices, both vital steps needed to reduce injury levels. The current evidence base related to the potential of health visitors is focused around a randomised control trial (RCT) by Watson et al (2005, 2007) and an RCT evaluating the effectiveness of injury prevention training for midwives and health visitors by Woods et al (2004). These studies along with an evaluation of an accident prevention scheme by peer educators by Carr (2005a) also provide evidence of the current role of health visitors and the challenges they face with regards to injury prevention.

Although it is difficult to generalise from the current literature base, there are indications of what health visitors are currently doing in the field of injury prevention work. From the literature we can infer that health visitors are primarily taking an educational role in injury prevention, often focusing on a micro, individual level, rather than on the broader public health level (Watson et al, 2007). However, the literature does not extend to a fuller discussion of what health visitors do, rather it focuses mainly on the barriers that health visitors experience and the reasons why they cannot adequately perform this educational role. Reporting on a survey of 51 health visitors and 7 nursery nurses taking part in a large injury prevention RCT in a deprived area, Watson et al (2007) identified that although health visitors were in theory well placed to work alongside families in injury prevention work they faced

many barriers in practice, such as pressure from competing priorities, leaving them with insufficient time available for prevention work. Woods et al (2004) also claim that a lack of training is a significant barrier for midwives and health visitors to be effective in injury prevention. The authors found that injury prevention training was associated with greater knowledge of safety practices, although they are unable to link this training to injury reduction. We could infer that such barriers limit the impact that health visitors could have on injury prevention rates. However, there is no evidence of a reduction in injury rates even when health visitors are engaging in safety consultation work and providing free safety equipment (often cited as a barrier to injury reduction Watson et al 2005, 2007). Watson et al (2005) reported on an RCT conducted by health visitors with 3428 families, which included safety consultations and the provision of free safety equipment to those on low incomes, but found no significant difference in the proportion of families with children with medically attended injury between the control and intervention groups. The authors did find at follow up that the intervention families were more likely to have a range of safety practices but it is hard to draw strong conclusions from the results as a number of families in the intervention did not receive safety consultations or the free safety equipment.

Some successes in injury prevention were reported by Carr (2005a) although the scheme did not involve health visitors rather peer educators who took on the educational role of health visitors in a deprived community in the North of England. Carr trained up three mothers to work as peer educators who would act as conduits of advice or information to their local community. Such a scheme was successfully trialled in Northern Ireland by Mullen and Smithson, 2000 (cited by Carr 2005a). It showed that peer educators had the potential to have a successful impact on accident prevention education and that the peer educator approach appeared to offer a means to help develop trust between service providers and marginalised populations, those most reluctant to accept statutory service interventions. Carr claims that peer educators have the advantage of being from the local community, which enables them to gain greater access to and engage with community members. This advantage was thought to be important because of reports from community workers in the area that families were reticent to engage with statutory services such as health visiting services (Carr, 2005b). The points of success for Carr's study were that the families welcomed the peer educators into their homes and had an interest in their work. Health visitors also commented that they were happy with the peer educators' work and were confident that injury prevention was not being neglected because now peer educators were taking on the prevention role under the professional leadership and guidance of the health visitor who was acting in a leadership role for this aspect of service delivery.

## Vaccination and Immunisation

Vaccination is an important health promotion activity within the HCP and subsequently within the scope of health visiting work (Redsell, Bedford, Siriwardena, Collier & Atkinson, 2010). The high uptake rate for primary vaccines in the UK has led to a significant reduction in mortality and morbidity

(Bedford & Lansley, 2006). However, this high uptake is dependent upon parents being well informed and knowledgeable about vaccinations as parental consent is a key part of the process, seen in the recent decline in Measles, Mumps and Rubella (MMR) vaccine uptake because of health concerns sparked by the media (McMurray et al, 2004). Therefore providing parents with information must form an important part of immunisation services (Bedford & Lansley, 2006). Health visitors are a key link in this information sharing process chain, and along with local practitioners, are a traditionally trusted source of information (McMurray et al, 2004). However, it is health visitors who routinely provide immunisation information for parents, whereas GPs and practice nurses tend to administer vaccines and respond to parents' questions (Redsell et al, 2010). Supporting this assertion is the work of Bedford and Lansley (2006), who in a survey of parents' views about information on immunisations in three English PCTs, found that along with NHS leaflets, health visitors were the most frequently mentioned source of information. They also found that parents agreed that their health visitor was able to answer most of their questions. The approach that health visitors take to the provision of immunisation information is also different to other health professionals. Redsell et al (2010) explored health visitors' perceptions of their role in the universal childhood immunisation programme through semi-structured interviews with 22 health visitors in one county in the UK and found that health visitors used a parental decision making model, whereas other health professionals took a more paternalistic approach to immunisation provision. The 'parent-centred' approach used by health visitors could be especially important with regards to the complexities surrounding vaccination decisions.

Redsell et al (2010) explains that because childhood immunisations are voluntary, parents balance concerns for vaccine side effects with concerns about the risk of disease. Health visitors also need to achieve a balance between their public health role and that of providing (non-judgmental) support to parents. Redsell et al showed that health visitors were not only responsible for actively promoting the immunisation programme and persuading parents who were not sure, but also felt that they needed to maintain relationships with parents. Health visitors described the difficulties of the trade-off between pressurising parents and maintaining relationships with them. In developing strategies to encourage uptake, health visitors reported modifying their practice to accommodate their different family (client) groups. Health visitors reported that middle class families required more information regarding the MMR vaccine (because of the controversy surrounding it in recent years, McMurray et al 2004); whereas health visitors felt that they should provide just the basics of timing and administration of immunisations to other families. This provides evidence of health visitors adapting their practice and considering the needs of different parent groups.

The tension felt by health visitors who wanted to be seen as not just pushing immunisations is reflected in the finding that health visitors were seen by parents as government agents, who couldn't be trusted (Redsell et al, 2010). A key theme in the literature suggests that with respect to immunisation, parents can perceive that rather than being a neutral expert source, health professionals lack political and financial impartiality (Bedford & Lansley, 2006, McMurray et al, 2004).

McMurray et al (2004) conducted 69 one-to-one interviews with parents of children aged 4-5 years and 12 interviews with primary care practitioners, including health visitors in England. They found that parents were concerned about consultation legitimacy and impartiality and the authors called for parents not to be seen as 'passive receptors or empty cognitive vessels waiting to be filled' (p. 524). However, Redsell et al (2010), maintain that the health visitors in their study believed that they were enablers of parent choice and not tainted by financial incentives, as GPs were. They also distinguished themselves as experts in communicating with parents about immunisation. In their communications the health visitors in Redsell et al's study saw themselves as being sensitive to the needs and priorities of parents, although the authors do not report on how parents perceived the health visitors.

In light of the controversies around vaccinations Benin et al (2006, cited in Bedford & Lansley, 2006) argue that parents must be able to trust the health professional who is communicating the immunisation information. Where health visitors have built relationships, as described earlier in this chapter and in Appendix 1 (Bidmead's 2013 work), health visitors are in a good position to develop this trust. McMurray et al (2004) claim that health professionals must develop collaborative approaches to information exchange to secure more informed decisions around immunisations, such as the approach by health visitors seen in Redsell et al's 2010 study. McMurray et al argue that practitioners 'can only guide parents through conflicting evidence as part of facilitated learning process where they are seen as a trusted information source' (McMurray, et al., 2004, p. 521). This highlights the key and distinct contribution of health visitors to immunisation provision and also links to discussions on how health visitors build trusting relationships with parents.

The literature also calls for health professionals to give more time to parents. Bedford and Lansley (2006) found that 20% of parents surveyed were not satisfied with the information they had received, citing that it was inadequate, which meant that they had to spend time searching for sources of information. McMurray et al (2004) also reported that parents also had insufficient contact with health professionals, which meant that the decisions that they made about vaccinations did not reflect an informed choice. They maintain that information must be delivered in 'time-rich contexts' to enable parents to construct their own understanding. Redsell et al (2010) also found inconsistencies in how health visitors perceived their role in immunisation. They found that some health visitors believed that immunising children themselves was an integral part of their role as they were trained immunisers; however, others felt that health visitors' main responsibility was the provision of information and that the administration of vaccinations should be left to practice nurses. This difference in perception of role links to wider discussion on how you define the work of health visitors.

An additional barrier cited by Redsell et al (2010) is that health visitors found that although they were required to discuss immunisations with parents during the birth visit at 14-28 days, most felt that this was not the most appropriate time as parents had other priorities and may feel 'overloaded'. The authors cite this as an example of the challenges of putting policy into practice, in that health visitors

did not necessarily support policy which states that birth visits are the most appropriate time for vaccination discussions but that this should rather be part of a series of contacts between the health visitor and the family initiated in response to identified needs and as proposed within the new service vision.

## Conclusions

### Summary of findings

The Universal provision is the cornerstone of the health visiting service, which is reflected in the questions we asked.

**Question: What is known about how health visitors deliver the Universal level of the 'new service vision'?**

- The 'health visiting orientation to practice' (described in Chapter 3) appears to influence the way health visitors work in any situation, but is particularly evident in delivery of the Universal service, which then operates as a gateway to other levels of provision.

- Although they are researched as separate processes, three core practices appear to operate together in delivering the Universal service:
    i. the health visitor-client relationship,
    ii. health visitor home visiting and
    iii. health visitor needs assessment.

  Research about each of these three components of practice describes similar skills and attributes, and cross-references the other two, indicating that they operate as a single process.

**Question: What is known about specific health visiting skills?**

- Parents value health visitors' specific knowledge about child and family health, particularly when combined with highly developed interpersonal skills. The ability to be empathic, client-centred and

reflexive leads to reciprocity (e.g., respect for the parent is likely to be returned) and a greater likelihood that parents will accept health visitor information or advice.

- Research suggests that health visitors need more topic-specific education and training about working with fathers, breastfeeding support and promoting safety in the home.

- Health visitors need support and education to deal with potential contradictions if the need to promote official targets conflicts with the need for sensitivity to service users' views and cultural expectations.

**Question: What is the evidence about current health visitors' practice and what makes this work effective?**

**Question: How and in what ways does this work benefit families in terms of outcomes?**

- There is some evidence that health visitors successfully promote breastfeeding and home safety on a one-to-one basis, which they are well placed to undertake, but the effectiveness of these approaches are limited because wider family/cultural issues are also important.

- Time and timeliness are both issues that enhance or inhibit effectiveness; for example, providing weekly home visits for only six weeks (whereas 12 months is the usual minimum) showed little benefit, and health visitors struggled to promote immunisations sensitively within a single, crowded post-natal visit.

- There is evidence that mothers receiving monthly home visits are less anxious and use services more confidently, whilst ante-natal and post-natal promotional interviewing by specially trained health visitors is associated with improved mother-child interaction.

**Question: What is the nature of the health visitor-client relationship?**

**Question: Identify the different elements of the health visitor-client relationship and provide an evidence-base for the impact of these on child and family life.**

- That preliminary work details the nature of the health visitor-parent relationship, explaining how it operates as an integral part of the health visiting process, (as outlined above). The qualities and skills of both health visitor and parent influence formation of the relationship, which then enables health needs to be identified and met in partnership with parents, then through:
  - exploration,
  - understanding and clarification,
  - setting goals and aims
  - identifying strategies to achieve them.
  - implementing, then
  - reviewing with parents

- Key processes involved in relationship-formation often proceed in tandem with home visiting and clinic attendance. Organisational factors may permit or inhibit factors such as relational continuity (e.g., health visitor being able to carry out return home visits, and see family in clinic), or the opportunity for health visitors to focus on issues that are important to parents rather than on predetermined priorities alone.

- Professional-parent relationships feature regularly as one element of research (e.g. in post-natal depression and mother-infant attachment) but we did not identify any studies that focused on evaluating the impact of the health visitor-parent relationship.

- There is research in progress at King's College to develop instruments to measure the health visitor-parent relationship and we include a report of the first phase of this study in Appendix 1 (Bidmead 2013). Validating the instruments will allow future research to assess any impact of the health visitor-parent relationship on child and family life.

## Discussion

The core, summarising question for this chapter was ***"What are the key components of health visiting practice and how are they reflected in implementing the 'new service vision' and HCP?"*** The literature identified for this chapter described the key components of health visitor interventions through relationship-formation, within the home generally and for the purposes of health needs assessment. These are the visible signs of the approach to practice described as 'salutogenic' or health-creating, involving a sense of 'human valuing' and human ecology, as described earlier in this chapter and in Chapter 3. We would argue that a focus on health, rather than on illness, is demonstrated through this triad of core practices (home visiting, relationship formation and needs

assessment) and that, combined with the underpinning 'orientation to practice,' it sets health visiting apart from other workers in health and social care. It informs the practice of health visiting and shapes its unique contribution to child and family health promotion, which makes health visitors the most appropriate workers to deliver the Healthy Child Programme.

The evidence is consistent in the above fields, giving a clear description of what is intended and linked with some evidence of success when the approaches can be fully implemented. However, the picture is less clear when we drill down into some specific fields of practice for the Universal service. We looked at work to involve fathers, support for breastfeeding, supporting safety within the home and promoting immunisation uptake. In each of these important fields, there is wide recognition of their importance and of the opportunities available to health visitors, as a result of their Universal service provision, but the research is widely dispersed and small in scale, without a strong theory base. Whilst there is some evidence of effectiveness, recorded effects are often small or seen only in secondary outcomes, possibly because of short-term and potentially over-ambitious targets – for example, reduction of unintentional injuries has much to do with the state of housing and wider family support, so when health visitors delivered educational packages and access to home safety equipment, they achieved a change in individual safety behaviours, but not a reduction in the number of accidents.

In each of our selected fields, too, there was a clear message that health visitors needed more topic-specific education, as well as support and help to overcome barriers to activities that arising from organisational constraints, such as lack of time or requirements to deliver health-related messages at key times. Similar features recurred in other chapters, so we will return to them.

# Chapter 5 - Universal Plus services

## New service vision:  Universal Plus services

Families may need help 'some of the time' with particular issues of concern, which may require a short or slightly longer intervention, depending on the nature of the worrying issue and the extent of family vulnerability. Using the terminology of the 'family offer,' families are advised that 'Universal Plus gives you a rapid response from your health visiting team when you need specific expert help, for example with post-natal depression, a sleepless baby, weaning or answering any concerns about parenting.'  Health visitors are expected to use their professional judgement and expertise to provide, delegate or refer to other services, such as Sure Start Children's Centres or to other health professionals to enable families to access appropriate services when they need them. The ability to collaborate across local community services - as detailed in Chapter 3 - and assess health needs - as detailed in Chapter 4 - are inherent in and critical for the Universal Plus level of provision.

This Chapter explores the requirements for leading skillmix teams and delegation, as well as delivering specific interventions or packages of care. To find out what is known about how health visitors implement the Universal Plus level and whether it enables families who need more support to access the services they need, we asked some key questions:

- How and in what ways does the Universal Plus health visiting work benefit families in terms of outcomes?
- Does the health visiting service enable families who need more support to access other services? How?
- What is the evidence about safe and effective delegation or referral pathways, to inform skillmix models?

The core question for this service level is:

- **What is the health visiting contribution to leading and delivering services where families need support or help with specific issues?**

## The evidence from the literature

Universal Plus describes a form of family offer that is not very well specified, but which potentially encompasses a breadth of issues. Guided by the He selected key commonly arising concerns as

topics for our structured search, and examine here the evidence about how health visitors deal with post-natal depression (as a key mental health issue in the peri- and post-natal period), nutrition and obesity and support for parents and parenting and any evidence of how the Universal Plus service benefits families in terms of outcomes. Also, we reviewed the literature for evidence of how health visitors implement the Universal Plus service, how families access other services, how skillmix has been implemented in health visiting teams and how this influences service delivery. This chapter is therefore divided into these two key areas:

1. Benefits to families and child health outcomes

2. Service implementation, skillmix and enabling access to other services

## Benefits to families and child health outcomes

### Supporting parents experiencing post-natal depression

Post-natal depression affects between 10 and 15% of women having a baby (Royal College of Psychiatrists[4]), so this is one of the most frequent reasons that women will need the Universal Plus level of service provision. Data on the prevalence of paternal post-natal depression are less clearly defined (a meta-analysis by Paulson & Bezemore, 2010, reporting a meta-analytic average of 10.4%) but the detrimental effects of paternal depression on children's behavioural and emotional development and its economic impact on health care costs have also been documented (Edoka, Petrou & Ramchandani, 2011; Ramchandani, Stein, Evans & O'Connor, 2005). However, the majority of studies investigating the role of health visitors in detecting and addressing parental mood disturbances following the birth of a child refer to maternal depression and we report therefore only on these in this section.

Based on an analysis of systematic reviews of the evidence, in 2007 the National Institute for Health and Clinical Excellence (NICE) published official guidelines for the prevention and treatment of maternal post-natal depression (NICE 2007). Further details on the evidence on 'what works' in this area of care are elucidated by Barlow and her colleagues in their detailed examination of systematic reviews on parenting interventions in pregnancy and the early years (Barlow et al, 2008). In their 2008 report, these authors summarise that "*there are currently no effective interventions to prevent postnatal depression in low risk populations*", that "*the use of simple questions to identify women with postnatal depression appear to have similarly low predictive validity to screening tools such as the EPDS* [Edinburgh Postnatal Depression Scale]*, but appear to be more acceptable to women*". With regard to the treatment of post-natal depression, they conclude that:

> *Inter-personal psychotherapy, cognitive behavioural therapy or listening visits in the home*
> *are effective for women who have developed symptoms of depression. One-to-one therapy*

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[4] http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/postnatalmentalhealth/postnataldepression.aspx

*appears to be more effective than group work. Treatments should be combined with patient education about the illness, the treatment selected, and other mechanisms for promoting health such as social support and a healthy lifestyle. Women requiring psychological treatment should be seen for treatment normally within 1 month of initial assessment, and no longer than 3 months afterwards. Social support (individual, including home visiting, or group-based interventions) is recommended for women who have subthreshold symptoms and who have not had a previous episode of depression or anxiety. Dyadic treatment is recommended to improve parent-child interaction in women experiencing depression in the postnatal period. (p.71)*

These considerations are essential for the design and implementation of cost-effective services. However, further evidence has become available since the completion of the review by Barlow and her colleagues. We review here only the papers that report on the specific role and contribution of health visitors, hence the relatively small number of publications cited from the much broader literature on peri-natal and post-natal depression and related issues. In addition, some of the studies discussing post-natal depression but focusing primarily on a different health issue are reviewed under a different heading (e.g. seldom heard groups).

Our structured searches identified over 35 papers relating to post-natal depression, which were reviewed in full text. Once they had been filtered to identify whether the contribution of health visitors was specified, that number was reduced to 19. Most of the other papers contained little information about health visiting practice, whilst others were non-empirical or primarily about another issue, such as the needs of minority ethnic mothers (Baldwin & Griffiths, 2009) or social support for mothers living in a disadvantaged area (Wiggins et al, 2005), so they were reported under a different heading (seldom heard groups). A couple of papers were mainly about instrument development and use (Ingram & Taylor, 2007; Milford & Oates, 2009), so they are not included. Of the remaining papers, some are more useful than others.


The systematic review by Morrell et al (2006) summarises the main findings from 57 trials examining ante-, peri- and post-natal interventions – by midwives and/or health visitors – for the prevention and/or treatment of post-natal depression. The review highlights that the evidence of effectiveness was limited and that many studies had methodological or reporting limitations. In addition it signals that, with the exception of the PoNDER (Post-Natal Depression Economic Evaluation and Randomised) controlled trial carried out by the authoring team, the studies examined would all require further economic evaluation. The PoNDER trial, carried out in England between 2003 and 2006, is the study that most strongly supports the impact on health outcomes of training health visitors to identify depressive symptoms in mothers and to provide psychologically oriented support (Brugha, Morrell, Slade & Walters, 2011; Morrell et al, 2011; Morrell et al, 2009). The authors found that when health visitors underwent training in identifying depressive symptoms, developing therapeutic relationships and providing psychological approaches to managing depression, women with all levels of risk as predicted by EPDS score at 6 weeks post-partum showed improvement on later EPDS scores. In fact,

the effects of this training on women with low EPDS scores is the most interesting, as they did not undertake the psychology-oriented sessions with health visitors. The authors hypothesise that the health visiting services that had adopted the experimental protocol were probably characterised by a more supportive practice environment in which the focus of care encompassed the psychological wellbeing of the mother as well as the physical welfare of the child (p.745). It is possible that the training offered to health visitors within these services enhanced their communication skills and empathic approaches more broadly, enabling them to better tune in to the emotional and psychological needs of the mothers they visited. This interpretation is somehow supported by the findings of Christie and Bunting's cluster randomised trial, in which weekly post-natal visits to 'low risk' families - in the absence of any specific training for health visitor - had varying effects and did not seem to be linked to improved health outcomes, as measured through EPDS scores, in the intervention group (Christie & Bunting, 2011) Although more research is needed to consolidate the promising results of Brugha and colleagues, this work indicates that health visitors can have a central role in the prevention and early treatment of post-natal depressive symptoms. The cluster randomised study carried out by Barnes, Senior and MacPherson (2009) did not find any evidence that informal preventive volunteer support, delivered as part of a 'Homestart[5]' scheme in a deprived area by volunteers with their usual preparation plus two days additional training specifically for the study, can have substantial impact on measures of depressive symptoms at 2 and 12 months after birth, which adds strength to the argument that this work should be central to health visitors' role .

To some extent the findings by the PoNDER team also indirectly support the argument for the important role of health visitors in mental health support for families. Health visitors in the PoNDER trial were trained to use the EPDS scale and to use clinical assessment skills to assess a mother's mood and any possible suicidal ideation. They were also trained to deliver psychologically informed sessions by drawing upon specific theories – either cognitive behavioural principles or person-centred principles (Morrell et al, 2009). This type of training appears too specialised to be suitable for lay support workers and is best aimed – we suggest - at qualified health professionals who are versed in the subtleties of needs assessments and who can readily familiarise with and confidently utilise psychology-oriented intervention tools. Although this does not exclude the potential suitability of other health professionals for this type of intervention, due to their availability in the community and – where services work well – ongoing relationship with the family, health visitors are particularly well placed to provide effective support with peri-natal depression and some of the strongest evidence of positive outcomes comes from this form of intervention by health visitors.

In 2005, McConnell, Baker & Marks had already signalled the importance for health visitors' effective practice of more in-depth understanding of depressive symptoms and interpersonal dynamics in the course of consultations. In two publications appearing in *Community Practitioner* in 2005 these authors explored health visitors' conceptualisations of post-natal depression, their emotional

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[5] Homestart is a charitable organisation that helps to increase confidence and independence of families, by visiting them in their own homes to offer support, friendship and practical assistance. http://www.home-start.org.uk

involvement in professional-client exchanges, and the role of sustained supervision in psychology-oriented training (Marks, Mcconnell & Baker, 2005; McConnell, Baker & Marks, 2005). These, we suggest, are all themes central to the analysis and development of health visitors' professionalism and that are only too often neglected by health visiting research.

Indeed, our review highlighted the weak analytical character of a significant proportion of the articles identified. For example, some survey-based studies report interesting statistics but lack methodological detail and offer underanalysed results (e.g. Russell 2006; 4Children 2011); some qualitative studies present stimulating data excerpts, such as on the reporting of health visitors delivering listening visits (Shakespeare, Blake & Garcia, 2006; Turner, Chew-Graham, Folkes, & Sharp, 2010), but offer little in-depth analysis of these (e.g. Brown & Bacigalupo 2006; Poole, Mason and Osborn 2006; Shakespeare, Blake & Garcia, 2006; Chew-Graham et al, 2008); and finally there are papers reporting on potentially interesting initiatives that are not illustrated in much detail (e.g. Lewis, Ilott & Lekka 2011).

## Nutrition and obesity

The time and energy parents dedicate to feeding activities is significant however, infant feeding is wrought with challenges, from the physical and emotional challenges associated with breastfeeding, to weaning decisions regarding appropriate timing and choice of food. Alongside this parents are confronted with strong public health messages surrounding obesity. Parents are encouraged to breastfeed as it provides their children with protective elements against infection and allergies and lessens the risk of obesity, as well as develops healthy eating patterns and an active lifestyle for their children upon commencement of weaning (Department of Health and Department for Children Schools and Families, 2009a). We have explored health visitor's involvement in breastfeeding/formula feeding in Chapter 4; here we examine evidence about the role health visitors play in weaning and post-weaning infant feeding, with a particular focus on obesity. Help with tackling infant obesity (for example through a tailored obesity programme) is an example of an additional care package provided to 'some families some of the time' as part of the Universal Plus level. Weaning support could be considered both a universal service as well as a Universal Plus service when taking into account the relationship between decisions made about food choice and portion size and an infant's obesity risk.

Weaning refers to the transitional period for feeding in the first year of life, when infants move on from milk-based nutrition to a varied diet including solids (Gildea, Sloan & Stewart, 2009). The Healthy Child Programme (Department of Health, Department of Children, Schools and Families 2009a) recommends that parents delay weaning until their infants are around six months of age and only introducing healthy foods whilst controlling portion size. This can be a difficult time for parents, partly because of the numerous, conflicting sources of information regarding infant feeding for parents. Gildea et al. (2009) attempted to establish which of these sources was the most common for parents in Northern Ireland. Of the 215 mothers of one-year old infants interviewed in this qualitative study,

70% of mothers cited the health visitor as a source of feeding advice during the first year, making them the most common source, followed by grandparents (53%). Other health professionals were not rated as highly as health visitors, for example only 15% cited the doctor as a source of feeding advice. For 21 out of the 215 mothers the health visitor was the only source of advice, suggesting that health visitors play a key role in supporting mothers with infant feeding decisions.

However, Watt et al (2009) - in their paper on a social support intervention randomised controlled trial on infant feeding practices - refer to two studies which identified that parents' decisions to wean their infant sometimes conflicted with health professionals' advice as they were determined largely by the infant's physical characteristics and behavioural actions. This suggests that there is some ambiguity as to the extent to which parents are reliant on formal sources of feeding advice such as health visitor support. This may, however, reflect the lack of detail regarding the weaning role of health visitors in the Healthy Child Programme guidance framework for health visitors. The secondary literature also questions to what extent health visitors can be effective in guiding parents to make appropriate (and safe) choices in weaning. For example, commenting on their research conducted in a deprived area of the UK, Daly et al (1998) drew attention to the strong cultural and family impact on weaning and feeding choices, often guiding mothers towards weaning practices that are not recommended. They concluded that health visitors by themselves are unlikely to be successful in addressing problems of early weaning and the premature introduction of cow's milk (both potentially harmful to the infant), because nutritional educational interventions (which a health visitor could feasibly provide) on their own are insufficient to overcome such influences.

An area where health visitor intervention has been more clearly documented (at least in formal reports) is the area of obesity prevention and reduction. Within the Healthy Child Programme clear actions are identified for health visitors to take the lead in obesity prevention and reduction work, including identifying children and families who are most at risk of obesity and, for some families, providing skilled professional guidance and support where the health professional works in partnership with the family, setting small goals and exploring family relationships (Department of Health, 2009a). Rudolf (2009) provides guidance to support health professionals in the obesity prevention work of the HCP in the form of a framework for action. In this report Rudolf argues that an approach such as the Healthy Child Programme is particularly appropriate for addressing obesity in children because of the emphasis of partnership working and parenting and the focus on the social model of health. The use of the social model within health visiting means that it is especially appropriate for health visitors to be involved in obesity work and to lead colleagues away from a medical model of health care (Rudolf, 2009). As with weaning, the evidence base is not significant with regard to the obesity work of health visitors. Barlow et al (2010) describe the activities of health visitors within a discrete EMPOWER (Empowering Parents to Prevent Obesity at Weaning: Exploratory Research) intervention for parents whose babies are at high risk of obesity. The programme was delivered by specially trained health visitors, suggesting that the practices described would not necessarily fall within the normal scope of health visitor practice, although the idea was that the 'package of care' developed by the research could be delivered to obese mothers whose infants are at risk of gaining excess weight. Barlow et al (2010) found that families considered the approach

of the EMPOWER health visitor helpful with its emphasis on listening, partnership working and shared problem-solving as part of the Family Partnership Model, which uses a strengths-based, solution-focused way of working with families (Davis & Day, 2010). The fact that some of these 'helpful' traits appear to be consistent with the everyday approach of health visitors could provide hints as to how health visitors could be effective in their obesity work as part of Universal Plus service provision, although we found no direct evidence to show this.

Sensitive engagement with families is vital in obesity work because of the perceived stigma associated with obesity. Barlow et al (2010) found that the women involved in EMPOWER valued health visitors providing on-going support, listening to them and showing them empathy. This empathy was especially important given the complex emotions the mothers experienced around feeding and obesity, and their heightened awareness of being 'blamed' for their children's obesity (Barlow et al., 2010). However, Rudolf (2009) cites a document produced for the Royal College of Paediatrics and Child Health (2006) on parents' and health visitors' views on preschool obesity, which finds that health visitors feel discomfort about raising the issue of weight gain in a baby particularly when mothers are obese themselves. This may reflect the assertion in Rudolf's report that health visitors feel that they lack the training, skills and time to work with parents on obesity problems. Additional challenges faced in tackling obesity may include the perception amongst health practitioners that weight management is an unrewarding part of the role. Edmunds (2005) explored parents' perceptions of help-seeking experiences with health professionals (including health visitors, although their specific contribution wasn't discussed beyond the finding that health visitors offered practical advice to parents) and found that their responses ranged from positive but not very helpful to negative and dismissive. Edmunds links these 'less-than-ideal' responses to the unrewarding nature of weight management coupled with the perception that obesity in the child was down to lifestyle rather than being a medical issue. Although not a link made by Edmunds, the nature of obesity – as a result of lifestyle – could be something that resonates well within health visiting, in that being privy to the home environment, and thus catching a glimpse of lifestyle, may mean that the health visitor is well placed to both address the lifestyle triggers and causes of obesity in the child. It also provides an example of how health visitors enable parents to access appropriate services through universal provision and additional care when needed.

## Support for parents and for parenting

Of 77 papers identified, 20 are reviewed below as providing relevant information about the contribution of health visitors. Some of the other papers described programmes that, whilst potentially important in their own right, made little mention of health visitors, perhaps mentioning them as referral agents or as participating in service delivery without giving further detail, or were more relevant to other chapters and included there. Scott (1998) made a distinction between work that is concerned

with supporting the needs of parents and the work that aims to alter parenting behaviours and practices. Furthermore, in order to alter how parenting happens, it may be necessary to address the situation or context surrounding the parent to enable desirable practices to flourish. As considered in Chapters 3 and 4, support for parents underpins much routine health visiting work, which also allows scope for the development of a relationship between the health visitor and parent (Chalmers, 1992; de la Cuesta, 1994b; McIntosh & Shute, 2007). However, there are often occasions when additional support is needed to help parents deal with specific behavioural concerns, such as sleeping (Merrifield, 2005; Milford, Kleve & et al, 2006) or conduct (Merrifield, 2005; Bateson et al, 2008), or with a specific condition such as autism or (see below) ADHD.

Papers discussing parenting and parenting support issues for health visitors covered all the different levels of the 'family offer', either providing messages for practice (Bayley, Wallace & Choudhry, 2009; Bloomfield et al, 2005; Gillies, 2006; Taylor et al, 2009; Whittaker & Cowley, 2012) or evidence of practice (e.g. McIntosh & Shute 2007; Bateson et al, 2008). The concepts within them were included in the analysis reported in Chapter 3, as were ideas from many of the papers reviewed below. However, in this chapter, we describe the evidence about parenting across all the service levels because the papers constitute a relatively coherent component of the literature.

The messages for practice typically concerned the need for practitioners to attune to parents' real lives in order to provide offers of help that are relevant and accepted by those who stand to benefit. This included the need for proactive effort to understand the perspectives and meet the needs of fathers as well as mothers (Deave et al, 2008), especially when the service is perceived as being female oriented (Bayley et al, 2009). In exploring ordinary family life experienced by working class parents, Gillies (2006) interviewed mothers (n=25) and fathers (n=11) across 27 households in England and Scotland as part of an Economic and Social Research Council (ESRC) study. Gillies' (2006) analysis demonstrates that those living with disadvantage invest no less in their children, just differently than middle class families. These differences are at odds with middle class parenting perspectives and raises potential for professional misjudgement and a blindness to the resources drawn on and provided by working class parents for their children. Similarly, Bloomfield et al.'s (2005) study using focus group interviews with parents (n=26), health visitors (n=19) and support workers (n=25), indicates some dissonance between parent and practitioner perceptions of child rearing challenges, with the associated risk that health visitors may misjudge clients' parenting priorities. Indeed in Taylor et al's (2009) factorial survey of 200 health visitors', judgements of 'good enough' parenting were found to be influenced by parental boundary setting, health behaviours and type of housing inhabited as opposed to family context, maternal age, medical history or child behaviour. This together with the analysis of family life provided by Gillies (2006) suggests the potential influence of socio-cultural factors and thereby bias that may be introduced to professional judgements if the practitioner is insufficiently sensitised to the parenting circumstances.

For parents in Bloomfield et al's study and elsewhere (Whittaker & Cowley, 2012), managing child discipline was identified as a particular challenge, which for Whittaker and Cowley's (2012) survey participants (n=168) was also correlated with greater levels of tiredness. Sufficient and timely

practitioner sensitivity to these seemingly ordinary parenting experiences may be important for helping parents manage difficulties early on to avoid escalation and problem development that would then require more intensive intervention.

Many of the papers we identified provide evidence of practice pertinent to the Universal level, however this is a collection of disparate studies that vary in methodology and quality and thus offer little conclusive evidence of service outcomes. Seven studies report on parental service experiences of health visitor-led support for parents, and use either survey methods (Russell & Drennan, 2007), pre- and post service questionnaires (Cox, 2008; Bateseon et al, 2008), an experimental method (Christie & Bunting, 2011) or qualitative interviewing (Hillen, 2004; McIntosh & Shute, 2007;Christie et al, 2008; Deave et al, 2008; Hogg & Worth, 2009). Unfortunately only two of the qualitative papers applied a theoretical interpretation to findings to support a wider relevance of results (Christie et al, 2008; Deave et al, 2008), although collectively they provide interesting parental insights following group and/or individual contact. These insights are summarised as the parental desire for access to knowledgeable, caring practitioners who are able to understand and appropriately support their individual needs. In the few reported examples of Universal Plus health visitor practice, authors suggest there can be promising outcomes from additional trained health visitors providing focused help for early identified sleep (Merrifield, 2005) and behaviour difficulties (Milford et al, 2006). However these papers illustrate the paucity of available empirical work for this service level, as we were only able to locate evidence of single projects reported as local evaluations using audit (Merrifield, 2005) or pilot data (Milford et al, 2006).

Other evidence of practice is derived from health visitors themselves who report on their activities in assessing child health (Puckering et al, 2011) and awareness that on occasions they lack sufficient knowledge to intervene when there may be psychological or behavioural problems (Wilson et al, 2008b). In two separate qualitative studies health visitors report a concern for having enough time to assess parent-child attachment and again emphasised the need for sufficient knowledge and skill to do this properly (Pettit, 2008; Wilson et al, 2008a).

Some forms of practice - for example where the health visitor had received additional training to deliver a targeted service via home visiting (Sonuga-Barke et al, 2001; Sonuga-Barke et al, 2004; Barlow et al, 2007a,b) or delivery of group parenting training (Edwards, Ceilleachair, Bywater et al, 2007; Hutchings et al, 2007; Patterson, Mockford & Stewart-Brown, 2005; Stewart-Brown et al, 2004) - fell within the Universal Partnership Plus level. The families participating in these studies were either parenting children with behavioural difficulties or children at risk of neglect. The work of Sonuga-Barke and colleagues involved health visitors working with parents of children with ADHD, although there were notable differences in the results of the two trials and the circumstances for delivering the intervention (Sonuga-Barke et al, 2001; Sonuga-Barke et al, 2004). The first achieved a reduction in the children's ADHD symptoms and improvements to maternal wellbeing following home support provided by specialist health visitors who regularly worked with this specific client group (Sonuga-Barke et al, 2001). The second involved generic health visitors who also provided universal services

and did not demonstrate the same reductions in ADHD symptoms and maternal wellbeing worsened in both control and intervention groups (Sonuga-Barke et al, 2004).

Kane, Wood & Barlow's (2007) review was a meta-ethnography of four studies examining parenting programmes for parents of children identified as having behavioural difficulties. In their review, Kane and colleagues aimed to examine what made focused parenting programmes meaningful for parents. They concluded that based on parental perceptions, programmes addressing knowledge, skills and understanding whilst also providing support from peers within the parenting groups, assisted individuals in regaining control and an ability to cope. This, in turn, reduced a sense of guilt and isolation and helped them empathise with their children. Little of the practitioner contribution is mentioned other than acknowledging the value of providing non-judgemental support, although it might be reasoned that this was important for creating a group environment that allowed parents' own needs to be acknowledged and learning to be facilitated. However, only two of the four papers (Kilgour & Fleming, 2000) and (Stewart-Brown et al, 2004) involved health visitors in delivery of interventions and because Kane et al.'s review is chiefly concerned with the programme as opposed to the practitioner it is unsurprising that the insight it offers into health visitor practice is limited.

## Specialisation, skillmix and health visitor team organisation

### Specialist health visiting

In Chapter 3, we examined the research about how health visiting services fit with other community provision and their broader organisation. Here, we consider the teams led by health visitors and the way they operate, including skillmix models.

When considering papers for the Universal Plus level of the family offer, we anticipated finding examples where 'packages of care' were delegated to more junior members of the skillmix team. This was hardly ever evident in the literature, with more attention being paid to situations where additional training or upskilling of health visitors enabled them to deliver specialist services, and/or where they were employed in atypical circumstances, which changed the terms on which they delivered practice. These circumstances would appear to be an important factor in how and whether outcomes are achieved. The New Forest trials tested the same home based intervention 'Parent Training' with parents of pre-school aged children with ADHD, but used health visitors working in differing situations, evaluating not only the parent training but also service delivery. In the first trial (Sonuga-Barke, Daley, Thompson, Laver-Bradbury & Weeks, 2001) the health visitors were working within the tier- two team (the Child and Adolescent Mental Health Service) and were described as 'health visitor therapists'. They did not hold responsibility for a generic caseload and only worked with families where a child was identified with behavioural difficulties. By contrast the second trial (Sonuga-Barke et al, 2004) tested the intervention when delivered by health visitors also delivering universal services and retaining responsibility for a generic caseload. This second trial aimed to test the intervention when

delivered as part of routine service and thus the health visitors were not immersed in a working culture focused on the specific needs of this client group, in the same way that those located within a tier-two team might have been.

The generic health visitors had received additional training (2.5 days) for delivery of the 'Parent Training' and were offered the option for weekly contact with a psychologist, however the authors acknowledge that the generalists may well have faced more challenges in being as fully involved in the project as compared to the specialist health visitors. It is feasible that the focused work that the specialists were regularly involved in gave them an advantage in terms of specific expertise and familiarity with the *experience of change* that the parents would necessarily undergo when engaging with the 'Parent Training' programme. Supporting parents whilst they face such changes means offering a degree of *containment*, so that uncomfortable feelings experienced can be faced in a managed way to avoid overwhelming the parent. Arguably this requires not only particular expertise on the part of the practitioner, but also a practitioner with sufficient 'mental space' to manage the complex demands. Thus the health visitor who is managing a range of differing needs associated with a generic caseload and seeking to provide specialist help for those with additional needs would benefit from careful assessment of workload capacity. Sonuga-Barke et al. (2004) suggest that there is a difficulty with structural and functional constraints on the role of the generic health visitor which limits the use of the 'Parent Training' intervention in routine practice. Arguably such constraints include large caseloads, reduced numbers of experienced colleagues, high numbers of families where there are safeguarding concerns, and organisationally imposed working boundaries that result from how commissioned services are interpreted.

## Referral agent

Even when health visitors had not necessarily received additional training it appeared that they had an important role in helping identify families where additional needs existed as a result of child behavioural difficulties or high risk of developing conduct disorder. This was apparent in the trials for parents of children with ADHD (Sonuga-Barke, Thompson, Daley & Laver-Bradbury, 2004) and the later extension of this work reported by Thompson et al (2009), although in the latter health visitors were not involved in the delivery of the intervention. Similarly, generic health visitors played a role in referring parents for the time-limited and targeted home based 'Parent Plus' programme, delivered as a component of the Welsh Flying Start scheme (Byrne et al, 2010). Here, as elsewhere (Halpin & Nugent, 2006) it is noted that even following referral the health visitor has an ongoing support role, helping the parents manage the experience of change that come with either a new diagnosis and or lifestyle and behavioural changes.

Other 'referral agent' examples include identifying parents suitable for referral to the Webster Stratton Incredible Years group parenting programmes through administration of the Eyberg child behaviour inventory. In two separate RCTs (one in Wales as part of the delivery of Sure Start services (Hutchings et al, 2007) and the other in Oxford as part of general practice-attached provision

(Stewart-Brown et al, 2004)), generic/caseload holding health visitors assessed families, and where risks for conduct disorder were identified, they referred to the parenting programme. In these studies different health visitors with additional training were then involved in leading the group sessions over 12 and 10 weeks respectively. The role of health visitor as referral agent is also evident in earlier work published by Godfrey (1995) who identified the health visitor as the most important means for service access for young children with mental health needs. More recently Chakrabarti & Fombonne (2005) note how the health visitor was the dominant professional in the identification of children with pervasive developmental disorders. This appears to be a function of health visitors' universal contacts and their professional ability to assess and identify 'cases' in need of additional support.

## Skillmix and service organisation

Providing an adequate and cost-effective combination of skills and abilities within the workforce is one of the most problematic aspects of designing and commissioning efficient health visiting services. However, the issue of health visitors referring to colleagues (as discussed above), or delegating to team members has not been widely considered in the literature (Smith, Prosser & Joomun, 2007). In her comprehensive review of skillmix issues in health visiting, Fisher (2009) calls for the government to urgently fund research into this area of service organisation and to issue clear guidance on skillmix ratio. One reason for the current lack of evidence on skillmix could be that primary and community workforce size and mix in the UK are historical and irrational at best (Hurst, 2006). Yet the lack of evidence is surprising given the amount of emphasis on team working and skillmix within health visiting services. In a survey of 980 caseload holding health visitors (reported in full in Chapter 3), Cowley et al (2007) found that over 73% worked in a skillmix team. These team compositions varied widely, some teams delegated work to a nursery nurse or trained family support worker, others to a clinic assistant or a registered nurse. Registered nurses form an important group in terms of recruitment into the profession, since it is a pre-requisite that entrants into health visitor programmes are registered with the Nursing and Midwifery Council (NMC). In this section, we offer a general overview of the reasons for, and benefits and challenges of, skillmix following a comprehensive review of the literature. We also draw upon publications that offer useful insights into skillmix and service organisation issues that are particularly relevant to health visiting and community public health.

### Benefits of skillmix

Skillmix has been cited as a cost-efficient way to fill posts, especially if staff joining the health visiting team are recruited on a lower salary band (McKnight, 2006). McKnight explains, that as health visitor and community posts were frozen, NHS trusts needed to make creative attempts to increase skills within multidisciplinary health visiting teams and so introduced (lower paid) staff such as nursery nurses to the teams. This had the advantage of freeing up health visitors' time allowing them to engage in more complex activities such as needs assessment and child health surveillance (Ebeid, 2000) cited in Smith et al, 2007). McKnight (2006) documented other benefits of skillmix, describing

the experiences of a health visiting team piloting the introduction of a staff nurse. McKnight found that stress levels were reduced in the team, and that there was an increase in client services. The new skills set the staff nurse (previously a registered sick children's nurse) brought to the team meant that the team could offer more services, such as health promotion activities. There were no difficulties with role boundaries within the team and a clear professional development pathway was made available to the staff nurse through sponsorship for a BSc Honours programme in health visiting, which may have facilitated group cohesion. The use of breastfeeding peer educators, who were trained and supervised by health visitors (Carr, 2005a) as reported in Chapter 4, also appeared successful, in that they were acceptable to the mothers and health visitors with clear lines of accountability and role delineation.

## Challenges of skillmix

Despite the perceived benefits of skillmix, there has been much controversy surrounding the introduction of non-health visiting skillmix staff (Gibbings, 1995). This controversy relates to several challenges associated with skillmix. Gibbings (1995) argues that skillmix is primarily a means to meet the needs of individuals as efficiently as possible in the current economic climate, as in an ideal world 'every patient and client would be cared for by highly trained staff, but cost-effectiveness will not allow this' (pg 46). She concludes her 1995 paper by saying that purchasers (of health visiting services) can 'buy more for their money if they opt for a diluted skillmix, and they may get what they pay for: diluted skills' pg 46, Thomas (1992 cited in Gibbings 1995). This implies that clients on the receiving end of skillmix service provision may receive lower quality care because of these 'diluted skills'. The use of skillmix in this way has been seen as a source of discontent by parents mainly because of the lack of relational continuity (Russell, 2008), as opposed to the perception that they were receiving diluted, lower-quality care. Qualitative research by Carr and Pearson (2005) identified that although tasks were often allocated to the most appropriate person for the job, task delegation was also found to be pragmatic, in that it was primarily determined by which professional was available at the time. This finding further links to concerns raised in the literature about service quality and the need for poorly performed tasks to be redone if skillmix delegation is not appropriately executed (Keys, 1996, cited in Smith et al 2007, Hurst 2006). In their evaluation of the effectiveness and acceptability of services provided by health support workers (HSW) in a Sure Start project in South Wales, Smith et al (2007) questioned the appropriateness of certain referrals made by health support workers. This meant that although the health support workers were able to take on some of the roles of 'the overstretched health visitors', the health visitors may have had to repeat or check over the work of health support workers. These concerns are magnified by the assertion that the close supervision required to monitor service quality and exercise clinical judgment using a skillmix model (with non-health visiting staff) is difficult in a community setting (Gibbings, 1995). Hurst (2006) argues that because community staff are isolated and autonomous workers, separating task and skill, 'may be unwise, particularly for practitioners used to assessing, planning, delivering and evaluating one patient's care in his or her home at one visit' (pg. 758).

Mackenzie (2006) described a pilot for a skillmix approach in the Starting Well public health demonstration project (which is reviewed in Full in Chapter 6), designed to bring about a change in child health within deprived communities in Glasgow. As local community members were employed as paraprofessional health support workers to assist health visitors with local home visits, the main challenge reported related to the deployment of vulnerable members of staff and co-management of paraprofessionals by health service and a voluntary section organisation. Health visitors also found the supervision of vulnerable staff to be burdensome and were hard-pressed to take on additional supervision responsibilities, despite having a much reduced caseload size compared to most areas. Whilst the evaluation did not examine skillmix challenges in any depth, it did (unusually) flag up the importance of sorting out forms of accountability, particularly when team members have different employers. Indeed, Mackenzie (2006) discusses the differences between professional health visitor delivered care and that of a mix of paraprofessionals, expressing reservations about the vulnerability of paraprofessional workers in such posts and the unpredictability of such skillmixes, as well as the difficulties of supervision.

Research by Carr and Pearson (2005) has shown that staff are concerned that if specified tasks are delegated to junior team members, health-promoting opportunities could be lost. Similarly, McDonald et al (1997, cited by Mackenzie 2006), and Williams and Sibbald (1999) have described that health visitors can feel threatened by practice nurses (within GP surgeries) taking on health promotion activities traditionally seen as the remit of health visitors (Williams & Sibbald, 1999, p. 739). Tensions can be further ignited by structural barriers which create differences in career patterns between skillmix team members. Smith et al (2007) also highlighted the need for the career pathways and salaries of health support workers to be prioritised to ensure that they did not leave the service, wasting a valuable resource. As McKnight (2006) describes above the creation of clear career development opportunities for skillmix members can help to minimise such tensions. The tensions between skillmix team members and the challenges described here may explain why the 2007 CPHVA survey (of their health visitor membership in England) found that 42% of the workforce was not satisfied that the level of skillmix in their workplaces would allow for safe and effective practice (Craig & Adams, 2007). Overall, issues of accountability, quality and safety of services appear to be largely absent from the limited amount of research concerning skillmix and team organisation in health visiting services.

## Corporate working

The national survey of health visitors reported in Chapter 3 showed that 60% (582) held sole responsibility for their caseload, whilst 35% worked in some form of team or corporate caseload system. Since 2005, when those data were drawn, this appears to have spread to become the usual way of delivering services. As skillmix teams have evolved in health visiting, there has been a corresponding move to corporate working where the client workload and resources for service delivery are shared (Brocklehurst et al, 2004). We identified only a few papers specifically discussing corporate working and this limited research is inconclusive: although it suggests opportunity for

strengthening team working and documentation standards, it does not demonstrate that these factors can have a positive impact on staff stress or client experiences of the service (Hoskins, Gow & McDowell, 2007). Indeed, service user reports suggest dissatisfaction with reduced continuity (Russell & Drennan, 2007), a practice feature that corporate working risks introducing if team systems are insufficiently planned (Hoskins et al, 2007).

## Conclusions

### Summary of findings

Where families have specific issues, health visitors provide packages of care, or arrange them by delegation or referral, which guided our questions.

**Question:  What is known about how health visitors implement the universal plus level of the new service vision?**

- The ability to reach all expectant/new mothers and form a relationship with them through the Universal service is essential for identifying where additional help is needed, particularly for sensitive issues such as obesity prevention, post-natal depression and parenting support.
- The importance of relationships was noted in prevention, sensitive identification and treatment of post-natal depression, identifying the need for parenting support and in early identification of children with special educational needs or behavioural issues.

**Question:  How and in what ways does this (universal plus) health visiting work benefit families in terms of outcomes?**

- Families turn to health visitors for advice about weaning more than other professionals, but there is little research about their effectiveness in this field. Family culture and expectations influence infant feeding, which can reduce the effectiveness of efforts to prevent obesity. Some progress has been made in identifying appropriately sensitive interventions but these have not yet been the subject of evaluative scrutiny in terms of outcomes.

- There is randomised trial evidence that health visitors with additional training can identify and treat post-natal depression effectively. This additional training appears effective in preventing post-natal depression, if health visitors are in a position to form relationships with the mothers and follow up early cues, not identified through routine screening at six weeks post-partum.

- There is some limited evidence that health visitors can effectively support and help parents to deal with troubling childhood behaviour and sleep problems.

**Question: Does the health visiting service enable families who need more support to access other services?  How?**

- Home visiting programmes (described in Chapter 6) are associated with more/more appropriate use of other services.
- Overall, evidence about how health visitors enable families to access other services stems mainly from the way the service is set up, as described in Chapter 3, which influences the 'service journey,' and implementation of the 'core practices' of home visiting, needs assessment and relationship formation described in Chapter 4.

- There is literature documenting the way health visitors enabled parents to access Sure Start Local Programmes and general or specialist parenting programmes. This enablement occurred through networking, building relationships and trust (e.g., between health visitors and parents and between health visitors and the other services) and through practical support (e.g. to help reach Children's Centres, ensuring availability of crèche if needed).

- Specialist health visitors working with mental health teams are able to help parents and their children when they have additional needs, but this benefit does not appear to transfer when generic health visitors use the same approach.

**Question:  What is the evidence about safe and effective delegation or referral pathways, to inform skill mix models?**

- Most of the research about skillmix reports effects on staff and organisations, rather than on families using the service. Although this topic has been studied in other fields, it is under-researched in health visiting.

- Referral pathways appear blurred, perhaps because health visitors retain responsibility when other colleagues (e.g. social care or Children's Centres) collaborate in care provision.

- Overall, there was little attention to accountability in the research, but a couple of examples described careful delegation of specific packages of care, which operated safely despite concerns

about the vulnerability of local women employed as workers in skillmix teams. Other reports suggested that work is more often allocated on an ad hoc basis, without regard for the necessary skills.

## Discussion

The core question for this chapter was: ***"what is the health visiting contribution to leading and delivering services where families need support or help with specific issues?"*** We focused on three commonly arising concerns from the potentially huge breadth of issues that families might face, and about which they may turn to health visitors and their teams (post-natal depression, nutrition and obesity prevention and parenting support). These provided examples of how health visitors might help families to receive the help they need through different forms of service implementation, including through specialisation, skillmix and health visitor team organisation.

Whilst we found very little evidence in some areas (such as weaning and obesity prevention) there is far more research about support for parents and for parenting, and in post-natal depression. In contrast to the large body of research about how health visitors operate, described in Chapters 3 and 4, which tended to focus more upon professional practice than outcomes, we found the research here tended to be more embedded with the wider bodies of research in the field, but then often paid very limited attention to the workforce delivering interventions or programmes. In a few cases, trials included both professional information (included about education and training), and attention to the intervention and outcomes of the trial, but this is unusual. It is possible that interventions might be more effective, if their design took more account of health visitors' professional knowledge and orientation to practice.

Research on peri-natal depression is fairly well established, but there is a strong need for research that focuses on the 'bigger picture' of health visitors' work, in particular with regard to service organisation and health visitors' leadership. This is especially the case in terms of research about forms of team leadership and skillmix, where implementation approaches appears to be running ahead of evidence in the field. Surveys suggest widespread changes have been introduced in the way health visiting teams operate, but there is limited research about the quality, safety or effectiveness of new approaches.

Overall, the integrated nature of health visiting practice, which operates across the different levels described in the *Implementation Plan* and in conjunction with other local services, was evident in the research which, likewise, encompassed different levels and boundaries. As in other chapters, we found that much of the literature appears to favour a predominantly descriptive approach to the data.

This appears to be the case across a range of topics and themes and we suggest that this approach to health visiting research may be contributing to the fragmentation and poor thrust of what could be a much stronger body of academic literature. Furthermore, the use of alternative titles for health visitors made identifying the studies difficult (for example, only personal correspondence with the authors (Sonuga-Barke et al, 2006) confirmed that the 'nurse therapists' used to deliver the New Forest interventions were, in fact, health visitors). The lack of a consistent label for this workforce complicates literature searches, and illustrates the lack of coherence across health visiting research.

# CHAPTER 6: UNIVERSAL PARTNERSHIP PLUS SERVICE

## New service vision: Universal Partnership Plus services

The 'Universal Partnership Plus' level is for families dealing with complex issues, such as long term conditions or disability, or where children and families are vulnerable for a host of other reasons. Families are advised that 'Universal Partnership Plus provides ongoing support from your health visitor team plus a range of local services working together with you, to deal with more complex issues over a period of time. These include services from Sure Start Children's Centres, other community services including charities and, where appropriate, the Family Nurse Partnership'. This level of provision is closely linked with the child protection role of health visiting services, which is described in Chapter 7. For Chapter 6, key questions are:

- What is known about how health visitors implement the Universal Partnership Plus level of the new service vision?
- What is known about how different programmes or projects influence health visitors' responses to the higher needs of vulnerable families?
- What is known about how health visitors work with families living with domestic violence?

The core question for this service level is:

> **What is the health visiting contribution to provision for vulnerable families and groups, or those with complex needs, who need continuing support?**

## Evidence from the literature

Three broad approaches are adopted across health visiting provision to support families with complex needs. One approach is based on the whole service being organised in a way that enables anyone to access it, promoting client-centredness and acceptability for all. The evidence supporting this approach is reported in Chapters 3 and 4, which note the way health visitors aim to adopt a salutogenic (health creating) focus, valuing the person on their own terms and in their own situation (social ecology). A second approach, discussed in this chapter, is grounded in health visitors' proactive engagement with 'seldom heard' population groups who are known to find services hard to access. Next, we report on evidence about how health visitors work with families living with domestic violence, as an example of one important vulnerable group with complex needs. The third approach rests on the implementation of evidence-based home visiting programmes delivered by various professionals, including health visitors, as part of the Healthy Child Programme. This chapter concludes with a review of these programmes, including the outcomes identified in the literature.

## 'Seldom heard' groups

The academic literature on socially excluded and 'hard to reach' groups is very broad but the number of studies that explore the role of health visitors in supporting parents and families with young children in these groups is relatively small. Searching for and reviewing this literature proved particularly challenging as the very definition of 'hard to reach' population groups is not entirely straightforward. The umbrella term 'hard to reach' is often used to refer to people who happen or choose not to engage to any significant extent with health and social care systems, or to people for whom services may be hard to reach, although it might (less helpfully) imply people who are hard for services to engage. Although we are aware of the limitations inherent in this and other umbrella terms, which can reproduce particular - often unhelpful - ways of framing lack of engagement with services, discussing this choice of terminology in detail would fall outside the scope of this report. We refer to 'hard to reach' (the most common wording in the literature) or 'seldom heard' (our preferred term) groups with the aim to provide an inclusive enough heading for bringing together insights from research that examine rather disparate aspects of disadvantage and inequity in health care. Drawing upon the work by Wilkinson's team (2009) at the University of East Anglia,[6] with the term 'seldom heard' we refer to the following groups: travellers (including those who prefer to be known as Gypsies); migrant workers; looked-after children; individuals within the criminal justice system; asylum seekers and refugees; black and minority ethnic (BME) groups; people with learning disabilities; people with long term mental health problems; lesbian, gay, bisexual and transgender people; homeless and insecurely housed people. Our literature searches identified publications for insecurely housed and travelling communities, asylum seekers and refugees, black and minority ethnic groups, and people with learning disabilities.

In exploring this literature with the aim to gather evidence on the specific contribution of health visitors to family and public health, we only identified a small number of studies that highlighted aspects of practice that should be taken into account in the development of Universal Partnership Plus services. These studies do not form a coherent whole but rather mirror the fragmented nature of the literature on health visiting that we noted in Chapter 2. However, we found that some important messages could be distilled from this work that may contribute to building a stronger knowledge base for Universal Partnership Plus services.

With reference to themes of disadvantage broadly understood, we identified one randomised controlled trial (which included an economic evaluation) investigating two alternative forms of post-natal support for mothers living in disadvantaged urban areas (Wiggins, Oakley & Roberts, 2004). Two interventions - health visitor support (in the form of listening visits for one year, for which health visitors undertook special training) and community group support - were compared with the 'care as

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[6] The work by Wilkinson et al. (2009) aimed to identify effective strategies to access the views on health care services of people described as 'hard to reach' in Great Yarmouth and Waveney.

usual' control. This study, which is described further below, shows that the support provided by health visitors was quite popular with mothers, whilst the uptake of the community support option was rather limited.

Jackson (2007) carried out a small questionnaire study of health visitors' beliefs and practices in relation to cultural competence within one locality in the UK. This author (a health visitor herself) was surprised to find that despite an over-representation of certain ethnic groups in the workforce, the responding health visitors (32 in total) did not feel well equipped to deal with families from minority ethnic groups. Jackson highlights the urgent need for appropriate cultural diversity training (whilst warning against the possibility that such training might reinforce rather than challenge cultural stereotypes) and the importance – for improved effectiveness – of involving community representatives in the development of such programmes. The author also calls for further research into the specificities of cultural sensitivity issues in the context of health visiting work. Reporting on a small interview study with 14 health visitors in one London borough, Burchill (2011) also refers to the importance of appropriate responsiveness to cultural issues for health visitors' work with asylum seekers and discusses the extent to which policy – immigration policy in this case – can influence health visitors' engagement with vulnerable families. In this paper, for example, Burchill's informants described working with asylum-seeking families who have no recourse to public funds or rights to receive health, housing or social care, leaving the health visitor as the sole provider of care to very vulnerable children and families who may 'go underground' at any time, to avoid identification by immigration officials.

Although with different emphasis, the theme of cultural competence recurs also in the literature on peri-natal mental health of mothers from minority ethnic groups. Edge's (Edge, 2007, 2010, 2011) work on the experiences of Black Caribbean women and Wittkowski et al's (2011) interview study with South Asian mothers both point to issues of cultural sensitivity amongst primary care health professionals. Edge's focus group study (2011), in particular, looks at black Caribbean mothers' experiences with midwives and health visitors, highlighting how women's concerns (e.g. health visitors' focus on the baby rather than on the mother, or the need for black Caribbean women to interact with mothers from other ethnic backgrounds in order to address their own cultural constraints) can be seen to mirror the concerns of many health visitors (e.g. finding it difficult to manage limited resources in balancing attention to the baby with attention to the mother) and policymakers (e.g. developing cost-effective culturally sensitive systems of support). Baldwin & Griffiths' (2009) exploration of health visitors' experiences with South Asian mothers and of the records documenting their practices also calls for more meaningful approaches to issues of cultural competence amongst SCPHNs (who were assumed from the service description to be health visitors) working with mothers from minority ethnic groups. This study, however, also highlights the importance for effective health visiting practice of having clear local guidelines for the assessment and management of mothers' mental health and wellbeing.

The adequate implementation of local policy is a prominent point also in Almond and Lathlean's (2011) investigation of the policy-practice tensions in a Primary Care Trust aiming to offer equitable post-natal depression services. Drawing upon their observations of home visits and interviews with health visitors, managers, English and Bangladeshi women, Bangladeshi cohesion workers and a mental health practitioner, Almond and Lathlean discuss how the equity policy of the Trust involved in the study did not translate into more equitable services for mothers from a minority ethnic group. The local health visiting service plan examined in this study included an explicit commitment to provide equitable services to asylum seekers and 'hard to reach' groups and to assess all women for depression. However, the authors highlight how some health visitors in their study were unclear about the policy and how their training did not include elements of cultural competence to adequately assess the needs of families from the minority ethnic group in question. The authors conclude that processes of policy development and implementation at local level should allow for more serious engagement with the population and for more effective communication of approved strategies to all those involved in implementation.

Also related to cultural competence, but with a focus on language acquisition and identity formation, the qualitative work by Tranter et al (2010) explores the role of health visitors and midwives on language transmission in bilingual (English and Welsh speaking) families in Wales. This study explores a very specific and circumscribed reality but also points to a potentially useful way of conceptualising public health in a more comprehensive and organic way. For Tranter and her colleagues public health promotion in Wales should encompass bilingualism promotion by professionals working with families with babies and young children. This view is justified by an understanding of public health that moves beyond strictly epidemiological concerns to include broader concepts of personal development such as cultural identity and employability. This work reminds us of how the multi-faceted role of health visitors with families from minority ethnic groups spans from the Community level through to the Universal Partnership Plus 'family offer.' It reflects the 'person in situation' (human ecology) thrust of health visitors' orientation to practice, as described in Chapter 3.

Alarmingly, a review of studies of interventions for disadvantaged (defined in this study as: from minority ethnic groups; suffering from mental illness; experiencing domestic violence; misusing drugs; asylum seeking; suffering from disabilities; from travelling communities; homeless; infected with HIV; or in prison) childbearing women shows that only limited accurate information is available on the types of services that are in place and on the way they are organised (D'Souza & Garcia, 2004). Barlow and her colleagues explore the views of mothers who had been identified as potential participants but declined to take part in their study investigating the value of intensive home visiting by health visitors who had been trained to work in partnership with families experiencing "significant environmental and psychological difficulties" (Barlow et al, 2005). From their analysis of individual interviews with 19 mothers the authors highlight the need for service providers "not only to be flexible about the type of

service provided to hard-to-reach families, but also to spend time establishing what type of help would be valued" (2005, p. 208). This provides an example of health visitors needing to understand the parents in their own situation (human ecology), as described in Chapter 3. These studies suggest that in order for 'seldom heard' and marginalised groups to be genuinely enabled to engage with services the characteristics of health visitors' work should not only be clearly defined and well disseminated but also shaped through processes that are sensitive to the expressed (and elicited) needs of all sections of the population served. Subsequent work from Barlow's team exploring the views of twenty mothers who had taken part in their randomized controlled trial provides recent evidence suggesting that non-directive, partnership-based approaches are helpful in supporting and consolidating the self-confidence of mothers in difficult social and emotional circumstances (Kirkpatrick et al, 2007). This work also emphasises the role of trusting relationships between parents and health visitors in creating the conditions for successful engagement with vulnerable families, as described in Chapters 3 and 4.

Also in relation to clear and easy-to-access information on services, we identified a potentially useful framework to map services for families that have difficulties in engaging with existing provisions and to contextualise health visitor interventions. The work by Feldman (2006) on primary health care for asylum seekers and refugees proposes a three-level reference framework for these services: gateway (providing information and facilitating registration with services), core (addressing health issues and provided through either mainstream services or dedicated services) and ancillary (to complement either dedicated or mainstream services in supporting refugees adequately - e.g. advocacy and health promotion). We suggest that this framework might prove useful in conceptualising the organisation of primary care and preventative services for 'seldom heard' groups more broadly and that Feldman's levels could be related to the 'family offer' with gateway services fitting within the Community level, core services being part – depending on the specific case - of either Universal or Universal Plus level, and ancillary services falling mostly within Universal Plus and Universal Partnership Plus level.

We did not find any recent empirical research that provided significant information on health visitors' contribution to the health of children and families with learning disabilities. We noticed that the role of health visitors in identifying the potentially complex needs of families with learning or physical disabilities was emphasised in published discussion and evaluation work (Cernik, Kelly & Grimes, 2007; Harrison & Berry, 2006), but we could not identify more structured research undertakings that focused on the characteristics of health visitors' work with these groups.

Our findings on research studies looking at homeless or insecurely housed people and travelling communities were similar. In line with our inclusion criteria, we do not report here details of non-empirical papers, such as accounts from individual experiences of proactive health visiting (Haynes & Parsons, 2009; Lydon, 2006) or data from official reports on the health conditions of travelling families in England (Parry et al, 2007) as these do not constitute examples of empirical research on health

visiting. However, we encountered one survey – described by the authors as a service evaluation study - that examined the extent to which parents in temporary accommodation were aware of, knew how to access, and indeed accessed health visiting and children services (Jenkins & Parylo, 2011). The report from this study summarises the responses of 49 hostel residents on issues such as knowing who the health visitor was (71% of respondents said they knew); being aware of how to contact the health visitor (82% of respondents said they would know how to do this); rating the health visiting service (51% of respondents described it as excellent or good; 14% as 'ok'; 10% as poor); knowing the location of the children's centre (60% respondents said they did); ease of accessing health care; desired services; and attendance at A&E, urgent care or walk-in centres. Similarly, Drennan & Joseph (2005) examine the views of 13 health visitors working with refugees and asylum seekers in two London boroughs and discuss the difficulties of health visiting work with these families because of their poor familiarity with services and their high mobility. Although these studies do not offer broadly generalisable messages, we mention them here to underscore the importance of gauging service users' and health visitors' perceptions of services and the contribution they can make to more effective planning of education and service provisions.

## Domestic violence and health visiting

Within Universal Partnership Plus, health visitors' practice involves enabling families to express their needs and discuss how they might best be met. The literature on domestic violence provides examples of how health visitors enable families to express their needs, in particular, it details how health visitors' work contributes to (or has the potential to contribute to) disclosure of domestic violence and the subsequent referral of families to appropriate services.

The term 'domestic abuse' may be considered broader than that implied by 'domestic violence,' but we considered the breadth encompassed in the following two definitions. Domestic violence encompasses "a range of abuses, largely experienced by women, from their partners or former partners" (Peckover, 2002a, p. 152) and these abuses have been linked to significant physical as well as mental harm, including post-traumatic stress disorder, depression, and self-harm (Rounsaville & Weissman, 1977, 1978, Carmen et al 1984, Haber 1985, Newberger et al 1992 cited by Bacchus et al 2003). In this review we focus on domestic violence as experienced by women, although we acknowledge that men can also be victims. Domestic violence against women, despite being seen as a private matter (Frost, 1999) and historically provoking professional silence amongst health professionals (Peckover, 2002b) is an issue in which health visitors have significant opportunities to be involved (Barlow et al, 2008). In the UK it is estimated that 27% of women will be affected by domestic violence in their lifetime (Mayhew 1996 cited in Cann et al 2000), and statistics suggest that pregnancy and early parenthood – the time when health visitors engage with women - is a particularly vulnerable time (Frost, 1999). However, research has revealed that disclosure rates in the UK are low

and that domestic violence remains underreported (Hester & Westmarland, 2005) partly due to its private nature and the stigma surrounding it.

A suite of qualitative studies published before 2004 conducted by Peckover with 24 health visitors and 16 women seeking help for domestic violence suggest reasons behind this underreporting, which include women being fearful of losing their children or feeling that they have nothing to gain from their disclosure (Peckover, 2003b). In this section we draw heavily upon literature published before 2004, as recent evidence is sparse. The issue of why there has been a dearth of studies on health visitors and domestic violence since 2004 is underexplored in the wider literature and is surprising considering the relatively high rates of domestic violence currently estimated in the UK. We could infer that this shortage reflects a shift in research interests or a decline in opportunities available to health visitors to engage in domestic violence activities. It also may relate to the inherent difficulties in measuring domestic violence activities (such as enabling disclosure or referral of services) as they take place in the home and are not routinely recorded in health visitor's professional records (Peckover, 2003a). The private setting of the client's home can contribute to the invisibility of health visitors' work more broadly (Pritchard 2005). Pritchard explains that 'invisible' is used to represent (things like) the outcomes of health visiting which cannot be measured. For example, Pritchard draws parallels between what Smith (1987) and Mayall (1993) describe as "'women's work', dealing with the complexities of life which need attention before a technical or scientific intervention is given" (p. 238) and the 'invisible' work of the health visitor. In addition, measuring 'contextual things' such as assessing the community in which a child develops is more challenging than measuring changes to individuals.

Amongst the recent evidence is a systematic review on domestic violence in adult victims by Robinson and Spilsbury (2008) and a report evaluating interventions for domestic violence by Hester and Westmarland (2005). Hester and Westmarland detailed the crucial contribution of health visitors to a doubling of domestic violence disclosure amongst a sample of women in a Suffolk project. The contribution of health visitors to this increase, as compared to other social care practitioners, was vital as they found that health visitors could incorporate routine domestic violence enquiry into their everyday work (Hester and Westmarland 2005). The work of Barlow et al (2008) supports this finding, and argues that primary care practitioners, in particular health visitors, have a number of key opportunities to identify problems such as domestic violence.

Studies published before 2004 have shown that the health visitor can play an important role in addressing domestic violence by virtue of the main arena of their work being in the home. Visiting women in their homes has several advantages from the perspective of identifying domestic violence and/or enabling disclosure. Visitors to the home are more likely to pick up social problems (Bacchus, Bewley & Mezey, 2003) which often coexist with domestic violence. An awareness of the social model

of health, as used within health visitor training, would facilitate this and help health visitors to be attuned to high risk domestic violence situations. This awareness amongst health visitors is especially important given the evidence that suggests that other health professionals such as GPs are not as interested in (and therefore attuned to) domestic violence as they don't see it as being a medical problem (Bacchus et al, 2003). Home visits also mean that the woman may be in a more private, potentially more personal location. A private location has been shown to facilitate disclosure partly because it reduces the potential for shame and embarrassment (Robinson & Spilsbury, 2008). Findings by Bacchus et al (2003) further support this assertion. They conducted a qualitative study interviewing 16 women who had experienced domestic violence seen at a London hospital, and identified that women were hesitant to discuss domestic violence in a hospital Accident and Emergency department because of a lack of privacy. Good timing also facilitates health visitor involvement. Health visiting services are amongst the most accessible services for abused women (Peckover, 2002; Peckover, 2003b), (Pahl, 1995 cited in Frost 1999), especially as women tend to come into more frequent contact with health services during pregnancy and after birth when their risk of domestic violence is greater.

Although factors of location and timing are important, there are additional factors which make health visitors well placed, and well suited - especially in terms of their skills set - to engage with domestic violence issues. In contrast to the wider health visiting literature, the literature compares the outcomes and potential role of health visitors with other health professionals. Bacchus et al (2003) found that the women in their study tended to regard GPs and A&E staff as less helpful than health visitors in response to domestic violence. The four women who had disclosed to their GP were not happy with the response they received. They attributed this to too brief GP appointments to deal with a complex issue such as domestic violence as well as the lack of continuity of care and the obstacle this posed to developing a trusting relationship (Bacchus et al, 2003). The women in the study described their contact with health visitors as being less formal, and that health visitors were more attuned to the needs of women. As a result they trusted the health visitors to act in their best interests. Although this is an older study - thus reflecting different health visiting circumstances – the 2011 increase in health visitor numbers might allow for relationship-building and increased informal contact, as outlined in Appendix 1, once more.

Bacchus et al (2003) cite a number of studies which show that women are more likely to disclose domestic violence to health professionals who are "supportive, non-judgemental and who ask questions in a sensitive manner" (p. 11). This sensitivity is especially important given the evidence that revealing domestic violence may make women more vulnerable to violent reprimand from their partners (Pahl, 1982) cited in Frost 1999) (Frost, 1999). By forming relationships with mothers, health visitors may not only facilitate disclosure but may also pick up on clues as to whether domestic violence is present. For example, in her study investigating health visitors' perceptions of domestic violence in the UK, Frost (1999) found that health visitors could be alerted to domestic violence by a

change in woman's conduct. Although Frost (1999) also noted that health visitors were cautious about enquiring into domestic violence as they didn't want their relationship with the mother to break down.

Despite these findings, the evidence suggests that health visitors are not meeting the public health needs of women in relation to domestic violence (Frost, 1999; Peckover 1999 cited in Pritchard 2005). Reasons for this could include insufficient time to handle domestic violence cases or a lack of knowledge about dealing with disclosure, and subsequent knowledge of interventions or services (L. Robinson & Spilsbury, 2008). This apparent lack of knowledge is reflected in the study by Peckover (2003a) who found that some women concealed domestic violence from health professionals partly because they were concerned about the absence of information about accessing services (others concealed their domestic violence as they wanted to be seen as a 'good mother' in the eyes of the health visitor).

## Programme descriptions

The Healthy Child Programme notes that some families need intensive interventions. These include referral for specialist input, action to protect children (discussed in Chapter 7) as well as structured evidence-based home visiting programmes. Some of these programmes detail elements of health visiting practice relevant to this review and so have been mentioned in earlier chapters. In this section we bring together the evidence on these key home visiting programmes. They were selected because of their relevance to health visiting practice, rather than because of either the particular outcomes or their research quality. We note that two of them (Family Nurse Partnership and Family Partnership model) are recommended in the HCP as having convincing levels of effectiveness.

The First Parent Visiting Programme (FPV), sometimes called the Early Child Development Programme, is one of the oldest structured home visiting programmes. It was delivered to first time mothers living in deprived areas of the UK (Barker, 1992; Deave, 2003; Emond et al, 2002). It is mentioned here because it was very influential in the 1980s and 1990s and is credited with introducing health visiting to concepts that are now widely taken for granted, such as collecting routine data about children's health and development, working in a strengths-based way ('empowerment' was the term that was used), focusing on children's diet, development and language, and also on the mother's health and social wellbeing (Luker & Orr, 1992). Although internal evaluations showed positive results (Barker, 1992), an independent evaluation found little statistical difference in the outcomes of families receiving the FPV and those of families receiving standard health visiting (Emond, Pollock, Deave, Bonnell & et al, 2002). Mothers did however report having positive experiences of the programme and appreciated the greater contact time and information about parenting and child development (Deave, 2003).

Another influential home visiting programme is the Family Nurse Partnership (FNP). It is often cited as the programme that has the longest and most substantial evidence base, having economic analysis and follow-up data for a sample of children who have reached 15 years of age. The FNP is focused on first time teenage mothers (Olds, 2006; Olds, Sadler et al, 2007), and starts early in pregnancy ending when the child reaches two years of age. Three trials from different parts of the USA showed positive results for the children and their mothers, with the economic advantage becoming particularly clear once the children reach their teenage years. This programme was piloted in England in 2007, and has now been implemented in 80 local areas, with a replication RCT underway to evaluate its effectiveness. Despite being a key part of the HCP and new service vision, the FNP is not reviewed fully here as it has been widely considered elsewhere and is not part of the generic health visiting service.

The 'Starting Well' project was a Scottish public health demonstration project in a deprived part of Glasgow, which aimed to improve child health through increased home visiting and community engagement (Shute & Judge, 2005; Killoran Ross et al, 2005; McIntosh & Shute, 2007; Mackenzie 2006; Mackenzie, 2008). The programme evaluation focused on examining the ways in which health visitors worked with mothers (but not fathers or other male carers) and emphasised the difficulties of working with mothers living with violence or substance misuse, who have little trust in service providers. The independent evaluation, which compared the outcome data for the infants of 213 intervention families with the infants of 146 comparison families, found improvements in maternal wellbeing and better use of health services, such as dental services (Shute & Judge, 2005). However, high mobility and significant drop out rates limited the interpretation of evaluation data, an issue that has wider implications on future work with deprived populations. This programme has been considered in Chapters 4 and 5 (Mackenzie, 2006; McIntosh & Shute, 2007).

The Social Support and Health project, as its name implies, was part of a wider programme of study about the impact of social support on health (Turner et al, 2005, Austerberry, Wiggins, Turner & Oakley, 2004; Turner, Wiggins, Austerberry & Oakley, 2005; Wiggins et al, 2004; Wiggins et al, 2005). Two birth cohorts from different London boroughs were randomised to one of two intervention arms or a control. Women either received home based monthly 'support health visiting' visits for a year or the opportunity to join a community group, although only 19% actually took up that offer (compared to 94% who accepted the home visits for a year). The 'standard' health visiting service, which consisted of only a single post-natal visit, served as a control. The support health visitors (SHVs) were trained to focus on the woman, rather than her child, and were encouraged to listen and respond to the mothers' needs and provide practical support and information on request. Evaluation data were collected through questionnaires completed by the mothers when their children were 12 and 18 months old. It showed no significant differences between the outcomes for the intervention and the control groups in relation to the primary outcome measures of reduced child injury, maternal smoking and depression.

However, the mothers receiving the SHV home visits reported a less anxious experience of parenting and had fewer visits to GP's or hospital doctors.

Three separate home visiting programmes have used the Family Partnership Model (FPM) (Davis & Day, 2010) as the main approach to training health visitors and providing additional supervision for programme delivery. FPM is described in Chapter 4, as it is a generic way of conceiving helping relationships. FPM programmes consist of eight steps, beginning with the establishment of a relationship between the parent and health visitor, progressing through to an exploration of need, setting agreed aims and goals, and finally planning strategies. These plans are then implemented, after which the plans may be revised, or a decision made to end the relationship. The FPM has many features in common with the health visiting process, as explained in Appendix 1, particularly in reference to the health visitor-parent relationship, and therefore, it can be effectively used to underpin intensive home-visiting programmes implemented by health visitors.

One example of an FPM programme is the Oxford Intensive Home Visiting study implemented across two English counties (Barlow et al, 2003, 2005; Barlow, Davies & et al, 2007a; Brocklehurst et al, 2004; Kirkpatrick et al, 2007; Barlow et al, 2007a,b). Although this programme reported recruitment difficulties because families were found to be 'hard to reach', or 'seldom heard' (as described earlier in this chapter, Barlow et al, 2005), 131 pregnant women were randomised into 2 groups to receive either standard health visiting services (n=64) or weekly health visitor home visits for 18 months, starting early in pregnancy (n=67), from FPM trained health visitors (Barlow et al 2007a). The main outcome measures were mother-child interaction, maternal psychological health attitudes and behaviour, infant functioning and development, and risk of neglect or abuse. The results showed a significant improvement in maternal sensitivity and infant cooperativeness in the intervention group. Although there was no significant difference in the incidence of child abuse or neglect between the two study groups, there were some non-significant improvements in some child protection measures. It was suggested that child maltreatment could have been picked up early (before the child was a year old) simply because the health visitors were visiting more frequently and exposed to concerns (Barlow et al, 2007b). The child maltreatment paper aspects of the study are considered further in Chapter 7 whilst the partnership working (Kirkpatrick et al, 2007) and the health visitor contribution elements of this study have been described in Chapters 3 and 4 (Brocklehurst et al, 2004).

Another example of a FPM programme is the European Early Prevention Project (EEPP) (see Davis & Tsiantis, 2005; Puura et al, 2005a). The UK was one of five countries involved in this non-randomised longitudinal comparison study. Families receiving the promotional service (FPM) were offered one ante-natal and one post-natal promotional interview and follow-up, and compared with families in similar geographical areas, receiving standard primary health care services (Puura, Davis, Cox et al 2005). In the UK, health visitors were involved with both comparison groups. There were a number of reported benefits of the intervention, particularly for the interaction between mothers and their children

and the home environment. Links between mental health services and the universal child health services provided by health visitors were considered critical to the project because they enabled FPM interventions to be delivered in the context of existing services (Tsiantis, Papadopoulou, Davis & Turunen, 2005). This contrasts with programmes such as FPV and FNP, where the team or home visitors are kept separate from routine services. In addition, the EEPP intervention was well received by professionals, in contrast to the difficulties experienced in the Starting Well project (Shute & Judge, 2005). The scope of the work was across Europe and demonstrated that health visitors (and their comparable European counterparts) were more accurate in identifying family needs than paraprofessionals and more effective at responding to them (Tsiantis, Papadopoulou, Davis et al, 2005). The results for Greek and British health visitors were particularly good at each stage of the longitudinal data collection from six months of age to two years. However, the non-randomised nature of the sampling in the EEPP studies complicated interpretations of results (Tsiantis, Papadopoulou, Davis et al, 2005). In addition, some outcome measures and the Needs Checklist of mental health risk factors used by health visitors were developed specially for the study and needed further work to validate them as instruments. Most of the outcomes measured used a wide range of well-standardised tools, which have also been used in other studies (Puura et al, 2005b). Despite these caveats, the acceptability of the intervention was remarkably high and both the training and the intervention programme has been rolled out in both Europe and Australia (Tsiantis, Papadopoulou, Davis et al, 2005).

The third programme to use the FPM approach is the Maternal and Early Childhood Sustained Home Visiting programme (MECSH) (Kemp et al, 2008; Kemp et al, 2011). Although originally implemented in a deprived area of Sydney, Australia, it is beginning to be taken up in England (Cowley, Kemp, Day & Appleton, 2012), partly because of its good fit with the *Health Visitor Implementation Plan*. In Australia, all Child and Family Health Nurses (the equivalent of UK health visitors) receive FPM training prior to qualifying. As this is not a requirement for qualification as a health visitor in the UK, FPM training is a pre-requisite to the programme roll-out in the UK. MECSH was designed to achieve goals in five areas of parenting and child development and offered a structured programme of 25 home visits to pregnant women starting ante-natally and continuing until the child was two years old, along with group activities and community services through a tiered system of support. The trial (Kemp et al, 2011) randomized 111 women to receive the MESCH programme, whilst 97 received the standard service. Pregnant women were recruited regardless of age and parity, but those experiencing 'psychosocial distress in pregnancy' evidenced by a score over 10 on the EPDS[7] and one other stress indicator (for example a lack of practical or emotional support, mental health issues, or family violence) were found to benefit most. Although results were initially modest, possibly because of the small trial size and short follow-up period, mothers receiving the intervention were significantly more emotionally and verbally responsive during the first 2 years of their child's life than

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[7] A score of 12 or more on EPDS is usually considered to be a marker of depression, signifying a need for further investigation and/or treatment

the comparison group mothers and were more likely to breastfeed for longer. As with the EEPP, the MECSH health visitors are expected to work as part of the local generic service, but with workload responsibilities adjusted to ensure fidelity to the programme.

All the studies discussed above experienced similar methodological difficulties, and the quality of the research has not been evaluated sufficiently in this review to allow definite conclusions to be reached about their suitability for general implementation. The methodological difficulties partly relate to the need for the programmes to be established with rigorous methods, large sample numbers and to be maintained for long enough to demonstrate outcomes. It is likely that many of the families selected in these studies would have had many factors in common, however, the separate studies explored different elements of the challenges these families faced, such as maternal depression, child abuse or mental health problems. Although each of the programmes described above define 'vulnerability' differently, in each case the families appear to be facing multiple areas of stress and have an increased risk of experiencing a wide spectrum of adverse outcomes. Each programme described in this section has been implemented by health visitors and has achieved some significant benefits, along with other beneficial changes that were either minimal or non-significant. The programme evaluations also generally report positive perceptions of home visiting programmes as they allow time for parents to develop a relationship with their health visitor. The women involved in these programmes also tended to report having less anxious parenting experiences, which is an essential basis from which to develop further behaviours and changes needed to improve child outcomes.

## Conclusions

### Summary of findings

For this chapter, the questions reflected our need to understand how health visitors enable the most vulnerable families to express their needs and decide how they might best be met.

**Question: What is known about how health visitors implement the Universal Partnership Plus level of the new service vision?**

- We identified six different home visiting programmes designed for vulnerable families (in addition to the Family Nurse Partnership Programme), although there was no information about how widely these approaches are used.

- The type and quality of the studies varied, with two external evaluations, one non-randomised longitudinal comparison study, one cluster randomised trial and two RCTs. However, each of the

programmes achieved some significant benefits in key areas, along with other beneficial changes that were either minimal or non-significant.

- Beneficial outcomes include mothers having a more relaxed experience of parenting, being able to use health services appropriately (with reduced use of emergency or GP care), more sensitive mother-child interactions and improvements to the home environment.

**Question:  What is known about how different programmes or projects influence health visitors' responses to the higher needs of vulnerable families?**

- We identified little evidence about how health visitors' work with families with higher level needs, but research that we did find underlined the level of knowledge and skill needed. One study about implementation of a Trust-wide policy espousing equity identified that the plans did not translate into practice, because of lack of clarity and education for staff.

- We identified a small number of publications about insecurely housed and travelling communities, asylum seekers and refugees. Survey evidence gathered from hostel-dwelling families identified that they knew their health visitor and how to make contact, generally valuing the provision and using it to avoid inappropriate use of emergency services.

- Concerns in this area mirrored ones that are common across health visiting (e.g. finding it difficult to manage limited resources in balancing attention to the baby with attention to the mother) and in developing policies (e.g. developing cost-effective culturally sensitive systems of support), but were particularly important when working with BME mothers.

- Cultural sensitivity and awareness of the complex nature of their lives is a fundamental requirement for all families facing disadvantage or with complex needs, but there is evidence that some health visitors feel ill-equipped to practice in a culturally-competent way.

**Question:  What is known about how health visitors work with families living with domestic violence?**

- The literature on domestic violence provides examples of how health visitors can enable families to express their needs, in particular, in relation to disclosure and the subsequent referral of families to appropriate services if such provision is available.

- Evidence of enhanced disclosure came from one area that included routine questions about domestic violence, with other studies emphasising the importance of privacy and trust gained through home visiting and relationships established through the Universal service.

## Discussion

The core question summarising this chapter is ***"What is the health visiting contribution to provision for vulnerable families and groups, or those with complex needs, who need continuing support?"*** We carried out a wide search for evidence about how health visitors work with seldom heard populations, identifying a small number of publications about insecurely housed and travelling communities, asylum seekers and refugees. These studies do not form a coherent whole, but rather mirror the fragmented nature of the literature on health visiting noted throughout the study. Descriptive studies identified the complexity and skill required to work successfully with families, such as asylum-seeking families who have no recourse to public funds or rights to receive health, housing or social care. This leaves the health visitor as the sole provider of care to very vulnerable children and families who may 'go underground' at any time, to avoid identification by immigration officials. The high level of skill required to deal with complex needs is underlined in many of the papers, which also show the importance of health visitors working in a non-judgemental way, focusing on people within their cultural context (human ecology) and being flexible about the goals to focus upon. Where this conflicts with organizational goals, health visitors need the ability to negotiate with managers and commissioners who, in turn, need to allow health visitors the professional authority to work flexibly with families. As in earlier chapters, the need for health visitors to receive additional education and support is reported, most notably in relation to cultural competence and in gaining the confidence to engage sensitively with Minority Ethnic groups.

The research underlines the importance of the Universal service in enabling access to vulnerable families who might otherwise reject the service and, through health visitor-parent relationships, the opportunity to enable disclosure and identify needs that may otherwise remain undetected and unmet. The core practices of home visiting, needs assessment and relationship formation, implemented in a way that reflects the health visiting 'orientation to practice' are particularly essential when working with vulnerable populations whose situation may be precarious and whose ability to use routine services is compromised. Domestic violence is one key example and, found some evidence of health visitors' ability to enable disclosure and access to appropriate services, where they existed. The presence of a wide network of support and back-up services is essential if routine questions about domestic violence are to be considered, as recommended in some research. Exposing abuse increases immediate risk, so the availability of a place of safety and continuing support (e.g., access to welfare benefits and legal advice) is essential.

The body of evidence about home visiting programmes appeared somewhat better integrated with wider research than other papers, but this was not always to the advantage of outcomes. As an example, the Social Support and Health trial (Austerberry, Wiggins, Turner & Oakley, 2004) was part of a wider programme about the effect of social support, so the 'support health visitors' who provided monthly home visits were trained not to independently raise health-related topics themselves, although they could respond if mothers asked questions. However, that approach runs counters to evidence that mothers attach great importance to health visitors' specialist knowledge about child and family health. It helps consolidate the relationship which, in turn, increases opportunities and acceptability of for health promotion messages (Collinson & Cowley, 1998a; Bidmead, Appendix 1). Despite some variability in the research, the reported home visiting programmes show that health visitors could effect positive changes and deliver beneficial outcomes, but we did not identify evidence of their widespread implementation. FPM training has been taken up in a number of areas, which would be well placed to implement one of the programmes based on its use. There were fairly consistent reports of more relaxed parenting and more appropriate use of services as a result of the home visiting programmes, both of which provide a sound basis from which to develop further benefits, such as improved mother-child interactions and improved maternal sensitivity, which were also reported. These immediate outcomes were designated as secondary outcomes in some instances, but they are realistic and represent considerable achievements, likely to enhance children's future health and potential. Some of the designated primary outcomes (like prevention of child maltreatment) appeared more ambitious or unrealistic in the follow-up time frame.

# Chapter 7: Safeguarding and child protection

## New service vision: Safeguarding and child protection

Safeguarding is major part of health visiting practice across the entire proactive and preventive service, but making sure the appropriate health visiting services form part of the high intensity multi agency services for families where there are safeguarding and child protection concerns is extremely important in its own right. The new service vision (Department of Health, 2010a) assumes that health visitors maintain contact with families while formal safeguarding arrangements are in place, so that families receive appropriate preventative health interventions and an effective service during a crisis. It also notes that health visitors contribute to all stages of the child protection process, including serious case reviews, and may be called upon to appear in court to explain the action they have taken. A description of the knowledge, skills and values required for child protection practice would help to explain how and when these are specific to health visiting and how they complement alternatives across health and social care. In turn, this would clarify what is known about how health visitors contribute to safeguarding and child protection. Key questions are:

- What is known about how health visitors contribute to safeguarding and child protection?
- How do health visitors identify families with high risk and low protective factors?
- What are the knowledge, skills and values required by health visitors to implement child protection practice?

The core question for this part of the service is:

**What is the role and contribution of health visitors to child protection?**

## Safeguarding children in the context of health visiting

### Background

Safeguarding young children aims to prevent problems, which may lead to child neglect of abuse, through supporting, educating and motivating parents. Most of the preventive work carried out across the community, universal, universal plus and universal partnership plus levels of service provision includes an element of safeguarding, which is a broad concept encompassing emotional and physical safety as well as protection from harm. However, if parents/carers cannot ensure that a child is safe living at home with their family, alternative arrangements may be needed as part of a comprehensive child protection plan.

The legal rationale for child protection intervention in the private sphere of the family in relation to child abuse and neglect is currently based on the existence of **significant harm**, or the **risk of significant harm** to a child. This term 'significant harm' was introduced into English law by the 1989 Children Act to justify compulsory intervention to protect children. A court may make an order to receive a child into local authority care or to enable the local authority or a probation officer to supervise their upbringing, if the child is suffering significant harm or is likely to do so AND that harm is attributable to a lack of adequate parental care or control. 'Significant harm' also has to be understood in the light of the normal development of children, whether this be their physical growth, mental and intellectual development, emotional or social development towards adulthood. This is important in the light of recent research into the development of young children, particularly neurological development, which draws on evidence of epigenetic processes in response to chronic stress and trauma early in life and the effects of adverse experiences on later psychopathology and behaviour (Murgatroyd & Spengler, 2011). Understanding of the nature of significant harm resulting from neglect, abuse and exposure to violence and traumatic experiences in childhood is changing in response to new knowledge about problems of attachment, behaviour and child development. This understanding of the development of infants and young children and their physical and psychosocial development is central to health visiting practice and the health visiting role with normal families and children enables early signs of problems to be picked up during normal supportive home visits where parents and children can be seen in their normal family context.

Internationally, here are two broad policy approaches to safeguarding young children in 'troubled families,' where there are already complex needs, problems and conflicts (Gilbert et al, 2009). The first underpins services in Western Europe, the UK and Scandinavia and takes a preventative approach through universal welfare systems to support all parents from the outset and through the early years of child rearing, ensuring that troubled and fragile families have the degree of support they need to enable children to achieve the best health and developmental outcomes (Barlow & Calam,

2011). The second underpins services in the USA and takes a more *laissez faire* approach, based on the current understanding that abuse and neglect of children are very rare and that most families cope adequately with minimal support. This policy approach allows few, if any, universal preventative or family support services. Families with greater needs are seen through the perspective of risk to children and intervention is based on perceived risks and mandatory reporting of concerns. With both approaches, the option of child rescue from failing parents and provision of substitute care forms a backstop, should this become necessary. In measurable terms, the rate of deaths from child protection related causes is much lower in societies, such as the UK where preventative family support services such as health visiting are provided universally (Pritchard & Sharples, 2008; Pritchard & Williams, 2010). Morbidity and adverse social and psychopathological outcomes of abuse are more difficult to measure and beyond the scope of this chapter.

Population prevalence of ongoing child maltreatment and family violence are difficult to measure because these are hidden and criminal activities, so shame and fear tend to lead to active concealment and denial, issues that also affect evaluation studies. Registration of children on a local child protection register depends on the availability of resources to offer a multi agency child protection plan and the individual local authority threshold for such provision, so it is not an adequate proxy measure of local prevalence. Thresholds may vary between local authorities (Laming, 2009). Children whose needs for protection fall below a financially determined local threshold for specialist child protection services may continue to be at risk of significant harm (Laming, 2009). The current[8] child protection guidance states:

> *'2.89 Health visitors are trained to recognise risk factors, triggers of concern and signs of abuse and neglect. Through their preventative work, they are frequently the first to recognise children who are being or are likely to be abused or neglect and therefore when safeguarding procedures need to be initiated.*
>
> *2.90 Health visitors must have time to maintain effective contact with the child and family, to establish and develop a successful working relationship so they can consider the situation objectively. Where formal safeguarding procedures are in place, health visitors need ongoing contact with families so that they continue to receive preventative health interventions both during the crisis and in the future.'*

<div align="right">(Department for Children, Schools and Families (2010) pages 42-3)</div>

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[8] This guidance is in the process of being updated, with a new version under consultation in 2012, see http://www.education.gov.uk/aboutdfe/statutory/g00213160/working-together-to-safeguard-children

This clearly identifies the child protection role of the health visitor as one of early identification (case finding) and a broader preventative role with children and families, both generally and in the specific context of a child protection process. There is no formal expectation that health visitors will work as lead professionals in situations where a child protection plan is in place, as that responsibility falls to social workers.

This chapter will, first, consider broadly how health visitors contribute to safeguarding and child protection, before examining the evidence about both case finding (assessment) and prevention roles across the different levels of the envisaged new health visiting service (Department of Health, 2010a).

## Evidence from the literature

### The health visiting contribution to safeguarding and child protection

In our structured search (for papers published since 2004, see Chapter 2), we identified 27 empirical papers that referred to health visitors in the context of child protection. However, screening revealed that only 17) of those papers gave useful information about the way that health visitors practice in the context of child protection. Several are reviewed in full elsewhere in the report, because child protection is only one small element of the study. Where that is the case, we made pragmatic decisions about where the main bulk of information sits best, and provide a link back to earlier chapters if they are additionally mentioned here. Faced with a relative paucity of rigorous research about the health visitors' role in child protection from our structured search, we included classic studies that shed light on, particularly, health visiting practice in case-finding. Evidence from the work of practitioners and small academic teams frequently has limitations – lack of funding, weak study designs, the predominance of small-scale qualitative approaches, methodological errors, poor reviews and the lack of replication of findings. The largest longitudinal study of risk of child abuse or neglect in the UK did involve health visitors as case finders, but the use of risk factors in a single post-natal assessment did not help to accurately identify those families who would go on to maltreat a child (Browne, 1995a; Browne & Saki, 1988; Dixon et al, 2005a; Dixon, Browne & Hamilton-Giachritsis, 2009a; Dixon, Hamilton-Giachritsis & Browne, 2005b). Their risk assessment tool was initially derived from studies describing the key characteristics of abusive families. The cases were followed up for five years and reviewed when the children were due to start school to identify the predictive power of the risk assessment. As Peters and Barlow (2003) found, both sensitivity and specificity were inadequate because of the low prevalence of abuse within the overall population. This presents an ethical problem because false negative and false positive risk assessments either fail to identify children at real risk or falsely label those who are not at risk. Given the stigma attached to any suggestion that parents may maltreat a child, such inaccurate risk assessments would be unacceptable to child protection practitioners and agencies.

Whilst these studies indicate a clear link between family circumstances, adult aggression and child maltreatment, they were unable to produce screening methods that can be universally applied to family circumstances in the absence of professional knowledge, judgement and direct health visitor involvement with the families over a period of time. The Healthy Child Programme offers families different levels of intervention based on need. In relation to child protection, the 'need' is to modify and reduce the risk of future significant harm to children through professional intervention, but it cannot reliably be predicted in advance. Although the prevalent characteristics of 'troubled' or vulnerable families are well known, the task of predicting the risk of child abuse is methodologically extremely complex and lies outside the remit of this review. Some of the key issues involved are explained in Appendix 5. However, effectively, their case-finding role means that health visitors are obliged to develop skills in practice to identify those child who may be at risk of significant harm, discriminating between those families who need a short term 'helping hand' for a specific problem ('Universal Plus' level of service provision, Chapter 5), those who will cope with continuing support ('Universal Partnership Plus' level of service provision, Chapter 6), and those for whom formal intervention through social services and/police is required, and which are the focus of this chapter.

In spite of the lack of effective risk assessment tools, health visitors are educated to recognise risk factors, triggers of concern and signs of abuse and neglect as well as protective factors (Department for Children Schools and Families, 2010). Health visiting is the only universal service for families with children where much of the service is delivered in the private sphere of the home, where pre-school children and parenting can be seen in the context of family life. This privileged access to normal family life is unusual in primary health care or child care and underpins the Laming report's concern about workforce reductions and loss of regular access to health visiting in the family home (Laming, 2009; Ly, 2009).

Evidence for the active and consistent involvement of health visitors in child protection work for younger children is demonstrated in a recent study of Serious Case Reviews, which showed that 78% of the index children had had recorded health visitor and/or school nurse contacts prior to the abusive incident which led to the case review and other agencies tended to be less frequently involved in the families (Woodman et al, 2011). Similar studies over time have noted the relatively high numbers of younger children (aged under five years) in such cases of serious abuse or neglect (Brandon et al, 2009; Brandon et al, 2008; Falkov, 1995; Ofsted, 2010; Sanders, Colton & Roberts, 1999; Stroud & Pritchard, 2001; Wood, 2011). This vulnerability of younger children to the most serious consequences of child maltreatment means that health visiting services are likely to be in direct contact with families at greatest risk and the earliest source of referrals to specialist agencies.

# Health visitors' assessment of risk

Broadly speaking, health visitors' professional assessment practices can be described in three ways: first there is the overall, professional judgement about a family's health needs, which emerges through partnership working and a health visitor-client relationship, as described in Chapter 4. Then there are a small number of validated, structured assessment instruments, which focus on particular issues, some of which may be pertinent to child maltreatment, such as behavioural concerns and mother-infant attachment, some of which are addressed below. Third, we explore the many contested approaches to the identification of risk, often bound up with work prioritisation, or prompted by a need to manage over-large workloads. Some successful and some less appropriate approaches emerged from our review, bearing in mind not only the methodological concerns explained above and in Appendix 5, but also the ethical issues that arise from the use of unvalidated screening instruments.

## Assessment as a form of prioritisation

The most recent studies about work prioritisation on the basis of risk and child protection has emerged from studies where services had been restricted through recent reductions in the health visitor workforce, prior to the current thrust to increase the numbers again (Department of Health, 2011). A large scale national survey of health visiting contacts and activities studied by Cowley et al (2007) and reviewed in Chapter 3, found that where services were under pressure, work was restricted to the most needy groups as perceived by the health visitors themselves, including families where children were deemed at risk, children with specific difficulties and adults where substance misuse or post-natal depression affected their ability to care for their children (Cowley et al, 2007).. The priorities did not seem to be determined formally but tended to be an ad hoc local coping strategy. Another large national study of health visiting service responses to national policy changes also showed that routine contacts had decreased for 76% of the respondents, but health visitors still worked within a prevention model with closer monitoring of families who caused concern, rather than using any formal risk factors for targeting proposed by employers (Condon, 2008). This was similar to the findings of a much earlier qualitative study, reviewed in Chapter 3, which acknowledged the difficulty of working to externally determined priorities rather than assessing families directly (Cowley, 1995b). The need for health visitors to maintain regular contact with vulnerable, complex families is clear from the evidence, reported below.

Family life is essentially dynamic and families change over time, so a risk assessment conducted with a family dealing with a new baby will not reflect the situation if the household or family circumstances change (e.g. divorce, separation, unemployment or parental ill health) or parents find it difficult to meet the needs of an older toddler. This changeability explains the views expressed by Browne, (1995b) and Wright et al, (2009) that sustained regular health visiting contact with families with young children is essential to ensure that the most vulnerable families receive early support from specialist agencies because early post-natal assessments do not predict needs effectively or for the long term.

Further, as the evidence from Barlow, Kirkpatrick, Stewart-Brown et al (2005) indicates, these groups are more likely to stay 'out of reach' and less likely to self-refer than families who are coping well and find it easy to articulate their needs.

Some forms of child maltreatment can be difficult to distinguish from other family difficulties. Neglect and emotional abuse are both subtle presentations of child maltreatment and there was evidence relating to assessment of these problems by health visitors. Emotional abuse was rarely covered in detail by studies involving health visitors, except for one study outlining the work of health visitors and mental health professionals with families where one child is singled out for abuse ('scapegoating') whilst others in the family are treated normally (Rushton & Dance, 2005). Parental expectations of children were noted as important in the management of parental concerns about their children's behaviour and one mixed methods study in Wales found surprisingly high levels of unrealistic parental expectations (Boot, 2010). Since health visitors are a regular source of advice about behaviour problems in young children, such parental expectations were an interesting finding.

## Structured assessments

Many risk assessments or vulnerability assessment tools prescribed by service managers for use by health visitors in universal services appeared to be ineffective and risky in themselves, because they lack a sound evidence base (Appleton & Cowley, 2004). An earlier report from the same study described the variable and invalid format of 179 assessments instruments that were designed locally, embodying the best intentions but with limited understanding of the requirements for producing standardised tools (Appleton & Cowley, 1997). Observation of practice in three different areas, one using a questionnaire-type of instrument, one with an aide-memoire format and one with no formal guidelines, showed that the health visitors largely disregarded these official guidelines in favour of their own professional judgement. This judgement is honed through a process of focusing upon seven 'critical attributes' of needs assessment practice (Appleton & Cowley, 2008a), which are:

- Holistic assessment

- Assessment is a complex and multi-factorial process

- Continuing/ongoing nature of assessment

- Taking account of difficult to articulate issues

- Recognising influence of practitioners' personal values/experience

- Recognising that all clients may/potentially have unmet need

- Assessment is intertwined with prioritisation

Two further qualitative studies, with one designed to follow the other, looked at the use of locally designed, structured instruments in practice as well. In the first study, the formal assessment tools had been designed locally in a questionnaire format, and there was a requirement for health visitors to complete them with all families before the infant was 16 weeks old (Cowley & Houston, 2003), which effectively meant it needed to be used at the only new birth visit in parts of the organisation, where staff shortages precluded follow up visits. Observation of 21 visits in practice, and interviews with 30 health visitors and 19 of their clients after the observed visits, revealed a mixture of opinions, but showed the format was largely unacceptable, particularly to the most vulnerable families, and it did not help to identify risks or needs. In the follow up study, a different structured instrument was in place, which again had been developed locally but not validated. Conversation analysis techniques were used to analyse audio recording from the first study and the follow-up area (ie, on two different instruments, both with a structured, questionnaire-type format (Cowley, Mitcheson & Houston, 2004). The analysis showed the formal approach to assessment largely suppressed the expression of needs by the mothers, and many expressed needs were discounted because they did not fit the framework (Cowley & Houston, 2003; Cowley et al, 2004). Again, many practitioners in these studies effectively ignored a prescribed formal structured assessment in which they had no confidence and relied instead on professional knowledge and experience. However, the studies have considerable relevance for situations where a mother (or other carer) may wish to raise concerns about her own relationship with a child, or any potentially abusive behaviour of another member of the household.

Ling and Luker (2000) sought to characterise the health visiting assessment of possible child protection concerns as based on intuition, which is detailed further in Chapter 4, but this would form an unlikely sole basis for making a formal child protection referral. It appeared that the process appeared to be one of noting deviations from the general 'normal' family circumstances observed on home visit contacts with families and using these as subtle cues to prompt concerns (Ling & Luker, 2000). One small UK study compared health visitor, nursery nurse and social worker ratings of parental care in 43 normal nursery school children with the scores of a group of 11 young children already on the Child Protection register for previous neglect, using a Graded Care Profile designed to identify early signs of child neglect (Srivastava & Polnay, 1997). The findings showed acceptable levels of inter-rater agreement, but the study was small in scale. There is anecdotal evidence this has already been used by health visitors in some areas, although full large scale validation has not yet been undertaken (Srivastava & Polnay, 1997).

Unlike a non-accidental injury (see Chapter 4), child neglect rarely presents in a form which can be readily 'diagnosed' as maltreatment and it may be confused with poor parenting or extreme poverty, chaotic home circumstances or perceived cultural differences and this becomes particularly difficult when working with parents with cognitive impairments and poor social support. It is not uncommon for health visitors to disagree on the relative importance of family and home related risk factors for neglect and the harmful effects on children may become obvious only over time (Lewin & Herron, 2007). Similar differences in assessing risks have been found between individual social workers

involved in child protection (Regehr, Bogo, Shlonsky & LeBlanc, 2010; Regehr, LeBlanc, Shlonsky & Bogo, 2010). The Peter Connolly case suggests that this can arise in complex families with multiple needs and frequent crises when the focus on the child is blurred by the behaviour of parents (Haringey Local Safeguarding Children Board, 2010).

A small qualitative study into parental responses to formal assessment suggests that some parents may be mystified by the assessment processes or suspicious of them (Sanders, 2006). Health visitors do not currently have access to assessment tools for use in child protection cases, beyond the Common Assessment Framework, so factors used may differ as well as their relative weighting (Selbie, 2009). The assessment process also may alienate some clients, particularly if they are already suspicious of public services. Robinson (2004) and Plews, Bryar & Closs (2005) found that clients in a deprived urban community identified ways in which the health visitor's home visits had been more helpful when not driven by service led priorities and they were allowed to express their own needs and concerns freely (Plews, et al 2005). Assessments and interventions which can be delivered in the home may be more readily accepted than group attendance, especially for mothers who lack confidence (Austerberry et al, 2004), and there is some qualitative evidence that health visitors can be resourceful in their approaches to families who find engaging with services difficult (Chalmers, 1994; Selbie, 2009).

The literature on risk assessment highlights health visiting dilemmas in the use of assessment tools in identifying possible child maltreatment cases where the tools are inadequately tested or inaccurate in practice. Their use as a substitute for regular health visitor contact with families risks preventable distress and injustice to families or failure to protect children who need multi agency interventions to safeguard them from harm. Currently, there are no effective and accurate screening/targeting tools to identify families who may maltreat children in future. Even if assessment tools could be perfected, the changing nature of family life would require the ability to respond over time to changing needs (Williams, 1997). Professional judgement on the safeguarding needs of young children requires regular professional contact with families in their own homes to observe parent/child interactions in their natural setting. Since health visiting is a universal service for families with young children under school age, reducing direct health visiting contact with families or substituting professional health visitors with paraprofessional staff may lead to concerns being missed, but there is also evidence that health visitors themselves may vary in their assessments of parenting behaviour and attachment. This emerges from studies using vignettes of cases and videoed parent/child interactions (Taylor et al, 2009; Wilson et al, 2010). The larger study focused on 'good enough mothering' and involved a sample of 200 health visitors in Scotland, although only 35% completed the vignette-based assessments (Taylor et al, 2009). Multiple regression was used to identify the most significant factors health visitors used to judge parenting behaviour, namely housing tenure type, boundary setting and health behaviours (Taylor et al, 2009). Wilson et al (2010) used four videos of parent/child interactions with a sample of 25 health visitors attending a study day to test the degree of agreement between

their assessments of the interactions. The levels of agreement varied between the videos and suggested that some kinds of parental behaviours may be more difficult to judge than others (Wilson et al, 2010). These findings would need to be seen as 'in vitro' examples, since neither example allowed sensitive questioning of parents as seen in a single case study by Puckering et al, (2011), but they do suggest that health visitors may differ in their professional judgements of potential child maltreatment.

The skills and knowledge required by health visitors in relation to child protection arise from their ability to identify children and families within the population who differ from those whose needs are met through the Universal level of services and who require more support through Universal Plus services and/or referral to other agencies who may be able to help them. Referrals require identification of additional needs and knowledge of the services that may meet them and the ability to communicate them effectively. Specialist services, such as social work, may have thresholds for eligibility for service provision and when a health visitor's referral does not meet these thresholds, the referral may not be accepted and family needs must be met through Universal and Universal Plus services.

## The Common Assessment Framework

The Common Assessment Framework (CAF) was introduced as part of the changes implemented following the Green Paper 'Every Child Matters' in response to the Laming Report on the case of Victoria Climbié (Department for Children Schools and Families, 2003; The Children's Workforce Development Council, 2009). It is a framework for multi-agency use in child health and welfare assessment and intervention planning. The CAF looks at child needs related to their developmental age, the family's capacity to meet those needs and the social and environment context in which the family lives. The CAF framework is designed to support early inter-agency communication about children who have additional needs and where more than one service will be required to help and support them and their families, so all families in need of a child protection plan should have a completed CAF. It is a key tool in enabling strong, interdisciplinary and interagency support for families with complex needs, whether from social issues or disability.

We did not find any research about its use, for either safeguarding or children with disabilities or other complex needs, but anecdotally hear that the CAF is being used in some areas in place of health visitor professional judgement, for all families (i.e. at the universal contact). Use of the CAF involves a period of assessment in which parental consent is sought and assessments of the three domains are undertaken, a period of information sharing in which different agencies form a Team Around the Child (TAC), the choice of a lead professional to lead the team, the allocation of tasks and identification of the review process. During this process the types of interventions and referrals for further work will be identified. Whilst the key domains included in the CAF apply to all, these embedded processes and

requirements mean it is not suitable as an instrument for universal assessment.

## Modifying risks to children and families through health visiting interventions

Universal health visitor support gives families access to preventative education programmes, for example programmes highlighting the risk to infants of brain damage from shaking and head injury (Coles, 2008; Coles & Collins, 2007). These studies take the issue of primary prevention of a specific form of harm from head injury and consist of a narrative review of evidence on ways in which health visitors can act to prevent child abuse and neglect. The review uses an epidemiological model of disease prevention to consider how CAN prevention can be developed as a concept. Traumatic head injury has been recorded as the cause of child deaths among other maltreatment deaths (Sidebotham, Bailey, Belderson, & Brandon, 2011). The wider implementation of such primary prevention messages can be very effective, as they were in the 'Back to Sleep' campaign in reducing cases of Sudden Infant Death Syndrome (SIDS) (Blair, Sidebotham, Berry, Evans, & Fleming, 2006). Coles and Collins (2007) use structured early home visiting by professionally-trained persons to prevent child maltreatment in high-risk families through parenting education, especially about safe handling of infants.

The Oxford Intensive Home Visiting study set out to test whether child maltreatment might be reduced by health visitors delivering a structured programme of visits. The multicentre RCT by Barlow and colleagues (2007b) into the effectiveness and cost effectiveness of an intensive home visiting programme in improving outcomes for vulnerable families is reported in detail in Chapter 6. Their programme resulted in a significant improvement in maternal sensitivity and infant cooperativeness in the intervention group, with non-significant improvements in some child protection measures and no significant difference in the incidence of child abuse or neglect between the two study groups (Barlow et al., 2007b). Despite its larger numbers of participants, which were drawn from 40 GP practices, this study is still a small-scale approach to such a rare phenomenon as child maltreatment over a twelve month period and the expectation of significant findings seems optimistic in public health terms, given the rarity of any child maltreatment across a whole birth cohort within the population. There were also considerable difficulties in initial recruitment, which gave rise to papers usefully exploring the complexities of reaching families who might, given some surface indicators of risk, be expected to need additional support (Barlow et al, 2005), which is also reported in Chapter 6.

The RCT reported by (Austerberry et al, 2004) is also explained in detail in Chapter 6. This compared regular (monthly) health visitor supportive home visits to new parents for the first year after their child was born and compared this model of service delivery with a single post-natal contact only, and with community group support. As with the Barlow study, this was a small study for a rare phenomenon such as child maltreatment, including families of just 731 babies born in Camden and Islington in 1999. Some significant differences emerged between the two groups in that parents receiving the

monthly supportive HV inputs reported high levels of satisfaction with their service, less anxiety, fewer GPs visits, better uptake of other NHS services and lower rates of subsequent pregnancy at 18 months after the index child's birth. One might also infer that the visiting HVs were also well placed to exercise their professional judgement to determine the potential risk of child maltreatment, although this was not measured. However, there were no statistically significant effects on the occurrence of their chosen adverse outcomes of maternal depression and child injury (Austerberry et al, 2004).

Barlow & Calam (2011) advocate media based midwifery and health visiting delivered parent education programmes as a universal level of support, using a formalised parent education programme (Triple P Parenting – the Carolina Positive Parenting Program) with teams of social workers and psychotherapists to intervene with families experiencing problems that may be considered a precursor to, or of escalating the risk of, child maltreatment (Barlow & Calam, 2011). Each of these approaches would require evaluation. In addition, the more complex the different teams and agencies involved in child protection, the more difficulty arises in communication of key information (Fifield & Blake, 2011). The interventions are not economically evaluated.

Macmillan et al (2009) provide a useful and concise summary of the state of research on primary prevention of child maltreatment and of the current options for intervention delivered by health visitors, the most positive were the American Nurse-Family Partnership, beginning during pregnancy, the Triple P Positive Parenting Programme and the education programme for parents on prevention of head injuries in infants. Whilst there is limited research evidence of effectiveness, these are promising avenues. There is no evidence that there is any way to prevent domestic violence to women and their children (MacMillan, Wathen et al, 2009), but health visitor approaches to this are reviewed in Chapter 6.

## Health visiting practice where there are active child protection plans

Health visitors still strive to operate on a population basis and their roots lie in public health practice. The risk assessment role of the health visitor in relation to child maltreatment is closely linked to their assessment of child development, parenting and behaviour in comparison with those of a wide range of families considered normal and not abusive. This base within the normal population enables health visitors to maintain a perspective based on the wider population of children, which can highlight the difficulties experienced by initiating health visitor contact with vulnerable groups such as asylum seekers/refugees and travellers, who may not be in effective contact with other agencies (Burchill, 2011; Doyal, Cameron, Cemlyn, Nandy & Shaw, 2002; Drennan & Joseph, 2005). This means that case finding for specialist child protection agencies remains important, but so does maintaining contact with vulnerable families who do not trust many providers and who can experience great stress (Sheppard, 2009). The workload required in such vulnerable cases can be heavy and Williams (1997)

describes health visitors spending around 20% of their time with such families although they made up just 5% of their caseloads (Williams, 1997).

Parents whose behaviour is, or is likely to lead to harm to their children may be cooperative or uncooperative, well-motivated or preferring to avoid the need to do so (Laming, 2003). The power relationships within families and child protection agencies may challenge assumptions about relationships and motives and unquestioning acceptance and support for parents who are unmotivated to improve their parenting may place children at greater risk if their actions are unchallenged (Haringey Local Safeguarding Children Board, 2010). Laming (2003) also identified problems arising from poor communication across service and professional boundaries and this was also identified by a UK study of largely health visiting, midwifery and nursing staff (While et al, 2006) and a study of parental perceptions of home visiting programmes in the US by Allen (2007). The increasing diversity and pluralism of service providers in health and social care could increase this problem in future.

Larger scale UK studies have identified that social workers tended to limit their involvement by prioritising child protection referrals at an early stage, based on limited assessment of needs (Brandon et al, 2008; Forrester, 2008). This may involve application of local thresholds for access to services rather than a full needs assessment, which is inclined to have a knock-on effect to health visitor workloads. If referrals are not picked up by social workers because they fail to meet the local threshold for service, then health visitors need to maintain responsibility and enhanced contacts, which affects their ability to respond to other needs on their caseload. Appleton (1996) described this as a role reluctantly assumed by health visitors when no other agency will agree to support the family. Referrals also need careful preparation and health visitors work to ensure that clients are aware of the reasons and the need for the referral (Luker & Chalmers, 1989).

Cooper (2003) states that social work currently offers little in the way of strategies for improving parental motivation to change and that there is even less empirical evidence for specific interventions reliably producing successful outcomes. This area of improving motivation to change behaviour and working in cooperation with parents is more congruent with the health visitor role because the relationships with parents are sustained throughout the operation of the child protection plan. The workload required in child protection cases includes regular contacts and monitoring parenting, and this is a frequent health visiting role with high risk families. In cases where other agencies are not involved due to operational thresholds for access to services, health visitors may feel entirely responsible for monitoring families with child safeguarding needs (Appleton, 1996, 2011; Cowley, 1995b).

The knowledge, skills and values required by health visitors to implement child protection practice relate to their involvement with families at every level of services, from identification of risks and extra needs across the population of families with young children to referral and continued support of

families who require multiagency child protection care plans to safeguard children. In this, health visitors perform a different role from nurses and Crisp and Lister (2006) identified that this is reflected in their takeup of specialist child protection training, whilst many of the nurses surveyed did not see child protection skills as important for their work or as part of their public health knowledge base (Crisp & Lister, 2006; Lister & Crisp, 2005; Peckover, 2011)

One summary overview of research on how the effects of maltreatment can be mitigated or abusers prevented from repetition of abuse or neglect was less positive about this tertiary prevention than primary prevention and concluded that better foster care for abused children could help them overcome their adverse experiences, but that other interventions were less conclusive (MacMillan et al, 2009). Few of the interventions covered by MacMillan and colleagues are delivered by health visitors and range from castration of male sex offenders to counselling and psychological therapies (MacMillan et al, 2009).

## Health visiting work in child protection teams

The lead role for child protection in the UK lies with social workers, but the health services' obligations are laid out in current guidance (Department for Children Schools and Families, 2010). The influence of health visitors has been seen as carrying less weight than other professionals in joint decision making processes in child protection, particularly relative to medical opinions (Glennie, 2007). Since a health visitor's referral of a family to social worker teams for child protection services can be delayed or refused if the social work departmental thresholds for access to services is not met, Brandon and colleagues (2003) note that some studies indicate undue delays in child protection can occur. During the process of social work assessment, the family faces intrusive enquiries, but the responses may be less protective than referrers expect (Corby, 2003). Cases for which there is no move to a multidisciplinary child protection plan remain the responsibility of the referring health visitor. Brandon et al (2008) also identified a 'start again' syndrome among social workers who received re-referrals or took an over-optimistic view of cases, which tended to discount past family history (Brandon, et al., 2008). The same review also identified thresholds at several points in a case, namely recognition, early intervention, safeguarding and compulsory safeguarding actions (Brandon et al, 2008). Given the difficulties which prompt referral, the problem of careful negotiation with families and the disruption which may result from social work assessment, both health visitors and families may feel that little help is has resulted (Luker & Chalmers, 1989; Rushton & Dance, 2005). The issue of continuing to provide a non-stigmatising universal service in cases where families are involved with multi agency child protection plans is one where professional practice requires both a supportive relationship and a surveillance component and this can be a difficult professional and ethical balancing act (Marcellus, 2005). Such cases may be difficult to delegate with confidence to paraprofessionals.

## Conclusions

### Summary of findings

Questions for this chapter reflected safeguarding across the whole service and the particular contribution of health visitors for families where there are child protection concerns.

**Question: What is known about how health visitors contribute to safeguarding and child protection?**

- There is a relative paucity of rigorous research about the health visitors' role in child protection, although some studies shed light on health visiting practice in case-finding and their continued engagement with families that often reject services.
- There is evidence, from Serious Case Reviews, for the active and consistent involvement of health visitors in child protection work, particularly for younger children, who are also the population group that are most at risk of the most serious consequences of maltreatment.
- The research shows that health visitors can contribute successfully to prevention by modifying risk factors, such as parenting behaviours and maternal anxiety, but there is no hard evidence that child maltreatment can be prevented by health visiting practice. This is in line with international research across the field, which is similarly inconclusive.

**Question: How do health visitors identify families with high risk and low protective factors?**

- The evidence suggests that health visitors use the needs assessment processes developed across the service spectrum (most notably within the universal level of provision – described in Chapter 4) as a form of prioritisation. Their familiar contact with the wide range of 'normal' parenting practices and behaviour is central to identification of variation from that norm.

- Longitudinal research over five years showed that health visitor screening for risk factors in a single post-natal assessment did not help to accurately identify those families who would go on to maltreat a child, so repeated contacts, preferably through home visiting as part of the Universal service, is required..

- Many unvalidated, structured instruments are in use, which do not help to identify needs and there is evidence that they hinder disclosure of risk. Instead, maintaining contact and enabling situations (such as home visiting) in which health visitors can use finely honed professional judgement skills, appear most appropriate.

**Question:  What are the knowledge, skills and values required by health visitors to implement child protection practice?**

- The knowledge, skills and values required across the spectrum of health visiting service delivery were repeatedly highlighted in research about child protection. In these situations, core capabilities need to be particularly highly developed. Personal and professional values and the ability to forge interpersonal relationships in challenging situations are key issues.

- Research highlights the difficult professional and ethical balancing act involved in continuing to provide a non-stigmatising service in cases where families are involved with multi agency child protection plans is one where professional practice requires both a supportive relationship and a surveillance component.

## Discussion

The core question summarising our interest in this chapter is:  ***"What is the role and contribution of health visitors to child protection and safeguarding?"*** There is a paucity of research in this field, which is surprising given the importance and amount of health visiting time involved. We looked specifically at the how health visitors work to assess families with high risk and low protective factors and to modify risky situations, and found most of the research mirrored practice by mentioning child protection as one aspect of a wider role. The contribution of health visitors arises from their provision of Universal services to all families with young children because this provides a unique perspective from which to identify the needs of families which go beyond the scope of Universal and Community services. Since child abuse and neglect are rare, health visitors can offer family support and preventative services to prevent the stresses and circumstances under which children may be maltreated. This is a dynamic and multi-factorial process, which requires repeated reassessments and awareness of the whole context ('person-in-situation') taking into account information and knowledge of individual families, factual knowledge of child health, as well as about theories of child development, attachment and family functioning. Health visitors view families who have extra needs in the context of the wider population of normal families and can identify families with suspected risk factors for child abuse or neglect, but there are no current standardised child protection risk assessment tools which have been validated for use by health visitors, so informed professional judgements are necessary to prioritise extra support and referrals.

Child protection work may lead to high levels of anxiety and concern, particularly when the health visitors is the sole worker involved with high-risk families, about both the child at risk and of other families for whom the health visitor is responsible, who receive a correspondingly lower share of time. More research is needed about how to support health visitors to maintain this balance, and as highlighted in earlier chapters, there is a need to be realistic about the extent to which health visitors

can influence child outcomes where there is extreme adversity, such as family violence. Apparently small advances (like reducing maternal anxiety or increasing their confidence in using services, which are both reported in the research) can form the basis for more substantial improvements in parenting practices. Continuing to provide a non-stigmatising universal service in cases where families are involved with multi agency child protection plans requires both a supportive relationship and a surveillance component, which can be a difficult professional and ethical balancing act, requiring both a high level of knowledge and skill, and strong organisational support:  more research is needed about how to achieve these.

# Chapter 8:  Conclusions and Recommendations

## Insights from the Review Process

### Focusing the review

This large scoping review incorporated a narrative study about the key components of health visitor interventions and relationships between the current health visiting service, its processes and outcomes for children and families. This could potentially have been an impossible task, and we did not set out to include everything that is relevant to health visiting practice; instead, we situated the review firmly within the context of current policy, the *Health Visitor Implementation Plan*. Even with that boundary, it was a formidable task made manageable only by focusing on some key elements identified from the Healthy Child Programme, which is a key part of the *Implementation Plan*, and we acknowledge that other researchers might have made different choices. For example, we selected 'post-natal depression' as a key marker for peri-natal mental health, but did not search separately for research about health visiting work in infant mental health. Also, whilst 'outcomes for children and families' were of central importance, our interest extended only to those papers that directly linked them to services or interventions delivered or facilitated by health visitors, which limited the field. The iterative process described in Chapter 2 was essential, not only because of the size of the task, but also because of the large team, which generated a need for co-ordination across a group of colleagues who came from different backgrounds and areas, and who all had other duties in addition to this review. Frequent meetings in pairs and small groups, as well as including the whole team, were essential for consistency and to keep the project on track.

### Study selection

The broad and unwieldy nature of the task and the literature meant that we needed to sacrifice depth in some areas, which is a widely acknowledged dilemma with scoping reviews (Levac et al, 2010). Whilst we incorporated three different and complementary search strategies to maximise coverage, we cannot be sure that we have identified all potentially relevant research. The process of identifying a clear search strategy was hampered by the multiple titles in use in the papers, even for UK-based research, including: 'community practitioner' (e.g., Bayley et al, 2009, Taylor et al, 2009, Roberts, 2012), 'community nurse' (Taylor et al, 2009),  'trained leaders' (of parenting programmes) (Bywater et al 2009), 'skilled specialist nurse-therapist' (Sonuga-Barke et al, 2006), 'specialist public health nurse' (Bloomfield & Kendall, 2007) and 'specialist community public health nurse' (Baldwin & Griffiths, 2009). In some papers, the term 'health visitor' was used in the body of the paper, but not in the title, abstract or key words (Patterson et al, 2005), which hampered search processes. In the case

of multi-disciplinary programmes, using a generic title such as 'primary health care professionals' seems justified (e.g., Velleman et al, 2011 and Davis & Tsiantis, 2005), although we excluded papers that were unhelpful for our particular purpose, i.e., where the contribution of the health visitor was not separately described. Whilst we included terms such as 'public health nurse' (used in Scotland and Ireland) including 'specialist community public health nurse' (the formal title regulated in the UK) in our searches, screening all the literature that might emerge from a search of the many and various alternative terms that we identified would have been impossible.

- **Research Recommendation: researchers in this field should ensure the term 'health visitor' is used in the title, abstract or key words of publications, to enable more effective searches in future**

- **Policy Recommendation: consideration should be given to how best to formalise use of the titles 'health visitor' and 'health visiting' to avoid confusion in future.**

We took the decision to exclude grey literature, non-empirical papers, historical and overseas studies for pragmatic (time and relevance) reasons, but recognise the limitations this places on our findings. We included a very small number of relevant papers from other countries where equivalent (to health visiting) work is undertaken if there was a particular reason, but generally avoided these as lying outside the scope of the *Implementation Plan* and our review. Also, we were very selective about the inclusion of surveys and service development evaluations, and included only commentary or discursive papers considered seminal by the health visitors on the team, or deemed essential for context. Although we formed judgements about the papers we read, study quality *per se* was not an inclusion or exclusion criterion. Rather the amount and quality of the information about health visiting practice was our main reason for inclusion, which was often unrelated to the quality of the research. In some instances (for example) we excluded papers where the research was high quality, but there was no detail of the specific contribution or skills/knowledge specifically provided by the health visitor (e.g., Sonuga-Barke et al, 2001; Stewart-Brown et al, 2004).

Decisions about which 'health visitor-focused' papers (particularly older papers, published prior to 2004) to include were informed by expertise in the team, bearing in mind the extent of relevant content. This form of purposeful sampling is widely used in qualitative research and the use of such decision-making processes about inclusion/exclusion are common in scoping reviews (Arksey & O'Malley, 2005) but, again, we recognise that there may be relevant papers that we have missed. Our decision to publish, in appendices, the papers we reviewed in full and those we read but excluded, is partly intended to mitigate this limitation. Also, we hope the appendices will serve as a resource for future researchers who need to find a way into the health visiting literature about a particular topic.

'Knowledge Support' by summarizing the evidence in this way is one key purpose of a scoping review (Mays, Pope & Popay, 2005).

The literature that we identified about health visiting practice is widely dispersed and does not form a coherent body of research, although there are some examples of papers that are well integrated to other research programmes, such as those about post-natal depression, parenting support and early interventions/home visiting. Across the board, papers with the strongest methodological base often told us least about health visiting practice, whilst many in-depth expositions about how health visitors work reported no outcomes. In general, the research is characterised by small-scale, single studies, often under-theorised or disconnected from the wider body of research, or forming part of Masters or Doctoral work that is not then followed up to create a convincing body of work.

- **Research recommendation:  greater collaboration is needed to embed research about health visiting within wider bodies of research to strengthen it academically and enable researchers from other fields to understand better the contribution and context in which health visiting takes place.**

We identified a paucity of research about health visiting in key areas of interest, notably within early nutrition and obesity prevention, speech and language development, engaging 'seldom heard' populations, child protection/complex needs (except in terms of needs assessment and prioritisation) and skillmix, teamwork or other organisational arrangements. This is not to suggest that these areas, themselves, are under-researched (which we did not assess), only that we found little evidence that health visitors have engaged with them, or that researchers in those fields have engaged with health visiting. Given the public health importance of each of these areas of interest, the lack of research is surprising and points, once more, to the need for greater collaboration, and also for far more scholarship within health visiting. This is likely to be difficult to achieve concurrently with the increased demand for education of new health visitor students, but it is essential for enabling the new cohorts to begin their careers with appropriate expectations about evidence development and use in practice. However, Peckover (2011), and Hoskins (2009) have both pointed to the lack of academic leadership and infrastructure in health visiting. There are no Professors of Health Visiting in the country, for example (although there are health visitors holding professorial appointments), and no scholarly journals specifically for this field[9]. Whilst multi-disciplinarity is to be applauded, it is best fostered within a situation where contributors are each valued and recognised for their discipline-specific expertise.

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[9] A new professional 'Journal of Health Visiting' has begun publishing just as this report was finalized.

**Research and Policy Recommendation:  The academic infrastructure for health visiting needs specific support and action to enable it to develop from its current very low base.**

## Analysing and reporting

Analysing and collating the literature for the report was a complex process, partly because of the extent to which each topic (identified from the HCP) and service level (identified in the *Implementation Plan*) crosses boundaries and is interconnected across other areas of research. We reviewed the literature about the way health visiting services are (or should be) set up as part of the Community, so they can then be delivered effectively through the Universal provision. Evidence from those two levels formed an essential basis for all the subsequent literature, which consistently referred back to the importance of the Universal service and key ways of working identified (and described again below) as a basis for the specific areas of practice and, most importantly, for those parents and population groups with continuing and complex vulnerabilities and needs. This highlighted the point that, whilst sub-divisions and separate descriptors are helpful for specifying elements of the service and topics of interest, approaches to health visiting practice embedded within the Universal level form an essential cornerstone of the entire service.

**Recommendation for Service and Policy:  Evidence about the multiple interconnections across different levels, priorities and approaches to practice indicates that the health visiting service should be planned and organised as a single, holistic form of provision, centred around the Universal service.**

We have aimed to identify which service level is most relevant to aspects of the literature, but some papers and aspects feature in several places, so we refer back or forward to other chapters to avoid too much repetition.

## Insights from the Literature

### Evidence about health visiting practice

Through a thematic analysis across some thirty years of research, including classic studies and more recent topic-specific evaluation studies, we identified approaches to health visiting practice that appear to have been widely valued and repeatedly mentioned in some form or another. We described two key components:  the first, we labelled the health visiting 'orientation to practice' and the second included a 'triad of core practices'.  In summary, the health visiting orientation to practice includes three main concepts:

i. It is salutogenic (health-creating), which involves being proactive, identifying and building strengths and resources (personal and situational) and being solution-focused

ii. It demonstrates a positive regard for others (human valuing), through keeping the person in mind and shifting (the health visitors') focus to align with client needs, recognising the potential for unmet need, actively seeking out potential strengths, maintaining hope

iii. It recognises the person-in-situation (human ecology), through assessing and acting as a continuing process, always taking account of the individual and their personal and situational circumstances, whether acting in the client's space, the community or the workplace.

These find expression through a triad of core practices, which all operate together as a single process, which are:

i. the health visitor-parent relationship, which incorporates

ii. health visitor home visiting and

iii. health visitor needs assessment.

Research across these three core practices identifies similar skills, knowledge, approaches and abilities, and our review of the literature showed they are intimately interconnected. The qualities and skills of both health visitor and parent influence formation of the relationship, which then enables health needs to be identified (assessed) and met in partnership with parents through a series of steps, identified in the literature. The ability to assess needs is closely linked with the relationship-formation process, which is enhanced by the opportunity to meet the parent in their own space at home, which also enables understanding of 'person-in-situation' (human ecology). Overall, the detailed descriptions of the 'orientation to practice' and the 'triad of core practices,' together provide a fully integrated description of the health visitors' values, skills and the knowledge and capabilities required for the work.

We argue that this unique combination, with its focus on health rather than illness, sets health visiting apart from other workers in health and social care, making them the most appropriate workers to deliver the Healthy Child Programme. When applied in practice as intended, these apparently separate components combine to enhance and clarify the 'service journey' for parents/families, enabling them to access and use health visiting services and, through them, be better placed to reach other services. This is of particular importance for families who may otherwise find services hard to reach or access. Research about other matters (such as cultural competence, obesity prevention, promoting immunisation and more) highlighted the importance of embedded components of the service orientation and triad of core practices, including non-judgemental attitudes, flexibility, proactivity, sound knowledge about child and family health matters and a positive (strengths-based) approach), which all featured repeatedly across the literature. On the other hand, we identified a number of papers highlighting service approaches and practice that failed to achieve the ideal forms

of practice summarised here, which points to the need for better education and organisational arrangements.

**Education Recommendation: Recruitment and preparation of student health visitors, and continuing professional development, should take account of the values, skills and attitudes embedded in the health visiting 'orientation to practice,' and to develop the capabilities required for the triad of core practices.**

**Service recommendation: Organisational arrangements need to take account of the interlinked nature of 'triad of core practices', so that health visitors charged with needs assessment have the opportunity to form relationships and undertake home visits**

We were encouraged by the continuity between older and more recent research about specific health visiting skills – whether identified through classic literature focused on theorising health visiting practice, or in more recent trials that test the application of some aspects of their way of working. However, there are inevitable limitations to the descriptions summarised above and detailed in Chapters 3 and 4. Much of the research was qualitative and descriptive, without a link to child and family outcomes. Also, we found very little material about health visitor-run baby clinics, although Plews and Bryar (2002) suggest they are valued for reassurance and advice, whilst Bidmead (2013, Appendix 1) indicates that it helps to consolidate the health visitor-parent relationship. We found too little research on this topic to show whether clinic work should also be deemed as a 'core practice'. A number of other papers included evaluative research showing positive outcomes achieved by using health visitors as intervention agents, without explaining the detailed processes involved. These aspects might all be a focus for research in future.

## Evidence of beneficial outcomes

Due to the relationships they can develop with families in the home, away from the threatening and disease-oriented environments of most hospital and many general practice settings, health visitors are perfectly placed to provide useful input for families that might need additional structure or support. As mentioned above, much of the literature was small in scale and, whilst some specific and positive outcomes were described and reported, few of the papers would meet contemporary levels of rigour in terms of 'evidence based practice'. We were, of course, primarily looking for evidence about how health visitors practice, which reduced the number of papers in this category, since many trials (as described above) gave little or no detail about health visiting practice. Also, we did not include papers reporting 'promising interventions' from home or abroad that might be suitable for implementation for health visitors, which would be included under the remit of the Healthy Child Programme. However, there was a small amount of rigorous research that also included information about how health visitors

practice, or detailed the additional training provided to support trial outcomes. These studies provided evidence of beneficial outcomes from health visiting practice in specific areas including:

- prevention, identification and treatment of post-natal depression (Morrell, Slade, Warner et al 2009, Brugha, Morrell, Slade & Walters 2011),
- parenting support by specialist health visitors (Sonuga-Barke, Daley, Thompson, Laver-Bradbury, & Weeks, 2001)
- structured home visiting visiting/early intervention programmes (Austerberry, Wiggins, Turner & Oakley, 2004, Puura, Davis, Cox et al, 2005, Shute & Judge, 2005, Barlow, Davis et al, 2007a,b, Kemp, Harris, McMahon et al, 2011).

We did not formally assess the quality of this literature, but found the outcomes were not uniformly large, and economic evaluations were rare. However, there is a need to be realistic about the extent of change that should be expected from health visiting interventions for families living in complex situations. Equally there is a need to acknowledge that apparently small changes (such as more relaxed mothering, improved mother-child interactions or early identification of post-natal depression) would be expected to translate into large benefits, either later in an infant's life, or through improved parental confidence in services, leading to their better use. We found little evidence that these approaches were being widely implemented in practice, but we suggest that they should be a priority for expanded services, as new recruits come on stream.

Two approaches operate in a similar way to the integrated approach to health visiting work described in this review, and are each recommended in the HCP, which we feel supports our analysis. These are the Family Partnership Model (FPM), (Davies and Day, 2010), which has proven effectiveness and beneficial outcomes when used with promotional interviewing techniques (Puura, Davis, Mantymaa et al, 2005). The Solihull Approach offers benefits as well, having positive pilot evaluations and a strong theoretical base that is helpful and compatible with health visiting (Douglas & Brennan, 2004; Bateson, Delaney et al, 2008). The key issue about these approaches, unlike the specific programmes, is that the skills and abilities that health visitors develop in learning to use them are generally transferable across the work, so would be expected to improve the quality of practice and service delivery across the board.

**Service Recommendation: Evidence based approaches (including the associated education and training) for post-natal depression, parenting support and early intervention/home visiting for disadvantaged families should be implemented as part of the Universal Plus and Universal Partnership Plus levels of service delivery, including the Healthy Child Programme.**

## Imperatives and tensions in practice

We identified a range of contradictions in the literature, where competing expectations on health visitors can create tensions that appear under-acknowledged. Examples include organisational arrangements (considered further below) and public health imperatives. The latter may create tensions, where health visitors are required to promote behaviours that may be essential in their own right, yet which require time, skill and sensitivity when working with parents who may hold views that run counter to the recommendations. Murphy (2003, p. 433) proposes that there is a paradox "at the heart of the relationship between the state and the family in contemporary liberal states" like the UK. On one hand, there is respect for the privacy and autonomy of individuals, whilst on the other hand there is a concern to regulate and influence social and economic life to foster well being and health. Whilst such tensions apply to many spheres, such as immunisations, obesity prevention, home safety and parenting practices, all of which are central to health visiting practice, infant feeding provides a good example of this paradox. There is significant government interest in promoting optimum infant nutrition as a means of ensuring the wellbeing of the future adult population (Murphy 2003), so health visitors may be locked in a paradox (tension) between providing client-focused care (and enabling relationships with parents) and serving the public health goals of the government – often mediated by firm service specifications and financially driven commissions.

Health visitors need to be able to negotiate this paradox – do they risk disrupting the relationship with the mother at the expense of pushing health targets or does the health visitor pursue a wholly client focused approach even if this contradicts commissioning targets and public health/ government expectations?  The literature suggests that the health visitor may not always be able to achieve meeting public health targets and maintaining the flexibility to meet parents perceived needs. The key message appears to be that in order to remain client-focused and provide 'non-judgemental' support to parents, health visitors must carefully balance the delivery of public health messages with a consideration of parental needs and wishes. Coping with these ethical and practical ambiguities was the subject of some earlier health visiting literature (Dingwall, 1982; Dingwall & Robinson, 1990; Twinn, 1991), with more recent debates about 'disciplinary power' (Peckover 2002b) and using health visitors as agents of state control (Greenway, Dieppe, Entwhistle & Meulen, 2008). However, we did not find any recent studies or intelligence to inform progress or even debate in this field. In order to remain family-centred and provide non-judgemental support to parents, health visitors need to balance the delivery of public health messages with a consideration of parental needs and wishes. By respecting the needs and wishes of the parents but still using their professional judgement, health visitors may continue to develop (non-coercive) relationships with parents and maximise the benefits that are associated with such relationships.

It is likely that, with firmer outcomes-focused policies, these tensions and paradoxes may increase, but the ethical concerns need to be borne in mind by commissioners when setting service

specifications. Also, educationalists need to enable health visitors to develop the level of skill needed to deal with these contradictions and paradoxes in practice.

**Service recommendation: Commissioners should write service targets (Key Performance Indicators) and commission services in a way that acknowledges the need for health visiting flexibility in meeting parents' perceived needs.**

**Education recommendation: Educationalists should enable health visitors to recognise and work with ethical and practical tensions in practice, arising from contradictory expectations.**

## Service organisation

As noted above, there is a paucity of research about organisational arrangements. These were also implicated in the range of contradictions in the literature, where competing expectations can create tensions for health visitors that appear under-acknowledged. Dilute skillmix, lack of time in the working day, or the expectation that specific questions will be asked at particular times (for example through structured needs assessments/guidelines, see Appleton & Cowley (2004)), may inhibit the forms of flexible working identified as central to good health visiting practice. Flexible timing and the ability of health visitors to choose when to raise issues is essential for enabling more vulnerable families to enter the 'service journey' and access provision, and for operation of the unified relationship-assessment-visit processes that enable human valuing and respect. All these components have been identified as essential across areas where sensitive practice is needed, such as for excluded populations, disclosure of domestic violence, prevention of obesity and more.

We did not identify any clear answers in the literature to questions about whether health visiting services are best integrated with children's centres or general practice, nor about the knotty issues of balancing community outreach and development with individual caseload work. Whilst there is some literature about each of these areas, there does not seem to have been any concerted research effort to identify preferred ways forward. Likewise, although there is research literature about skillmix and corporate caseloads, the majority is concerned with the change process, or the perceptions of professionals about new ways of working, rather than the impact on children and families. Skill-mix requirements of health visiting teams cannot be established on a one-size-fits-all basis. Rather, these requirements need to be carefully assessed and planned on the basis of an accurate analysis of local needs.

We did identify that skill mix teams have been widely implemented within health visitor services. Some project descriptions identified reduced stress where staff shortages had been relieved by the

introduction of junior staff, including community nursery nurses or staff nurses who were then enabled to access health visitor education themselves, an approach that minimised tension in the team. There were a few studies that identified the process of planned delegation to a junior team member because she or he had appropriate skills and could relieve the health visitors' time. Lines of accountability appeared clearest when they had been carefully considered ahead of time, but the most frequently reported approach to delegation involved pragmatically using team members interchangeably, which led to concerns about missed opportunities for health promotion and potentially reduced service quality. Indeed some papers challenged the idea that dilute skill mix reduced stress, because of the additional supervisory load and difficulty in maintaining quality of services. There was also concern about vulnerability, where local women were employed as support workers. One large survey of mothers found a preference for retaining a relationship with one health visitor rather than a team, even if advice was consistent across the team (Russell 2008). However, reported studies focused mainly on implementation and change processes rather than child and family outcomes. Successful skillmix has been shown to free up time for health visitors to deliver more appropriate care to clients resulting in a more manageable workload. The lack of attention to accountability issues and the safety and quality of services where team approaches and skillmix is introduced is somewhat surprising, given the extensiveness of such changes in practice, which appear to be running well ahead of the evidence. Of all the areas, this is perhaps the most urgent for future research.

**Research recommendation: Research should be carried out urgently to evaluate the safety, quality and acceptability to service users of different skillmix and team working (e.g. corporate teams) arrangements in practice.**

## Education and training

Finally, a key theme running through almost every area of research that we studied, is the need for health visitors to be better prepared in terms of specific education and training. We have raised the need for more education, specifically, about managing the practical and ethical tensions and for ensuring that health visitors have the capability to implement the 'triad of core practices' and aptitude for the health visiting 'orientation to practice'. A selection of the evidence where similar recommendations arose for more/better preparation of health visitors include:

- Community development/public health practices
- Multi-agency/multi-disciplinary engagement
- Need for more knowledge about breast feeding and immunisation
- Better preparation to promote home safety and unintentional injury
- More/better skills in dealing with post-natal depression and mental health
- Better understanding, knowledge and skills for obesity prevention

- Health visitors to be better equipped to deal with skillmix, including delegation
- Support to develop more skilful, culturally competent practice with seldom heard groups, including BME populations and those experiencing current major life problems such as insecure housing or seeking asylum
- Sensitivity and skills in enabling disclosure of e.g domestic violence, hidden needs
- Able to develop authoritative practice in complex needs, e.g. in child protection situations

Along the way, specialist skills-development appeared to be associated with more/better measures of beneficial outcomes, as well. The frequency with which the recommendation occurred in the literature we reviewed may be partly an artefact of the need for those delivering interventions for trials to be well prepared in order to maximise outcomes (so they are given trial-specific preparation), but the need for more information, better developed skills and greater knowledge and information was also expressed in studies that engaged health visitors and service users as participants. We have no way of knowing whether the frequency of the recommendations reflects the fact that there are many under-prepared health visitors, or if it is purely down to the tendency of researchers (ourselves included) to recommend education as one outcome of their study. However, the ubiquity of this theme suggests there is a particular need for improved initial preparation of health visitors.

To encompass the current programme content (all of which appears necessary) and even a small amount of the recommendations for additional learning would entail expanding the education period far beyond the current, very packed 45-week programme, perhaps to 18 months or even two years. This would require a major change to current educational arrangements, and alternatives are worth considering. In the meantime, a planned period of post-qualifying continuing professional development may be valuable, especially bearing in mind the proportion of the whole workforce who will be 'recently qualified health visitors' by the end of the *Implementation Plan* in 2015. There is also a need for more continuing professional development opportunities for existing qualified health visitors.

**Education and Policy recommendation: Consideration should be given to the changes needed to current health visitor education, including longer or differently configured programmes, to enable all the necessary content to be encompassed within initial qualifying programmes**

**Education and Policy recommendation: A planned period of continuing professional development should be introduced, following initial qualification as a health visitor**

## Conclusion

We were not the first group of researchers to puzzle about the impact of evidence-based practice on health visiting. Elkan, Kendrick, Hewitt, Robinson et al (2000) carried out a systematic review of one important aspect of practice, which prompted some reflection about the social construction through research of health visitor domiciliary visiting, by Robinson (1988), who was the lead investigator on that review. As background, she drew upon Berger and Mohr's description of the 1950s country general practitioner. This offers an exemplar of the 'universal man,' being a well-rounded individual, educated to have a good grasp of the currently available knowledge, skilled through practice in a number of roles (that is, acting as a 'generalist') and able to apply considered judgements to reach decisions. Robinson drew comparisons with health visitors, who also offered a universal and generalist service, working autonomously in clients' homes and traditionally making decisions based upon their own professional knowledge and skills. She remarked upon the potentially destructive impact on the profession of applying to a generalist activity, such as home visiting, forms of health technology evaluation that are more suited to discrete activities such as drug administration. Robinson warned that separating out single aspects of practice for evaluation is likely to lead away from the notion of a universal, generalist service based on a shared (by health visitor and parent) construction of need. Instead, there would be an *a priori* identification of need by specialists, who then prescribe the required interventions to be delivered by others, together with the outcomes by which these activities will be evaluated. This is neither a good nor a bad thing – merely a commentary upon the nature of social change.

Such changes are clearly in train across health visiting services, where the current emphasis lies upon evaluation of outcomes that have been determined by national policies, such as the Healthy Child Programme, or by local service commissioners who determine priorities. At the same time, the more interpersonal and relational qualities of health visiting practice appear to be still valued, and professional judgement and high level of knowledge about child and family health continue to be a priority for service users. This flags up the importance of ensuring that the processes involved in practice are considered more clearly in commissioning and research, since studying outcomes alone gives no information about how they are achieved. Even if programmes are well described, unless the context of service provision and skills of the workforce are taken fully into account, there will always be difficulties in translating research into everyday practice.

We identified changes occurring over time in the research literature, some of which appear to reflect the changing social and professional situation, with much of the earlier qualitative work describing and theorising a form of professional activity that would chime with Robinson's description of the autonomous 'universal generalist' health visitor. The more recent literature identifies similar skills, knowledge and values, yet does so within the context of modern health technology evaluation, usually providing specific additional training for health visitors delivering the experimental interventions.

Between the two, there are gaps in the research, with a host of small, one-off projects and studies either failing to meet contemporary levels of rigour or lacking the detail needed to clarify how health visitors work. We would suggest that the gaps should not be regarded as a deficit, but rather as a marker that change is under way and on-going. They do, however, mark a need for far more investment in future research.

The challenge for health visiting services is to marry their long-standing, valued professional approaches (described in this report as their 'orientation to practice,' and the 'triad of core practices') to the more recent technological descriptions and evidence-based techniques – and for researchers who aim to further the evidence base to more explicitly incorporate these health visiting professional approaches into their evaluations and trials. Future research teams brave enough to follow in our footsteps in accepting the challenge to review the evidence base again, might then encounter a less fragmented body of work, revealing the full impact of health visitors' professional approaches, together with the full effects of their practice on child and public health outcomes.

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