Health visiting – a universal service for the future?

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Why is a GP giving this talk?
Why health visiting is important – the power of early intervention

- David Olds – 3 randomised controlled trials in US with long-term follow-up
- Nurse-Family Partnership (NFP)
- Intervention was 9 antenatal and 23 postnatal nurse visits before age 2 Vs control – addressing:
  - General health promotion
  - Maternal personal development
  - “Competent care of their children”
The power of early intervention.

- Compared with controls, adolescents born to women who received nurse visits during pregnancy and postnatally displayed fewer:
  - instances of running away (0.24 Vs 0.60; P=.003),
  - arrests (0.20 Vs 0.45; P =.03),
  - convictions and violations of probation (0.09 Vs 0.47; P <.001),
  - lifetime sex partners (0.92 Vs 2.48; P=.003),
  - cigarettes smoked per day (1.50 Vs 2.50; P=.10),
  - days having consumed alcohol in the last 6 months (1.09 Vs 2.49; P =.03).
  - reported behavioural problems related to use of alcohol and other drugs (0.15 Vs 0.34; P=.08).
The power of early intervention

Key messages from Olds’ trials:

- Long term outcomes were generally better than short term ones
- Highly cost effective
- Nurses more effective and acceptable than “paraprofessionals”
- Interventions produce lasting effects on the mother’s life course as well as the child’s
- Some lack of clarity about which elements of the intervention are important
- Gains might be lower in low risk groups
- Continuity of care really matters (unpublished data)
Would we get the same results if we transplanted NFP to the UK?

- Probably not!
  - We already have a HV service
  - UK studies comparing standard HV service with enhanced HV input (eg Wiggins 2005, Starting Well) have produced little evidence of substantial gain
    - but some work in progress – eg Family Nurse Partnership pilots
So what are the key elements of UK health visiting?

- **In common with NFP:**
  - Health led (Sure Start evaluation)
  - Delivered by nurses
  - Continuity of care

- **The UK contribution:**
  - Professional judgement about level and type of input
  - Universal service
Policy responses

- Hall 4
- Review of Nursing in the Community (RONIC)
- The Glasgow Health Visiting Review
“PCOs should plan how to discharge their responsibility for the health care of all the children and young people living within their boundaries”

“Screening, surveillance, parent support and health promotion activities should, where possible, be prioritized on the basis of evidence of effectiveness”
Key recommendations in relation to HV:

- Reduction in screening activity
- Allocation of families to Core / Additional / Intensive status
- End of universal face-to-face screening contacts after 8 weeks (though some contact kept with children through immunisation, nursery visits, phone calls etc)
Many of Hall 4 recommendations are now out of date:

- New research on early social development and developmental trajectories
- New research on identifying problems
- New research on screening
- New research on effective early parenting support interventions
Hall 4 update: New research on early social development and developmental trajectories

Many examples, eg Morrell and Murray 2003:

**Figure 1** Path analysis showing the mediating effects of maternal depression and parenting in the continuity of 9-month emotional and behavioural dysregulation and subsequent conduct disorder symptoms for boys and girls. Standardised coefficients are shown adjacent to pathways and $R^2$ values adjacent to variables. Significant pathways ($p < .05$) are shown in bold.
Hall 4 update: New research on identifying problems

Figure 5: Percentage who had FNS recorded by each age and of those rated FNS3 for first time
Hall 4 update: new research on screening

- Miniscalco et al 2006:
  - Simple screen for language delay at 2.5 years
    - 2% already known to have developmental delay so excluded
    - 4% (25/625) of the rest had <50 words or no 2 word utterances
  - Follow up examinations at 6 and 7 years
  - 70% who failed the screen had major neuropsychiatric disorders (ADHD, ASD or other learning difficulties). All of these required additional educational, health or SW services
Hall 4 update: New research on effective early parenting support approaches

- Triple-P
- Webster-Stratton Incredible Years
- Mellow Parenting and Mellow Babies
Variable in Scotland, but local implementation strategies generally based on:
- Early risk stratification
- Geographical team working with team leaders making decisions about core/additional/intensive status
- Skill-mix team working
- End of universal contacts at 8-16 weeks

This has contributed to major de-motivation of HV workforce and falling numbers of HVs
Review of Nursing in the Community

“Visible, Accessible and Integrated care” 2006 (draft)

- Based on problems of the aging population
- Creation of Community Nurse role
- Abolition of health visiting, district nursing and school nursing
- No widely available community nursing workforce with a focus on children
- Geographically based teams with no clear links to general practices
RONIC

- Children barely mentioned
- No evidence base presented
- Likely to fragment the primary care team and holistic family care
- Likely to cause confusion amongst the most vulnerable
- No clarity about communication and record keeping
- Little clarity on accountability and inter-agency working
RONIC

- 4 pilot sites
- End of HV training in some areas, replacement with generic community nurse training
- Evaluation approach not clear
- “Staff remain confused and concerned about the pilot plans” (Linda Pollock)
- Recommendations to Scottish Government by April 2009
The Glasgow Health Visiting Review

**Conceived**
- out of concern at the RONIC model’s disregard for children
- because of health-social work joint working in CHCPs
- because of failures and understaffing in child protection services in Glasgow:
  - “Focus on the most vulnerable”
  - Lack of understanding that generalist services prevent many families needing intensive or specialist services
  - Lack of acknowledgement of the risk of a stigmatised service
The Glasgow Health Visiting Review

- Meetings held in secret – no minutes kept
- No input from professionals
- No input from parents
- Poor quality literature review
- Implementation before report published
- Token consultation exercise
The Glasgow Health Visiting Review

**Recommendations:**

- End of universal contact at 4 months
- End of HV attachment to general practices
- Multi-professional, social work-led geographical teams
- Corporate caseloads
- “Skill mix”
- End of administration of immunisations by HVs
The Glasgow Health Visiting Review

- Massive opposition from parents and professionals
  - 5000+ individual protest letters to Health Board
  - 21,000+ signatures on Holyrood petitions
  - HB negotiations with GP and HV representatives
  - Review is defunct in all but name
Where to now in Glasgow?

- **Things do need to change:**
  - We need a HV service based on evidence
  - We need to be able to show that the HV service works
  - We need a service that responds to the needs of both parents and children
The Glasgow Parenting Support Framework

UNIVERSAL INTERVENTIONS

ACTIVE FILTERING

Parents and professionals both believe no problems.

NO INTERVENTION

Parent or professionals believe there are problems.

INTERVENTION

Parents and professionals believe there are problems.

ADDITIONAL ASSESSMENTS

SPECIALIST SERVICES

Defaulters and families with continuing problems at HV assessment
Active filtering by HVs

- Partnership between parents/carers and professionals.
- Parents:
  - Generally “know when something is wrong”
    - With the child
    - With themselves
    - With the relationship
  - Early identification of neurodevelopmental problems is important
    - Because it’s good for parents
    - Because early intervention works best
- Professionals...
Active filtering by HVs

- HVs’ decision-making about families is already complex:
  - Depend on personal background, demographics of practice, inter- and intra-professional relationships
  - Crucially dependent on development and continuity of relationship with families
  - Major weakness lies in lack of training to evaluate the relationship between parent and child formally
    - Evaluation of the relationship important because its quality predicts outcome for children independently of problems in parent or child
    - Formal evaluation important for effective inter-agency communication
Proposed universal HV contacts

- Brazelton NBAS at 1st visit
- 6-8 week postnatal examination
- 13 month assessment evaluating parental wellbeing and parenting difficulties
- Contact at 2½-3 years for language and motor screening, and assessment of child psychological wellbeing
  - Possibly by phone or postal questionnaire
  - Possibly in collaboration with nurseries on entry
- And an “open door” to families
Operating, monitoring and evaluating the Framework

- Use of structured tools by HVs in collaboration with families:
  - Edinburgh postnatal depression scale (8-12 weeks)
  - Parenting daily hassles (13 and 30 months)
  - Adult wellbeing scale (13 months)
  - Language screen (30 months)
  - Eyberg Child Behavior Inventory (30 months)
  - Strengths and Difficulties Questionnaire (36 months?)

- And satisfaction data from families and professionals etc
What do you think?

- Does collection of structured data on parenting and child wellbeing:
  - Focus service priorities in the right way?
  - Increase access to services for those who need it most?
  - Help make the case for investment in early years support?
  - Or does it risk alienating families and professionals?