A sociological study of the implementation of Hall 4 and its impact on health visiting work

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In this presentation I will :

- Talk about the background to the study and how I have gone about it
- Talk about some of the emerging findings from the study
  - Focusing on how families become known through health visiting work and the implications of this
- Work in progress so often raising questions in the context of the developing analysis of the accounts

Background to the research

- 2003 – Hall 4 first published

2003 – A shift from universal to targeted care

A change in health policy (Hall 4) influenced how health visitors work with families. Health visitors were asked to target support to the most vulnerable, whereas before they worked with all families.

Background to the research

- 2003 – Hall 4 first published
- 2006 – Research partnership established

2006 – The need to examine the change

A research partnership is formed between NHS Lothian and the Centre for Research on Families and Relationships (CRFR) to investigate the impact of this policy change from the perspectives of parents and professionals.

Background to the research

- 2003 – Hall 4 first published
- 2006 – Research partnership established
- 2006/07 – Develop methodology around Appreciative Inquiry; Ethics reviews
- 2007/08 – Research recruitment and interviews

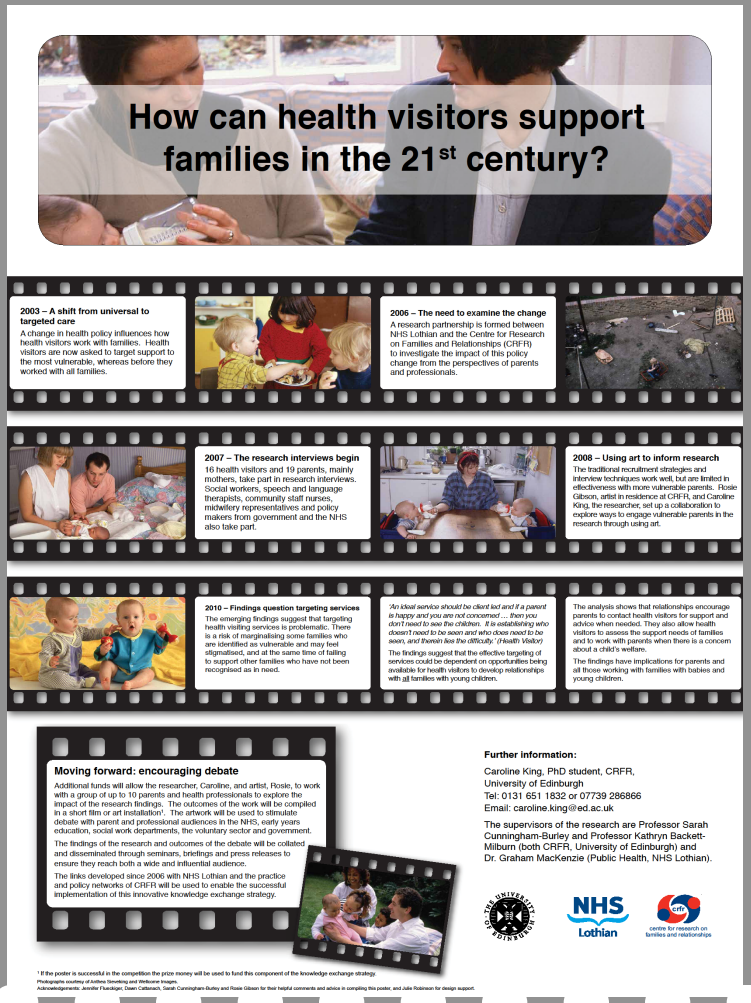
2007 – The research interviews begin

- 16 health visitors and 19 parents, mainly mothers, took part in research interviews.
- Social workers, speech and language therapists, community staff nurses, midwifery representatives and policy makers from government and the NHS also took part.

Background to the research

- 2003 – Hall 4 first published
- 2006 – Research partnership established
- 2006/07 – Develop methodology around Appreciative Inquiry; Ethics reviews
- 2007/08 – Research recruitment and interviews
- 2009 – Experience health visiting services
- 2010 – Funding to develop knowledge exchange work with CRFR artist in residence

Knowledge exchange work



Background to the research

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- 2010 – Funding to develop knowledge exchange work with CRFR artist in residence
- 2010/11 – Analysis and writing up of research

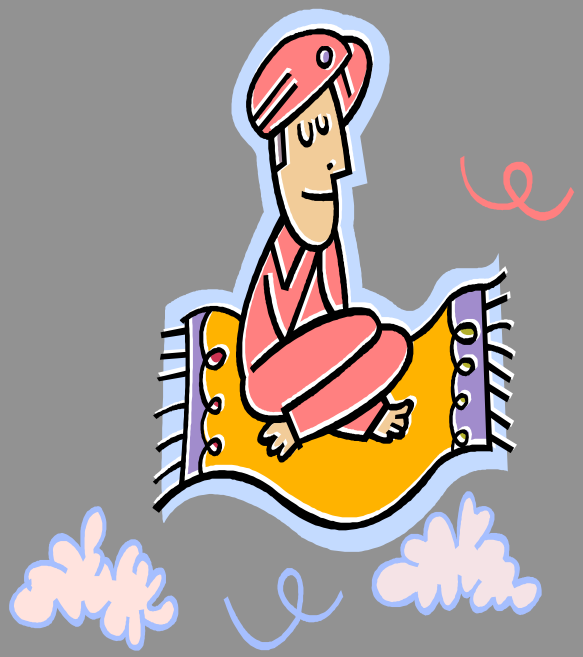
How do health visitors speak about the ‘family’?

- Focus on mothers and mothering
- Babies as the primary client to be ‘protected’ through the mother
- Fathers absent and present in accounts and in practice
- Discourse on the parent and parenting belies a gendered family

The home as a source of knowing

- Literal and metaphorical use of doors – keeping doors open, going to the door, getting back in the door
- Being invited into the home
- The fabric or physical environment of the home – in terms of cleanliness, safety, stimulation for babies/children

Sticky carpets



..I've been in homes that I've gone to that you can't see the colour of the carpet; so it's not like I'm being judgmental, but if it's clear that you are sticking to the carpet, you can't see the colour of it, there's a pattern on it, but, you know, it's just absolute filth (HV15)

The home as a source of knowing

- Literal and metaphorical use of doors – keeping doors open, going to the door, getting back in the door
- Being invited into the home
- The fabric or physical environment of the home – in terms of cleanliness, safety, stimulation for babies/children
- Relationships and routines of families

The home as a source of knowing

Observations of family relationships and routines

… if they want to breast feed, or change the baby, they have got everything there. And it is also good for us to see how they operate in their own surroundings. And hopefully what other supports are around for them as well. I feel you get a far better impression of how people are coping when you actually see them at home. And they are far more likely to tell you things than they are in a busy clinic. You often get more information. (HV6)

Rapport and relationships as central to ‘knowing’ families

- A technique of talk used most often with mothers
- Rapport used as a technique to build relationships
- Relationships as central to health visiting practice - ‘keeping mothers coming’
- Opportunities to develop relationships more limited?

What do health visitors know about families?

- Used photographic metaphors to illustrate the nature of knowing families
- ‘Building up a picture’ – dependant on opportunities to do so
- Spoke about knowing as only ever being partial

Getting a snapshot – the use of photographic metaphors

- ‘getting a snapshot’
- ‘getting a good picture of the family’
- ‘you have kind of built up a picture’
- ‘a fuller picture’

Knowing as partial

.. you don't know what is going on behind closed doors, you never do, and it is people's private lives, all you are doing is getting a snapshot each time, and trying to build up a picture (HV4)

Not knowing when to worry

- Not knowing families so well – and families and their circumstances change
- Not knowing your caseload so well
- Not knowing when there are things to be known – ‘I don’t think the problems have gone away’; ‘mothers aren’t contacting us the same way’
- A less responsive service?

Knowing when to worry

- *.. it worries me that the health visitor seeing this person can't know the background (if seen at a clinic). And, are they, I think if I have clients like that that I am not seeing then I, if they are a worry, if they are a known worry to me, then, I would be trying to see them in between times, anyway. I would be trying to get a hold of them. But I think what worries me is that I wouldn't now know when to be worried. (HV7)*

Not knowing your caseload so well

- *I think because I don't know my case load as well as I should because I don't have the regular contact, as I say to you, I assume everybody in these bottom three drawers is fine (of filing cabinet) or the bottom two drawers because you are concentrating on the top one and everyone you are just hoping is okay, so, I feel you are missing out on that. (HV3)*

Not knowing when there are things to be known

- *… what would be really interesting as well would be looking at and I'm sure someone will look at, the speech therapy and referrals to speech therapists, have they gone down, have they gone up, you know, who is referring now, because I don't feel it is me. I am not referring in the main as much to some of my colleagues.*
- **CK: Right so you have noticed?*
- **HV5: I've noticed that it has gone down, yes. I can only think it is because I don't see the children not because the problems have gone away. (HV5)*

Where are they going with this?

we would tend to find that at certain checks there would be certain issues that came up around toilet training, all these kind of things, so we were able to offer parents some kind of support and advice with dealing with these things, whereas now we don't really see a lot of older children. We find parents are not really tending to phone us so you're thinking well where are they going with this. (HV12)

A less responsive service?

It used to be very responsive, now it is not responsive at all. Because once you get to 6 months, everything is alright, you put them on core and then after that it just depends if someone says to you there is a problem. (HV1)

Professional knowing

- Plethora of interactions and observations beyond those between health visitors and the ‘family’
- With midwives, social workers, GPs, speech and language therapists, nursery workers
- Accounts suggest changes in the nature of these relationships - with potential implications for children and families?

So?

- Accounts suggest that knowing is only ever partial and that opportunities for knowing families are now fewer than before.
- With fewer opportunities does what 'needs' to be known become missed?
- Is health visiting work (as accounts suggest) becoming increasingly shaped by (narrow) child protection discourses over broader child health and welfare discourses?
- Will families start becoming increasingly 'resistant' to health visiting intervention?
- Would a focus on child health and welfare with all families provide a safer mechanism for ensuring that all children's needs in terms of their development and protection and met?

Discussion

- Does the current service allow for working with some vulnerable (risky) families rather than targeting to need/vulnerability in families?
- Do we need a well resourced universal health visiting service which works with all families for effective targeting to happen?

Contact Details

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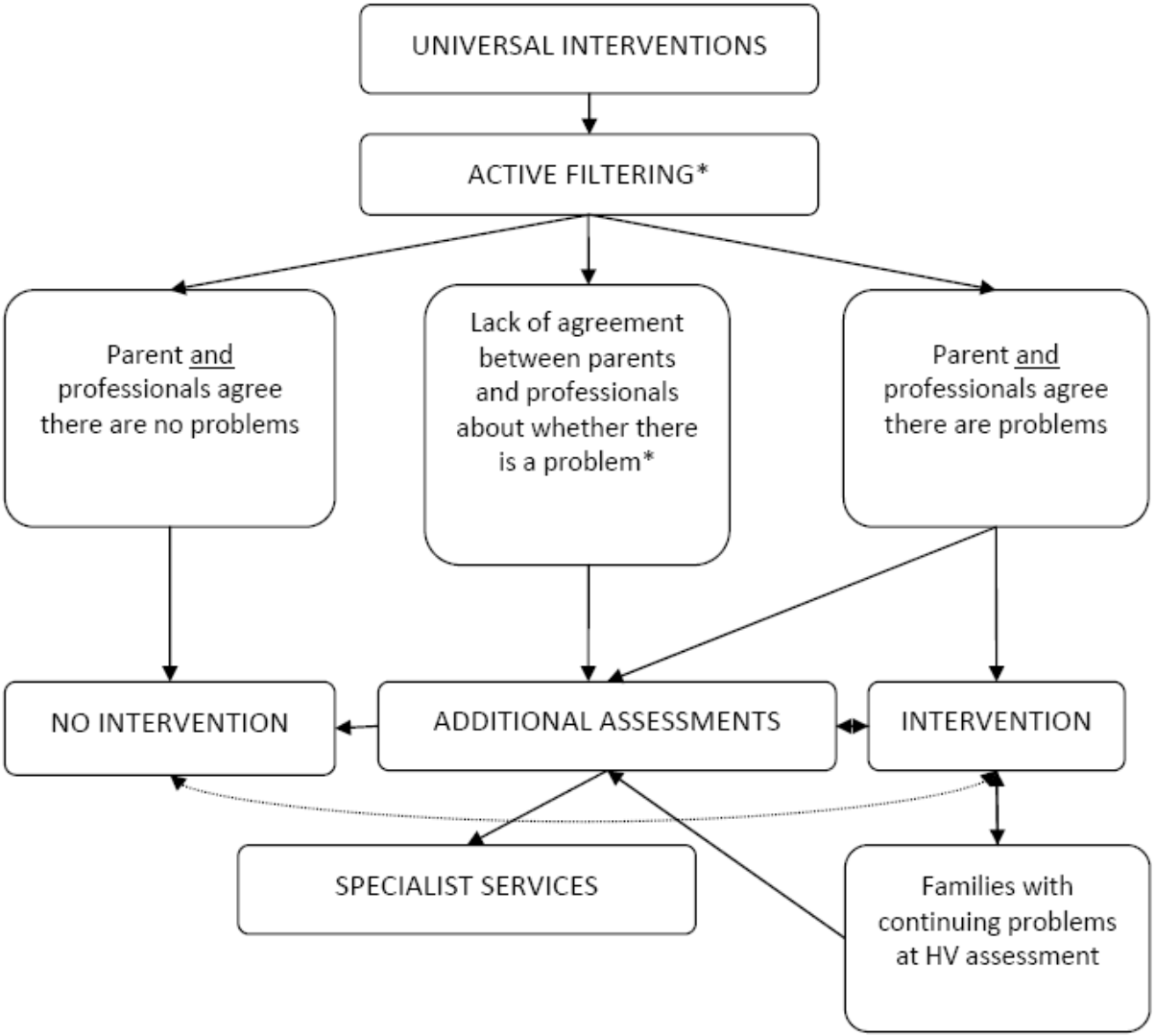
I would welcome contact from anyone interested in the research topic and findings.

Six month pilot of two new health visitor – family contacts in West Glasgow

Lucy Thompson
NHS Greater Glasgow and Clyde

Parenting Across Scotland, 10 Nov 2010



*Active filtering is based on a partnership between parents and professionals. Where parents and professionals disagree, a process of assessment and collaborative discussion regarding what is best for the child's wellbeing should take place.

Universal level

- What sort of support is already being given through day-to-day HV work?
- New universal contacts with HVs at 13 and 30m
- 4 functions:
  - Clinical use – identification of need for support
  - Needs assessment – for planning services
  - Service monitoring
  - Independent evaluation

Content of contacts

- 13m:
  - Adult Wellbeing Scale
  - Observation Checklist
  - Family context
- 30m
  - 2 question language screen
  - Parenting Daily Hassles Scale
  - Richman Behaviour Checklist
  - Family context

Introduction

Reporting data from:

- Health visitor daily activity including parenting support (July – Sept 09)
- 13 and 30 month universal contacts (July – Dec 09)

HV daily contact data

- Differences in frequency of contact according to HPI (i.e., Core families receiving fewer contacts on average)
- No differences in frequency of contacts according to SIMD 09
- Face-to-face contact most common form

Table 7: Type of contacts made by all HVs in West CHCP July – Sept 09

	all ages		child under 36months only	
Type of contact	Frequency	% of contacts	Frequency	% of contacts
Home Visit	2537	41.6	2119	43.3
Telephone	1028	16.9	785	16.0
Third Party	199	3.3	133	2.7
Clinic / surgery	2013	33.0	1667	34.0
Other	197	3.2	145	3.0
Missing	121	2.0	48	1.0

Table 8: Parenting advice and actions from routine contacts

	all ages		child <36m only	
	Frequency*	% of contacts	Frequency*	% of contacts
Parenting addressed				
Child behaviour	2670	43.8	2092	42.7
Adult mental health	2437	40.0	2032	41.5
Sensitivity / attunement	1599	26.2	1379	28.2
Other	1109	18.2	916	18.7
Not addressed	623	10.2	482	9.8
Action taken				
Advice	3647	59.8	2988	61.0
Refer GP	306	5.0	245	5.0
Refer parenting group	106	1.7	84	1.7
Other referral	332	5.4	230	4.7
Other action	1131	18.6	910	18.6
Other issues				
Nutrition / breastfeeding	2710	44.5	2481	50.7
Money	230	3.8	186	3.8
Adult relationships	593	9.7	469	9.6
Other	2374	38.9	1887	38.5

*HVs could tick as many of these as they liked, so totals will not equal 100% of contacts

West Glasgow – diverse population

- Population 139,000; 19,500 children aged 0-15 years
- 6,162 children aged 0-5 during the pilot period (July – Dec 09)
- No pattern in return rate by SIMD 09 quintile

Table 3: Percentage of populations and samples by deprivation (SIMD09) quintile

	13m contacts			30m contacts		
SIMD quintile	Eligible* (n=896) n(%)	Visited** (n=421) n(%)	Response rate per quintile*** %	Eligible* (n=819) n(%)	Visited** (n=330) n(%)	Response rate per quintile*** %
1 (most deprived)	389 (43.4)	192 (45.6)	49.4	361 (44.1)	127 (41.9)	35.2
2	137 (15.3)	67 (15.9)	48.9	110 (13.4)	46 (15.2)	41.8
3	113 (12.6)	54 (12.8)	47.8	108 (13.2)	51 (16.8)	47.2
4	111 (12.4)	50 (11.9)	45.1	85 (10.4)	26 (8.6)	30.6
5 (least deprived)	146 (16.3)	58 (13.8)	39.7	115 (18.9)	53 (17.5)	34.2

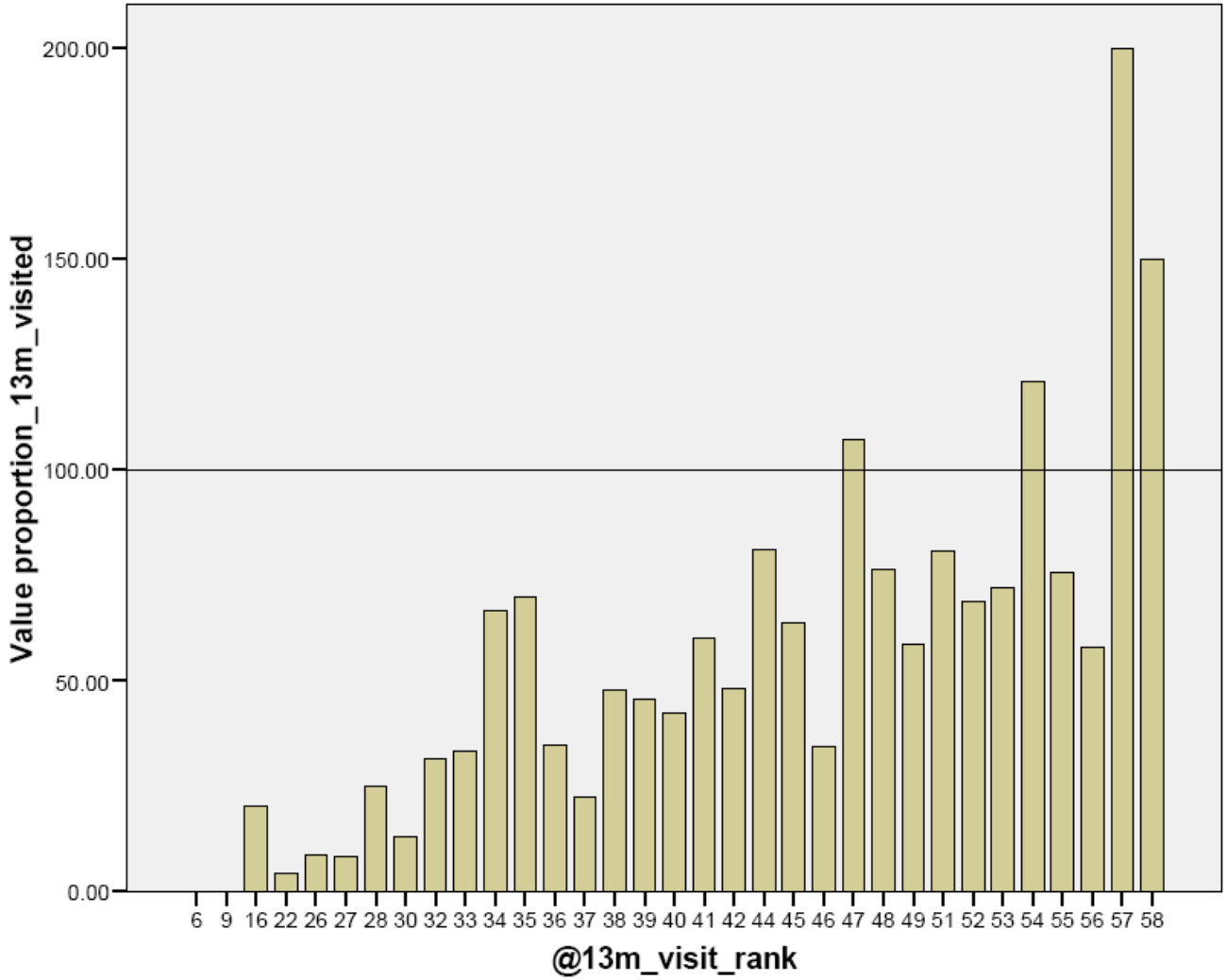
* families with children of relevant age July 2009 – Jan 2010 with valid postcode

** where contacts actually took place and postcode given (see relevant sections below for full explanation)

*** as proportion of those eligible for a contact

13 month contact

Figure 1: Proportion of eligible 13m contacts completed by individual health visitors



13 month contact

Table 10: Return and completion rates of 13 month contacts for July-Dec 09

Families visited (Denominator)	Observ[n] Checklist	AWBS	Complete data (both Obs Chklist & full AWBS)
% (n)	% (n)	% (n)	% (n)
100	93.9	88.0	77.9
(457)	(429)	(402)	(356)

Table 11: Return and completion rate by HPI status

HPI*	Population n(%)	Families contacted n(%)	Families completing appointment n(%)	Families with complete data n(%)
Core	369 (41.2)	323 (59.2)	276 (60.4)	214 (60.1)
Additional	391 (43.6)	178 (32.6)	145 (31.7)	115 (32.3)
Intensive	64 (7.1)	45 (8.2)	36 (7.9)	27 (7.6)
Unknown	72 (8.0)	-	-	-
Total	896 (100%)	546 (100%)	457 (100%)	356 (100%)

*HPI before visit as indicated by HV for sample, from Child Health Surveillance database for population.

Figure 2: AWBS depression scores by HPI

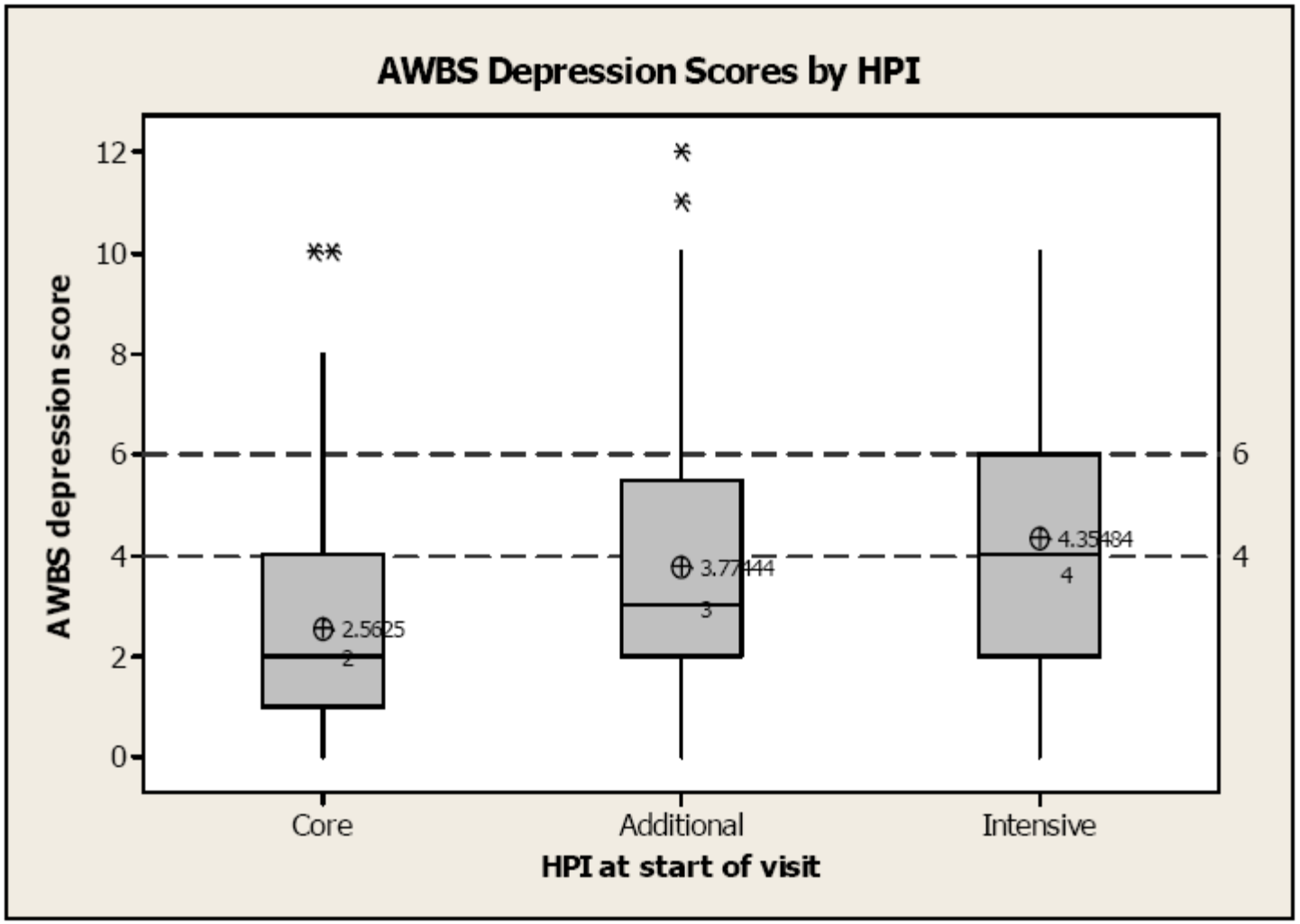


Figure 3: AWBS Anxiety scores by HPI

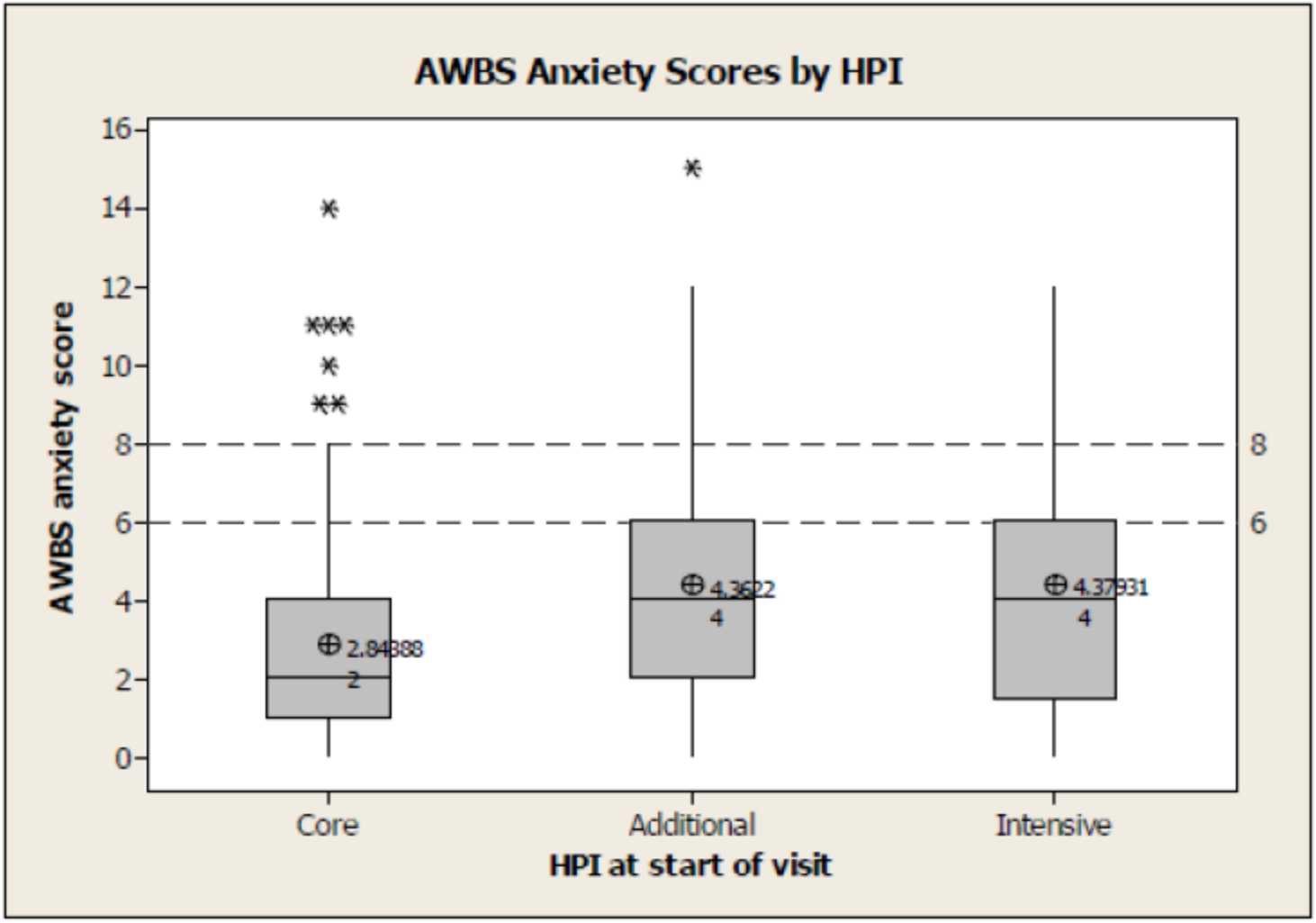


Figure 4: AWBS outward directed irritability by HPI

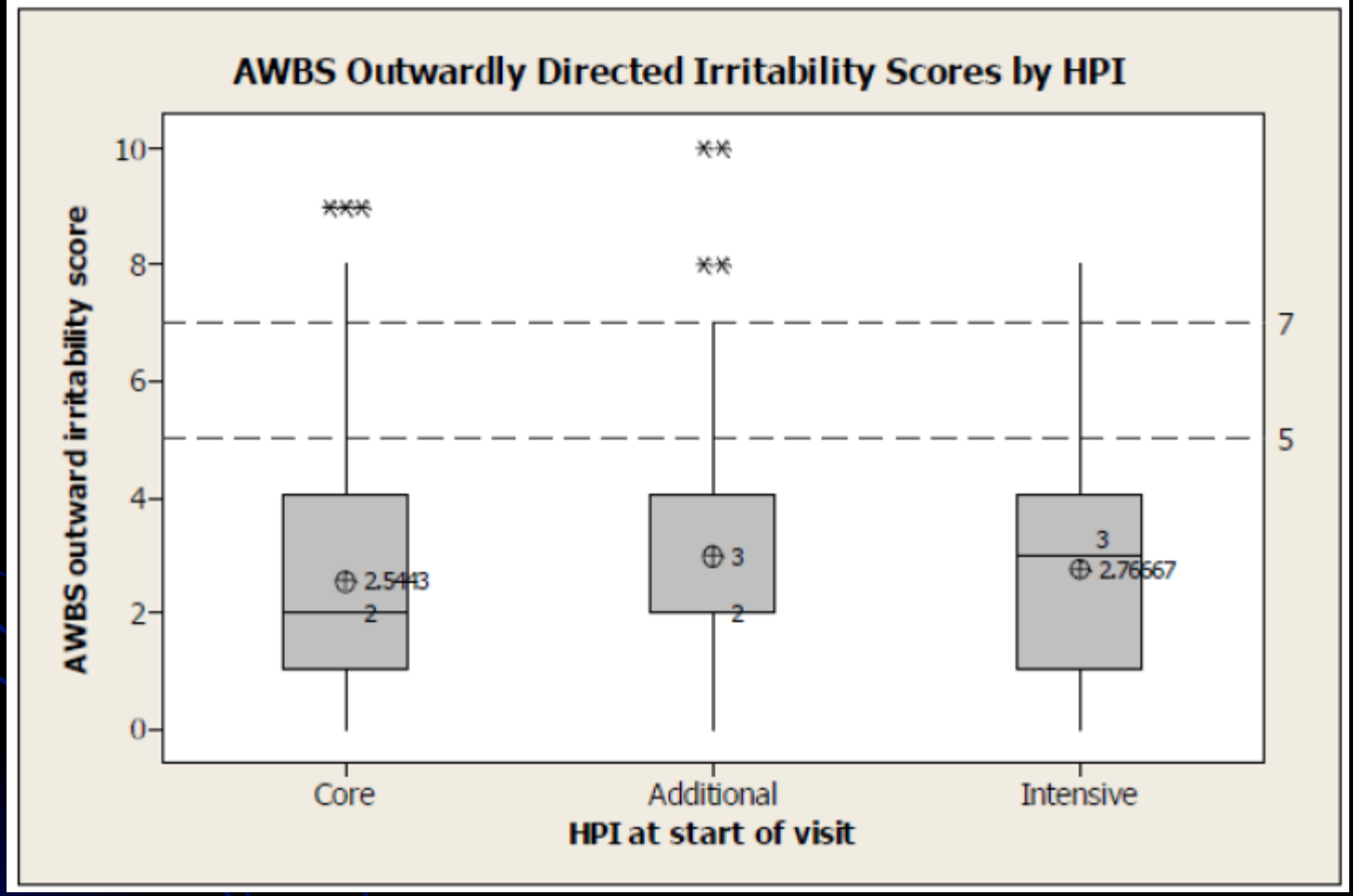


Figure 5: AWBS inward directed irritability by HPI

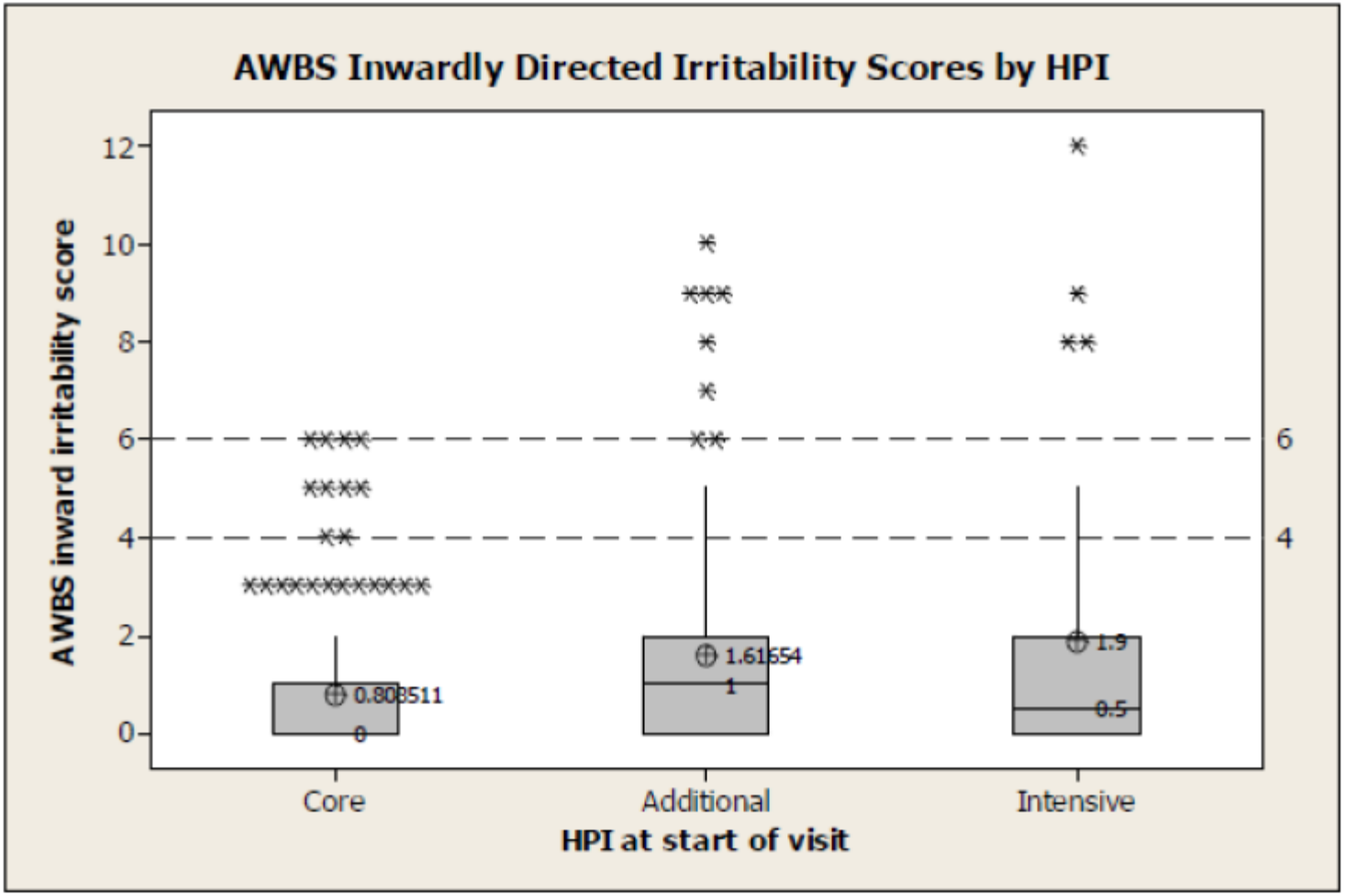
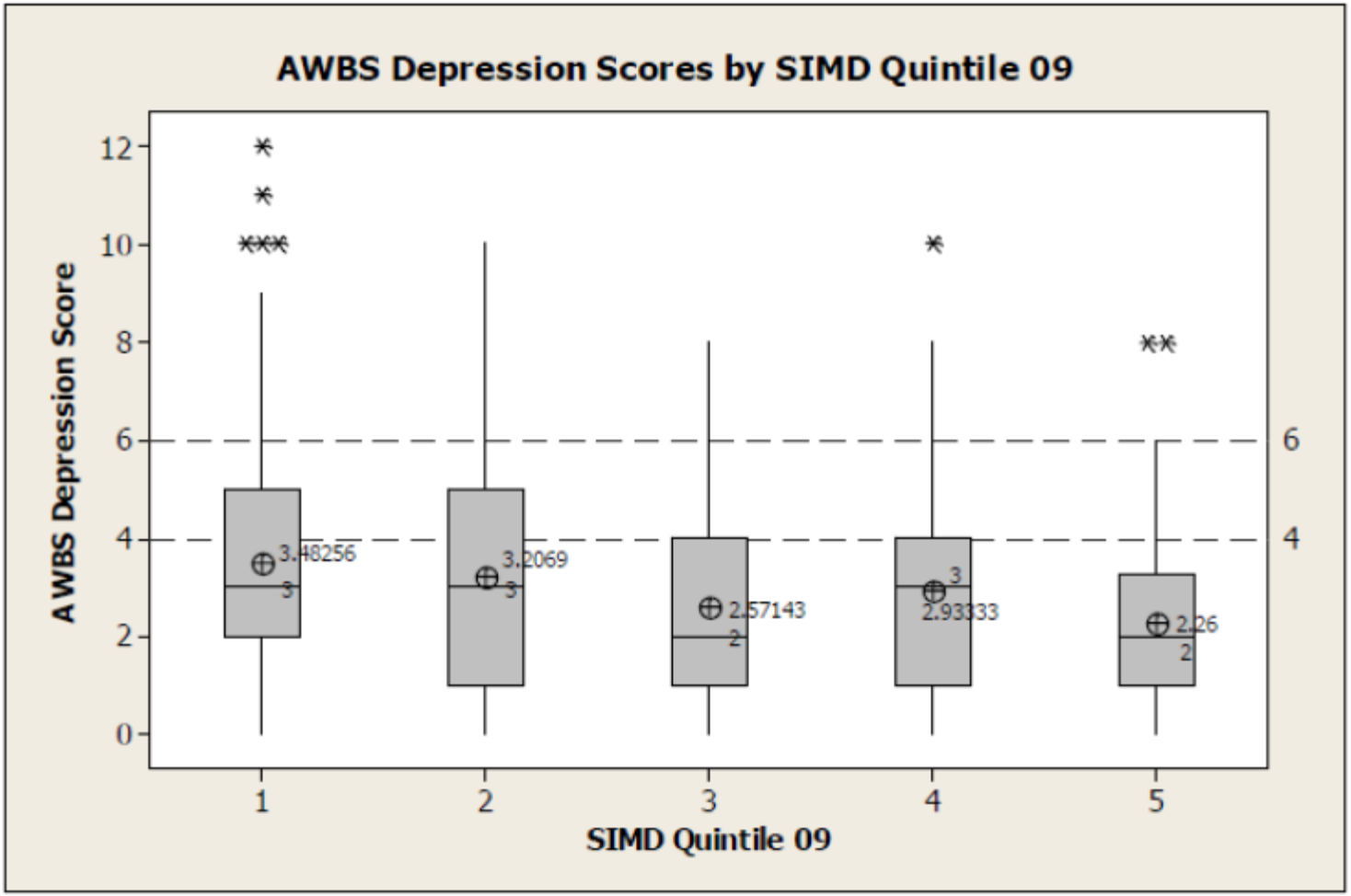


Figure 6: AWBS depression score by SIMD09



SIMD 1= most deprived; 5 least deprived

Figure 7: AWBS anxiety score by SIMD09

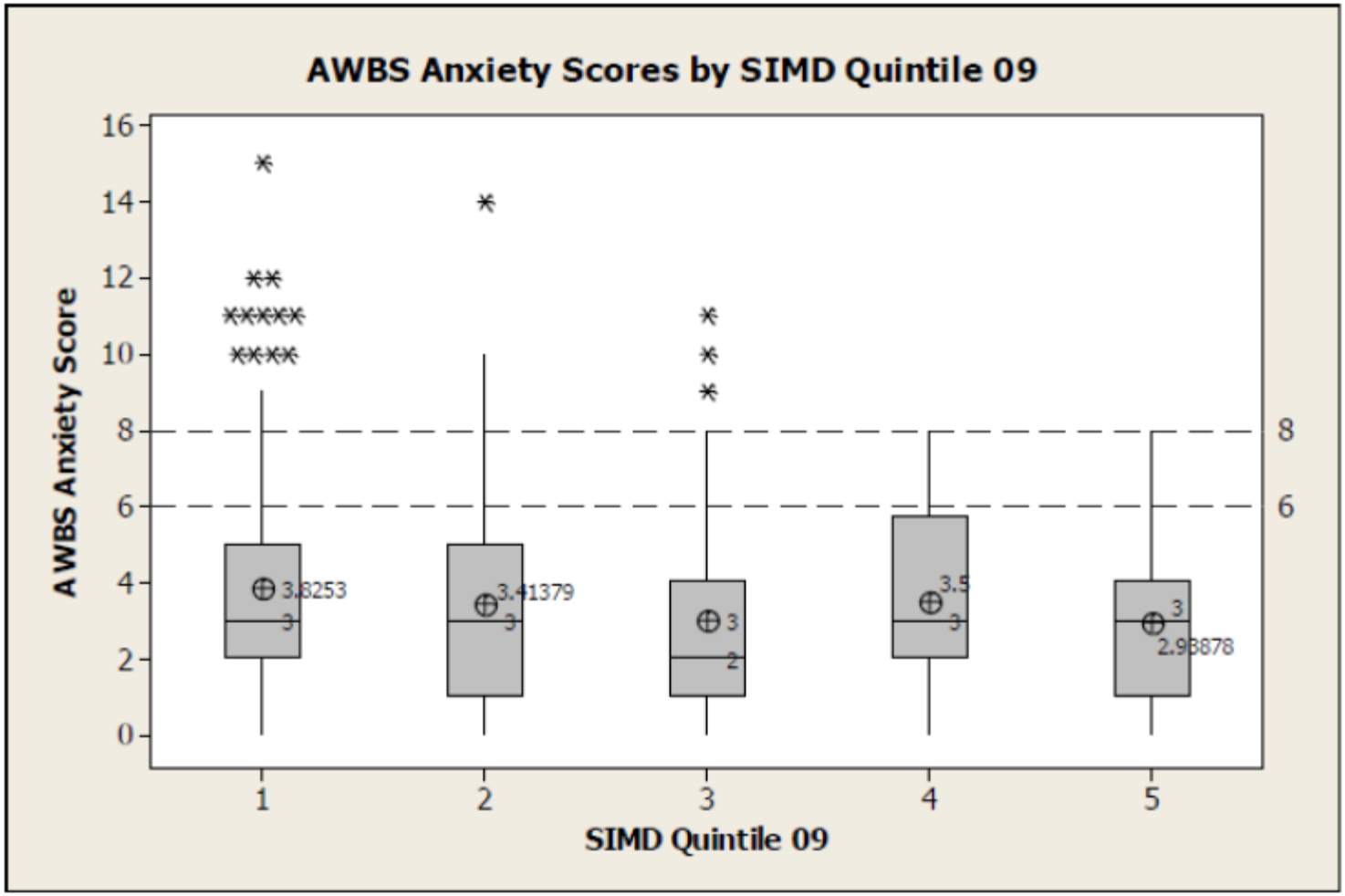


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Figure 8: AWBS outward directed irritability by SIMD09 SIMD09

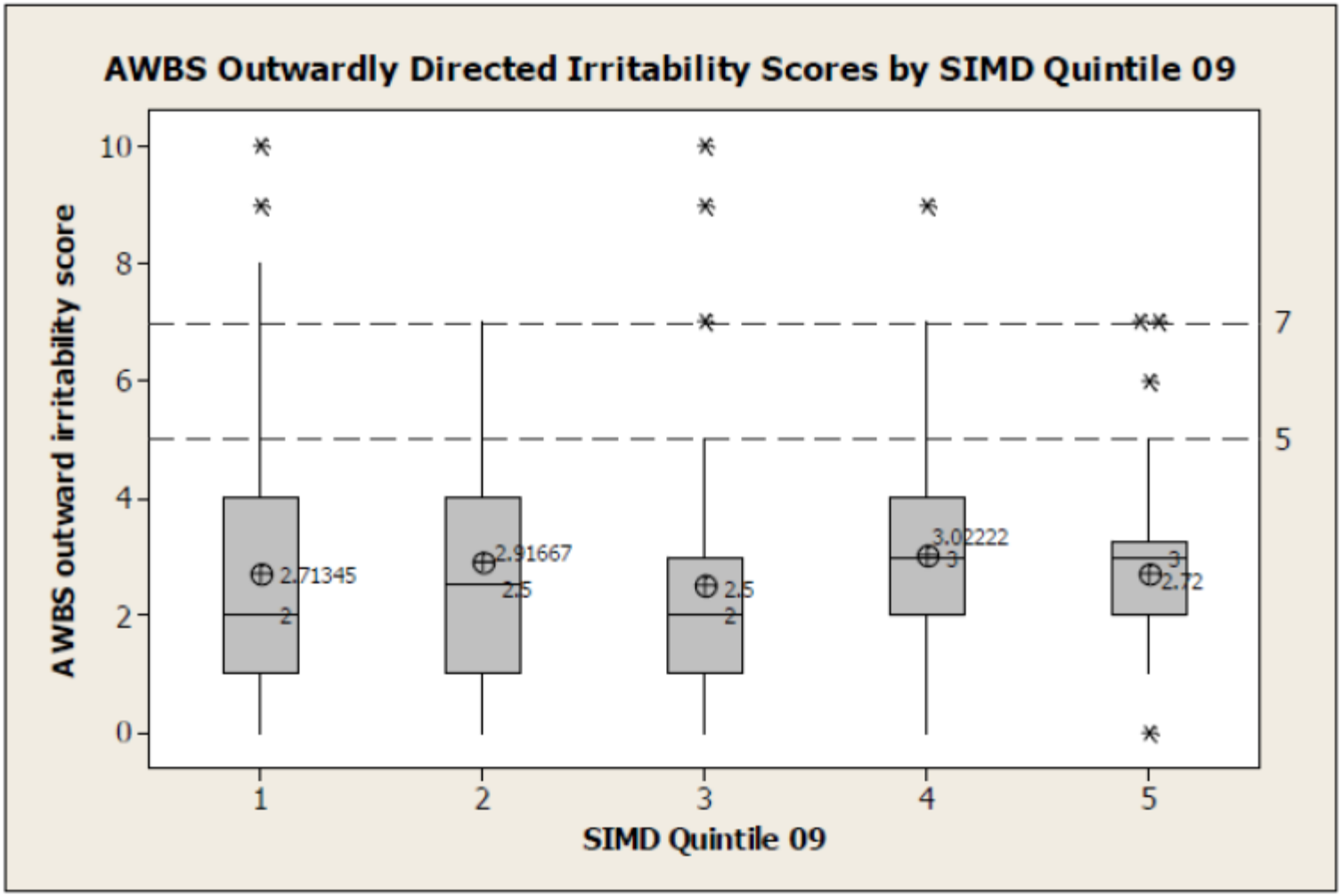

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Figure 9: AWBS inward directed irritability by

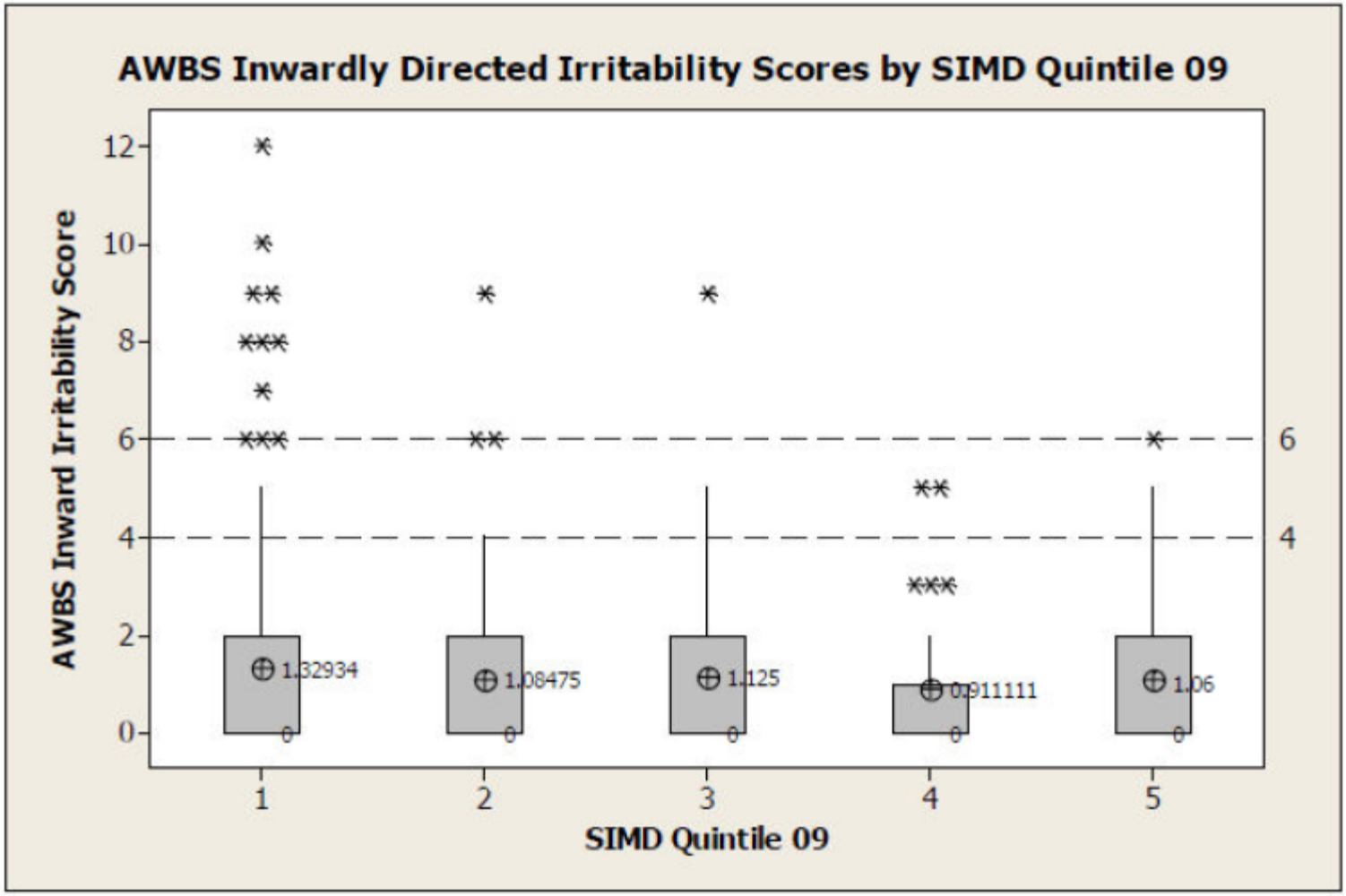

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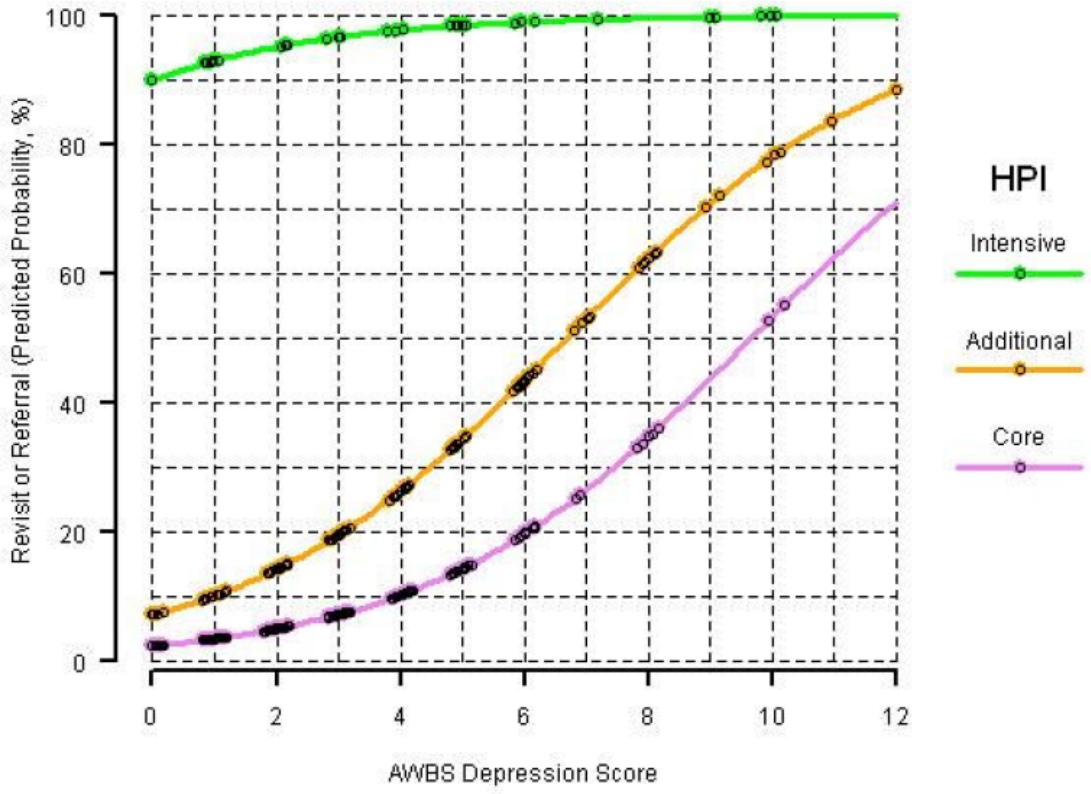
Table 8: Reasons for concern cited on Observation Checklists

Reason for concern	Frequency*
Parent didn't talk to baby	1
Little or no eye contact between parent and baby	2
Parent handled baby roughly	1
Other	4

*HVs could select more than one reason

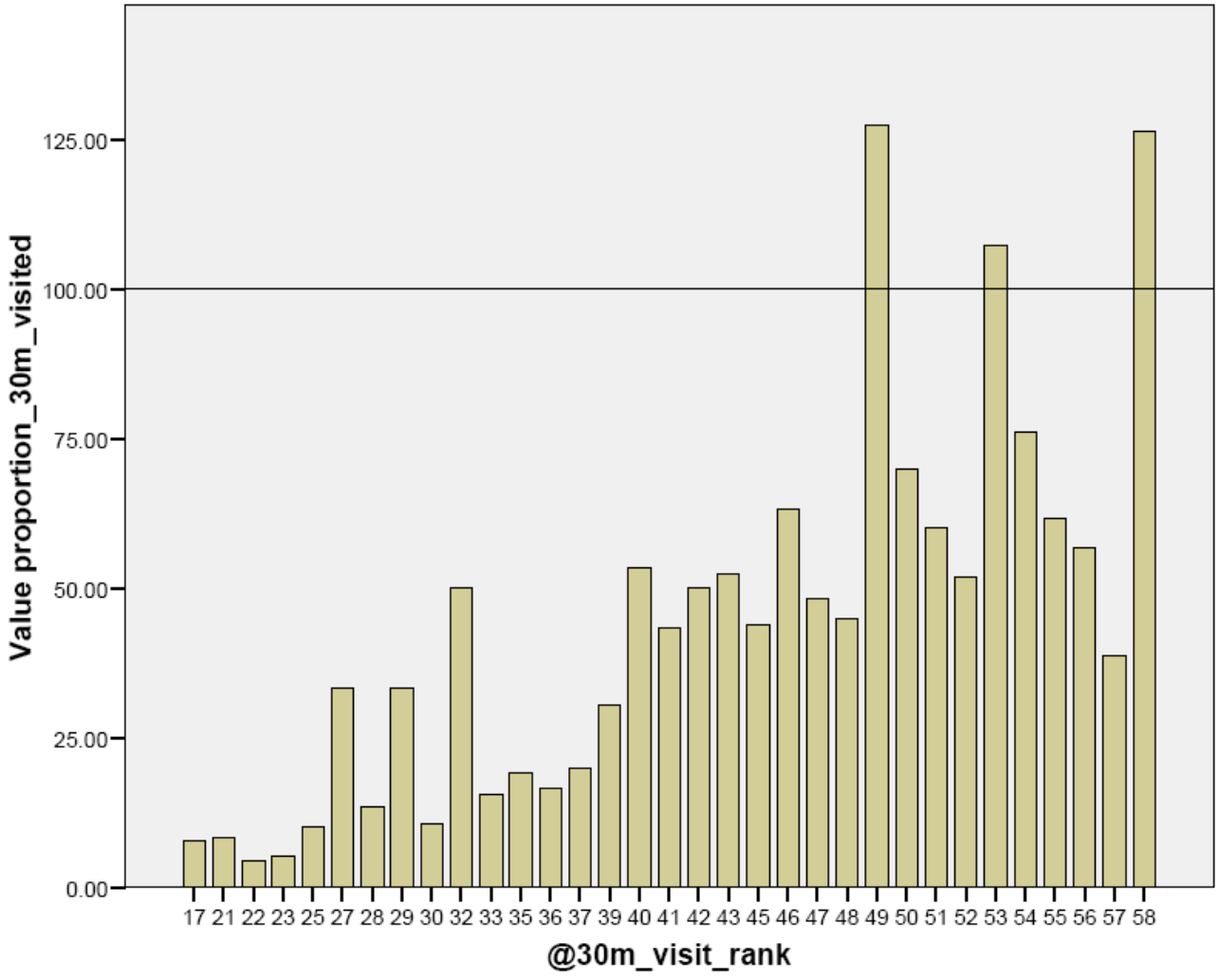
The depression scores from the AWBS influenced whether HVs decided to revisit or refer a family from the Core or Additional categories.
Intensive HPI families would be likely to be revisited or referred anyway (regardless of depression score).

Figure 10: Likelihood of a revisit or referral for the three HPI categories according to AWBS depression scale score



30m contact

Figure 11: Proportion of eligible 30m contacts completed by individual health visitor



30 month contacts

Table 19: Return and completion rates of 30 month contacts for July-Dec 09

Families visited (denominator) % (n)	Language Screen % (n)	PDHS % (n)	RBC % (n)	Complete data (all questions on all three questionnaires) % (n)	Complete date (following imputation of missing values)* % (n)
100 (330)	95.5 (315)	87.3 (288)	98.2 (324)	46.8 (155)	73.3 (242)

*missing values were imputed from mean subscale scores if respondent had completed at least 50% of questionnaire subscales

Table 20: Return and completion rate by HPI status

HPI*	Population n(%)	Families contacted n(%)	Families completing appointment n(%)	Families with complete data** n(%)
Core	531 (64.8)	280 (63.5)	211 (63.9)	160 (66.1)
Additional	208 (25.4)	118 (26.8)	87 (26.4)	60 (24.8)
Intensive	66 (8.1)	43 (9.7)	32 (9.7)	22 (9.1)
Unknown	14 (1.7)	-	-	-
Total	819 (100%)	441 (100%)	330 (100%)	242 (100%)

*HPI before visit as indicated by HV for sample, from Child Health Surveillance for population.
**after replacement of missing values

Table 21: Children showing suspected language delay

Screening question	N	%
Can your child put two words together?	10	3
Does your child know 50 words?	33*	10

*this figure includes the 10 families in the row above

- 14 of the 33 children were originally allocated to a Core HPI
- No social patterning (i.e., didn't vary with SIMD 09)

Figure 13: PDHS intensity score by HPI

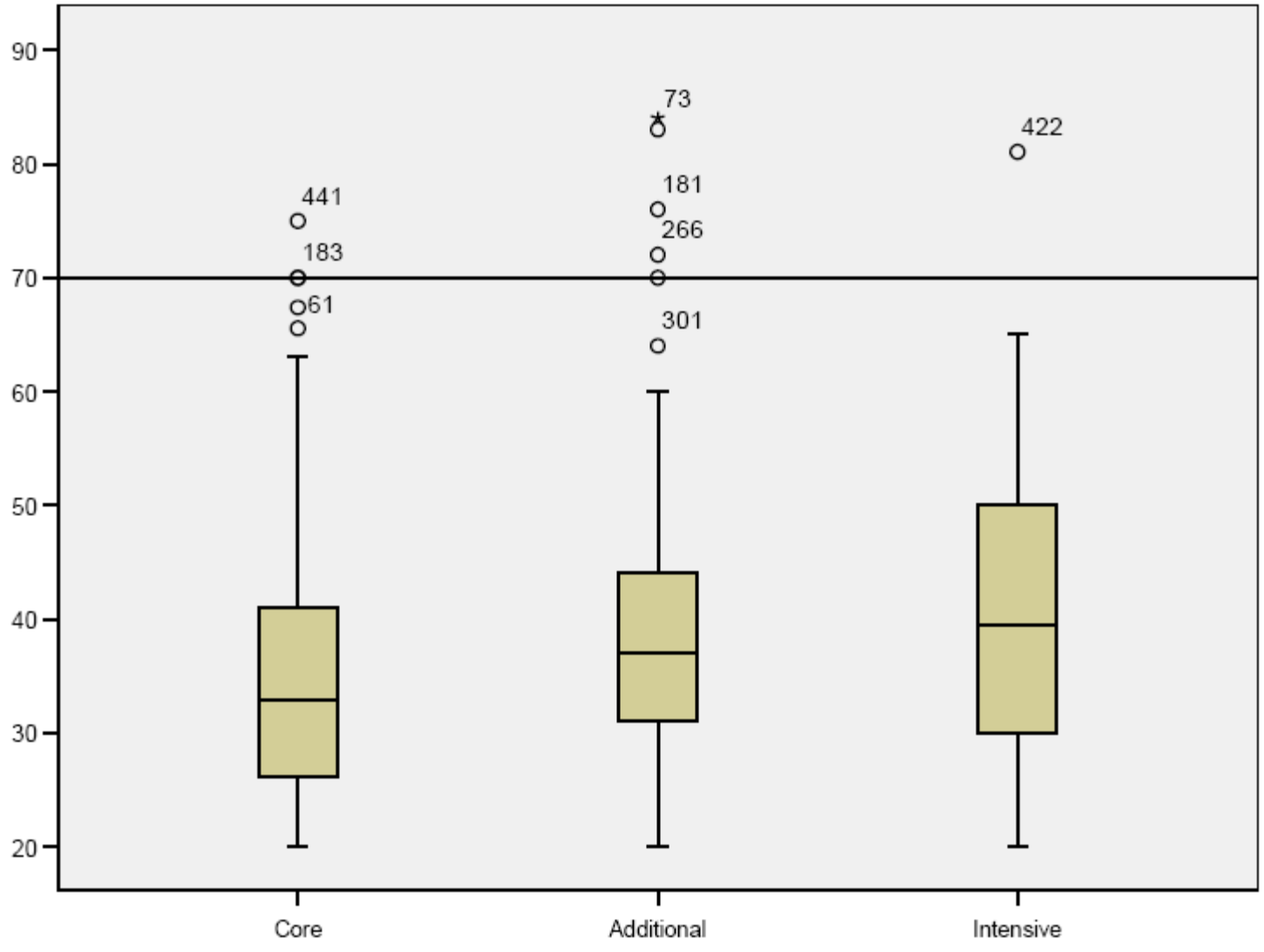
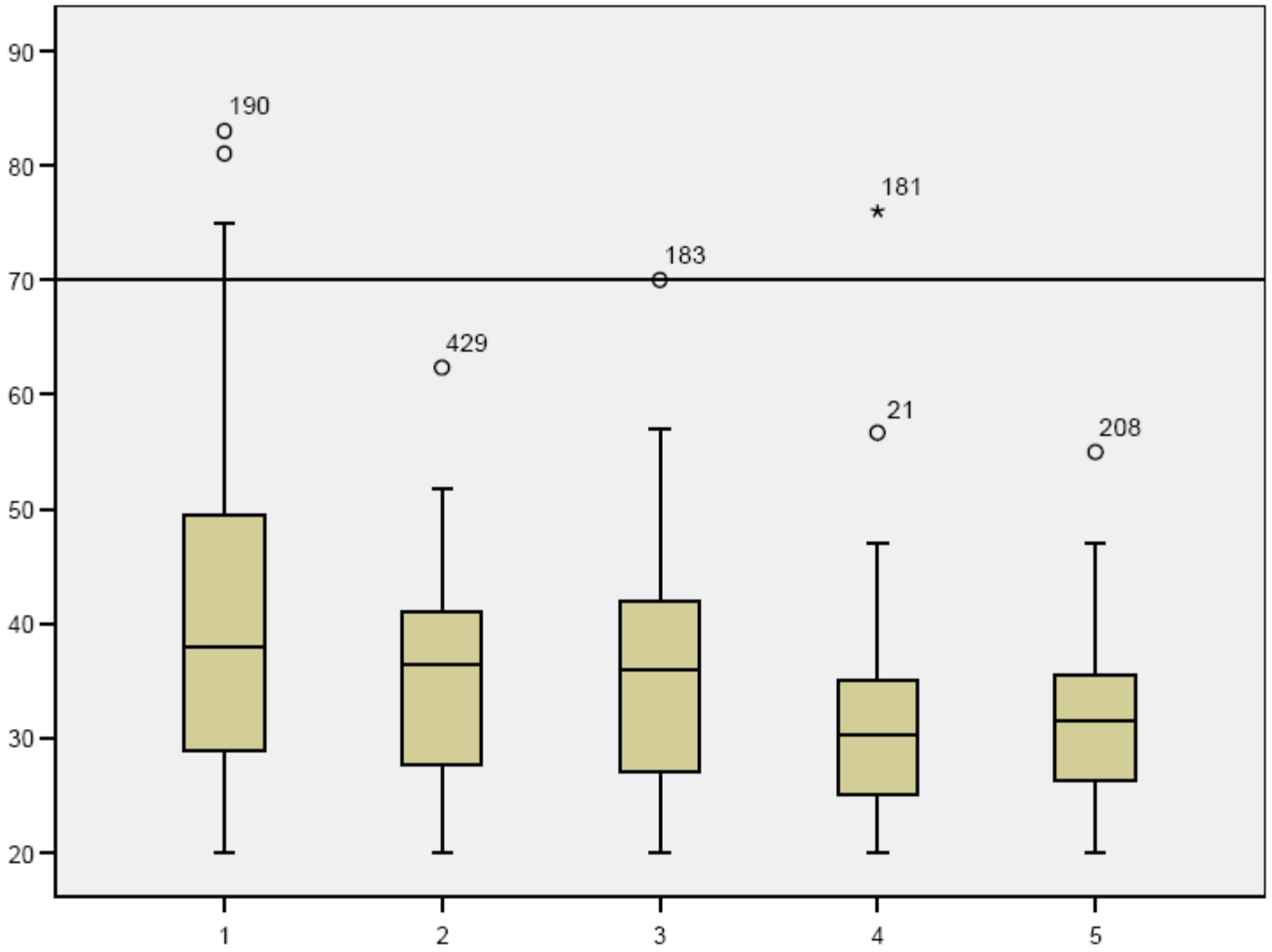


Figure 15: PDHS intensity scores by SIMD09



SIMD 1= most deprived; 5 least deprived

Figure 18: Richman Behaviour Checklist scores for families receiving 30m contacts

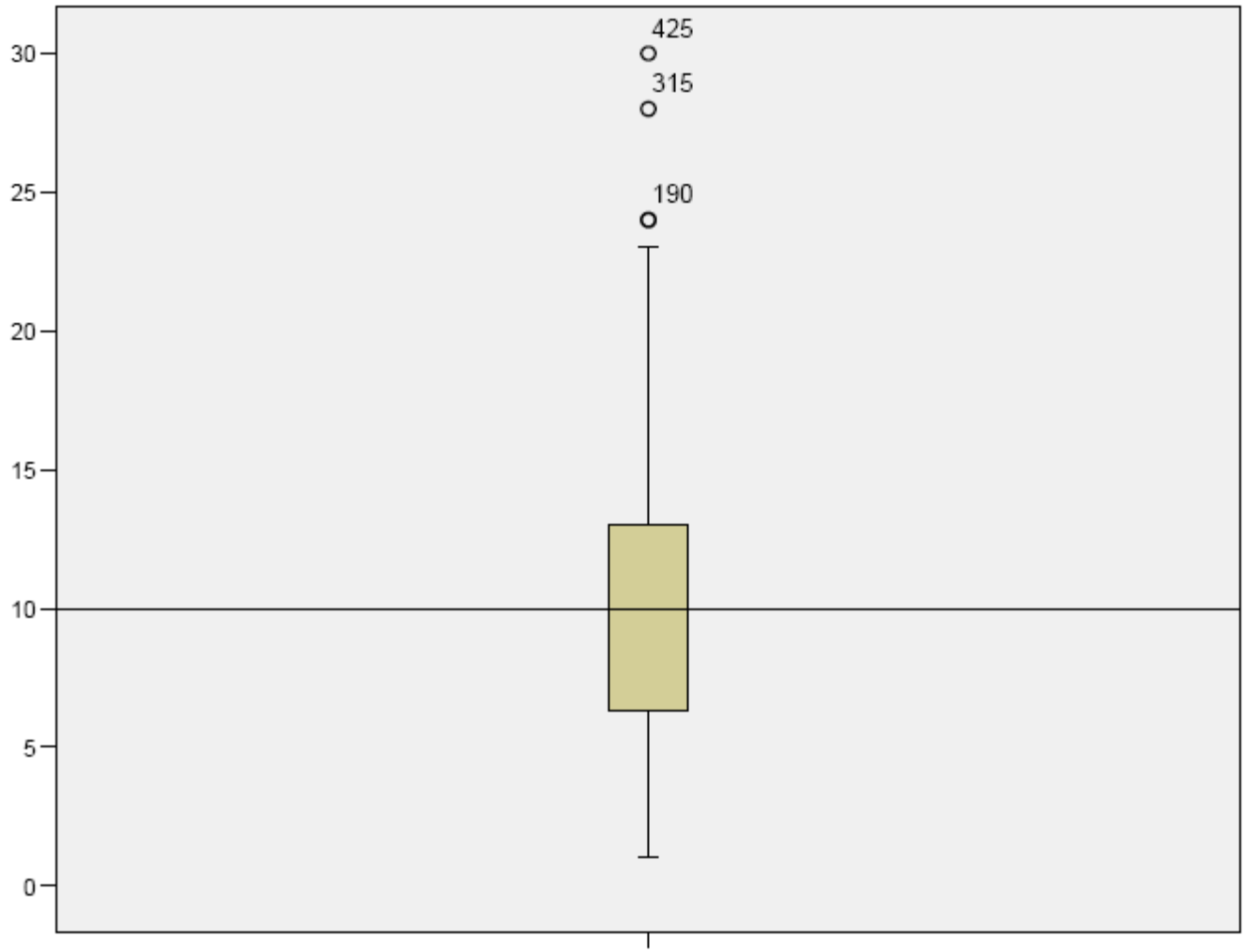


Figure 19: RBC total score by HPI

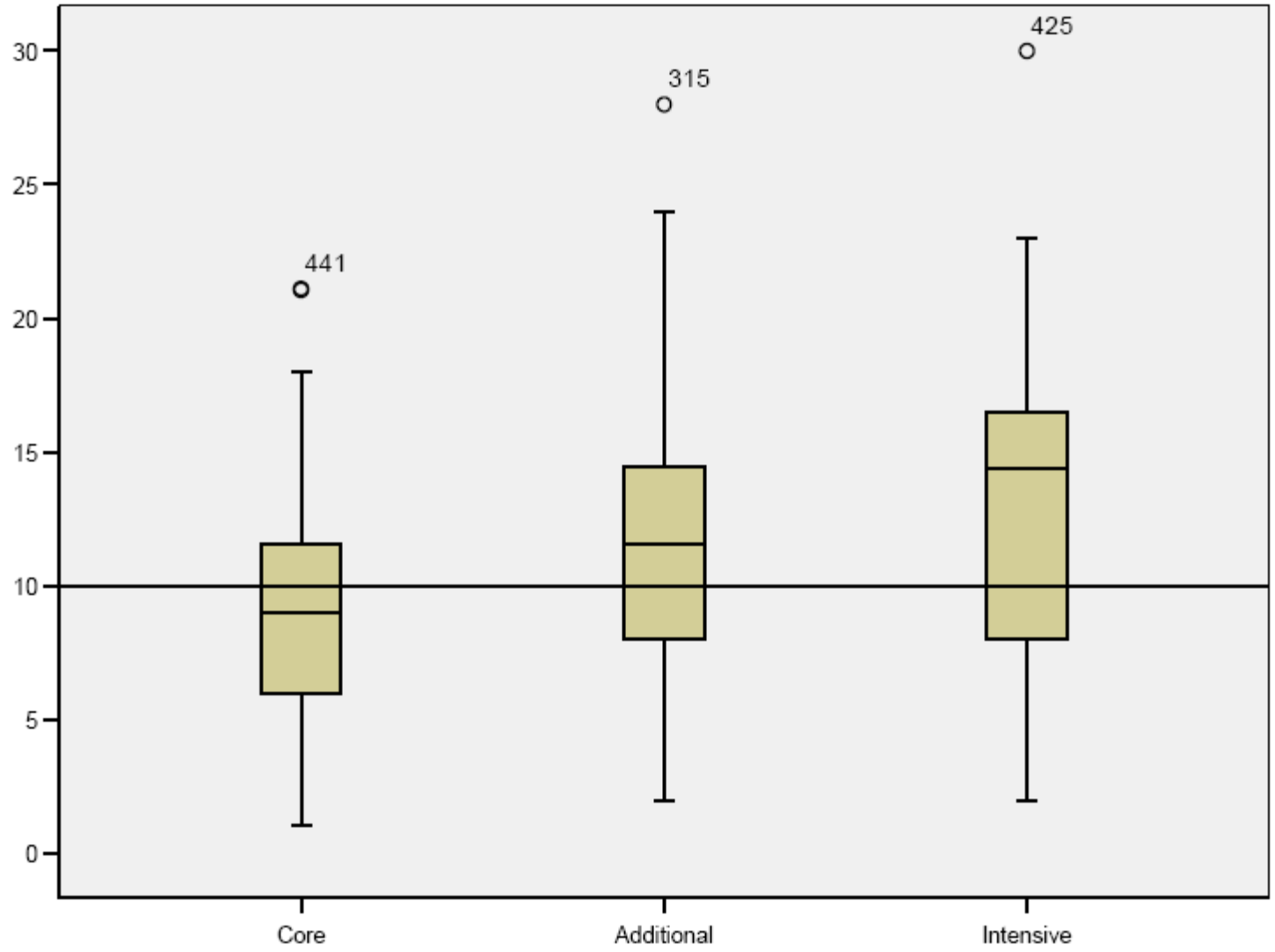
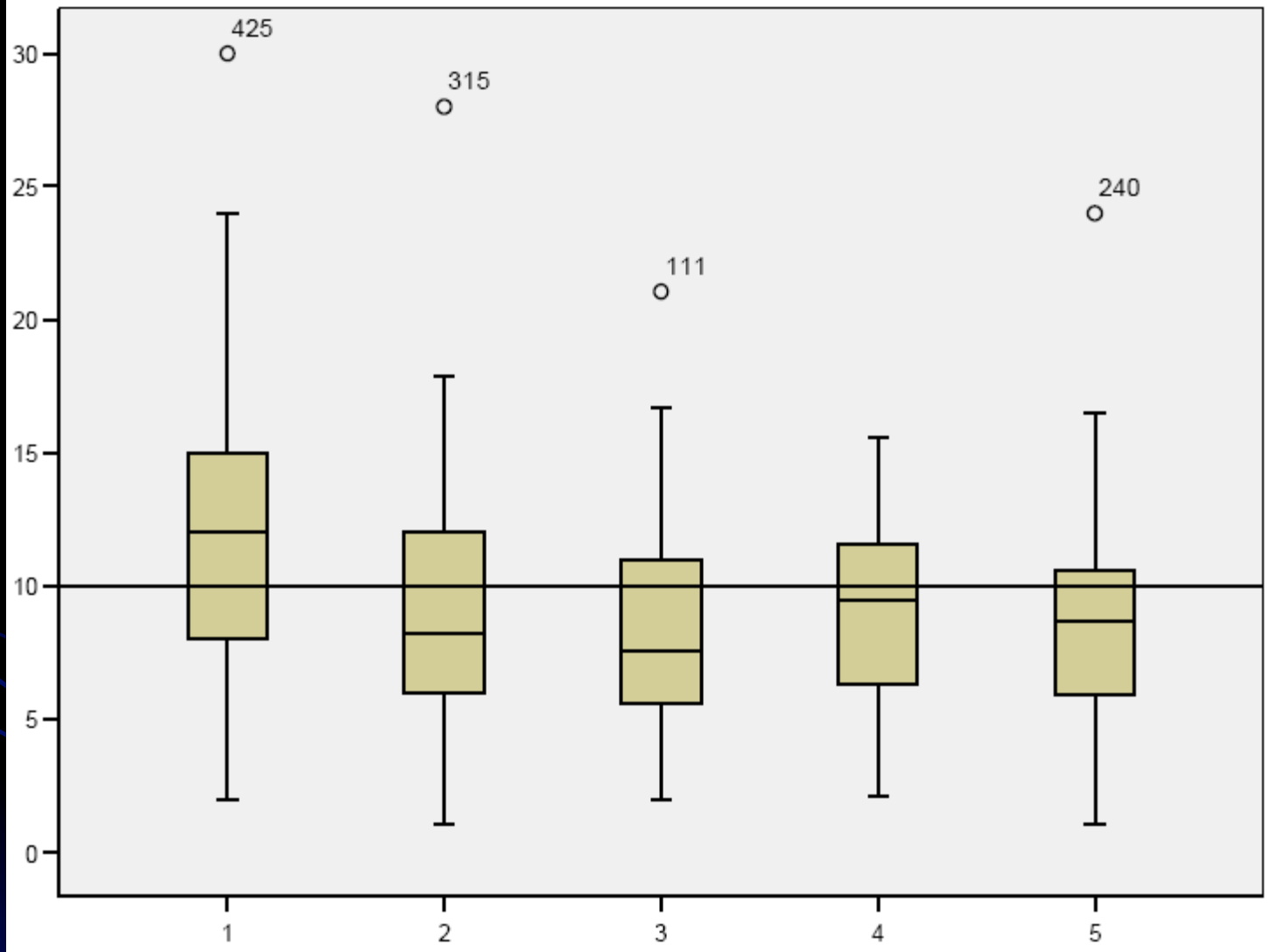


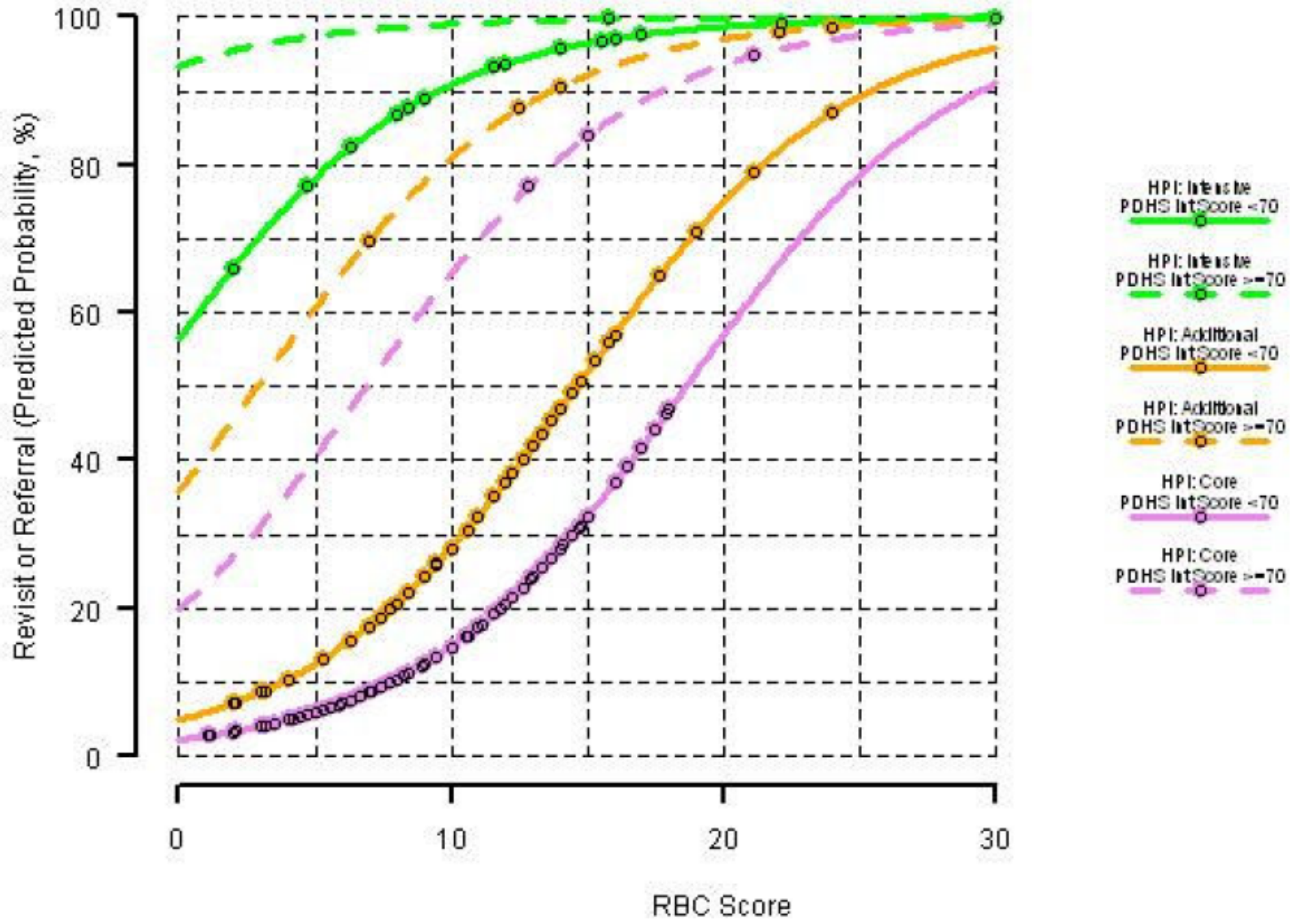
Figure 20: RBC total score by SIMD09



SIMD 1= most deprived; 5 least deprived

- Behaviour problems score influenced likelihood of HV deciding to revisit or refer in families who were Core or Additional and/or had a high parenting stress score

Figure 21: Likelihood of a revisit or referral for the three HPI categories according to RBC score



Recommendations

- Great variation between health visitors. Further work needed to understand this.
- Need to explore and develop clinical IT systems
- 13 month contact should continue in West CHCP until a review in mid 2012
- Modify 30 month contact: remove the PDHS and RBC questionnaires, replace with Strengths and Difficulties Questionnaire and Adult Wellbeing Scale.
- Language screen should be continued in its present form.
- 30 month contact should be rolled out across Glasgow.
- Need to work more closely with HVs to develop this work.
- Need for trials of interventions to support families where problems are identified.
- Interventions to improve parent-infant relationship problems at 13 months and tackle language delay at 30 months are priorities.
- Information systems need to be improved upon to ensure efficient coordination of information so that service development may be effectively informed.

Discussion

- How do we enhance child health surveillance without investing more resource?
- How do we deal with the paradox of professional judgement vs structured tools?
- If we had a magic wand, how would child health surveillance look?

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