Evidence in support of the Universal Health Visiting Pathway

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Introduction

The nature of the health visiting role

There is compelling evidence that health visitors can have a positive impact on child and family health¹, but their effectiveness depends on practising in particular ways. Successful health visiting relies on:

- Organising health visiting services to support best practice
- Delivering proven programmes and interventions to promote health and wellbeing
- Having a suitably skilled and trained workforce.

Robust analysis of more than 30 years of research² shows that to improve parents’ experience and uptake of services, health visiting needs to have a strong orientation towards practice and service delivery which is characterised by the following:

- Adopting a ‘salutogenic’ (health-creating) approach; being proactive; identifying and building strengths and resources (personal and situational) and being solution-focused.
- Demonstrating a positive regard for others (human valuing), through keeping the person in mind and shifting the health visitors’ focus to align with parents’ needs; recognising the potential for unmet needs, and actively seeking out potential strengths.
- Acknowledging the person-in-situation (human ecology), through a continuing process; always taking account of the individual, their personal and situational circumstances, whether acting in the client’s space, the community or the workplace.

² See Cowley et al. (2013) on next page.
This strong practice orientation is underpinned by a ‘triad’ of interconnected core practices:

1. Development of the health visitor–parent relationship
2. Home visits
3. Needs assessment by the health visitor.

Additional information about the nature of the health visitor role is presented in Appendix A.

To ensure that the Universal Health Visiting Pathway was informed by the best available evidence to support the activities associated with each planned visit, two key evidence documents were scrutinised along with additional relevant publications and grey literature. The details of the main documents used are provided below.


This literature review analysed nearly 350 research papers focused on health visiting practice in order to assess the relationship between current health visiting provision and outcomes for children and families. The research review showed that health visitors can have a positive impact on health and add value, if they practise using a particular orientation to practise, which is given expression through a process that combines relationship-formation with home visiting and needs assessment. Health visitors need a particular set of skills, attitudes and attributes, and the health visiting service needs to be organised in ways that support this form of practice, along with implementation of proven programmes and approaches to promote health and wellbeing.
The report included recommendations for researchers, community health organisations, educationalists and policy-makers. The evidence from the Cowley et al. (2013) review is denoted by #.

2. **Rapid Review to Update Evidence for the Healthy Child Programme 0–5.**

The purpose of this rapid review was to update the evidence to support the Healthy Child Programme (HCP). Specifically, the aim was to synthesise relevant systematic review level evidence about ‘what works’ in key areas. In addition, the review sought to draw out key messages in relation to identifying families in need of additional support; the delivery/effective implementation of interventions at the programme/service level and individual practitioner level; workforce skills and training and the economic value/cost benefits of the HCP including both health and wider societal costs.

To ensure the integrity of the information published in both these publications, the text presented here is largely presented verbatim with permission from the authors. In addition, four appendices (A–D) about the health visitor contribution to a) the health visitor remit and relationships; b) community services; c) safeguarding children and d) responding to seldom-heard groups are provided as this evidence has overarching relevance to the Pathway.

The following pages provide a summary of the evidence as it relates to the Universal Health Visiting Pathway. The reader should note that in all instances the evidence that relates specifically to health visiting (from Cowley et al. 2013) is presented,

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3 See www.kcl.ac.uk/nursing/newsevents/news/2013/Health-Visitors.aspx
4 A systematic review is a complex and time-consuming approach for summarising the results of several carefully designed studies (i.e. controlled trials). As the authors pool together numerical data about the effects of interventions through a process called meta-analyses these reviews are extremely valuable. They also consider the evidence about the benefits and/or harm arising from specific interventions. In this way, systematic reviews summarise the existing research on a topic and the findings are often used to inform recommendations for healthcare policy and practice.
followed by the relevant evidence that was generated to support the Healthy Child Programme. This often includes new evidence that is denoted: [New]. Where available, evidence about workforce issues and training is included.

In addition to the evidence presented in the following pages, taken from the two key documents cited above, the reader is encouraged to also consider the evidence and context that is included in the following sources:

- *Interventions for Promoting Early Child Development for Health: An environmental scan with special reference to Scotland.*


Interpretation and translation of evidence to inform the Universal Pathway

In the course of reviewing the evidence cited above and in discussion with academics and experts in health visiting practice\(^5\), a number of noted discussion points from advisory group meetings shaped the development of decisions that influenced Scotland’s Universal Health Visiting Service and Pathway:

- Improved outcomes and relationships that are achieved when the health visitor-parent rapport, assessment and associated interventions begin antenatally.
- Analysis of the child health review data gathered at the 27-month review and at school demonstrates the need to ensure earlier and more continuous assessment and intervention.
- Continuity of care for the purpose of relationship building, assessment and intervention is significant for achieving improved outcomes among children and their families.
- Assessments should be conducted in the course of home visits by appropriately trained professionals and these should be conducted at regular intervals (as indicated in the Pathway) throughout the early years of life.

In the following pages the evidence that supports the pathway is presented exactly as published in the documents that are cited on pages 2 and 3.

\(^5\) A list of advisory group members is provided within the Health Visiting Pathway document.
Introductory letter: standard service letter to pregnant women on notification of pregnancy

- Introduction to health visiting services/national leaflet.

Visit 1: Pre-birth contact at 32–34 weeks: home visit

- Face-to-face contact to introduce health visiting service and to begin to develop and build therapeutic relationship with mother/family.
- Begin early assessment of maternal/family health, wellbeing and early identification of vulnerability or additional needs.
- Initiate additional interventions as appropriate, such as Alcohol Brief Interventions.
- Commencement of transition of care from Midwife to Named Person.
- Introduction of Red Book.
- Initiate additional joint visit with Midwife where additional need is identified.
- Engage and share public health information and guidance to promote positive attachment and health and wellbeing.
- Assessment and support for infant nutrition: making an informed feeding decision; benefits of breastfeeding; value of skin-to-skin. Support decision making and access to support workers for breastfeeding including in-reach into the postnatal ward.
- Routine enquiry about family finances/money worries and raise awareness of the advice available and offer families a direct referral to advice services.

Supporting evidence: preparation and support with childbirth and the transition to parenthood

Preparation and support with childbirth: antenatal education

- Evidence in support of the Healthy Child Programme indicates that although there is insufficient evidence to show that the techniques taught in traditional childbirth classes can reduce pain in labour, there is evidence that
participation in such classes can increase satisfaction with the birth experience. [NEW]

- For antenatal education there is no evidence of impact on low birthweight; limited evidence of impact on parental health behaviours, including personal responsibility for healthcare, exercise, and nutrition; and no evidence of impact on the onset of depression. But there is some evidence to show that group-based social support, including antenatal preparation for parenthood classes, can be effective in supporting women with sub-threshold symptoms of depression and anxiety. Antenatal group work which has an interactive component and involves local experienced breastfeeding as volunteers is among a range of effective interventions to support the initiation and continuation of breastfeeding.

- No studies were found for the effectiveness of group-based antenatal education involving drug-dependent pregnant women.

- There is limited evidence (from three studies, including one RCT) of the effectiveness of multimodal programmes for adolescent parents that included a combination of nurse home visiting and/or enhanced Doula programmes with group-based social support.

- Parents from minority ethnic groups value information about potential conflicts that may arise between cultural mores and messages communicated in antenatal classes. Limited evidence has found that parents from some minority ethnic groups also value the opportunity to attend classes in community-based settings rather than city centre hospitals. [NEW]

- While there are numerous studies highlighting the increased health and mental health risks to women in prison, there is limited research on antenatal preparation for this vulnerable population.

Preparation and support with childbirth: antenatal preparation for parenthood programmes

- Antenatal programmes that focus on the transition to parenthood in high-risk couples and aim to alleviate pressures on the couple’s relationship are effective in reducing relationship deterioration and strengthening parenting roles after the birth of a first child.
• The strongest effect is for home-based interventions for couples with multiple difficulties. Since these are expensive they are recommended as part of a stepped care approach (i.e. moving from practice-based assessment and advice to more intensive support). [NEW]

**Preparation and support with childbirth: antenatal education for fathers**

• Review-level evidence of the impact of antenatal classes on men’s preparation for their partner’s labour, birth, and early fatherhood shows that fathers-to-be benefit from participation in adjunctive, men-only sessions within standard antenatal classes, and that adolescent fathers benefit from participation in men-only preparation for fatherhood groups.

**Preparation and support with childbirth: identifying families with additional needs**

• Psycho-education for the transition to parenthood might only be necessary for couples assessed as being high-risk for future adjustment problems, suggesting that a stepped care approach is warranted.

**Preparation and support with childbirth: implementation issues**

• There is a wide range of formats for the delivery of antenatal preparation for childbirth and parenthood. Care needs to be taken to provide support that is accessible and attractive to expectant parents in higher-risk groups (for example teenage mothers) and in minority groups. Qualitative studies with fathers show that men value preparation for parenthood that includes a focus on fatherhood, which may involve men-only sessions or sessions led by experienced fathers.

• A review of antenatal education that is designed to enhance couple relationship functioning or parenting, or to prevent relationship deterioration after the birth of a first child, found that the best outcomes are achieved with programmes that are designed for couples with high level of needs due to a combination of social, personal and relational difficulties; involve skills training; and are delivered in the couple’s own home.
Preparation and support with childbirth: workforce skills and training

- The delivery of home visiting programmes by professional staff (usually nurses) produces more positive effects on parent and child outcomes than delivery by para-professionals or volunteers.

Supporting evidence: drugs and alcohol: antenatal education

See previously presented evidence that relates to antenatal education.

Drugs and alcohol: brief interventions

- Evidence in support of the Healthy Child Programme indicates that NICE (2014a) guidance on antenatal and postnatal mental health recommends that if hazardous drug or alcohol misuse is identified in pregnancy or the postnatal period, the woman should be referred or offered brief interventions in line with section 1.3.1 of the guideline on psychosocial interventions for drug misuse (NICE 2007b, guideline CG51) or the guideline on alcohol-use disorders and preventing harmful drinking (NICE 2010b, guideline PH24).

- These brief interventions typically provide information and advice, and seek to motivate participants to change their behaviour (for example covering potential harms of their behaviour, reasons to change, barriers to change, strategies, setting goals).

Drugs and alcohol: psychosocial / psychological interventions

- NICE (2014a) further recommends that if harmful or dependent drug or alcohol misuse is identified in pregnancy or the postnatal period, the woman should be referred to a specialist substance misuse service for advice and treatment. This may entail the use of psychosocial or psychological

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6 The evidence in this category is not specific to women in pregnancy or the postnatal period.
7 The reader should note that on occasions antenatal and postnatal interventions are discussed together as this is the way the evidence has been presented in support of the Healthy Child Programme.
8 The evidence in this category is not specific to women in pregnancy or the postnatal period.
interventions (it may also require other forms of treatment, including assisted alcohol withdrawal and detoxification).

- NICE (2007b) states that a range of psychosocial interventions are effective in treating drug misuse, including contingency management, behavioural couples therapy for drug-specific problems, and various evidence-based psychological interventions, such as CBT, for common comorbid mental health problems.
- For harmful levels of drinking and mild alcohol misuse, NICE guidance on the diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE 2011, guideline CG115)\(^9\) recommends the use of psychological interventions (such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol-related cognitions, behaviour, problems, and social networks. For harmful drinkers and people with mild alcohol dependence who have a regular partner who is willing to participate in treatment, behavioural couple’s therapy is recommended.
- For pregnant women who are dependent on alcohol or opioids, it is important to note that NICE (2014a) recommends offering assisted alcohol withdrawal and detoxification respectively.

**Drugs and alcohol: integrated and non-integrated interventions**

- There is some evidence that both integrated (such as comprehensive services that address substance abuse as well as maternal and child wellbeing through antenatal services, parenting programmes, child care, and/or other child-centred services in a centralised setting) and non-integrated (such as standalone substance treatment) programmes can improve some birth outcomes for infants of women who have substance misuse problems during pregnancy. Integrated programmes showed a small improvement in parenting, but not on child protection outcomes. [NEW]
- There is some evidence that substance abuse programmes integrated with onsite pregnancy, child or parenting services are effective in reducing

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\(^9\) See [www.nice.org.uk/guidance/cg115](http://www.nice.org.uk/guidance/cg115)
maternal substance use, but no evidence that they are more effective at reducing substance use than standalone interventions. [NEW]

Supporting evidence: maternal mental health: identification of ante/postnatal anxiety and depression

Postnatal depression #

- According to Cowley et al. (2013), postnatal depression (PND) was identified as a key mental health issue with known effects on infants as well as mothers. Despite being one of the most widely researched areas, the evidence related to the effectiveness of health visitor interventions for postnatal depression was limited because of methodological or reporting issues.

- Relatively recent RCT evidence demonstrates positive health outcomes as a result of training health visitors to identify symptoms of depression in mothers and to provide psychologically oriented support through home visiting. Such training resulted in significant improvements for women with all levels of risk as predicted at six weeks post-partum including (in a later analysis of data) improved prevention among women who initially appeared to be at low risk.

- The opportunity to reach all women and form a positive 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).

Maternal mental health: identification of ante/postnatal anxiety and depression

- Evidence in support of the Healthy Child Programme indicates that the NICE guidance on antenatal and postnatal mental health (NICE 2014a, guideline CG192), which is based on a series of systematic reviews, recommends that at the first contact with primary care or the booking visit, and all contacts after, the health visitor and other healthcare professionals who have regular

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10 The reader should note that the evidence in support of the healthy child programme considers antenatal and postnatal anxiety and depression together. It is replicated here in this evidence paper.

11 See www.nice.org.uk/guidance/cg192
contact with a woman in pregnancy and the postnatal period (first year after birth) should consider asking the two Whooley depression identification questions and the GAD-2 as part of a general discussion about her mental health and wellbeing and using the EPDS or the PHQ-9 as part of monitoring. [NEW]

Maternal mental health: identification of severe mental illness and alcohol/substance dependency

- NICE (2014a) recommends that a woman’s first contact with services in pregnancy and the postnatal period should also include identification of severe mental illness.
- If alcohol misuse is suspected, the Alcohol Use Disorders Identification Test (AUDIT) should be used as an identification tool in line with recommendation 1.2.1.4 of the guideline on alcohol-use disorders and preventing harmful drinking (NICE guideline CG115). [NEW]
- If drug misuse is suspected, the practitioner should follow the recommendations on identification and assessment in section 1.2 of the guideline on psychosocial interventions for drug misuse (NICE guideline CG51). [NEW]

Maternal mental health: prevention of antenatal/postnatal depression

- There is currently insufficient evidence of the benefits of feedback during ultrasound and a variety of alternative therapies in preventing maternal anxiety or stress during pregnancy.
- Women who receive a psychosocial or psychological intervention during pregnancy or the post-partum period that is designed to prevent postnatal depression are significantly less likely to develop postnatal depression compared with those who receive standard care.
- Promising interventions include interpersonal psychotherapy, intensive home visiting by professionals, and peer-led telephone support (although evidence on the latter is inconsistent).

12 See www.nice.org.uk/guidance/cg51
• Interventions that are not supported by the evidence currently (i.e. evidence of no impact, or uncertain evidence) include antenatal classes that address postnatal depression, lay-based home visiting, and in-hospital psychological debriefing.

• Group-based parenting programmes can improve a number of aspects of maternal mental health, including depression and anxiety, although they are not recommended as primary treatments for these conditions.

Maternal mental health: treatment of antenatal/postnatal depression

• NICE (2014a) recommends that women with persistent sub-threshold depressive symptoms, or mild to moderate depression in pregnancy or the postnatal period should be offered facilitated self-help [NEW], and that where women with a history of severe depression initially present with mild depression in pregnancy or the postnatal period, a TCA, SSRI or (S)NRI13 should be considered. [NEW]

• For a woman with moderate or severe depression in pregnancy or the postnatal period, options should include a high-intensity psychological intervention – for example cognitive behaviour therapy (CBT); a TCA, SSRI or (S)NRI; or a high-intensity psychological intervention in combination with medication. [NEW]

• Evidence from reviews of interventions other than pharmacological, psychosocial and psychological for treating antenatal/postnatal depression is inconclusive, and does not permit recommendations for depression-specific acupuncture, maternal massage, bright light therapy, or omega-3 fatty acids to treat antenatal depression.

• There is no evidence to support the use of group CBT, exercise interventions, or omega-3 fatty acids for the treatment of postnatal depression.

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13 Tricyclic antidepressants (TCA); Selective serotonin reuptake inhibitor (SSRI) and Serotonin and norepinephrine reuptake inhibitors (SNRIs).
Maternal mental health: treatment of antenatal/postnatal anxiety

- NICE (2014a) recommends that a woman with persistent sub-threshold symptoms of anxiety in pregnancy or the postnatal period should be offered facilitated self-help. This should consist of the use of CBT-based self-help materials over 2–3 months with support (either face to face or by telephone) for a total of 2–3 hours over 6 sessions. [NEW]
- Women with anxiety disorders in pregnancy or the postnatal period should be offered a low-intensity psychological intervention (such as facilitated self-help) or a high-intensity psychological intervention (such as CBT) as initial treatment in line with the recommendations set out in the NICE guideline for the specific mental health problem. [NEW]

Maternal mental health: treatment of other mental health problems

- NICE (2014a) also makes a range of recommendations for women with eating disorders, alcohol and drug dependency (see section below on ‘Drugs and alcohol’), and severe mental illness in pregnancy and the postnatal period.

Maternal mental health: the mother–baby relationship

- NICE (2014a) recommends that the nature of the mother–baby relationship should be assessed, including verbal interaction, emotional sensitivity and physical care, at all postnatal contacts. Practitioners should discuss any concerns that the woman has about her relationship with her baby and provide information and treatment for identified mental health problems. [NEW]
- Practitioners are recommended to consider further intervention to improve the mother–baby relationship if any problems in the relationship have not been resolved. [NEW]

Maternal mental health: identifying families in need of additional support

See section above on the identification of mental health problems.
Maternal mental health: implementation issues

- Midwives and health visitors are in a key position to educate and support women about mental health and wellbeing, and to identify women at risk.
- NICE (2014a) recommends that all interventions for mental health problems in pregnancy and the postnatal period are delivered by competent practitioners. Psychological and psychosocial interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention. Practitioners should consider using competence frameworks developed from the relevant treatment manual(s) and for all interventions practitioners should receive regular high-quality supervision; use routine outcome measures and ensure that the woman is involved in reviewing the efficacy of the treatment; and engage in monitoring and evaluation of treatment adherence and practitioner competence – for example, by using video and audio tapes, and external audit and scrutiny where appropriate. [NEW]
- NICE (2014a) also recommends that managers and senior healthcare professionals responsible for perinatal mental health services (including those working in maternity and primary care services) should ensure that there are clearly specified care pathways so that all primary and secondary healthcare professionals involved in the care of women during pregnancy and the postnatal period know how to access assessment and treatment.
- Further interventions for mental health problems in pregnancy and the postnatal period should be provided within a stepped-care model of service delivery in line with recommendation 1.5.1.3 of the guideline on common mental health disorders (NICE guideline CG123). [NEW]

Maternal mental health: workforce skills and training

- NICE (2014a) guidelines recommend that all healthcare professionals providing assessment and interventions for mental health problems in pregnancy and the postnatal period should understand the variations in their presentation and course at these times, how these variations affect treatment, and the context in which they are assessed and treated (for example, maternity services, health visiting and mental health services). [NEW]
Many psychological and psychosocial interventions to improve maternal mental health and wellbeing in the perinatal period require additional training of midwives and health visitors, but no intervention can currently be definitively recommended in clinical practice. It would therefore be premature to consider introducing any of the identified interventions into midwifery training and practice.

Supporting evidence: smoking: antenatal interventions

- Evidence in support of the Healthy Child Programme indicates that psychosocial interventions during pregnancy can increase the proportion of women who stop smoking in late pregnancy, and reduce low birthweight and preterm births. Incentive-based interventions show the largest effect, although caution is needed, because they were only effective with intensive delivery and the studies were in the US.

- Financial incentives to promote non-smoking during pregnancy show promise, and may meet the treatment needs of socio-economically disadvantaged women and heavy smokers. [NEW]

- There is insufficient evidence to assess the efficacy, safety, or impact on birth outcomes of nicotine replacement therapy (NRT) when used to promote smoking cessation during pregnancy.

- The provision to pregnant women of feedback on its own (i.e. not in conjunction with other strategies, such as counselling) about the effects of smoking on the unborn child and on their own health is not effective in smoking cessation.

- Proactive telephone counselling is effective in helping to reduce smoking in smokers who seek help from quit lines.

- Self-help smoking cessation interventions for pregnant smokers appear to be effective but it is unclear whether more sophisticated and intensive approaches increase intervention effectiveness. [NEW]

- A review of smoking cessation relapse prevention interventions found no effect overall or by type or timing for behavioural relapse prevention interventions for pregnant or postpartum women.
• The evidence for the efficacy of interventions to establish smoke-free homes in pregnancy and in the neonatal period is inconclusive.

• Specific behavioural change components within effective behavioural smoking cessation interventions during pregnancy include the provision of rewards based on smoking cessation; utilising carbon monoxide (CO) measures; facilitating relapse prevention (helping the smoker understand how lapses occur and how they lead to relapse and to develop specific strategies for preventing lapses or avoiding lapses turning into relapse); information on consequences of smoking and cessation; facilitating problem-solving; identifying relapse triggers; goal setting; assessing current and past smoking behaviour; assessing readiness to quit; appropriate written materials; and facilitating social support. [NEW]

Supporting evidence: smoking: identifying families with additional needs

• The NICE guidance on quitting smoking in pregnancy and following childbirth (NICE 2010a, guideline PH26) recommends that pregnancy clinics implement routine carbon monoxide (CO) testing to help identify women who smoke. All current smokers and those who stopped in the previous two weeks should be referred to NHS stop-smoking services, as should those with a CO reading of 7 ppm or above, and light or infrequent smokers even if they register a lower reading (e.g. 3 ppm). [NEW]

• In addition, NICE (2010a) recommends that health visitors and other health professionals (such as GPs, family nurses) should use any meeting to ask women who are pregnant if they smoke and, if they do, to advise them to stop, explain how NHS stop-smoking services can help and make a referral to the service (with consent). [NEW]

• Women who quit smoking during pregnancy may demonstrate high rates of relapse after pregnancy, and consequently may need additional support.
Supporting evidence: smoking: implementation issues

- Barriers to the implementation of smoking cessation interventions in healthcare settings include healthcare professionals having different perceptions of their respective role in smoking cessation and negative perceptions about intervention efficacy.

- NICE (2010a) recommends that NHS stop-smoking service specialist advisers should undertake a range of activities, including discussing the benefits of smoking cessation for the mother and child, offering personalised information, advice and support throughout pregnancy and beyond, and regularly monitor the woman’s smoking status. [NEW]

Supporting evidence: smoking: workforce and training

- Based on evidence that professionals often perceive themselves to have limited knowledge and skills to deliver effective smoking cessation interventions, NICE (2010a) recommends that midwives who deliver intensive stop-smoking interventions (one-to-one or group support) should be trained to the same level as specialist NHS stop-smoking advisers (and receive ongoing support).

- Health visitors and other health professionals (including midwives) should understand the risks of smoking to women and children/unborn babies; the significant role of partners; and what NHS stop-smoking services provide and how to make a referral to them. [NEW]

- An assessment of the presence of effective behavioural change techniques within English stop-smoking services concluded that only a limited number were used in practice. [NEW]
Visit 2: 11–14 days new baby home visit: first of five proposed National Data Collection Points

- Engage with family following birth.
- Assessment and initiation of Getting it Right for Every Child (GIRFEC) and identification of child/family strengths and health/mental health and wellbeing needs and provisional HPI.
- Engage and share public health information and guidance to promote positive attachment and health and wellbeing.
- Physical developmental check of the baby.
- Introduce immunisation and developmental assessment schedule.
- Advice on sources of community support.
- If not previously carried out, carry out routine enquiry for gender-based violence and risk assessment undertaken following disclosure. Build on and strengthen therapeutic relationship between practitioner and mother/family.
- Agree future plan of care with parents/carers.

Supporting evidence: fathers #

- Cowley et al. (2013) report interest in improving the extent to which health visitors engage and work with fathers.
- Despite the identification of various resources designed to enhance practice, including a pilot questionnaire that aimed to improve communication with fathers in the course of practice, there is limited evidence about the impact of health visitors’ work with fathers.

Supporting evidence: breastfeeding #

- There is some evidence reported by Cowley et al. (2013) which acknowledges that health visitors have an important role to play in supporting breastfeeding, particularly in its continuation.
- Training health visitors in breastfeeding support has been shown to be effective in improving breastfeeding 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 breastfeeding (usually with the support of midwives) to continue to breastfeed.

- Evidence in support of the Healthy Child Programme indicates that effective strategies to promote breastfeeding include peer support, either one-to-one or as part of a group, and structured support from professionals. Those that rely mainly on face-to-face support are significantly more likely to help with breastfeeding initiation and to sustain breastfeeding than other forms of advice offered at a distance (for example via telephone).

- There is some new evidence that online interventions may also contribute to breastfeeding initiation and duration. The duration of effective online support is unclear.

- A review of workplace interventions to support and promote breastfeeding in an employment context (on-site or outside of the workplace) among women returning to paid work after the birth of a child found no RCT or quasi-RCT studies.

- No form of antenatal breastfeeding education has been found to be significantly more effective than another in increasing breastfeeding initiation or duration.

Supporting evidence: drugs and alcohol: postnatal

Drugs and alcohol: brief interventions
See evidence related to Visit 1.

Psychosocial interventions
See evidence related to Visit 1.

Integrated programmes
See evidence related to Visit 1.

Identifying families in need of additional support
- Evidence in support of the Healthy Child Programme indicates that NICE (2014a) guidance on antenatal and postnatal mental health recommends that
if alcohol misuse is suspected, the Alcohol Use Disorders Identification Test (AUDIT) should be used as an identification tool in line with recommendation 1.2.1.4 of the guideline on alcohol-use disorders (NICE 2011, guideline CG115). [NEW]

- NICE (2014a) further recommends that if drug misuse is suspected, the recommendations on identification and assessment in section 1.2 of the guideline on psychosocial interventions for drug misuse (NICE 2007b, guideline CG51) should be used. This involves asking questions about drug misuse (the nature of the questions depends on the setting), making an assessment and agreeing a care plan, and using biological testing as part of a comprehensive assessment of drug misuse.

**Implementation**

- NICE (2007b) guidance on psychosocial interventions for drug misuse states that staff should discuss with people who misuse drugs whether to involve their families and carers in assessment and treatment plans, and to support families as appropriate.

**Workforce skills and training**

- NICE (2007b) states that all interventions for people who misuse drugs should be delivered by staff who are competent in delivering the intervention and who receive appropriate supervision.
- NICE (2010b) guidance on alcohol misuse states that managers of NHS-commissioned services should ensure that staff have enough time and resources to carry out screening and brief intervention work effectively, and that staff have access to recognised, evidence-based packs.

**Supporting evidence: attachment**

**Preparation for parenthood programmes**

See evidence in support of Visit 1.
Kangaroo Mother Care (KMC) and skin-to-skin care (SSC)

- Evidence in support of the Healthy Child Programme indicates that KMC in LBW\(^{14}\) infants can increase some measures of infant growth, breastfeeding, and mother–infant attachment.
- Early SSC appears to benefit breastfeeding outcomes and cardio-respiratory stability, and decrease infant crying, with no apparent short- or long-term negative effects.

Infant massage

- There is no evidence to support the use of infant massage on a population basis [NEW] but some evidence to support its use with disadvantaged and depressed mothers of babies.

Mentalisation-based programmes

- There is some evidence (from two RCTs) to suggest that mentalisation-based programmes are effective in reducing rapid subsequent childbearing, reducing the risk of child abuse, improving mental health, and improving maternal reflective functioning. [NEW]

Video feedback

- There is good evidence to suggest that video feedback and Video-feedback Intervention to promote Positive Parenting (VIPP) can improve parental sensitivity and improve secure attachment. There is also evidence of improvement in both internalising and externalising problems in older children. VIPP can also improve emotional availability, child behaviour, and family environment. There is also evidence of improved attachment security in highly (but not moderately) irritable infants.

Home visiting programmes

- There is evidence from one review supporting the use of home visiting to improve maternal behaviours, including sensitivity, and limited evidence to support its use with preterm infants.

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\(^{14}\) Low birth weight.
Sensitivity-focused interventions for preterm infants

- Evidence from two systematic reviews suggests that some brief sensitivity-focused interventions (such as Mother-Infant Transaction Programme; Nursing Systems Towards Effective Parenting-Preterm; Guided Interaction) may be effective in improving maternal sensitivity in mothers of preterm infants. [NEW]

Parent–infant/toddler psychotherapy

- There is evidence from one systematic review to suggest that parent–infant/toddler psychotherapy can improve infant attachment security, and limited evidence from one RCT to show improvements in a range of aspects of child functioning in traumatised children (such as child depression, co-occurring diagnoses, child behaviour, maternal post-traumatic stress disorder (PTSD) and maternal depression). [NEW]

Attachment and biobehavioural catch-up (ABC)

- There is limited evidence (two RCTs) for ABC to show reduced negative affect expression, and higher levels of secure attachment and reduced disorganised attachment, although the findings for attachment were not sustained over time. [NEW]

Group-based programmes

- There is limited evidence (one small RCT) to show that a group-based programme with adjunctive components can improve maternal depression and some aspects of parent–infant interaction. [NEW]

Identifying families in need of additional support

No specific issues were identified.

Implementation issues

- One robust review concludes that the most effective programmes for promoting attachment are shorter in duration, provide direct services to the
parent–child dyad, use interveners with professional qualifications, and assess parent–child interactions with free-play tasks.

- Recent reviews on the promotion of attachment security in preterm infants recommend routine inclusion of psychosocial support for the infant’s mother. One study found different effects among families of higher and lower educational groups, and recommends additional reinforcement sessions for mothers in lower educational groups.
- Infant massage programmes are most effective with parents in the middle tier of need, and should not be used on their own with parents who are high risk. A total of 14 mechanisms need to be present to promote the likelihood of massage programmes being effective, including consistency of facilitator, small groups that are provided in appropriate settings, the teaching of infant cues, and opportunities for parental socialisation.

**Workforce skills and training**

International Association of Infant Massage (IAIM) training provides practitioners with better preparation to deliver infant massage training compared with other training programmes.

**Supporting evidence: immunisation #**

- According to Cowley et al. (2013), in order to achieve a balance between their public health role (i.e. to promote uptake and herd immunity) and that of providing (non-judgemental) support to parents, most health visitors adopt a ‘parent-centred’ approach when informing and supporting decisions about immunisation.
- The need for additional training was raised by the research, as were barriers to successful practice. 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 postnatal visit.
- As with breastfeeding, health visitors were aware of the tension between the expectations that they would promote the ‘approved line’ and anxiety that this
might undermine the trust and relationship upon which the acceptance of health advice depends. In relation to primary immunisation, health visitors need support and education to deal with the potential conflict between the need to promote official targets and the need for sensitivity related to parents’ views and cultural expectations.

Supporting evidence: keeping safe: SIDS (sudden infant death syndrome)

- Evidence in support of the Healthy Child Programme indicates that the impact of home monitoring systems on preventing SIDS is inconclusive owing to the dearth of studies with a comparison group and the difficulty of drawing conclusions from the cohort studies that have been conducted (owing to different inclusion criteria, and different types of device). However, observational studies of interventions show that advice on avoiding prone sleeping position and tobacco exposure markedly reduces the incidence of SIDS. [NEW]

- NICE guidance on postnatal care (NICE 2014c, guideline CG37) recommends informing parents and carers that there is an association between co-sleeping (parents or carers sleeping on a bed or sofa or chair with an infant) and SIDS; the association between co-sleeping and SIDS is likely to be greater when they, or their partner, smoke; and the association may be greater with a) parental or carer recent alcohol consumption; b) parental or carer drug use; or c) low birth weight or premature infants. (These NICE recommendations cover the first year of the infant’s life.)

Supporting evidence: community support

- See Appendix B.
Visits 3 & 4: 3–5 weeks (all families) two home visits

- Continue Getting it Right for Every Child (GIRFEC) assessment process and identification of child/family health strengths and wellbeing needs.
- Build on and strengthen therapeutic relationship between practitioner and mother/father/family.
- Engage and share public health information and guidance to promote positive attachment and health and wellbeing.
- Observe and discuss developmental progress of infant.
- If previously disclosed, routine enquiry for gender-based violence and risk assessment undertaken.
- Routine enquiry about family finances/money worries. Raise awareness of the advice available and offer families a direct referral to advice services.
- Agree plan of ongoing care.

Supporting evidence: domestic violence\textsuperscript{15} #

- Cowley et al. (February 2013) cites dated evidence (from 2003) that provides examples of how health visitors can enable families to express their needs, particularly in relation to disclosure and the subsequent referral of families to appropriate services.
- Reasons for under-reporting include women being fearful of losing their children or feeling that they have nothing to gain from their disclosure. These responses are often linked to a lack of trust in health visitors and/or others.
- Evidence of enhanced disclosure was derived from one area that included routine questions about domestic violence and other studies that emphasised the importance of privacy and trust gained through home visiting and established relationships.

\textsuperscript{15} Domestic violence is the term used by Cowley et al. (2013) while the Healthy Child Programme rapid review refers to intimate partner violence (IPV). The term gender-based violence is the term used by Scottish Government.
• Scrutiny of the recent NICE guidance (February 2014) makes no reference to health visitor practice in response to this issue (see www.nice.org.uk/guidance/PH50).

Intimate partner violence (IPV): prevention and identification of intimate partner violence (IPV)

• Evidence in support of the Healthy Child Programme indicates that there is insufficient evidence on the benefit of interventions to justify universal screening for intimate partner violence in healthcare settings.

• While screening programmes increased screening, disclosure and identification rates, referrals to specialist agencies and services did not increase. There is no evidence that screening impacts on levels of violence or positive health outcomes.

• Self-administered screening instruments were more likely to encourage disclosure than face-to-face screening interviews. It was not possible to identify any particular screening tool as more effective at identification than another, given the variability in studies.

• Prevention and screening efforts for female genital mutilation (FGM) are best framed in relation to benefits for women’s health, rather than opposing traditional practices or beliefs about women’s rights. Training local healthcare staff may be beneficial if developed and sustained. [NEW]

• The NICE guidance on domestic violence and abuse (NICE 2014b, PH50) reported that while insufficient evidence was found to recommend screening or routine enquiry within healthcare settings, routine enquiry is viewed as best practice by some professionals. The review of evidence underpinning the NICE (2014b) guidance found insufficient evidence for the efficacy of primary prevention programmes relating to IPV.

Intimate partner violence (IPV): interventions to support pregnant women at high risk of IPV

• The evidence supports the use of multi-session psychological therapy, based on CBT, during pregnancy for women who are at risk or who have experienced IPV. Women who receive such support are less likely to have
recurrent episodes of abuse compared to those receiving standard care. [NEW]

- Perinatal HV programmes that screen for IPV can identify significant numbers of cases, but are unlikely to reduce IPV and improve maternal and infant health unless effective interventions are implemented.
- Intensive advocacy may be effective in reducing physical violence for women leaving shelters two years later but not within the first year. There is insufficient evidence to support less intensive advocacy interventions.
- There is no evidence to support interventions to respond to pregnant women who have experienced FGM. Alternative evaluation designs should be considered. [NEW]

**Intimate partner violence (IPV): preventing further IPV and the adverse consequences of IPV**

- There is evidence for the effectiveness of a range of different types of intervention concerned with preventing IPV, or re-abuse, and the adverse consequences of IPV (such as for parent mental health). These include advocacy services, skill building, counselling, therapy, and multi-component interventions. [NEW]
- NICE (2014b) recommends that practitioners in specialist domestic and sexual violence services should provide all those currently (or recently) affected by domestic violence and abuse with advocacy and advice services tailored to their level of risk and specific needs. It further recommends that practitioners in primary, mental health and related care services should provide people who experience domestic violence and abuse and have a mental health condition with evidence-based treatment for that condition.
- There is evidence for the effectiveness of single component therapeutic interventions aimed at the mother and child (including young children) in improving child behaviour, mother–child attachment and stress and trauma-related symptoms in mothers. [NEW]
- NICE (2014b) recommends providing specialist domestic violence and abuse services for children affected by domestic violence and abuse, matching the support to the child’s developmental stage and seeking to address the
emotional, psychological and physical harms arising from a child or young person being affected by domestic violence and abuse, as well as their safety.

**Intimate partner violence (IPV): group-based interventions for perpetrators of IPV**

- There is insufficient evidence to draw clear conclusions about the effectiveness of CBT with men who had physically abused their female partner.
- A review of a broader range of interventions, including CBT, psycho-educational and pro-feminist (Duluth) models found a number of positive outcomes but was unable to attribute these results to particular intervention programmes.
- The effectiveness of perpetrator programmes is largely limited to an assessment of their impact on criminal justice outcomes, such as arrest, assault and aggression. There is scope to extend evaluation work to include other measures of behaviour change.
- NICE (2014b) recommends that health and wellbeing boards and commissioners who commission perpetrator interventions should commission and evaluate tailored interventions for people who perpetrate domestic violence and abuse in accordance with national standards.

**Intimate partner violence (IPV): identifying families in need of additional support**

- NICE (2014b) recommends that trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children’s and vulnerable adults’ services ask service users whether they have experienced domestic violence and abuse. This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse.

**Intimate partner violence (IPV): implementation issues**

- NICE (2014b) recommends that practitioners in specialist domestic and sexual violence services should provide all those currently (or recently)
affected by domestic violence and abuse with advocacy and advice services tailored to their level of risk and specific needs. The support should be offered (although not necessarily delivered) in settings where people may be identified or may disclose that domestic violence and abuse is taking place.

**Intimate partner violence (IPV): workforce skills and training**

- NICE (2014b) recommends that frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse.

NICE (2014b) further recommends that health and social care professionals are trained in how to respond to domestic violence and abuse. Health visitors and various other professionals (such as GPs, children’s centre workers) should be trained to ask about domestic violence and abuse in a way that makes it easier for people to disclose it. Health visitors with additional domestic violence and abuse training should be trained to provide an initial response that includes risk identification and assessment, safety planning and continued liaison with specialist support services.

**Supporting evidence: parenting support #**

- Cowley et al. (2013) indicates that evidence about support for parents and parenting support offered limited insight into health visiting practice, as they were a collection of disparate studies that varied in methodology and quality with little conclusive evidence of service outcomes.

- Home visiting programmes are associated with more (and more appropriate) use of other services.

- 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 children’s problematic symptoms and improved maternal wellbeing. However, this success was not replicated when health visitors tried to implement the same approach in response to a generic caseload.

- As well as specialist health visitor services, health visiting enabled timely access to other services, through initial case-finding (such as pervasive developmental disorder or young children with mental health needs), then referring children on to appropriate services.
- Health visitors also enabled parents to access Sure Start local programmes and general or specialist parenting programmes. This was done through networking, building relationships and trust (for example between health visitors and parents and between health visitors and the other services) and through practical support (for example to help reach Children’s Centres, ensuring availability of crèche if needed).
- Overall, the evidence about how health visitors enable families to access other services stems mainly from the way the service is set up, which influences the ‘service journey’, and implementation of the ‘core practices’ of home visiting, needs assessment and relationship formation that has been previously described (see appendix A).

Preparation for parenthood programmes
- See evidence in support of Visit 1.

Kangaroo Mother Care (KMC) and skin-to-skin care (SSC)
- See evidence in support of Visit 2.

Parenting programmes
- See evidence in support of Visit 11.

Parenting support: postnatal education programmes
- Evidence in support of the Healthy Child Programme indicates that behavioural interventions for infant sleep in the first six months have not been shown to decrease infant crying, prevent sleep and behavioural problems in
later childhood, or protect against postnatal depression. In addition, behavioural interventions for infant sleep that are used during the first weeks and months are associated with unintended outcomes, including increased amounts of problem crying, premature cessation of breastfeeding, increased maternal anxiety and, if the infant is required to sleep either day or night in a room separate from the caregiver, an increased risk of sudden infant death syndrome (SIDS). [NEW]

- For older children, both family-based and pharmacological interventions that target sleep and eating problems are effective in the short term, but only systemic interventions have positive long-term effects on young children’s sleep problems. [NEW]

**Parenting support: identifying families in need of additional support**

- One review of self-help parenting programmes found evidence to support the application of the Eyberg Child Behaviour Inventory in order to identify children with conduct disorders exceeding the clinical range. [NEW]

**Parenting support: implementation issues**

- The implementation programmes with fidelity is an important component of clinical effectiveness in relation to the use of behavioural and cognitive-behavioural group-based parenting programmes. Authorised workshops, a group leader certification/accreditation process, a detailed treatment manual, and checklists can all help achieve a high level of treatment fidelity.

- Key barriers to engaging fathers in parenting programmes are: cultural (e.g. relevance to co-parents); institutional (e.g. how father-friendly the organisation is); professional (e.g. staff capabilities, attitudes); operational (e.g. disaggregation of data by sex); content (e.g. relevance to fathers); resource (e.g. sufficiency for implementing changes needed); and policy (e.g. clear recognition of co-parents in strategies, action plans). [NEW]

**Parenting support: workforce skills and training**

- Several included studies draw attention to the need to train practitioners in the delivery of manualised programmes.
Visit 5: 6–8 weeks

- Continued Getting it Right for Every Child (GIRFEC) assessment process and identification of child/family health/mental health strengths and wellbeing needs and update recording of Health Plan Indicator.
- Discuss and enquire about depressive symptoms and complete the Edinburgh Postnatal Depression Scale (EPDS).
- If not previously carried out, undertake routine enquiry for gender-based violence and risk assessment undertaken following disclosure. Build on and strengthen therapeutic relationship between practitioner and mother/family.
- Engage and share public health information and guidance to promote positive attachment and health and wellbeing.
- Agree plan of ongoing care.

Supporting evidence: nutrition and obesity prevention

Nutrition and obesity prevention: promotion of breastfeeding

- Evidence in support of the Healthy Child Programme indicates that effective strategies to promote breastfeeding include peer support, either one-to-one or as part of a group, and structured support from professionals. Strategies that rely mainly on face-to-face support are significantly more likely to begin and sustain breastfeeding than advice offered from a distance (for example via telephone).
- There is some new evidence that online interventions may also contribute to breastfeeding initiation and duration. The duration of effective online support is unclear.
- A review of workplace interventions to support and promote breastfeeding in an employment context (on-site or outside of the workplace) among women returning to paid work after the birth of a child found no RCT or quasi-RCT studies.
- No form of antenatal breastfeeding education has been found to be significantly more effective than another in increasing breastfeeding initiation or duration.
Visits 6 & 7: 3 & 4 months

- Continuous assessment and identification of child/family health/mental health and wellbeing needs.
- Discuss and enquire about depressive symptoms and complete Edinburgh Postnatal Depression Scale (EPDS).
- Engage and share public health information and guidance to promote positive attachment and health and wellbeing.
- Continue to observe child’s developmental progress.
- If not previously carried out, undertake routine enquiry for gender-based violence and risk assessment undertaken following disclosure.
  - Advise on sources of community support.
  - Following assessment, commission additional support via Early Years Support Workers as required.
  - Complete Getting it Right for Every Child (GIRFEC) assessment process and update Health Plan Indicator.
- Introduce the subject of weaning and highlight importance of delaying introducing solids until around six months.
- Agree plan of ongoing care.

Supporting evidence: nutrition and obesity prevention#

- Cowley et al. (2013) report that there are 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.
- 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.
Studies focused on the need for a clear knowledge base and sensitive communication, because of the strong cultural and family impact on weaning, and sensitivity about obesity instances in which health visitors may feel inhibited in raising issues of risk. This draws attention once more to the need for good health visitor–client relationships along with awareness and use of an ecological approach and the non-judgemental orientation implicit in ‘human valuing’.

**Nutrition and obesity prevention: prevention and treatment of child overweight and obesity**

- Evidence in support of the Healthy Child Programme indicates that the most effective interventions for the prevention and treatment of overweight and obesity in children involve a multi-component and holistic approach that aims simultaneously to improve diet and physical activity in the multiple domains of children’s lives. Specifically, they involve parents/the whole family, physical activity, nutritional education, and – for children in school/preschool – support from teachers. Attention to social and environmental factors is important and often given insufficient attention. Narrow interventions focusing on single aspects of behaviour are unlikely to achieve long-term change in efforts to tackle obesity. [NEW]

- The following have been identified as effective components of interventions: decreasing preschoolers’ screen time; decreasing consumption of high fat and high calorie drinks and foods; increasing physical exercise; increasing sleep; modifying parental attitudes to feeding; and promoting authoritative parenting. [NEW]

- Interventions to reduce children’s sedentary behaviour have a small but significant effect on reducing time spent in these behaviours and/or improvements in anthropometric measurements. Parent training can have a significant effect on reducing children’s screen time. There is evidence to recommend the use of electronic TV monitoring devices in order to achieve this. [NEW]
• While there is evidence to support a positive relationship between increased or higher physical activity and favourable measures of adiposity in preschool children, there is a need for more rigorous research designs in this age group. [NEW]

• In terms of the promotion of healthy eating, the most effective strategies to increase children’s acceptance of unfamiliar (and healthy) foods are: intensive, incorporate behavioural strategies, give a clear message, and are tailored to the educational level and material resources of families.

• There is strong evidence that the involvement of whole families (parents and children) in interventions that promote both healthier diet and more exercise can have an impact on reduction of BMI. [NEW]

• Interventions to increase fruit and vegetable consumption in children aged under six years show no, or at best mixed, effects.

• There is evidence that general parenting programmes that include lifestyle components such as physical activity and nutrition have small-to-moderate effects on weight-related measures.

• There is a relative lack of evidence about what is effective with children under the age of six in terms of lifestyle weight management for overweight and obese children.

• Findings from recent RCTs not included in the systematic reviews, but including children in the 0–3 years age range, and addressing effective methods of preventing obesity in young children, indicate that some home visiting programmes delivered during the postnatal period have positive effects on family/parental nutritional practices (such as increased duration of breastfeeding, later introduction of solid foods, less use of food as a reward or to make children feel better) and – in one study – on children’s intake of water, vegetables and healthy snacks. These programmes focus on diet and/or exercise. [NEW]

• There is also emerging evidence – again from recent RCTs that include some children in the 0–3 years age range – to support the use of group-based interventions with mother–infant dyads in altering maternal feeding practices (for example reduced sweet snack intake, increased consumption of water
and fruit/vegetables) and reducing the time that children spend watching television. [NEW]

- Findings from recent RCTs (as above) of multi-component and anticipatory guidance interventions are also promising, with evidence of impact on, for example, television viewing and family nutritional practices. [NEW]

**Nutrition and obesity prevention: infant feeding problems**

- There is evidence that family-based behavioural programmes are effective in improving severe feeding problems in children under the age of five.

**Nutrition and obesity prevention: identifying families with additional needs**

- Universal healthcare checks in the early years provide an opportunity for health professionals to identify families who may need additional support.
- Several socio-demographic factors are associated with a lack of physical activity, indicating groups of children and families to be given special attention.
- NICE guidance on managing overweight and obesity in children and young people (NICE 2013, guideline PH47) recommends that if health professionals (including health visitors) have concerns about a child’s weight they should measure their BMI and use UK-WHO growth charts to determine if children are overweight or obese. They should tell parents or carers of children who have been identified as being overweight or obese about local lifestyle weight management programmes and make a referral if it is clinically appropriate and the family is ready. (The guidance notes that programmes specifically aimed at children aged under six are excluded from the recommendation owing to no evidence about the effectiveness of these interventions being identified.)

**Nutrition and obesity prevention: implementation issues**

- NICE guidance on maternal and child nutrition (NICE 2008, guideline PH11) recommends a coordinated programme of interventions across different settings to increase breastfeeding rates: raising awareness of the benefits; giving information about the barriers and how to overcome them; providing training for professionals; offering peer support programmes; providing
education and information for pregnant women on how to breastfeed; offering proactive support during the postnatal period; and implementing structured programmes that encourage breastfeeding – with the UNICEF ‘Baby Friendly Initiative’ as a minimum standard.

• Greater efforts should be made to deliver parent interventions to address obesity in an accessible format (such as online), since for young children parents are the primary agent of change and parents can find it hard to attend face-to-face sessions owing to time commitments.

**Nutrition and obesity prevention: workforce skills and training**

• NICE (2008) recommends that health professionals who provide advice and support to breastfeeding mothers have the required knowledge and skills, and that support workers are also adequately trained and receive ongoing support.

• Interventions that involve physical activity should be delivered by trained staff in order to ensure intervention efficacy.

**Supporting evidence**

See Visit 2 evidence about attachment.

See Appendix B about Community Support.
Visit 8: 8 months

- Review Getting it Right for Every Child (GIRFEC) assessment and identification of child/family health/mental health and wellbeing needs and update Health Plan Indicator if required.
- Engage and share public health information and guidance to promote positive attachment and health and wellbeing.
- Continue to observe child’s developmental progress and undertake additional interventions as required – for example advice; referral.
- Signpost to local community services.
- Agree future plan of care.

Childsmile is an organisation aiming to improve the oral health of children in Scotland. Their advice about registering with a dentist is as follows:

Aim to register your baby with a dentist soon after birth or by the time they are six months of age. From then on, take your child to the dental practice every six months, or as advised by your dental team. Taking your baby to the dental practice as early as possible helps them to get used to the sights, sounds and smells of a dental practice and gives you access to information, advice and support for looking after your child's teeth.


Supporting evidence: oral health: evidence-based guidance

- Evidence in support of the Healthy Child Programme indicates that there is strong evidence for interventions that contribute to the oral health of children aged 0–5 years, for example in relation to feeding practices, diet, and tooth-brushing with fluoride toothpaste. Public health interventions for this age group should follow these guidelines.
**Oral health: access to fluoride**

- The targeted and timely provision of toothbrushes and fluoride toothpaste reduces tooth decay.
- There is high-quality evidence from a number of systematic reviews that fluoride varnish is effective in preventing caries. There is evidence that targeted fluoride varnish programmes are effective in reducing caries. [NEW]
- NICE guidance on oral health (NICE 2014e, guideline PH55) recommends that local authorities and health and wellbeing commissioning partners should consider fluoride varnish programmes for nurseries in areas where children are at high risk of poor oral health.

**Oral health: oral health education and promotion**

- There is inconclusive evidence for the impact on child oral health outcomes of person-centred counselling based on motivational interviewing, for example with new mothers. [NEW]
- One-off education by dental staff in the general population (such as dental staff providing education to new mothers or visiting schools annually) has limited effects on clinical outcomes. [NEW]
- There is a lack of RCT evaluations of providing training to health, education and social care professionals to help them deliver oral health interventions as part of their daily professional role. However, there is some evidence of effectiveness (for example on maternal tooth-brushing behaviour, child tooth decay). The success of such interventions will depend largely on the extent to which the education provided by practitioners is evidence-based. [NEW]
- There is evidence from comparison group studies that integrating oral health advice into home visits by health/social care workers, targeted at families at higher risk of oral disease, can reduce tooth decay. This requires building the capacity of health and social care workers to provide such support and providing regular update training. [NEW]
Oral health: supervised tooth-brushing

- Supervised tooth-brushing (with fluoride toothpaste) in targeted childhood settings is effective in reducing tooth decay. Targeting is important: programmes are more effective in areas with high rates of tooth decay and less effective when children are already brushing their teeth twice a day with fluoride toothpaste. [NEW]

- NICE (2014e) recommends that local authorities and health and wellbeing commissioning partners should consider commissioning a supervised tooth-brushing scheme for early years settings in areas where children are at high risk of poor oral health.

Oral health: healthy food and drink policies in childcare settings

- Reviews did not identify any comparison group studies of healthy food and drink policies in childcare settings but it is argued that this intervention has value for other reasons (such as reducing inequalities by creating a health-promoting atmosphere, low cost/resource implications, potential for sustainability).

Oral health: multi-component strategies

- There is evidence from one interrupted time-series evaluation that oral health promotion campaigns delivered through multiple venues and targeting several aspects of oral health may be associated with a reduced risk of dental decay in children under the age of five living in deprived communities. [NEW]

Oral health: identifying families with additional needs

- The main risk factors for poor oral health in children are well established. Tools that help health visitors and other professionals to assess risk are available, although as yet there is no consensus on which one is best. [NEW]

Oral health: implementation issues

- Where possible, high-quality oral health advice should be integrated into health programmes. [NEW]
• NICE (2014e) recommends that frontline health and social care staff are able to give parents, carers and other family members advice on the importance of oral health and how to promote it (for example promoting breastfeeding, healthy food and drink, the use of fluoride toothpaste).

• Targeting high-risk families is important to achieve the best effects, as is good engagement with parents, schools and dental practices. [NEW]

• Public health approaches need to provide education that is in line with evidence-based guidelines. [NEW]

Oral health: workforce skills and training

• All frontline staff in early years services, including education and health, should receive training at their induction and at regular intervals, so they can understand and apply the principles and practices that promote oral health. [NEW]

• NICE (2014e) recommends that health and social care staff working with children at high risk of poor oral health should receive training on a range of issues, including how good oral health contributes to people’s overall health and wellbeing, the consequences of poor oral health, how to prevent tooth decay, techniques for maintaining good oral hygiene (such as the use of fluoride toothpaste), and what advice to give carers.

Supporting evidence: unintentional injury #

• Cowley et al. (2013) indicate that the evidence 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.

• 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 to mothers and more effective. They were also welcomed by the health visitors who trained and supervised them.

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

• Evidence in support of the Healthy Child Programme indicates that parenting interventions, most commonly provided within the home, are effective in reducing child injury and improving home safety. [NEW]

• Home safety education increases the use of home safety practices and there is some evidence that it can reduce overall injury rates. There is conflicting evidence regarding the provision of home safety equipment in terms of its impact on safety practices and injury rates. [NEW]

• There is a general lack of evidence about the impact of education to prevent dog bites in children. [NEW]

• There is evidence that interventions to promote the prevalence of smoke alarms or the use/maintenance of fire alarms in households with children that include education, the provision of equipment, and home inspection are effective in increasing the household possession of a functioning smoke alarm. More intensive interventions that include the fitting of equipment in addition to education, the provision of equipment, and home inspection are most effective. [NEW]

• Home safety interventions improve poison-prevention practices such as the safe storage of medicines and cleaning products, the possession of syrup of ipecac, and having poison control centre numbers accessible, but the impact on poisoning rates is unclear. [NEW]

• Home-safety interventions are effective in increasing stair-gate use and reducing baby-walker use. However, the evidence does not show an increase in the possession of window locks, screens or windows with limited opening, or nonslip bath mats. Only two studies measured falls, and these found no effect on baby-walker related falls. There is limited evidence (one cohort
study) that the provision of home safety information by health professionals and relatives can also reduce falls and fall-related injuries, and more research is needed on this subject. [NEW]

- There is limited evidence of the effectiveness of interventions that modify the home environment in terms of injury reduction (such as the provision of free/low-cost home safety equipment, advice/information, and home-based hazard-assessment). [NEW]

Supporting evidence: abuse and neglect

- Evidence in support of the Healthy Child Programme indicates that there is insufficient evidence to support the use of one-to-one and group-based parenting programmes to prevent the reoccurrence of physical abuse or neglect in families where there is a history of this, although there is some, albeit limited, evidence that some parenting programmes improve outcomes associated with physically abusive parenting.

- There is evidence that home visiting interventions in early childhood for at-risk families lead to reductions in Child Protective Services (CPS) reports, accident and emergency visits, hospitalisations and self-reports of abuse, as well as improved adherence to immunisations, although there is some inconsistency in results across the programmes identified. Home visitation by paraprofessionals holds promise for socially high-risk families with young children, including in the area of reducing harsh parenting. [NEW]

Abuse and neglect: identification of families with additional needs

- Objective risk assessments are the best way to identify families at risk of child abuse and neglect, and clinicians in contact with families during early child years (i.e. paediatricians, health visitors) are well positioned to conduct these. [NEW]

- Risk factors include: young age; single/first-time mother; history of child maltreatment; substance misuse; unemployment; and low socioeconomic status. Attention needs also to be paid to specific features of the family’s physical environment.
• NICE provides guidance on when to suspect child maltreatment (NICE 2009a, guideline CG89), and the associated care pathway outlines the actions health visitors should take if child maltreatment is suspected.

• NICE guidance on preventing unintentional injuries in the home among under-15s (NICE 2010d, guideline PH30) recommends that local authorities, safeguarding children services, and health and wellbeing boards should prioritise households at greatest risk, through the assessment of local needs, priority delivery, and equipping professionals with relevant materials/knowledge. [NEW]

• NICE (2010d) recommends that home safety is integrated into home visits (including by health visitors). Specifically, those undertaking the home visits should provide home safety advice and, if the family or carers agree, refer them to agencies that can undertake a home safety assessment and can supply and install home safety equipment that complies with recognised standards. Parents/carers should be encouraged to conduct their own home safety assessment using an appropriate tool. [NEW] High-risk families regarding child safety include, among others, those in rented or overcrowded accommodation with high levels of turnover.

**Unintentional injury: implementation issues**

• There are numerous facilitators (home visits, asking families to make minimal changes) and barriers (socioeconomic constraints, parental habits, cultural norms, issues of trust or a lack of control over the home environment) regarding the implementation of injury prevention interventions for children aged under five. [NEW]

• NICE (2010d) recommends that education, advice and information about safety are provided during both a home safety assessment and the supply and installation of home safety equipment.

• Home safety assessments and interventions should be followed up to see if there are any new requirements, and to assess whether the equipment installed is still functional and appropriate. [NEW]
The timing regarding the provision of injury prevention information and the cost of safety equipment are important considerations in relation to injury prevention. [NEW]

**Unintentional injury: workforce skills and training**

- The most effective home visiting interventions to reduce unintentional injury for children in the home are delivered by trained healthcare professionals (such as social workers, child health nurses, qualified family support workers, and family nurses).

- Where home safety equipment requires skilled fitting, it is essential in socio-economically deprived communities that it is installed by technicians in order for it to remain installed in the longer term. [NEW]
Visit 9: child health reviews 13–15 months, third of five proposed National Data Collection Points; Visit 10: 27–30 months and Visit 11: 4–5 years

- Review Getting it Right for Every Child (GIRFEC) assessment and identification of child/family health/mental health and wellbeing needs and update Health Plan Indicator if required.
- Assessment should include: quality of parent–child relationship and mental health of the principal carer.
- Engage and share public health information and guidance to promote positive attachment and health and wellbeing.
- Undertake developmental and wellbeing review.
- Child Health Review – refer to guidance in Appendix 2 (guidance on delivery and national minimum dataset).
- Advise on local services for children and families.
- Review immunisation status and prompt attendance where required.
- Routine enquiry about family finances/money worries and raise awareness of the advice available and offer families a direct referral to advice services.
- Agree future plan of care.

Visit 10: 27–30 months, fourth of five proposed National Data Collection Points

- In addition to the above, a routine enquiry for gender-based violence and risk assessment is conducted.

Supporting evidence
See evidence related to Visits 3 & 4.
Visit 11: 4–5 Years, fifth of five proposed National Data Collection Points

- Undertake pre-school review.
- Child Health Review – refer to guidance in Appendix 3 (guidance on delivery and national minimum dataset).
- Update Getting it Right for Every Child (GIRFEC) assessment and Health Plan Indicator.
- Engage and share public health information and guidance to promote positive attachment and health and wellbeing.
- Routine enquiry about family finances/money worries and raise awareness of the advice available and offer families a direct referral to advice services.
- Arrange discussion or meeting with school nurse for children with a Health Plan Indicator of additional needs.
- Transition to school.
- Arrangements for transition to the incoming named person – such as Education.

Supporting evidence: parenting support: parenting programmes

- Evidence in support of the Healthy Child Programme indicates that a review of targeted self-administered programmes for parents of children aged 2–9 years found that self-administered programmes led to outcomes similar to those achieved with more intensive therapist input. [NEW]
- The evidence supports the use of targeted group-based parenting programmes to improve the emotional and behavioural adjustment of children aged 0–3 years and reduce conduct problems in that age group. The relative effectiveness of different parenting programmes (for example group-based versus self-administered) requires more research.
- There is also strong evidence to support the use of group-based parenting programmes, such as Incredible Years, to treat early signs of behavioural problems.
• For children with or at high-risk of developing ADHD there is strong evidence for the effectiveness of behavioural interventions in reducing child behaviour problems.

• There is evidence for the effectiveness of Stepping Stones Triple P as an intervention for improving child and parent outcomes in families of children with disabilities. [NEW]

• There is some evidence that group-based parenting programmes targeting adolescent parents are effective in improving a number of aspects of parent–child interaction both in the short- and long-term, but further research is needed.

• There is evidence that parent training interventions (including one-to-one, home-based, and small group) can improve the parenting knowledge and targeted skills of parents with intellectual disabilities/learning difficulties, and also improve child behaviour and health. However, there is a need for more and larger studies and for more evaluation of the impact on child outcomes and the generalisation of parenting skills.

• Recent RCT studies – not included in the systematic reviews – provide further evidence for the impact of parenting programmes in terms of reducing behaviour problems. They also provide evidence for the effectiveness of individual or group-based parent training on reducing child maltreatment in families at risk, and for the positive impact on behaviour of parenting programmes that address specific challenges (such as ‘fussy eating’ or mealtime difficulties, and divorce). [NEW]

**Supporting evidence: promotion of child development, including speech, language, and communication**

• Evidence in support of the Healthy Child Programme indicates that speech and language interventions that take place in preschool settings have a significant effect on mainly cognitive outcomes, but also social skills and progress within school.

• Interventions aimed at improving vocabulary through instruction, such as dialogical reading and storybook reading, have a large effect on vocabulary measures, especially when delivered by trained professionals. However,
middle- and upper-income at-risk children are significantly more likely to benefit from vocabulary interventions than those children also at risk and from low-income families. [NEW]

- Early childhood education and care programmes aimed at young children from socially disadvantaged backgrounds have considerable positive short-term effects and somewhat smaller long-term effects on cognitive development. However, they cannot compensate completely for developmental deficits that are due to children’s socio-economic background.

- Parent-implemented language interventions are effective for young children with language impairments, showing a positive impact on children’s receptive and expressive language skills, receptive and expressive vocabulary, expressive morphosyntax, and rate of communication. [NEW]

- Speech and language therapy (SLT) interventions for children with primary speech or language delay or disorder have mixed effects, which include a positive effect for children with expressive phonological and expressive vocabulary difficulties. [NEW]

- There is limited evidence of the effectiveness of home-based interventions (such as home visiting programmes) that are specifically targeted at improving developmental outcomes, such as cognition and intrapersonal development, for preschool children from socially disadvantaged families. The Nurse Family Partnership seems to be an exception to this statement. [NEW]

- Recent RCTs (not included in the systematic reviews) that evaluated the effectiveness of interventions aimed at improving young children’s speech, language and communication show evidence of a positive impact for some (though not all) interventions aimed at helping parents to read to, and use enriched language with, their children. They also show a generally positive effect for interventions aimed at supporting teachers to work more effectively (through training and/or new curricula). The interventions are mostly targeted, either at socio-economically disadvantaged children or at children with signs of difficulties in the areas of speech, language or literacy. [NEW]
Social, emotional and cognitive development

- There is evidence that programmes that aim to improve young children’s self-control are effective for improving self-control and reducing problem behaviours.

- Home visiting interventions for at-risk families show positive benefits, including for parent–child interaction, parenting behaviour and children’s cognitive and socio-emotional development. NICE guidance on social and emotional wellbeing in the early years (NICE 2012, guideline PH40) recommends that health visitors or midwives should offer a series of intensive home visits by an appropriately trained nurse to parents assessed to be in need of additional support. Activities should be based on a set curriculum and cover issues such as maternal sensitivity, home learning and parenting skills.

- There is moderate evidence that programmes in educational and day care settings for young children can have a positive impact on various outcomes, including cognitive development, school readiness, behaviour and attainment. NICE (2012) recommends that children’s services (including health visitors) should ensure that all vulnerable children can benefit from high-quality childcare outside the home on a part- or full-time basis and can take up their entitlement to early childhood education, where appropriate. Services should aim to enhance children’s social and emotional wellbeing and build their capacity to learn.

Identifying families with additional needs

- A range of factors indicate that children may need additional support with language and communication in the early years, including low income, low level of maternal education, low birthweight, and parental substance misuse.

- A range of factors indicate that children may need additional support with socio-emotional development in the early years, including speech and communication difficulties, parental substance misuse, and intimate partner violence. Relevant professionals (including health visitors) should engage in outreach activities to reach vulnerable families.
• NICE (2012) recommends that health professionals in antenatal and postnatal services should identify factors that may pose a risk to a child's social and emotional wellbeing (including factors that could affect the parents' capacity to provide a loving and nurturing environment). They should discuss with the parents any problems they may have in relation to the father's or mother's mental health, substance or alcohol misuse, family relationships or circumstances and networks of support.

Implementation issues
• There needs to be a closer relationship between speech and language therapists, teachers and parents to increase the chances of speech and language interventions being successful.
• Barriers to involving parents in interventions to improve young children’s social, emotional and cognitive development include a lack of parental knowledge about the content and potential benefits of services and a lack of programme flexibility.
• A range of approaches can enhance parents’ ongoing commitment to home visiting interventions, including home visitors being flexible to parental needs in terms of delivery, and tailoring programme content based on parental needs.
• NICE (2012) recommends that health and early years practitioners are systematic and persistent in their efforts to encourage vulnerable parents to use early years services. Examples of recommended activities are targeted publicity campaigns, sending out repeat invitations, and home visits by family support workers.

Workforce skills and training
• Speech, language, and communication interventions need to be implemented by individuals who have received appropriate training.
• For home visiting programmes, the more structured and intensive interventions (with a focus on child–mother interaction) delivered by specially trained nurses during the first 18 months appear to be more effective in terms
of impact on vulnerable children’s social and emotional wellbeing than lower intensity and less structured interventions involving lay providers.

Implementation issues: identifying families with additional needs

- Early identification takes place over a period of time as the child develops and the parent builds trust in the practitioner, and as the practitioner is able to assess and analyse the information from an ecological perspective.
- Identifying families with additional needs involves the following: universal assessment points being used as an opportunity to promote wellbeing as well as to identify risk; the use of a partnership model of working; training the workforce, for instance to undertake promotional interviews and use a range of standardised assessment tools alongside their professional skills; and infrastructure arrangements to enable reviews to take place.

Matching needs and services

- Not all families are able to benefit from services being provided, so it is important to match needs and services.

Reaching the ‘hard to reach’

- Difficulties in engaging families, including both recruitment and retention, are one of the main reasons for interventions failing.
- There is evidence from the evaluation of parenting and child mental health programmes to suggest that brief, intensive engagement interventions that target both practical (e.g. schedules, transportation) and psychological (e.g. family members’ resistance, beliefs about the treatment process) barriers, at the point of entry to treatment, can be effective in improving engagement in early sessions.

Working with families, and family readiness to change

- One of the key factors in facilitating behaviour change is the relationship that programme staff are able to establish with the participating families. Such relationships need to be based on a partnership model of working – that is,
they need to be supportive, guiding, motivating, strengths-based, and consistent.

- A number of interventions have been developed to promote parent engagement with programmes by providing practitioners with core sets of skills to enable partnership and collaborative working.
- In addition to partnership working, the evidence suggests the importance of continuity in terms of the extent to which pregnant women and new mothers/parents are provided with the opportunity to establish a small number of key relationships.

Practitioner readiness and motivation to change

- A range of factors can affect a practitioner’s readiness to take on board the practices involved with the delivery of new ways of working and new services. This has implications for recruitment, training, and supervision.
- The design and introduction to practice of evidence-based ways of working need to take account of practitioners’ motivations (e.g. concern for social injustice, professional autonomy, desire to build relationships with families).

Fidelity

- Some local adaptation or co-construction to ensure that a programme is delivered in a culturally sensitive way can result in the most effective delivery. However, adaptation that involves core programme components being delivered sub-optimally or not at all is likely to diminish the impact.
- Various strategies are recommended to help strengthen implementation fidelity, including training, coaching and monitoring.

Workforce development

- Good recruitment, training and supervision are all core to the effective delivery of interventions.
- Further training will be required for many of the evidence-based ways of working that have been identified in this review. Skills training for the workforce on an ongoing basis should therefore be a major part of investment plans for trusts.
Cross-cutting interventions are outlined in Appendices A–D as these activities are relevant throughout the pathway.
Appendix A: summary of health visitor contributions to the health of children and their families – universal service

**Source:** Why Health Visiting? A review of the literature about key health visitor interventions, processes and outcomes for children and families (Cowley et al. (2013))

The key findings and discussion points are largely presented here verbatim with permission.

- The literature identified by Cowley et al. (2013) describes 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.

- Cowley et al. (2013) 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.

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16 To address the overarching question: 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? 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. Following review of all abstracts the number was reduced further to 49 papers that reported on empirical UK-based studies and from countries with services similar to health visiting.
Cowley et al. (2013) 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.

While 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 arise from organisational constraints, such as lack of time or requirements to deliver health-related messages at key times.

Summary of findings (taken directly from Cowley et al. (2013))

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

What is known about how health visitors deliver the universal level of the ‘new service vision’?

- The ‘health visiting orientation to practice’ 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:
  - The health visitor–client relationship
  - Health visitor home visiting
- 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.

**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 (i.e. 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.

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

**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 is 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 postnatal visit.
- There is evidence that mothers receiving monthly home visits are less anxious and use services more confidently, while antenatal and postnatal promotional
interviewing by specially trained health visitors is associated with improved mother–child interaction.

**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.

- 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
  - 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 (such as 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 (for example in postnatal depression and mother–infant attachment) but Cowley et al. (2013) 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. Validating the instruments will allow future research to assess any impact of the health visitor–parent relationship on child and family life.
Appendix B: summary of health visitor contributions to the health of children and their families: community services


The community level of service is about building and using capacity to improve health outcomes and leading the HCP for a population.

The key findings have been copied verbatim with permission and are presented below.

The core summarising question is ‘What is the health visiting orientation to practice, and how is this represented in service organisation?’

- To answer this, Cowley et al. (2013) focused on research drawn from both older and more recent qualitative and evaluative studies about how health visiting practice is delivered.
- Cowley et al. (2013) 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.
- They describe 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.
- They 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.
They 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.

Cowley et al. (2013) 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.

They highlighted the use of the term ‘persuasion’, 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.

**Exploration of how the health visiting service fits 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.
Exploration of how different workforce models in health visiting, influence effectiveness and service delivery

- Some studies explored the impact of multi-agency work and team composition and culture on service users, and Cowley et al. (2013) 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.

Exploration of 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).

- Cowley et al. (2013) 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, but which remains a hypothesis that has emerged from their analysis, which needs testing in research.
Appendix C: summary of health visitor contributions to the health of children and their families: safeguarding and child protection


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 relative paucity of research in this field, which is surprising given the importance and amount of health visiting time involved.
- Cowley et al. (2013) 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 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.

- 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.

The health visitor’s contribution to child protection is about ensuring that appropriate health visiting services form part of the high intensity multi-agency services to support 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.

- Health visitor’s 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**

• 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.

• 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.

• 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.

• Rather than relying on structured assessments, 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.

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 were reported.

• Reports about health visitors’ work where there is a child protection plan 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, but who receive a correspondingly lower share of their 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.
Concluding comment

‘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 multi-agency 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 uptake of specialist child protection training, while 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.’

Cowley et al. (2013)

Abuse and neglect

- There is insufficient evidence to support the use of one-to-one and group-based parenting programmes to prevent the reoccurrence of physical abuse or neglect in families where there is a history of this, although there is some, albeit limited, evidence that some parenting programmes improve outcomes associated with physically abusive parenting.

- There is evidence that home visiting interventions in early childhood for at-risk families lead to reductions in Child Protective Services (CPS) reports, accident and emergency visits, hospitalisations and self-reports of abuse, as well as improved adherence to immunisations, although there is some inconsistency in results across the programmes identified.

- Home visitation by paraprofessionals holds promise for socially high-risk families with young children, including in the area of reducing harsh parenting.

[NEW]
Identification of families with additional needs

- Objective\(^{17}\) risk assessments are the best way to identify families at risk of child abuse and neglect, and clinicians in contact with families during early child years (such as paediatricians, health visitors) are well positioned to conduct these. [NEW]

- Risk factors include: young age; single/first-time mother; history of child maltreatment; substance misuse; unemployment; and low socioeconomic status.

- Attention needs also to be paid to specific features of the family’s physical environment. NICE provides guidance on when to suspect child maltreatment (NICE 2009a, guideline CG89), and the associated care pathway outlines the actions health visitors should take if child maltreatment is suspected.

- NICE guidance on preventing unintentional injuries in the home among under-15s (NICE 2010d, guideline PH30) recommends that local authorities, safeguarding children services, and health and wellbeing boards should prioritise households at greatest risk, through the assessment of local needs, priority delivery, and equipping professionals with relevant materials/knowledge. [NEW]

- NICE (2010d) recommends that home safety is integrated into home visits (including by health visitors). Specifically, those undertaking the home visits should provide home safety advice and, if the family or carers agree, refer them to agencies that can undertake a home safety assessment and can supply and install home safety equipment that complies with recognised standards.

- Parents/carers should be encouraged to conduct their own home safety assessment using an appropriate tool. [NEW]

- High-risk families regarding child safety include, among others, those in rented or overcrowded accommodation with high levels of turnover.

\(^{17}\) We acknowledge that this is an ongoing activity carried out by health visitors throughout their interactions with children and their families.
Appendix D: summary of health visitor contributions to the health of children and their families: responding to seldom-heard groups


The core question was ‘What is the health visiting contribution to provision for vulnerable families and groups, or those with complex needs, who need continuing support?’

- Cowley et al. (2013) 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 organisational 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.
• 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 (such as 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.

• Additional supporting evidence: evidence-based home visiting programmes

• The HCP and Implementation Plan both emphasise the importance of evidence-based home-visiting programmes for vulnerable families.

• While FNP lay outside the remit of the WHV? review, other home visiting programmes were identified that provide evidence that health visitors are able to implement parenting programmes with fidelity.

• Each of the programmes reviewed achieved some significant benefits in key areas. These included 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 in the home environment.

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

• Cowley et al. (2013) 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.

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

- Cowley et al. (2013) 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.
- They 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 (such as finding it difficult to manage limited resources in balancing attention to the baby with attention to the mother) and in developing policies (including 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.
What is known about how health visitors work with families living with domestic violence?

- According to Cowley et al. (2013) 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.
Appendix E: NICE guidance referred to in the Healthy Child Programme evidence document


