THE DEVELOPMENT AND VALIDATION OF TOOLS TO MEASURE THE PARENT/HEALTH VISITOR RELATIONSHIP

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Abstract

Research Question: Is it possible to measure the parent/health visitor relationship?

Aim: To develop and validate tools to measure the parent/health visitor relationship.

Background: The helping relationship has been the subject of intense scrutiny in other helping professions, particularly psychotherapy where research has shown that it is crucial to positive outcomes for the client. Although health visitors assert that their relationships with parents are also of paramount importance to outcomes, no tools to measure these relationships exist.

Methods: An extensive literature review of measures used in other helping relationships across a number of helping professions was carried out to identify their suitability for use in the parent/health visitor relationship. No appropriate measures were found. Stimulated recall interviews were carried out with six parents and health visitor dyads. These were analysed thematically in order to identify indicators of good working relationships. Once identified, TELER dichotomous questionnaires were developed and piloted in the community with 11 health visitors and 36 parents across three Primary Care Trusts and adjusted according to their comments. The newly devised TELER tools were then used with 15 health visitors and 53 parents. The data were analysed using the TELER method and a statistical interpretation made.

Results:

The outcomes of the study were that indicators of the parent/HV relationship were shown to be measureable together with five major contributions to health visitor knowledge and theory development:

1. Identification of the HV micro-skills and qualities involved in forming working relationships with parents.
2. Identification of the parental contribution to the HV working relationship in terms of their qualities and skills.
3. Identification of the health visiting process.
4. The creation of valid instruments to measure these relationships.
5. The creation of a valid instrument to measure the impact of organisations on HV and parent working relationships.
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Chapter 1 Background

1.1 Introduction

The year 2012 saw the 150th anniversary of the founding of the Manchester and Salford Ladies Sanitary Reform Association in 1862, which is widely regarded as the forerunner of the modern health visiting service (While 1987). Originating in the 19th century philanthropic public health movement, British health visitors [HVs] provide a universal, health promoting and supportive service to all families with new babies, maintaining contact with them until the infant is of school age. Since their beginnings in Victorian Britain they have had unparalleled access to the homes of all families with new babies with the Notification of Births Acts of 1907 and 1915 laying the foundations for the development of modern-day health visiting (Bidmead & Cowley 2008).

The service has gone through various transitions as it has developed. Prior to 1974, Local Authorities employed HVs under local public health departments. With the transition to the health service came attachment to General Practices [GPs] in the 1980s and a loss of the community and public health aspects of their work (Smith 2004). Practice became focused on the individual family and followed a medical model of service delivery that identified problems and reacted as appropriate. However, in the late 1990s HVs were encouraged to develop a ‘family centred public health role’ (Department of Health 1999). This and declining numbers of health visitors has led to an adoption of skill-mix teams and corporate working. Cowley et al. (2007) found that an increase in the variety of staff within health visiting teams led to more group work in the community. However, a study of health visiting support and group support (Wiggins et al. 2004) found that the take-up of home visits from support HVs was 96% compared with 19% take-up of community groups.

The early development of the health visiting service was patchy due to the lack of central government control or strategy (While 1987); each local authority decided what they would do in their area. The same is true now of the approach to health visiting on a national basis with devolution of responsibility for health to each of the four countries comprising the United Kingdom.

As each country is developing the health visiting service in a slightly different way a policy review was carried out to examine differences and overlaps in the health visiting services. A search was made of the devolved Government websites for relevant policy documents and the Community and Practitioners Association professional officer for Scotland, Wales and Northern Ireland was
contacted to ensure that the relevant documents had been retrieved. Although the services in each country were different they nevertheless, all acknowledged that HVs have an important role in improving health and reducing health inequalities.

In England the care that HVs provide is laid out in policy through the Healthy Child Programme (Department of Health 2009) and the recent Health Visitor Implementation Plan (Department of Health 2011). Here the focus is on building the workforce so that by 2015 there are 4,200 more full-time HVs in post. They will deliver a new service that comprises: a community intervention, a universal service to all parents with a child under five years, a universal plus programme for families experiencing short-term difficulties and the universal partnership plus service for families with complex needs (Department of Health 2011). Each level of service reflects a greater level of health visiting team input.

In Northern Ireland the Healthy Futures 2010-2015 document (Department of Health Social Services and Public Safety 2010) is the strategy driver. HVs are moving from independent working to leading skill mixed teams. The new organisation will be integrated with school nursing providing a seamless service for 0-19 year olds. It follows a model of progressive universalism, which has a universal team to deliver the child health promotion programme and identifies those families most in need. The skill mix team,

‘enables those with the greatest skill and competence to work with families with the most complex and challenging needs. All members of the team work collaboratively with each other to ensure best use of the team’s range of skills’ (Department of Health Social Services and Public Safety 2010 p.36).

In Scotland the Government has produced pathways of care for universal services and for vulnerable families (The Scottish Government 2011). The HV is designated as the named person for the care of the family after handover from the midwife. There is a paragraph at the end of the guidance document about developing the skills of the workforce and states very clearly that,

‘the most effective approaches and methodologies are more likely to achieve their potential when parents are partners in the endeavour rather than being coerced’ (The Scottish Government 2011, p.34).

There is less emphasis on skill-mix or on HVs leading teams, although in the Starting Well (Greater Glasgow NHS Board 2006) projects, which aimed to target children in areas of greatest deprivation, HVs were designated leaders of multi-disciplinary teams.
In Wales the focus is firmly on the Flying Start intervention for the most deprived communities, with the Welsh Assembly investing heavily in the programme (Welsh Assembly 2009). Here the centre of attention is children aged 0-3 years living in areas of greatest deprivation. Health visiting caseloads do not exceed 110 children per HV. The Flying Start guidance particularly notes that,

‘Other health professionals should not be counted into this ratio’ (Welsh Assembly 2009, paragraph 30).

The reduction in caseload size is to facilitate a greater number of contacts between the HV and parent and therefore supports relationship building between them. There does not appear to be a strategy for the universal services delivered by HVs.

Although it is interesting to note these differences to service delivery between the countries of the United Kingdom, this study is set in the English context. However, the long-standing debate about whether health visiting serves its purpose best through a relationship-centred or problem-oriented approach (Orr 1980; Robinson 1982) may be relevant to all of the four countries, but has resurfaced particularly in England in current practice, in two ways.

First, the national shortage of HVs has led to a plethora of different forms of team working and skill-mix, which is broadly approved in policies that promote the idea of HVs as leaders of teams, who delegate functions and families on their caseloads to team members (Lowe 2007; Department of Health 2009; Department of Health 2011). This approach embodies the problem-oriented approach, assuming that the HV can identify an issue to address, and then prescribe an intervention, which can be carried out by another team member. Relationships based on continuity of care appear to be deemed only necessary when working with families with medium to complex needs, the ‘universal plus or partnership plus’ level of service, (Department of Health 2011). This is unpopular with parents, who express a clear preference for being able to develop a relationship with a single HV, even where advice from the team is consistent (Russell 2008).

These conflicts in health visiting remain, as although the latest policy documents (Department of Health 2009; Department of Health 2011) in England appear to support the need for HVs to build relationships with parents, in practice there remains a huge emphasis on skill-mix.
The Department of Health (2009), itself appears contradictory in the approach that it wishes HVs to adopt; on the one hand advocating that HVs are leaders of the Healthy Child Programme (HCP) to be delivered in collaboration with others, whilst on the other, suggesting that,

‘a partnership with parents as key to effective delivery of the HCP’ [p 29].

It asserts that if this partnership is in place then,

‘the practitioner can take advantage of other effective techniques for promoting sensitive parenting, maintaining infant health or supporting health promotion more generally’ [p.29].

They suggest that the Family Partnership Model [FPM] (Davis & Day 2010) and Solihull approaches (Douglas & Brennan 2004) encapsulate this partnership approach, but that they are suitable for families identified ‘in the middle range of need and risk’. This appears to suggest that at the universal level of service delivery it is not necessary to work in partnership with parents.

Second, professional-client relationships appear increasingly relevant in this field, with rising awareness of the importance to mental health of the relationship between mothers, fathers and infants. It is suggested that continuity of care is particularly necessary for assessing the parent-child relationship (Wilson et al. 2008) and that parent-professional relationships are significant in intensive home visiting programmes (Olds et al. 2007).

To some extent this practice divide has also split the research community as to what might constitute the best evidence for health visiting effectiveness. The focus on a problem orientated approach leads to the provision of evidence of HV effectiveness for interventions to particular problems, for example childhood behaviour problems (Lane & Hutchings 2002). Investigators ask what the effectiveness of the HV trained in a behavioural intervention is on the outcomes of children’s behaviour problems. Answers result in establishing an evidence-base for an intervention but ignore the processes whereby the intervention is delivered.

On the other hand, a process approach to research asks questions about how HVs achieve positive outcomes. From enquiries such as these arise evidence to support health visiting practice. Evidence-based interventions may be necessary but how HVs work is also important for evidence-based practice. Elkan et al. (2000a p.229) suggested that research evidence linking health visiting process and outcomes was notably lacking and there appears to have been little progress since.
The parent/HV relationship is believed to be part of the process whereby the HV does the work of health visiting and there has been a wealth of qualitative studies exploring the parent/health visitor relationship (Chalmers & Luker 1991; De La Cuesta 1994; Collinson & Cowley 1998; Normandale 2001) many of which have been positive.

However, an important facet of health visiting work is the protection of children and vulnerable adults. This has led to theories of the nature of the ‘disciplinary power’ (Foucault 1976, 1979) exercised by the health visitor through relationships with parents being proposed (Bloor & McIntosh 1990; Abbott & Sapsford 1990; Dingwell & Robinson 1993; Peckover 2002). The notion of health visiting as a form of ‘social policing’ (Abbott & Sapsford 1990) develops out of its historical roots in the 19th century. Dingwell (1977) reminds us that only two in five army recruits were fit for service in 1902-3. The causes of the poor health of working class men were attributed to poor housing, pollution, poor diet, and a lack of health education. This led to a recommendation that a national health visiting service be developed to train mothers in ‘personal, domestic and infant hygiene’. The State needed fit and healthy men to fight wars and health visiting was considered as the appropriate vehicle to bring this about.

Whether the processes employed by health visitors at the turn of the century were considered supportive by mothers or whether they felt coerced by them it is not possible to tell. Nevertheless, there is evidence to suggest that in more modern times health visitors have taken a top down, authoritarian approach (Sefi 1985; Abbott & Sapsford 1990; Foster & Mayall 1990; Mitcheson & Cowley 2003) which parents have found disempowering.

However, it is theorised that openly coercive relationships do not have to be apparent for health visitors to exercise their role as a social police. Positive relationships with parents can also be a covert way of gaining entry into the private world of the family in order to carry out surveillance. Marcellus (2005) calls the ethical nature of such relationships into question within the realm of child protection. Indeed, Peckover (2002), draws attention to this ethical dilemma drawing on the work of Davies (1988) who identified the health visitor as the ‘mother’s friend’. This very informal relationship, it is asserted, disguises the real nature of the visit, which is to ‘ensure surveillance’ and take control of ‘private spaces of family life’ in a non-threatening way so as not to engender collective resistance.
However, the qualitative studies of health visiting of the 1990s identified a number of skills necessary for a positive HV/client relationship (Chalmers & Luker 1991; De La Cuesta 1994; Collinson & Cowley 1998). A review of these and other qualitative studies resulted in a definition of an effective parent/HV relationship as a:

‘respectful, negotiated way of working that enables choice, participation and equity, within an honest, trusting relationship that is based in empathy, support and reciprocity. It is best established within a model of health visiting that recognises partnership as a central notion. It requires a high level of interpersonal qualities and communication skills in staff who are, themselves, supported through a system of clinical supervision that operates within the same framework of partnership’, (Bidmead & Cowley 2005a p.207).

This kind of partnership relationship depends upon highly developed relational skills so that societal control of the family to protect children and allow the vulnerable much-needed support is not experienced as intrusive and threatening.

Research to determine the effectiveness of this relationship approach or whether a problem orientated approach to health visiting would be better has been hampered by the lack of a specific measure. Whether it is possible to measure such an elusive concept as the parent/HV relationship is unknown. The aim of this study, therefore, was to identify whether this would be possible by developing just such a measure.

More specifically it aims:

- To assess whether it is possible to measure indicators of the parent/HV relationship by:
  - Developing and validating an instrument for the measurement of the relationship between the parent and HV.
  - To assess the feasibility, acceptability and suitability of the TELER methodology among others for use in this field by:
    - examining existing tools relevant to measuring relationships between the parent and the helper, e.g. those used for measuring relationship development
    - identifying key processes used in the practice of promoting child health specifically focusing on effective parent/HV relationships
• developing and piloting indicators using the TELER format working in partnership with parent and HVs.

The premise for this chapter is that understanding how helping relationships are conceptualised is the key to the development of a tool to measure that relationship. Previous tools have been developed from different relationship theories but the concept of the ‘working alliance’ has been shown to be pan-theoretical (Bordin 1979). An important starting place, if a measure of parent/HV relationship is to be successfully developed, is therefore, to consider the theories underpinning helping relationships. The next section of the chapter sets out to build a clear understanding of the theoretical underpinnings of relationships so that the relevant factors can be identified and possibly extrapolated to parent/HV relationships.

1.2 Theoretical Considerations of the Helping Relationship.

According to the Oxford English Dictionary (OED 2012) a ‘theory’ is,

‘A scheme or system of ideas or statements held as an explanation or account of a group of facts or phenomena; a hypothesis that has been confirmed or established by observation or experiment, and is propounded or accepted as accounting for the known facts; a statement of what are held to be the general laws, principles, or causes of something known or observed’.

The explanations, ideas and accounts of helping relationships have been established and developed over time, lending clarification to the concept of the ‘working alliance’. It is therefore useful and important to consider the historical context of relationship theory.

1.2.1 The Historical Context of Relationship Theory

Understanding that the relationship is key to allowing a patient to explore his or her problems has developed from the work of Sigmund Freud (1940), the Austrian neurologist who is known as the founding father of psychoanalysis. He believed that a positive attachment to the therapist was a necessary prerequisite for a successful analysis, even though this was not seen as a ‘real’ relationship. Unlike Freud (1940), the early behaviour therapists emphasised the role of techniques to change behaviours rather than the centrality of the relationship in therapy (Horvath 2000). However, later therapists in this field, perhaps influenced by Freud, took a more positive view of the value of the therapeutic relationship seeing it as creating the context in which the patient felt safe and was able to trust the therapist enough to implement the behavioural techniques suggested as being beneficial (Horvath 2000).
It was the work of Carl Rogers (1959) that took the theory of relationships in therapy one step further than that of Freud or the early behaviour therapists asserting that the relationship itself was sufficient for therapeutic change to occur in the patient. Rogers (1959) advocated creating the necessary conditions of unconditional positive regard, empathy and congruence. He argued that it was the therapist’s relationship with the client that was important rather than the techniques they applied. This client-centred approach was the first that implied that it was the therapist alone who needed to be responsible for providing the conditions necessary for the client’s growth and development (Horvath 2000). This theory has given rise to research that has shown that the therapist-offered relationship is indeed the major means whereby clients are aided in many forms of helping endeavours. A positive relationship is correlated to positive outcomes. However, one of the most interesting outcomes from all this research has been the fact that it is the client’s subjective evaluation of the relationship rather than the therapist’s actual behaviour that has the most impact on the outcome of therapy. It is not the objectively measured congruence, empathy and unconditional positive regard that have the most powerful impact on therapy but the client’s perception of these qualities that is key to the positive outcomes of the helping process (Horvath 2000).

In psychotherapy recognition of the importance of the non-transferential relationship, the ‘real’ relationship, or working alliance, was emerging in the 1960s (Greenson 1963) and by the mid-seventies Edward Bordin (1979) had re-formulated the concept of the working alliance presenting it as generalisable across all helping relationships. Unlike Rogers (1959), however, he emphasised agreements and collaboration between the therapist and the client so that the responsibility for the relationship became two-way (Horvath 2000). Bordin (1979) identified three components to the relationship; the bond, the tasks and goals. From this construct of the working alliance many researchers formulated measures and the mounting evidence from research shows that the strength of the relationship that is created between the professional and the patient or client is associated with positive outcomes across a number of therapies, and is a robust predictor of therapy outcome (Horvath 2000; Martin et al. 2000). It is not the relationship that is therapeutic in itself but the ‘working alliance’ that makes it possible for the client to co-operate in therapy and follow the treatment plan (Bordin 1979). When considering a measure of parent/HV relationship therefore it was important to build on this construct of the working alliance.
Although the working alliance can be measured from three aspects; the client, therapist and observer, when considering all the research, it is the clients’ perspective on the relationship that is most accurate in predicting therapy outcome followed by observers and then therapists. Horvath (2000) explains this by theorising that the therapist comes to the relationship with knowledge of relationship theories and measures his or her relationship with the client against these expectations. However, the client comes with no knowledge of such theories but uses past experiences and measures this ‘here and now’ experience against these. The client’s knowledge and experience is clearly subjective and entirely individualised. Horvath’s (2000) other explanation is that therapists may fail to be sensitive to the client’s experience of the relationship. If therapists fail to notice that the relationship is not going well then there may be poor outcomes if steps are not taken to remedy the situation. Because the experience of the parent is highly individualised it was important that the newly developed measure be flexible enough to capture this individuality and be useful enough in practice to alert HVs to the possible difficulties that the parent might be experiencing in the relationship.

More recent research has examined the working alliance over time (Horvath & Bedi 2002). This work indicates that it does not follow that the longer the relationship lasts, the deeper the alliance. The length of the relationship is also not associated with the client experiencing successful outcomes or feeling better. A good working alliance needs to be established early in therapy [3-5 sessions] but the quality of the alliance is not constant over time. It has to withstand disruptions when therapist and client may not agree. It appears from the research that the alliance has to be established early on with mutual respect, trust and commitment and a sense of responsibility for the goals of treatment (Horvath 2000). If this is not established early on then the client may drop out of therapy or become de-motivated to invest the necessary energy in the change processes (Bachelor & Salame 2000). The question remains as to the generalisability of this particular theme within the parent/HV relationship. It may be that the HV has only limited time and will only see the parent a couple of times. This raises a key issue as to whether the HV is able to establish a good working alliance quickly enough to accomplish the goals of visiting.

From this point of view it is interesting to consider Horvath’s (2000) last point that although the concept of the working alliance is generalisable across all helping situations, it may be that some aspects of it are more important in some situations of helping than others. The early phases of the development of the relationship are likely to be very similar where the helper and client
collaborate and agree the helping process. However later phases of the relationship may be different depending on the tasks required of the client, the length of the intervention and whether the outcomes are broad or specific. A suitable measure needs to be sensitive to the nature of the parent/HV relationship in the community, in the family home, and to reflect the differing nature of some interventions i.e. that some maybe purely preventative and promotional whilst others maybe more therapeutic addressing specific problems and all may vary in their duration.

Other factors for consideration of the establishment of a working alliance early in the helping situation are those that influence the client’s or therapist’s ability to develop a good relationship. Research shows that the client’s early experiences and the quality of current relationships correlate modestly with the ability to develop a good working alliance early in therapy (Horvath 2000). These tend to moderate over time suggesting that the therapist works with these experiences with an awareness of the patient’s struggles, thereby facilitating a working environment, which ensures that the client remains in therapy (Horvath 2000). The severity of the client’s symptoms may also interfere with the development of the alliance but this particular variable seems to be relatively independent (Gaston et al. 1988). It is thought that strengthening the alliance may compensate for the client’s symptoms. Nevertheless, when developing the measure of parent/HV relationship it may be useful to collect some evidence of parental problems.

Therapist factors may also interfere with the establishment of the working alliance (Barrett-Lennard 1962; Horvath & Bedi 2002). It appears that the amount of training a therapist has may not be related to the ability to form positive relationships. However, less qualified therapists are more likely to misjudge their relationships than more qualified therapists (Horvath 2000). Interestingly though, training to help therapists in relationship development has not been very successful and researchers speculate that this may be to do with the therapists own early relationship experiences and unresolved relationship difficulties. Attention to the relationship within the therapy session is likely to improve the alliance in most therapies (Horvath 2000). In developing the tool it was considered expedient to gather information about the training and experience of the HV involved as a possible variable.

Research on the working alliance has been plentiful but the different theories of relationship have given birth to different methods of researching them and different outcomes have been measured.
It is therefore important to consider a theory of relationships to identify one which sits well within health visiting. The next section of this chapter explores these theories.

1.2.2 Theoretical underpinning of measures

McGuire et al. (2001) identify six central theories that have been used in research that examine the therapeutic relationship: role theory, psychoanalysis, social constructionism, systems theory, social psychology and cognitive behaviourism. They noted that there was a link between a particular relationship theory, the research methods used the development of instruments and outcomes measured [Table 1-1].

Table 1-1 offers a summary of the different theories of relationship based on the work of McGuire et al. (2001). It can be noted how the theories result in different methods of research and outcome.
Table 1.1. Summary of Theories of Relationship [based on McGuire et al. 2001]

<table>
<thead>
<tr>
<th>Theory</th>
<th>Definition</th>
<th>Methods</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role theory</td>
<td>Identities that define a commonly recognised set of people by their functions or behaviour patterns within a social context.</td>
<td>Investigates repeating patterns across people, situations and time explained by roles and each person’s understanding of them. Conversation analysis in medical practice. Rating scales in psychiatry.</td>
<td>Patient and professional passivity leads to non-compliance, high early drop-out rate. Collaborative approach in psychiatric settings, leads to increased treatment adherence, patient satisfaction, positive self-rated changes in condition.</td>
</tr>
<tr>
<td>Psychoanalysis</td>
<td>Difficulties experienced by the person regarded as the result of early life experiences. These are perpetuated in newly encountered relationships. Three types of relationship, the transference, developmentally reparative &amp; real relationships.</td>
<td>Kelly grid and rating scale methods in psychotherapy. Patient attachment styles-Relationship Questionnaire. Psychotherapy status report Scale to Assess the Therapeutic Alliance California Psychotherapy Alliance Scale.</td>
<td>Patient earliest relations predicted therapeutic alliance ratings. Internalised comparisons of mother/father images with therapist affected alliance ratings. Securely attached individuals form strong bonds with counsellor, fearfully attached do not. Extent of patient engagement in ‘real’ relationship with therapist - better patient outcomes in psychotherapy and psychiatry.</td>
</tr>
<tr>
<td>Social constructionism</td>
<td>Events are constructed within relationships &amp; expressed through language. Identities are co-constructed by the people involved. Problems are examined within socio-cultural-political context</td>
<td>Research focus on patients &amp; professionals’ constructs of their identities in relation to one another. The Narrative Process Model – a coding system to identify and evaluate organisational processes and represent sense of self. Participant text- letter writing, journal. Conversation analysis in GP practice.</td>
<td>Asymmetry in doctor/patient relationship. Focuses on the process by which asymmetry is accomplished i.e. the role expectations that they bring to the encounter.</td>
</tr>
<tr>
<td>Systems theory</td>
<td>Relationships considered part of a complex system of relationships</td>
<td>Two part question assessing relational differences toward patient illness. Descriptive clinical case studies.</td>
<td>Differences in attitude to illness between key relative and professionals predict better outcomes among depressive patients. In medical practice patients may seek a ‘compensatory alliance’ with Dr for deficits in family system.</td>
</tr>
<tr>
<td>Cognitive behaviourism</td>
<td>Focus on link between belief systems and behaviour. Difficulties are regarded as dysfunctional patterns of thinking and behaviour.</td>
<td>Investigated using two concepts: 1. The self-concept, 2. The causal schemata. Behaviourists focus on reinforcing patterns of behaviour through conditioning. Techniques to identify positively and negatively reinforcing behaviours in therapeutic interactions. 'Coached client' method developed to rate client interactions with counsellor from 'very low rapport' to 'very high rapport'</td>
<td>Resistance to incorporating mental illness into the self-concept, barrier to effective care. Causal schemas investigated professional approaches to patients on the basis of perceptions of patient responsibility for their illness. Medical students more willing to prescribe drugs to patients viewed as victims of unmanageable life stressors than to patients whose illness was viewed as self-inflicted. Hospital staff may provide more or less help for some patients dependent on their view of ‘deservingness’.</td>
</tr>
</tbody>
</table>
The example of the role theory of relationship is developed further below [1.2.2.1] as it has had an influence on some health visiting research already. This theory focuses on the roles, as defined by functions of people involved within a particular social context. Four different styles of communication behaviour have been identified; paternalistic or expert, consumer based (McGuire et al. 2001), collaborative or partnership (Davis & Day 2010), and transplant (Cunningham & Davis 1985).

1.2.2.1 Role Theory

In the paternalistic or expert relationship the role and authority of the professional is paramount and the patient is the passive recipient of his or her expertise. The professional decides what information is required and asks closed questions to elicit this in order to make a diagnosis. They give advice on what should happen as a consequence and may even carry this out where medical procedures are involved. The professional dominates and the patient remains passive (Davis et al. 2002a).

The consumer based model is characterised by an emphasis on the authority of the patient and the passivity of the professional (McGuire et al. 2001). The interaction is dominated by the patient who asks most of the questions and makes most of the decisions (Ong et al. 1995; Roter & Larson 2001). The consumer-based model was prevalent in the early nineties within health visiting and so the language of the profession referred to the ‘HV and the client’. This puts the parent in the role of a consumer of health visiting services. In this study, the ‘client’ will be referred to as the ‘parent’ as the word ‘client’ already presupposes a relationship and role within the relationship.

The collaborative or partnership model of relationship is characterised by equity in the interaction where patient and professional combine their expertise or resources and equally contribute to the information, share the decision making process and work together towards a common goal (Roter & Larson 2001; Davis et al. 2002a).

The transplant model of interaction identified by Cunningham and Davis (1985) is really a variant of the expert or paternalistic model but adds a quality of sharing, recognising the advantages of parents working with their children. They are provided with the expertise by the professional who teaches the parent their skills and knowledge. These are expected to take ‘root’ and ‘grow’ effectively to the benefit of the parents and hence their children (Davis et al. 2002a).
research methods used to understand the relationship from this perspective aim to investigate repeating patterns from the people involved. Their context is explained by the roles performed and each participant’s understanding of them. To this end, conversation analysis has often been utilised. There is evidence of this approach in Primary Care where doctor/patient and parent/HV relationships have been assessed using conversations analysis (Roter 1977; Falkum & Forde 2001; Cowley, et al. 2004). In psychiatry, a quantitative rating scale has also been used (Geller et al. 1976).

The collaborative or partnership model was shown to be associated with positive outcomes in the community, in psychiatry and in general medical practice (Priebe & Gruyters 1999; Little et al. 2001a). The paternalistic or expert and the consumer models, however have been shown to correlate with negative outcomes such as non-compliance and early drop-out rate in psychiatry and medical practice (Geller et al. 1976; Britten et al. 2000).

The theories of the therapeutic relationship have been helpfully synthesised by Cahill et al. (2008) who reviewed eighty-three therapist-patient measures of relationship and were able, as a result, to build a conceptual map of therapist/patient interactions. They identified three developmental processes necessary for the provision of an effective therapeutic relationship: ‘establishing a relationship’, ‘developing a relationship’ and ‘maintaining a relationship’. They were able to identify the processes and objectives of each phase of the relationship [Figure 1-1]. However, it is not certain that this model translates into the health visiting context. There is no doubt that, given all the factors noted above, a theoretical understanding of parent/HV relationships is important to consider prior to instrument development.
<table>
<thead>
<tr>
<th>Processes</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploration</td>
<td>Openness to therapy process</td>
</tr>
<tr>
<td>Reflection</td>
<td>Trust in therapist</td>
</tr>
<tr>
<td>Secure base-client feeling safe in relationship</td>
<td>Commitment to work with therapist</td>
</tr>
<tr>
<td>Feedback-particularly positive feedback-positive reinforcement.</td>
<td></td>
</tr>
<tr>
<td>Relational interpretations- addressing themes and links in stories.</td>
<td></td>
</tr>
<tr>
<td>Non-verbal communications e.g. laughter and humour, silence</td>
<td></td>
</tr>
</tbody>
</table>

### Engagement Processes

<table>
<thead>
<tr>
<th>Empathy, warmth and genuineness</th>
<th>Expectancies-building positive expectations of therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negotiation of goals- reaching goal consensus</td>
<td>Intentions and Motivation for change</td>
</tr>
</tbody>
</table>

### Collaborative Framework – mutual involvement in the helping relationship

| Hope-therapists expressed hope for the usefulness of therapy |

### Support – tolerance and guidance

### Affirmation-mutual

### Threats

<table>
<thead>
<tr>
<th>Therapist Behaviour</th>
<th>Processes</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invasive</td>
<td>Self-reflection</td>
<td></td>
</tr>
<tr>
<td>Defensive</td>
<td>Metacommunication</td>
<td></td>
</tr>
<tr>
<td>Negative feelings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-disclosure</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Behaviour</th>
<th>Processes</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resistance</td>
<td>Flexibility</td>
<td>Satisfaction</td>
</tr>
<tr>
<td>Hostility</td>
<td>Responsiveness</td>
<td>Alliance</td>
</tr>
<tr>
<td>Negative feelings</td>
<td></td>
<td>Cohesion</td>
</tr>
</tbody>
</table>

### Relationship Challenges

<table>
<thead>
<tr>
<th>Repair</th>
</tr>
</thead>
</table>

Ruptures  
Misunderstandings

Figure 1.1. Conceptual Map of the Therapist/Client Relationship [based on Cahill et al. 2008]
1.2.3 Theories of Parent/HV relationships

The stages of the therapist/client relationship, shown in Figure 1-1 provides a potentially helpful framework for the parent/HV relationship, but the complete model may not translate into the health visiting situation as the following discussion demonstrates. The former is predicated on continuity of care by one therapist over a number of sessions whereas HVs working in the community may only see a parent on one occasion. That visit may, however, be all-important for the further take up of services should they become necessary and is dependent upon the HV being able to establish a relationship with the parent very quickly. The HV may not be working with the parent to address a particular problem, as the visit may be purely promotional and preventive. The relationship is not in these circumstances ‘therapeutic’ in the sense that it is not being used intentionally as a vehicle of treatment for a particular relational problem. The question arises therefore, as to what constitutes an effective relationship for these purposes. At present this remains relatively unknown and there has, consequently, been little attempt at measuring this elusive concept.

In a literature review of partnership working to engage the client and HV, Bidmead and Cowley (2008) suggested that the closest theory that the health visiting profession has to a theory of their working relationships may be found in the Parent Adviser Model, now called the Family Partnership Model [FPM] (Davis et al. 2002a; Davis & Day 2010).
Briefly, this model specifies a set of overarching outcomes to be achieved [e.g. to do no harm, to enable parents] and provides a framework of the process of helping as a set of tasks. These include, the building of an effective relationship, exploring issues from the family’s perspective, developing a clear understanding of the problems experienced, agreeing aims/goals, planning strategies, supporting their implementation and reviewing the outcomes [Figure 1-3]. The nature of an effective helper/parent relationship is made explicit as a partnership, which involves working closely together, sharing power, using their mutual expertise, showing each other respect, clear communication, and negotiation of differences and searching for agreement on all aspects of the work together. Within the model, helper qualities are also defined to enable the development of this working partnership [i.e. respect, empathy, genuineness, personal integrity, humility and quiet enthusiasm] and the skills to implement these [e.g. active listening, focused attending, empathic responding, the skills of exploring and the skills of effective challenging]. Finally the model provides an understanding of how people adapt to their situations based on the framework of personal construct theory (Kelly 1955).

Many HVs have been trained in this model, which brings clarity to the elusive concept of parent/HV relationships that is helpful. This approach is advocated in the Healthy Child...
Programme (Department of Health 2009). Central to the Family Partnership approach is the helping process, which has been conceptualised simply in Figure 1-3 below.

![Diagram of the Helping Process](image)

**Figure 1-3. The Helping Process (Davis & Day 2010)**

For the sake of simplicity, and an understanding of the processes, the qualities and skills of the practitioner have been omitted in this representation of what occurs. The conceptual map of the therapeutic relationship [Figure 1-1], on the other hand, includes these as part of the process, which includes the formation, development and maintenance of the relationship. The difference between the therapeutic approach and the helping process illustrated in Figure 1-3 therefore, is the expressed intent of the therapist to use the relationship itself as the instrument of treatment. Through it the client comes to know themselves and how they relate to others. In health visiting the relationship has a much more utilitarian objective; that of exploring, and identifying health needs and facilitating the enhancement of health, which may or may not mean that a therapeutic relationship is required.

On occasions HVs may be required to establish a purely therapeutic relationship. This is particularly apparent when a mother is suffering from postnatal depression or may have other mental health problems. This therapeutic relationship may also be necessary in order to help
mothers and fathers recover from traumatic birth experiences or when a child is diagnosed with special educational needs or a serious medical condition.

As a HV may never know when she may need to be more therapeutic in her approach to parents it is therefore important that at all times she maintains a respectful approach and a listening ear. She or he needs to be able to demonstrate that they could be relied upon to support parents therapeutically if the need arose. The FPM training (Davis et al. 2002b) develops these skills in HVs and is a useful means of ensuring an effective relationship is formed with the parents.

The FPM (Davis & Day 2010) approach to health visiting formed the basis of a theory of parent/HV relationships for the purposes of this study. It provided a helpful foundation from which to further explore health visiting practice and identify any similarities or dissimilarities.

Although there are differences between the therapeutic relationship with clients in mental health settings and the HV relationship with parents, the measures that exist within the former provided an informative area of exploration.

1.3 Discussion

The evidence presented in this chapter clarified differences between the therapeutic relationships that therapists develop with clients and the relationships that HVs develop with parents. Nevertheless, it was important to bear in mind that the wealth of knowledge based on research about therapeutic relationships, has implications for the parent/HV relationship. This is particularly true for the research that shows that the strength of the early relationship in therapy is correlated positively with client outcomes. This early relationship in therapy is based on the expectation of continuity of care from one therapist over the course of a few weeks [3-5 sessions]. HVs may not have the luxury of so many contacts with a parent and so it is beholden upon them to endeavour to establish this relationship as early as possible, often in just one visit.

Bachelor and Salame (2000) show that if the early relationship [3-5 sessions] is unsuccessful then there is more likely to be client drop-out and de-motivation to invest the necessary energy in the change processes required. There is also evidence in mental health services that not being listened to and lack of participation in the decision-making process as reasons for disengagement (Priebe et al. 2005). In medical practice too, when the relationship was not experienced as collaborative but as a paternalistic or expert relationship then this was associated with non-
compliance and drop-out (Britten et al. 2000). If HVs are going to be effective in their practice then there is evidence from other professions that they need to be able to establish collaborative relationships with parents as quickly as possible. Parents have contact with the health visiting service for the first five years of their child’s life. During this time many issues may arise concerning the child’s health, development, behaviour or the parents’ health that may require the intervention of the HV. Only if the parent feels comfortable within the relationship with the HV is she or he likely to contact her and work towards resolution of difficulties or problems.

The research evidence on the experience and training of the therapist in relation to the alliance is ambivalent. Horvath and Bedi (2002) discuss this point, quoting Dunkle and Friedlander (1996), who found no relationship between the experience of the therapist and the quality of the alliance and Bein et al. (2000), who found that there was partial support for such a relationship. They explain this by quoting another study (Kivlighan et al. 1998) which found that more experienced therapists were better at developing an alliance with clients who found establishing relationships difficult. Clients who did not find relationships difficult did not show any differences in the strength of their alliances with experienced or inexperienced therapists. This may have implications for health visiting practice with families that are more complex. An experienced HV may be more adept at forming effective relationships with them than those newly qualified. It was therefore felt to be appropriate to gather data during the study as to the HVs’ years of experience as well as notes pertaining to the problems experienced by the family.

1.4 Conclusion

This chapter has described the motivation for this study and has set out the context of health visiting in Britain in which the parent/HV relationship can be further explored and a measure created. Psychotherapy literature and research has been reflected upon and provided a useful starting point when considering how to measure the parent/HV relationships. The development of a theory of parent/HV relationships draws on the foundation of the FPM as a useful framework on which to build. The following chapters reveal the steps taken in the creation of the measure of parent/HV relationship.
1.5 Overview of the thesis

Chapter 2: Review of the Measures of Helping Relationship and Facet Analysis

This chapter reviews a number of the most used measures of the working alliance from the mental health and psychotherapy literature. It also considers a number of measures from the fields of medicine, nursing and social work as well as more generic measures of relationship that are not profession specific. Throughout the chapter the relevance of each measure to the parent/HV relationship is considered as well as its validity and reliability. The chapter concludes with a facet analysis of the concepts measured within the instruments and considers the differences between the three perspectives of measurement from the observer, therapist and client. It is argued that no existing tool is equal to measuring the parent/health visitor relationship.

Chapter 3: Research Design and Methods

This chapter explains the rationale for the choice of methods used to meet the aims and objectives of the study. It demonstrates a systematic approach to the formation of the tool from a qualitative study to explore the parent/HV relationship to the synthesis of the qualitative data and the formation and piloting of the newly designed TELER questionnaires. Details of the study sites and samples are given and ethical issues addressed. The subject of rigour is dealt with explaining the credibility of the qualitative study and the validity and reliability of the new tools. Evidence of the research analysis paper trail is provided.

Chapter 4: Qualitative Analysis

This chapter provides detail of the in-depth analysis of the qualitative interview data. The analysis revealed a new model of parent/HV relationships based on the FPM. The detailed theory of the model is presented under the headings of the main components of the relationship i.e. the parent relational qualities and skills, the HV relational qualities and skills, the parent/HV relationship and the health visiting process. The influence of organisational issues on the abilities of parents and HVs to establish relationships could not be ignored and is also detailed.

Chapter 5: Distilling the Content of the Questionnaire Indicators

The interview data revealed a number of common themes in both the parent and HV data. This chapter begins with a comparison of these themes and those identified in the therapist and client measures in Chapter 2. The common themes are recognised and evidence provided for the
careful wording of the indicators on the questionnaires. Three sets of questionnaires were formulated, comprising one each for the HV and parent. The three sets were created for use at a first visit, for an established relationship and to measure the impact of organisational issues. Each section presents one of the six questionnaires with the evidence from the qualitative data and/or research literature supporting each of the relationship indicators.

Chapter 6: Establishing the Content and Construct Validity of the Questionnaires

The newly designed dichotomous questionnaires were subjected to a small pilot study to establish their construct and content validity. The chapter details the adjustments and refinements made to the indicators on the questionnaire because of the comments received from HVs and parents. Each section of the chapter begins with a presentation of the pilot questionnaire, demonstrates the evidence for changes made, and then presents the new questionnaire. Not only were the questionnaires piloted but the statistical tests that were to be used for subsequent hypothesis testing of the questionnaires were also assessed for their suitability.

Chapter 7: Questionnaire Analysis

The adjusted and refined questionnaires were subjected to a further pilot to test their construct validity through hypothesis testing. This chapter sets out the demography of the participants and the statistical findings of the quantitative analysis of each of the questionnaires. The statistical data are considered in tandem with field notes made at the time of questionnaire completion. This allows insight into the concurrent validity of the statistical analysis. Details of the quest for the clinical significance of the analysis are presented. The questionnaires prove to be valid and reliable instruments for measuring the parent/HV relationship.

Chapter 8: Critical Review and Conclusions

This chapter critically reviews the outcomes of this study in the light of the philosophical and methodological issues outlined in chapter three. The discussion supports the conclusion that the new measures for the parent/HV relationship are underpinned by theories of measurement and a new model of parent/HV working relationships and are appropriate for use in health visiting research and practice, following a rigorous research process. The strengths and limitations of the study are addressed and its contribution to health visiting knowledge and theory explored.
Chapter 2 Review of Relationship Measures

2.1 Introduction

This chapter is presented in two sections, the first being the review of the instruments to measure helping relationships, and the second a qualitative analysis of the components of the relationship measured by these tools.

As described in Chapter 1, since the time of Freud [1856-1939] the importance of the relationship between clients and their helpers has received greater attention as the therapeutic nature of the relationship has been realised. Consequently, enormous interest has arisen in developing tools that can measure this relationship to assess its importance in the outcomes experienced by the client. Starting in the psychotherapeutic community, this interest has spread to other helping relationships resulting in a plethora of different measures.

The following section of the chapter explores the tools developed and assesses their utility for measuring parent/HV relationships in the community. However, it is important to consider initially what is meant by measurement especially of a concept as intangible as a helping relationship.

2.2 Measurement – the concept

The psychophysicist Stevens (1946) defined measurement as:

‘The assignment of numerals to things so as to represent facts and conventions about them’. [p. 480]

Prior to this definition measurement had only been defined as a form of empirical quantification that could be accepted or rejected experimentally (Hand 2004). In nursing research terms, measurement has been described as the ‘rules for assigning numeric values to qualities of objects to designate the quantity of the attribute’ (Polit et al. 2001).

Hand (2004) quotes John Arbuthnot [1617-1735] who wrote:

‘There are very few things which we know, which are not capable of being reduced to a mathematical reasoning, and when they cannot, it’s a sign our knowledge of them is small and confused’. [p.5]

There is much knowledge about helping relationships as shown in Chapter 1 and so theoretically it is possible to measure them.
The notion of measurement necessarily involves the assignment of numbers. This is a straightforward process when counting objects or measuring length or weight or another physical property. A problem arises, however, when trying to measure something less tangible, such as a relationship. Stevens (1946) defined four levels of measurement in order to clarify the issue.

These were:

1. Nominal scale. At this level of measurement, numbers are used to classify things. Although numbers are often used, the items might also be classified with letters or other symbols.
2. Ordinal scale. At this level of measurement there is an ordering or ranking of the variables under scrutiny. There is a relationship between the numbered items.
3. Interval scale. Here the numbers are ordered and the intervals between the numbers can be ordered, but the interval between the numbers is constant, they are all of equal size.
4. Ratio scale. This is the same as an interval scale with the exception that there is an absolute zero, which means that there is ‘nothing there’.

Knowledge of these levels of measurement is important, as numerals do not necessarily equate to quantities. This means that appropriate statistical tests must be applied to the level of measurement being carried out. The statistical tests fall into two categories, parametric and non-parametric. Parametric tests are suitable for interval or ratio data only. Non-parametric tests are suitable for the nominal or ordinal data (Clegg 2001).

Researchers trying to devise measures of relationship between professionals and clients are forced, by the complexity of the phenomenon, into the position of having to make pragmatic choices as to the variables that will be chosen to measure it. Thus, the measure is never a true measure of a relationship but a measure of the variables that the researchers have decided will represent this relationship. Other researchers may combine the variables differently or choose other completely separate ones; the choice may be guided by common sense and dependent on the researcher’s theoretical background.

Over the last four decades there have been many so called, definitive measures of helping relationships devised. However, not only does the validity of the measure depend on an accurate defining of the attributes of the concept by the researcher, as explored in the consideration of relationship definitions [Chapter 1, 1.2], but also depends on whose view of the relationship is
measured. Whether it is the view of the therapist or helper, the observer/researcher or the client, may make a difference to the attributes measured. Even between the same two people different attributes may be important at different times and may not be constant across relationships for other people. This raises the question of how a standardised measure can be produced.

Each professional discipline has sought to measure the relationship that the therapist has with the client each devising a measure that is suitable for their particular agency or theoretical understanding. However, in spite of these differences of approach to the therapeutic relationship, there is an overall opinion that, it is the relationship with the therapist that brings about client resolution to his or her difficulties (Horvath 2001).

The many measures of relationship developed within the psychological therapies and other helping professions may or may not be useful in health visiting where there may be little acknowledgement of the relationship as having any therapeutic value. Therefore, prior to embarking on a quest to create such a tool, a comprehensive review of existing measures of relationship in a variety of settings was undertaken.

2.3 The Review

2.3.1 Aim

The aim of the review was to identify measures of relationship between professionals and their clients’ already in existence and assess their validity and reliability for use in community child health services provided by HVs working with parents.

2.3.2 Methods

The review was carried out between 2006 and 2008 to present an unbiased appraisal of the helping relationship measures. This was updated in 2011/12, and will be presented in a separate section [2.3.4]. The question the review sought to answer was: What measures of helping relationships already exist that may be relevant to measuring the parent/HV relationship?

2.3.2.1 Search Strategy

A systematic search of the Cochrane Library, PsycINFO, EMBASE, Medline and CINAHL and Journals@ovidfulltext was carried out. All were searched for relevant studies. Based on a facet analysis [Table 2-1], identical free text, MESH terms where appropriate, and truncations, were used on the searches of the databases. Terms were combined in the population group using the
Boolean operator ‘or’. The same procedure was performed to combine the intervention set of terms and again for the outcome terms. At this stage, the results were combined using the Boolean operator ‘and’ [Table 2-1]. Duplicates were removed and the results screened for appropriate items.

Table 2-1. Facet Analysis of Search Terms

<table>
<thead>
<tr>
<th>Population</th>
<th>Intervention</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist or</td>
<td>and Measure/s or</td>
<td>and Relationship or</td>
</tr>
<tr>
<td>Psychotherapist or</td>
<td>Scale/s or</td>
<td>Working alliance or</td>
</tr>
<tr>
<td>Psychiatrist or</td>
<td>Questionnaire or</td>
<td>Helping alliance or</td>
</tr>
<tr>
<td>Nurse or</td>
<td>Inventory or</td>
<td>Helping relationship or</td>
</tr>
<tr>
<td>Community nurse or</td>
<td>Rating scale or</td>
<td>Therapeutic alliance or</td>
</tr>
<tr>
<td>Health visitor or</td>
<td>Instrument or</td>
<td>Therapeutic bond or</td>
</tr>
<tr>
<td>Public health nurse or</td>
<td>Tools</td>
<td>Alliance or</td>
</tr>
<tr>
<td>Mental health nurse or</td>
<td></td>
<td>Bond</td>
</tr>
<tr>
<td>Community Mental health nurse or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric nurse or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helper or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor</td>
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<td></td>
</tr>
</tbody>
</table>

2.3.2.2 Inclusion Criteria

The following inclusion criteria were used for the review:

- The study described the formation of a measure of a helping relationship
- The study was a review of relationship measures
- That the study correlated the relationship between the helping professional and client in relation to outcome.
- The papers were in English.
- That the measures of relationship could be retrieved or was published with the papers describing their development.
Papers that were published up to January 2008. The starting date was kept open in order to maintain a wide search but the oldest retrieved was from 1969.

The studies that provided information about the development of the measure of relationship or about its performance in research were the most helpful. Overall there were 24 of these [Table 2-2]. 180 other papers described the helping relationship in relation to outcome. These were saved and reviewed as useful background reading to the study. The search was supplemented with papers from the reference lists of included papers or reviews found.

2.3.2.3 Quality Assessment

Although many of the measures that were included had reported validity and reliability scores some did not but were included because they had face validity and were used in a community context.

The reliability of an instrument is a determination of its accuracy. Papers were assessed looking for at least one of the three aspects of reliability. The aspects of reliability that were examined in each paper where applicable were:

1. stability as measured by the reliability coefficient determined by test-retest reliability,
2. internal consistency using Cronbach’s alpha or coefficient alpha, and
3. equivalence as assessed through inter-rater reliability.

The validity of the measure is the degree to which an instrument measures what it purports to measure. Papers were assessed for validity looking for at least one aspect of validity report, which may have been:

1. Face validity, which means that it looked as though it was measuring the appropriate construct.
2. Content validity – whether the chief attributes of relationship were covered in the measure. As there are no truly objective means for determining this it is ultimately the subjective judgement of experts that is relied upon.
3. Criterion-related validity – seeks to establish the relationship between scores obtained on an instrument and some external criteria. The validity is calculated producing a validity coefficient. Coefficients range between .00 and 1.00. The higher the score the greater the criterion related validity. Coefficients of .70 or higher were sought.
4. Construct validity. Attempting to measure an abstract concept such as a helping relationship is fraught with the difficulties of ensuring that the instrument is actually measuring that particular construct. As a result, some researchers used a statistical factor analysis approach to identify clusters of attributes on a scale and distinguish them from each other. However, like content validity it relies on the judgement of the researcher.

2.3.3 Findings and Critical Appraisal

Over all 24 measures were retrieved but some are examined together here, as they were by the same authors [e.g. Penn Scales and Vanderbilt Scales]. This meant that 18 scales were examined and critically appraised with regard to their validity and reliability and suitability for use within the community health and parenting support services [Table 2-2].

2.3.3.1 Scales used in Psychotherapy

Many scales of therapist/client relationships have been created in the field of psychotherapy. Because of the long history of relationship measure development and the extensive theories of relationship that underpin this development, this proved a fruitful source of knowledge.

The Vanderbilt Scales also known as the Toronto Scales [VPPS, VNIS, VTAS]

These scales were developed to measure psychodynamic properties of the alliance as well as Bordin’s pantheoretical model (1979).

The Vanderbilt Psychotherapy Process Scale (Suh et al. 1986) was created so clinical observers could rate a segment of therapy. The 80 items were rated on a five-point scale (O’Malley et al. 1983) but it was not explicitly designed to measure the alliance. It is lengthy to administer and formulated for psychotherapy relationships. For these reasons it is not suitable for use in health visiting.

The Vanderbilt negative interaction scales (Suh et al. 1986) were developed to explore negative effects in psychotherapy and therefore again not designed as a measure of relationship.

However, building on the previous work, Strupp and colleagues developed the Vanderbilt therapeutic alliance scale [VTAS] specifically to measure the alliance (Hartley & Strupp 1983). It consists of an observer scale for a segment of therapy for each of the 44 items rated on a six-point scale: 14 patient items, 18 therapist items, 12 items of patient-therapist interaction. There
are seven items specific to psychodynamic therapy which when adapted by others for use elsewhere has simply been omitted. This instrument is most suited to evaluating psychodynamically oriented therapies and requires highly trained therapists to apply the scale.

The scales showed excellent internal consistency Cronbach’s alpha .91, inter-rater reliability .83 and overall reliability .86 (Martin et al. 2000).

**The Penn Scales (Alexander & Luborsky 1986)**

These were one of the earliest developed measures of the therapeutic relationship and were based on Freud’s view of the transference process. They seek to measure the non-neurotic, friendly feelings between the patient and the therapist which Luborsky (1976) designates as the ‘Helping Alliance’. The scales acknowledge two main domains:

1. Type one signs which are the patient’s experiences of the therapist as helpful,
2. Type two signs which are the patient’s experience of treatment as a process of working together with the therapist towards the goal of treatment.

All of the scales developed by Luborsky et al. (1983) assess these two dimensions of the alliance. The overall reliability coefficient as reported by Martin et al. (2000) is .74 which is regarded as moderate. The test re-test reliability was poor at .55 and inter-rater reliability moderate at .68. There are three sets of scales assessing the alliance from the perspectives of the therapist, client and observer.

The Penn Helping Alliance Counting Signs method [HCA CS] uses a manual and transcripts in a lengthy analysis process so this may make it unsuitable for health visiting practice. However, inclusion of the two domains, the parent’s experience of the HV and the parent’s experience of the health visiting process, may be useful in a new measure of the parent/HV relationship.

The scales have been criticised for lack of conceptual clarity as not only do they contain items relating to the patient bond but also to the patient satisfaction which also covers outcomes (Gaston 1991). This served as a reminder to ensure conceptual clarity of the parent/HV relationship in this study.
The Barrett Lennard Relationship Inventory [BLRI] (Barrett-Lennard 1962; Barrett-Lennard 1986)

As was noted in Chapter 1, the work of Carl Rogers (1959) took the theory of relationships in therapy one step further than that of Freud by asserting that the therapist-generated conditions of the relationship were sufficient for therapeutic change to occur in the patient. The BLRI is clearly based upon the Rogerian core conditions of empathic understanding, congruence and unconditional positive regard. Its face validity is high when confirmed by Rogerian therapists as it covers all the core conditions. It has high reported internal consistency (Catty et al. 2007).

Unsurprisingly, as it was developed from a different theoretical model of relationship, it was found that this measure did not correlate with the Vanderbilt therapeutic alliance scale [VTAS] (Catty et al. 2007).

This measure is not suitable for use in health visiting because it only measures the therapist contribution to the relationship whereas, in health visiting it is recognized that health visitors and parents work together in a collaborative way (Davis & Day 2010). Therefore it will be necessary to capture the health visitor and parent perspectives.

The Working Alliance Inventory [WAI] (Horvath & Greenberg 1989)

Taking the pan-theoretical model of relationship developed by Bordin (1979), Horvath and colleagues developed the WAI to measure the alliance in all types of therapy. It was developed to measure Bordin's (1979) three aspects of the alliance [Chapter 1,1.2.1].

The instrument measures 36 items on a seven point scale. Different measures were constructed to assess the alliance from the patients’, therapists and observer perspectives. There is strong research support for this scale’s reliability .85 to .93 (Martin et al. 2000) and it has been extensively validated for use in psychotherapy (Catty et al. 2007). Factors within the measure are highly correlated so therefore they may not measure different elements of the relationship (Horvath & Greenberg 1989). The observer measure asks the rater to assess video-tapes in a lengthy process.
The Therapeutic Bond Scales [TBS] (Saunders et al. 1989)

This measure was based on Orlinsky and Howard’s (1986) model of psychotherapy which has three dimensions to the therapeutic bond: working alliance, empathic resonance and mutual affirmation. There is also a Global bond scale, which is the sum of the three subscales. Saunders et al. (1989) report shows research support for reliability of the scales.

Internal reliability of each subscale: \( r = .72 \) to \( r = .87 \) and the Internal reliability of Global Bond Scale \( r = .62 \). The Global Bond scale is somewhat lower in reliability than its component scales.

The scale was developed specifically to measure the patient’s experience of therapy. They are asked to rate this on a 21-point scale. Like many of the measures developed in psychotherapy the development of this instrument was based on a theory of relationship and on some previous work. It was not developed with patients.


These scales were formulated by Gaston (1991) in an attempt to develop a measure of the alliance, which removed the ambiguities of the concept from the scales, making a distinction between the ‘working alliance’ and the ‘therapeutic alliance’. The working alliance was conceptualised as the patient’s ability to change between observing and experiencing therapy. The therapeutic alliance was defined as the friendly and affectionate feelings that the patient had for the therapist (Gaston 1991).

This CALPAS-P consists of 24 items on a seven-point scale to measure four aspects of the alliance (Gaston 1991): working capacity to measure the working alliance, patient commitment to measure the therapeutic alliance, therapist understanding and involvement to measure the therapist contribution to the alliance and the working strategy consensus to measure the goals and tasks. The latter two concepts, goals and tasks, were combined as it seemed likely that when measured through the WAI they were indistinct. The scales showed adequate test-retest reliability and high inter-rater reliability. Two factors: the alliance and therapist influence highly correlated with the WAI-P and VTAS indicating that they were measuring the same concept.

The patient version was retrieved in this review from the published paper (Gaston 1991) but there are also versions for therapists and trained independent observers which were not available.
Client Reactions Systems (Hill et al. 1988)

The rationale for developing this measure was, that a previously used stimulated recall system of evaluating psychotherapy clients reactions to therapy, involved a process that was too lengthy and impractical for reviewing whole therapy sessions (Hill et al. 1988).

The system of measurement uses a video-tape of the interaction and then asks psychotherapy clients to rate reactions at different points of the tape. It lists 14 possible positive and seven negative reactions to the interaction. The validity and reliability of this system was not reported by the authors. Video-taping interactions and obtaining client and helper feedback on the tapes is a lengthy process. However, it may be a methodology ideal for a more qualitative approach to relationship understanding. Although a group of four patients were involved in the development of the system the items on the scale were predominantly developed by experts in the field.

The measure lists the client’s possible reactions to psychotherapists’ interventions, but this may not explicitly measure the relationship between them. However, the interventions of the therapists can have an impact on the relationship. Measuring subjective reactions may not be a very objective way of measuring the relationship.

2.3.3.2 Scales used in Psychiatry

Because the scales used in psychiatry have been adapted from psychotherapy these scales were examined to provide an example of how previous work in relationship measurement informs ongoing developments in other different but related professions.

Inpatient Treatment Alliance Scale [I-TAS] (Blais 2004)

This is a ten-item scale developed from a factor analysis of WAI, Penn Helping Alliance questionnaire and California Psychotherapy Alliance Questionnaire. It was developed to measure relationships within the psychiatric in-patient setting.

I-TAS measures three components of relationship: the primary bond [three items], goals [four items] and collaboration [three items]. It has reported strong psychometric qualities related to relevant outcome variables, strong internal consistency and adequate test-retest reliability (Blais 2004). Because this is an in-patient scale in its present format it is not suitable for use in the community but it could be adapted. I-TAS is based on the scales used in psychotherapy so
therefore intended to measure the therapeutic relationship which may or may not be useful in the context of health visiting.

The professional/patient relationship has also been measured in psychiatry using the psychotherapy measures without adaptation.

2.3.3.3 Scales used to Measure Nurse/Patient Relationships

HVs are all qualified nurses. It was therefore, considered important to reflect on how the nurse/patient relationship had been measured. Whilst there are differences in how nurses and HVs work the basic training is core to both professions. No measures of the nurse/patient relationship were found. However, empathy and caring may be concepts which are associated with positive relationships in health visiting and so were considered in this review.

Perception of Empathy Inventory [PEI] (Wheeler 1990)

This scale was developed from the BLRI as a patient rated measurement of nurse’s empathy by inpatients in a hospital setting. It consists of 33 items rated on a four-point scale. It has high reliability scores [Cronbach’s alpha .94] and item-to-item correlation [alpha .94]. Two experts in the field determined the content validity. Four patients determined the face validity of the scale. Empathy, as expressed by the nurse, has been shown to relax patients (Drew 1986) which was why the construct validity was determined by correlation with Spielberger State Anxiety Inventory used extensively in anxiety research. A significant relationship was determined with this inventory \[r = .52, p = .008\]. A Pearson Correlation was carried out for demographic variables. The scale focuses on empathy but some of the items cover other aspects of relationship e.g. hope, respect, listening. The emphasis is on the importance of the patient’s perception as this determines responsiveness even if a nurse measures high on empathic ability.

This is of importance to the present study as the empathy expressed and perceived within the relationship is of interest and not just the amount of empathy expressed by HVs. Only ten items were retrieved but the scale could be adapted for use in the community.

Nurse/Client Relationship Inventory (Barnard 1998)

The measure was developed from the Penn scales (Alexander & Luborsky 1986) to measure public health nurse relationships with clients in the community and so is closely linked to the quest for a suitable measure of parent/HV relationships in the UK. The nurses were specially trained to
work in the Early Head Start Programme in America. The scale consists of 27 items rated on a five-point scale. No statistical information was given regarding validity and reliability, but face and content validity were present. It is a community-based measure, which is easy to administer. However, it has some items, which may not translate well to UK health visiting. For example, there are two items that begin ‘my nurse praises me’; even if altered to ‘my HV praises me’ this does sound a little patronising or paternalistic. There is only a questionnaire for the parent and none for the nurse so only one perspective of the relationship is measured.

**Caring Professional Scale [CPS] (Swanson 2002)**

This scale was based on Swanson’s five items of caring theory. Caring was conceptualised as,

‘a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility’ (Swanson 1991, p.162).

The items measure knowing, being with, doing for, enabling and maintaining belief. This scale was created for use with patients cared for by nurses in hospital. It consists of 18 items rated on a five-point scale. Criterion validity was established by correlation with the BLRI \[ r = .61, p < .001 \] and internal consistency by Cronbach’s alpha .74 - .97. All the items on the scale seemed appropriate although the development of the scale was based on a nursing theory of caring. The author states that the measure has clinical relevance across settings, populations, and health care professionals so may therefore be adapted for use in the community.

**Caring Nurse-Patient Interaction Scale [CNPI] (Cossette et al. 2006)**

The short version of the Caring Nurse-Patient Interaction Scale [CNPI-Short Scale] is based on an explicit theoretical model, of nurse caring (Watson 1985). The short scale was developed after finding that the previous 70-item questionnaire was impractical in the research setting especially with severely ill patients. Some of the items on the previous questionnaire were also found to be non-independent.

The new short questionnaire measures four domains of care: humanistic care, relational care, clinical care and comforting care. The reliability coefficients of humanistic care scale are low 0.63-0.74, however for relational care 0.90 to 0.92. The scale validity, which was established by factor analysis, was very high [0.94]. Of the domains measured only relational care and humanistic care are suitable for consideration as components of a measure for use in the community as the other factors relate to medical treatment and care-giving.
Other measures of nurse caring (Coates 2002)

A review of 21 measures of caring in nursing (Coates 2002) found that most of these scales were based on theory and had a reasonable level of content validity. Often studies failed to report standard deviations for different groups but there were reasonably high levels of internal consistency reported [Cronbach’s alpha] for most scales. A factor analysis was only reported for about half the scales but more than half of them reported convergent or divergent validity. No studies were found that confirmed the measure’s predictive ability.

Caring as a concept is of interest in this review but only as factor that may facilitate the relationship between the parent and HV. For this reason, although it may have been possible to access all the measures in the Coates review (2002), this was not done as it was evident from accessing the two selected instruments that these would be of limited use in measuring the parent/HV relationship.

2.3.3.4 Scales used to measure Doctor/Patient Relationships

HVs can be considered as part of the Primary Health Care team often working with or alongside general practitioners [GPs]. For this reason, it was hoped that how the doctor/patient relationship had been measured might throw light on how the parent/HV relationship might be measured.

Relational Communication Scale for Observational Measurement of doctor/patient interactions (Gallagher et al. 2001)

This is an observational scale developed for rating relationships between doctors and their patients in America. It consists of 34 items covering six domains rated on a seven-point Likert scale. The domains are immediacy/affection, similarity/depth, receptivity/trust, composure, formality and dominance. The internal consistency was reported as strong but not for dominance. There was inter-rater reliability for formality and dominance scales but the construct validity was not statistically significant for formality or dominance. The main drawback of this scale is that it requires specially trained raters of the video interaction.


This is another observation method for coding interaction processes between doctors and their patients and is interesting as it includes non-verbal as well as verbal responses to assess micro and macro-features of interaction. It was developed specifically as a measure of relationships
between oncologists and patients with cancer. Patient codes and doctor codes are analysed for mode, content, and affective global categories. The validity and reliability of the system was tested twice. The inter-rater reliability of the first data set was: mode, patients 0.96, doctors 0.94, content, patients 0.98, doctors 0.97, affective global categories, patients 0.96 and doctors 0.94. For the second data set the inter-rater reliability was: mode, patients and doctors 0.88, content, patients 0.91 and doctors 0.95. The convergent validity was assessed by correlating comparable content categories with RIAS [Roter Interaction Analysis Scale] (Roter & Larson 2001), a well-validated scale to measure doctor/patient relationships in primary care [Spearman rank coefficients exceeded 0.50]. This indicated a good level of concurrence between the behaviours measured by the two interaction systems indicating a level of construct validity.

Although the RIAS (Roter & Larson 2001) was retrieved it was not included in this review. It is a highly complex system of coding audio-taped doctor/patient interaction utterance by utterance exploring not only content but also the tonal voice quality giving access to the affective element of the interaction. There are 40 categories used for coding. The one direct category regarding the relationship of partnership is coded for the doctor only. This is a major drawback to the use of this system as psychotherapy research has shown that it is the client's view of the relationship that is most related to outcome (Constantino et al. 2002). As with the other medical interaction scales the focus is on the processes of interaction and although there is a relationship component to the scale this appears to be a very small part of the whole.

2.3.3.5 Scales used to Measure Social Worker/Client Relationships

Social workers often work in the community with the same complex families as HVs. How their relationships with these families have been measured was explored to throw possible light on how parent/HV relationships might also be measured.

Helping Relationship Inventory for Social Work [HRI] [worker version] (Poulin & Young 1997)

Although most social work texts stress the importance of the helping relationship it appears that in Social Work theory and literature there is no operational definition of the concept of the helping relationship (Poulin & Young 1997).

This instrument assesses the strength of the helping relationship in social work. It has two versions; one for the client [HRI: C] measuring client perspectives of the relationship and one for
the worker [HRI: W] measuring the relationship from the social worker perspective. Each measure has two domains: a structural index pertaining to the helping process; ten items rated on five-point scale and an interpersonal index; ten items rated on five-point scale. However, unlike many other measures, in psychotherapy, for example, the authors did not create parallel measures building on the idea that both client and worker may have different views about what is important in the relationship as intimated by Horvath and Greenberg (1994).

Both the client and worker versions of the inventory have acceptable reliability and validity estimates. The structural index of the HRI: C had a reliability score of alpha coefficient .91. The interpersonal index HRI: C had a reliability score of alpha coefficient .96. Overall the combined 20 item HRI: C had an alpha coefficient of .96. The structural index of the HRI: W had a high reliability score [alpha coefficient .86 and the interpersonal index of the HRI: W had an alpha coefficient score of .91]. Overall, the 20 item HRI: W had an alpha coefficient of .93.

Validity of the HRI: W and HRI: C was established using the WAI (Horvath & Greenberg 1989) which already had an established validity as a measure of the therapeutic alliance. The HRI: W and HRI: C were highly correlated with the WAI .84 [\( p < .001 \)]. Construct validity was also established through a factor analysis which supported the author’s conceptualisation of social work practice as a collaborative effort involving both structural and interpersonal components.

The notion that there may be differences between workers and client’s perceptions of the helping relationship and helping process was supported by a factor analysis. This approach was important to the development of an instrument for use with parents and HVs. The questionnaire looks easy to administer and could be adapted for use with parents and HVs.

### 2.3.3.6 Generic Scales of Helping Relationship Measurement

Generic measurement scales seek to measure all helping relationships and purport to be useable in a number of different contexts. Just one such measure is reviewed here as it is one of the oldest and best-known scales of its kind.

Because the expression of empathy within a relationship may be crucial to its development and maintenance, these well-used scales were reviewed to judge their suitability for use in measuring the parent/HV relationship.
Scales for the assessment of interpersonal functioning (Carkhuff 1969)

This observation tool measures the observer’s perception of empathy, not demonstrated skill. Empathy is important in the formation of the helping relationship and almost all of the other scales attempt to measure this. These scales assess interpersonal functioning: empathic understanding, communication of respect, facilitative genuineness, facilitative self-disclosure with personally relevant concreteness of specificity of expression, and confrontation. It has been validated in extensive outcome research (Truax & Carkhuff 1967). It has good inter-rater reliability \( r = .84 \) inter-rater correlation coefficient.

2.3.3.7 Scales used to Measure Parent Satisfaction with Services

Many of the parent advisers who worked in the Parent Adviser service [now re-designated the Family Partnership Model] were HVs (Davis & Spurr 1998). This tool was used in the evaluation of this service. As it has already been used with parents who were working with HVs this tool was examined as to its utility in measuring the relationship.

The Parent Adviser Service Satisfaction Questionnaire (Davis & Spurr 1998)

This scale was included as a measure of relationship as it was developed by Davis whose theory of relationship, defined as a partnership, has widely influenced the delivery of health visiting and parenting support services in the UK, Finland and Australia [Figure 1-2. The Family Partnership Model [FPM] (Davis & Day 2010)]. It consists of 22 questions rated on four-point scale. A 23\textsuperscript{rd} question asked for a qualitative appraisal of service. There are eight items on how the Parent Adviser made the mother feel, seven items of parental perception of Parent Adviser and three items about the quality of the relationship with the Parent Adviser.

The authors report no information about validity and reliability of the tool but it has face and content validity being grounded in a specific theory of a partnership relationship consisting of: working together, power sharing, common aims, complementary expertise, mutual respect and trust, open communication and negotiation. Although primarily a satisfaction survey this measure contains many factors consistent with measuring the client’s perception of the parent/helper relationship. It was devised for and used in one study in the community. It is undoubtedly easy to administer but not a measure of relationship as no parallel helper questionnaire has been devised.
A summary of the review of the measures is presented in Table 2-2 overleaf, followed by a presentation of the methods and findings of the updated review.
### Table 2.2. Summary of Review of Relationship Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Client Group</th>
<th>Scale Description</th>
<th>Validity &amp; Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Reactions Systems (Hill et al. 1988)</td>
<td>Psycho-therapy clients</td>
<td>Uses a video-tape of the interaction &amp; asks client to rate reactions at different points of the tape. Lists positive &amp; negative reactions.</td>
<td>Validity and reliability not reported.</td>
</tr>
<tr>
<td>The Relationship Inventory [BLRI] (Barrett-Lennard 1986)</td>
<td>Person-centred psychotherapy clients</td>
<td>64 items rated by client questionnaire. Empathic understanding: Congruence, Positive regard.</td>
<td>High internal consistency: Subscales highly inter-correlated. Highly correlated with WAI.</td>
</tr>
<tr>
<td>The Therapeutic Bond Scales [TBS] (Saunders et al. 1989)</td>
<td>Psycho-therapy clients</td>
<td>Measures the three dimensions of the therapeutic bond (Orlinsky &amp; Howard 1986): Working alliance -15 items, Empathic resonance -17 items, Mutual affirmation - 18 items. Also a Global Bond Scale which is a composite of the above. Patients rate their experience during therapy on a 21-point scale. Developed specifically to measure patient experience.</td>
<td>Research support for reliability of scales (Saunders, Howard, &amp; Orlinsky 1989). Internal reliability of each subscale: ( r = .72 ) to ( r = .87 ). Internal reliability of Global Bond Scale ( r = .62 ). Two scales failed to correlate. All three scales and the Global Bond Scale related to patient ratings of session quality ( [r = .34 \text{ to } .60] ). Only Global bond scale related to observer ratings. Adequate test-retest termination outcome ( [r = .19] ).</td>
</tr>
<tr>
<td>The Working Alliance Inventory [WAI] (Horvath &amp; Greenberg 1989)</td>
<td>Psycho-therapy clients</td>
<td>Measures three aspects of (Bordin 1979) alliance on a 7-point scale using 36 items: Patient, Therapist, Independent observer</td>
<td>Strong research support for reliability. High inter-rater reliability and internal consistency. Reliability ranges from ( r = .85 ) to ( r = .93 ) (Horvath &amp; Greenberg 1989) &amp; Greenberg 1989). Highly correlated with CALPAS and VTAS. Subscales highly inter-correlated.</td>
</tr>
<tr>
<td>Penn Scales (Alexander &amp; Luborsky 1986)</td>
<td>Psycho-therapy clients</td>
<td>Rates the alliance from the patients’, therapists’ and observers’ perspectives. Based on the working alliance measuring: 1. The patient’s experience of the therapist as providing the help needed. 2. The patient’s experience of treatment as a process of working together with the therapist toward the goals of treatment. (Martin et al. 2000).</td>
<td>Moderate inter-rater reliability.88 Test re-test reliability .55 Overall reliability .74 Internal Consistency .91 Cronbach’s alpha .91</td>
</tr>
<tr>
<td>The Parent Advisor Service Satisfaction Questionnaire (Davis &amp; Spurr 1998)</td>
<td>Parents in the community In England</td>
<td>22 questions rated on four-point scale. Question 23 qualitative appraisal of service. 8 items on how the Parent Adviser made the mother feel. 7 items of parental perception of Parent Adviser 3 items about the quality of the relationship with the Parent Adviser.</td>
<td>No information about validity &amp; reliability but has face and content validity.</td>
</tr>
<tr>
<td>Nurse Client Relationship Inventory (Barnard 1998)</td>
<td>Parents at home treated by nurses in USA</td>
<td>27 items rated on a 5 point scale</td>
<td>No statistical information re validity &amp; reliability. Face &amp; content valid.</td>
</tr>
<tr>
<td>Helping Relationship Inventory for Social Work [client version] [HRI –C] (Poulin &amp; Young 1997)</td>
<td>Social work clients</td>
<td>2 main components described as: Structural i.e. focus on goals and tasks -10 items rated on 5 point scale and Interpersonal i.e. focused on psychological bond between social worker and client – 10 items rated on 5 point scale.</td>
<td>Factor analysis described. Reliability of structural index alpha coefficient .91 Reliability of interpersonal index alpha coefficient .96 Overall 20 item alpha coefficient .96. Correlated with WAI .84 [p &lt; .001]</td>
</tr>
<tr>
<td>Scale</td>
<td>Description</td>
<td>Patients/Doctors rated</td>
<td>Items/Scale</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Caring Professional Scale [CPS]</td>
<td>Swanson 2002</td>
<td>Patients cared for by nurses</td>
<td>18 items</td>
</tr>
<tr>
<td>Vanderbilt Psychotherapy Process Scale [VPSS]</td>
<td>Swanson et al. 1986</td>
<td>Patients cared for by nurses</td>
<td>80 items</td>
</tr>
<tr>
<td>Vanderbilt Therapeutic Alliance Scale [VTAS]</td>
<td>Hartley &amp; Strupp 1983</td>
<td>Psychologists rate therapist</td>
<td>44 items</td>
</tr>
<tr>
<td>Relational Communication Scale</td>
<td>Measurement of doctor-patient interactions (Gallagher et al. 2001)</td>
<td>Doctors and their patients in America</td>
<td>34 items</td>
</tr>
<tr>
<td>Scales for the assessment of interpersonal functioning (Carkhuff 1969)</td>
<td>Six scales: Empathic Understanding Communication of respect Facilitative Genuineness Facilitative Self-disclosure Personally relevant concreteness of specificity of expression Confrontation</td>
<td>Doctors and their patients</td>
<td>6 domains</td>
</tr>
<tr>
<td>The Medical Interaction Process System [MIPS]</td>
<td>Ford et al. 2000</td>
<td>Doctors and their patients</td>
<td>Observation method for coding interaction processes includes non-verbal as well as verbal responses to assess micro and macro features of interaction. Patient codes and Doctor codes are analysed for mode, content, and affective global categories.</td>
</tr>
<tr>
<td>Caring Nurse-Patient Interaction Scale</td>
<td>Cossette et al. 2006</td>
<td>Nurses</td>
<td>Two domains: structural index 10 items rated on 5 point scale and interpersonal index 10 items rated on 5 point scale.</td>
</tr>
<tr>
<td>Helping Relationship Inventory for Social Work [worker version]</td>
<td>Poulin &amp; Young 1997</td>
<td>Social workers</td>
<td>Two domains: structural index 10 items rated on 5 point scale and interpersonal index 10 items rated on 5 point scale.</td>
</tr>
</tbody>
</table>
2.3.4  2008-2012 Update on Review of Measures of Helping Relationships

2.3.4.1 Methods

Similar methods were used to update the original search for measures of helping relationships as were carried out in the previous review [2.3.2.1]. The differences only will be presented here.

2.3.4.2 Search Strategy

Although similar to the previous search the effort to remain up to date with publications was greatly aided by setting Scopus e-alerts during the study. This ensured that when a paper of relevance was published that an electronic connection to the paper was sent enabling immediate downloading and reading. The most significant publication identified in this way was the Cahill et al. (2008) review of measures of relationship in mental health setting the findings of which is discussed below [2.3.4.4]

However, in order to ensure coverage of all that may have been published a search was made of the databases to scan for any papers that may have been missed.

2.3.4.3 Inclusion criteria

In light of the previous review it was decided that the inclusion criteria for an updated search could be narrowed to focus on measures that may be more directly relevant to the parent/HV context. Papers were included if:

- they detailed a review of measures of relationship or
- described the development of a new measure of helper relationships in the community,
- the tool was accessible electronically and
- was published in English between 2008 and 2012.
- Observer rated instruments would be removed as these were the least feasible to use in a community context.

2.3.4.4 Findings and Critical Appraisal

No new measures of relationship were identified in the updated review. However, two helpful systematic reviews were identified along with a measure of the therapeutic relationship that had been used in a study involving HVs (Morrell et al. 2009; Brugha et al. 2010).
Review of Therapist/Patient Interaction Measures in Mental Health Settings (Cahill et al. 2008).

Following the assessment in this study of measures of helping relationship a new review and critical appraisal of measures of therapist/patient interaction in mental health settings was published (Cahill et al. 2008). This comprehensive study reviewed 83 relationship measures published before 2002. They were judged against the industry standard of six of the seven Fitzpatrick criteria (1998) of:

1. Reliability, which is defined as the extent to which measure produces consistent results from the same research participants at different times when no changes have occurred. Internal, test-retest and inter-rater reliability were assessed. A measure needed to address at least one of these criteria in order to be judged adequate.

2. Validity, which is defined as the extent to which the measure actually measures the relationship. Face, content, concurrent, predictive, construct, and discriminant validity were assessed. A measure needed to demonstrate at least one of these criteria in order to be judged adequate.

3. Responsiveness, which is defined as the extent to which the instrument detects changes, which are important to the client over time or the extent to which the measure discriminates between individuals or within an individual over time.

4. Acceptability, which is defined as the extent to which the measure is acceptable to users. This was rated on six components i.e. Practicality of administration, time taken to complete, length of instrument, translations, access by ethnic minorities and reading age.

5. Feasibility, which is defined as the extent to which the instrument is easy to use and analyse. This, like the acceptability was rated on six components i.e. cost and burden to administrative staff, electronic/optical scanning options, scoring systems, training package, training manual, support from measure developers, frequently asked questions facility.

6. Precision, which is defined as the extent to which the measure is precise.

The seventh Fitzpatrick criterion of ‘appropriateness’ was not considered to be relevant for the review measures of relationship. This was because the criteria were originally designed for patient outcome measures and not measures of process, such as those of the relationship. The authors identify that there is currently a gap in the literature for the development of criteria for
process measures and that their review was hampered by using the criteria for outcome measures.

This meant that only 43 of the 83 measures of relationship met the minimum standard and only 30 displayed adequate responsiveness or precision. None of these 43 measures fully addressed acceptability and feasibility evidence and none of the 83 were found to meet industry standards (Cahill et al. 2008).

Table 2-3 presents the valid and reliable measures included in this present study alongside the Cahill et al. (2008) scores representing the number of items, out of a possible six, addressed by the measure developers for their acceptability and feasibility, and whether or not the responsiveness or precision of the instrument was addressed.

Table 2-3. Reliable Measures Included in Cahill et al. (2008) and this Review

<table>
<thead>
<tr>
<th>Measure</th>
<th>Acceptability Score [Max = 6]</th>
<th>Feasibility Score [Max = 6]</th>
<th>Responsiveness or precision</th>
<th>No. of primary references</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Relationship Inventory [BLRI] (Barrett-Lennard 1986)</td>
<td>4</td>
<td>3</td>
<td>Addressed</td>
<td>16</td>
</tr>
<tr>
<td>Working Alliance Inventory [WAI] (Horvath &amp; Greenberg 1989)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Therapist</td>
<td>2</td>
<td>2</td>
<td>Addressed</td>
<td>7</td>
</tr>
<tr>
<td>Observer</td>
<td>2</td>
<td>3</td>
<td>Addressed</td>
<td>4</td>
</tr>
<tr>
<td>California Psychotherapy Alliance Scale [CALPAS-P] (Patient version) (Gaston 1991)</td>
<td>4</td>
<td>4</td>
<td>Not demonstrated</td>
<td>6</td>
</tr>
<tr>
<td>Scales for the assessment of interpersonal functioning (Carkhuff 1969)</td>
<td>2</td>
<td>3</td>
<td>Addressed</td>
<td>8</td>
</tr>
</tbody>
</table>

It will be noted that some of the measures included in this present study, did not meet the industry standard in the Cahill et al. (2008) review. Table 2-4 below presents those measures with the exclusion criteria, from the Cahill et al. review (2008). The exclusion score was calculated out of a possible score of six according to each of the Fitzpatrick criteria (1998). A score of three or less indicates the inadequacy of the measure.
This important review (Cahill et al. 2008) notes a number of difficulties that were also encountered in this present study, not least of which were the difficulties found when trying to retrieve measures and information relating to them. For the review team a major difficulty was the lack of review guidelines or standards for reviewing process measures. They relied upon the Fitzpatrick criteria, which were developed for patient based outcome measures. This meant that there were issues that arose relating to validity, responsiveness, acceptability and feasibility as well as inter-rater reliability estimates.

Validity is multi-faceted and concerns the way in which a measure assesses what it is supposed to assess. However, there is a lack of understanding in psychotherapy how the various components of the relationship work. The process-outcome correlation logic overlooks the therapist/client responsiveness to the client needs and therefore may cause null findings, as responsiveness is a non-linear process (Cahill et al. 2008).

None of the instruments reviewed demonstrated that they had the ability to detect change over time and again the reviewers suggest that this may have been a reflection of the non-linear nature of client and practitioner responsiveness.

Acceptability and feasibility were not well addressed by the reviewers by their own admission. They suggest that this was because in psychotherapy research, historically process measures were used more for in-house research trials and the monitoring of therapist skills or therapeutic relationships rather than benchmarking for dissemination purposes.
Inter-rater reliability estimates were absent in the review and the review authors needed to revise the coding structure to provide a more succinct operational definition and assessment of the rigour of the study’s design methodology.

Very few of the measures reviewed were developed in the UK 86% were developed in the USA whilst the remaining measures were developed in the UK [n=5] and the rest in Canada, Australia and Germany. The majority of the measures were pan-theoretical, psychodynamic/psychoanalytic in orientation, were observer-rated and pertained to adult population groups. The review team recommend that future research in the UK be developed to assess the transferability of these process measures. They also suggest that any development of future measures should relate to other theoretical perspectives and more diverse population groups and focus on the therapist and patient constructs.

Agnew Relationship Measure [ARM] (Agnew 1995; Agnew-Davies et al. 1998)

This relationship measure was not included or retrieved during the first search of the databases for measures in 2006/07, although it was identified by Cahill et al. (2008). The original search had revealed many relationship measures but relatively few papers included the instrument in the description of its development. A careful content search of the papers was carried out to find the measures. The first paper retrieved about the ARM, (Stiles et al. 2002) through the first search, did not include the measure and was therefore discarded. When a study, concerning interventions for post-natal depression, was published (Morrell et al. 2009; Brugha et al. 2010) a short form of this instrument [12 items] was used to measure the parent/HV relationship. Because of its high relevance to this present study a search was made of the article’s references and a paper was identified and retrieved that included the measure (Agnew-Davies et al. 1998). It is included here to address its suitability for measuring parent/HV relationships generally rather than when addressing post-natal depression.

The measure was designed to capture the psychotherapeutic relationship. The reason for the formulation of a new measure in the late nineties was that previous instruments had suffered with,

‘a lack of discrimination among component subscales, a blurring of the alliance construct with the therapists’ technique and with early manifestations of treatment outcome, a failure of each instrument to capture important aspects measured by some other instruments, and a bias or restriction of applicability to one or a few theoretical approaches (Agnew-Davies et al.1998, p.196)’.
The ARM was designed as a pan-theoretical instrument for use by clients and therapists. The full version consists of 28 items concerning the bond [six items], partnership [four items], confidence [seven items], openness [five items] and client initiative [four items]. The items are rated on a seven-point Likert scale from strongly disagree to strongly agree. There are parallel questionnaires for both the client and the therapist.

The convergent validity of the ARM was established using the WAI, a measure, that was previously critiqued by the authors as justification for the creation of the new measure (Stiles et al. 2002). However, similar to the WAI, there was a lack of statistical independence for two of the domains, in this case, bond and partnership. Nevertheless, the measure does avoid inclusion of therapist techniques and outcomes of therapy. Cahill et al. (2008) report that the demography of the clients that have used the measure is limited to white-collar workers, suffering with depression. However, in the health visiting study for post-natal depression (Morrell et al. 2009) 1,484 new mothers took part in the intervention arm of the trial and 89 HVs. This means that a greater variety of mothers from all walks of life have now used the short form of the instrument.

The HVs in the intervention arm of the trial all received training in one of two psychological interventions, either person-centred counselling or cognitive behaviour therapy. The training included the development of warm, empathic relationships with mothers. There was emerging evidence that this ability of HVs to form these relationships was preventive of post-natal depression in women who screen negatively for post-natal depression and that this had an enduring effect (Brugha et al. 2010).

Although the ARM measures the therapeutic relationship, which is used as an intervention in post-natal depression it appears that, this ‘therapeutic relationship’ has a universal application in the prevention of post-natal depression. The ARM may therefore, be of use in measuring the parent/HV relationship at a universal level with HVs who are untrained in establishing therapeutic relationships. However, this remains to be tested.

**Nurse/Patient Relationships**

Although the measurement of empathy is not the same as a measure of the relationship, the ability to demonstrate empathy, as noted previously, is an important skill, which may affect the nurse/patient relationship. A systematic review paper of the evaluation of tools to measure empathy in nursing (Yu & Kirk 2009) found that of the 12 measures reviewed none were
psychometrically robust or covered all the domains of empathy. Users' involvement in tool development was limited and only five of the measures were developed within the nursing context. Eleven of the 12 instruments were developed in the USA so may not be transferrable to a UK setting.

Interestingly they applied quality criteria suitable for outcome measures based on a framework developed by Greenhalgh et al. (1998). This did not cause them to question their findings, however, where responsiveness to change was tested in only three of the reviewed measures. As noted above in the Cahill et al. (2008) review change may be non-linear and therefore not be detected by measurement tools as nurses respond to patient need for empathy. The three questionnaires that did test responsiveness to change were for evaluating empathy training for students and were used in a pre and post-training evaluation. The purpose of the development of these tools may have therefore influenced what was measured.

Two measures of the nurse/patient relationship were identified in the review; one new observation measure developed in the Philippines; the nurse-patient bonding instrument (Tejero 2010) and the Nursing Relationships Scale (Ku & Minas 2010) developed in Australia. The former was not reviewed in depth as it is an observer-rated instrument.

The nursing relationships scale was a tool that relied upon the presentation of two vignettes, one to psychiatric nurses and the other to general nurses. The psychiatric nurse's vignette concerned a patient with mental illness whilst the vignette for general nurses concerned a diabetic patient. Following reading of the vignette, the nurse participant was invited to complete the nursing relationships scale. This consisted of 34 items drawn from the work of Caris-Verhallen (1998) and Watson and Lea (1997). The psychometric evaluation of the nursing relationship scale suggested that it was a reliable instrument for measuring the nurse/patient relationship. However, the reliance on the vignettes and the lack of patient input makes this measure unlikely to be successful in measuring the parent/HV relationships where the concept of partnership working is paramount. To assess this it would be necessary to consider the relationship not only from the HV's perspective but also from the parent's.

### 2.3.5 Discussion

Nearly all of the measures discussed use a Likert style rating scale to measure the responses. The data collected are therefore ordinal data with intervals on an ordinal scale that cannot be said
to be equal. Only the rank order of the data is known. The way in which these ordinal data are subjected to statistical tests is controversial. Interval data can be subjected to parametric tests but the validity of using parametric tests with ordinal data is disputed (Knapp 1990; Jamieson 2004; Norman 2010). There is a danger that the wrong statistical technique is used, with the result that the researcher is more likely to come to the wrong conclusion about the statistical significance of the research results. In order to avoid the possibility of these errors the data collected by a new measure of parent/HV relationship, which is ordinal, was only subjected to non-parametric tests.

In order to establish concurrent validity the developers of instruments use another measure of relationship. However, they also argue that the present measures are inadequate for their purposes. If there is concurrent validity with another valid relationship measure then it would appear that it was not necessary to create a new instrument. However, researchers may be driven to make pragmatic choices when faced with the dilemma of how to demonstrate the concurrent validity of their measure and may use a subscale of another measure if not the whole of the instrument.

The question of user participation in the development of measures arose both in the original and updated reviews of measures of relationship. The measures within psychotherapy and mental health services have relied primarily on expert groups of professionals to formulate items for questionnaires reliant upon particular theoretical backgrounds. The patient’s or client’s perspective and use of language has not been taken into account.

Building on the idea that therapists, clients and observer tools may measure different aspects of the relationship [2.3.3.5] it was important to examine the retrieved measures more closely to ascertain what was measured from each perspective. This is reported in the next section of the chapter.

### 2.4 A Comparison of Scale Facets

#### 2.4.1 Method

In the computer programme, EXCEL, a database was constructed of all of the measures reviewed. The items on all the questionnaires in the initial review were coded according to the themes in the key to Figure 2-1. The questionnaires were then colour coded to identify the three
relationship perspectives, therapist, observer, and client. A separate database was then constructed for each of these and a separate analysis undertaken.

### 2.4.2 Findings

Figure 2-1 shows the number of relationship components that were present across all 24 relationship measures and the number of instruments in which they were present. It can be seen that empathy and understanding was the most frequently measured facet. The other most frequently measured facets were mutual trust and respect along with hope, enthusiasm and motivation. However, although it was interesting and helpful to understand this, it was more beneficial to understand the analysed components from the three different perspectives.

![Bar chart showing relationship measures and factors](chart.png)

<table>
<thead>
<tr>
<th>Key to Relationship Measure Factors</th>
<th>Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Empathy &amp; helper understanding</td>
<td>1</td>
</tr>
<tr>
<td>6. Hope, enthusiasm and motivation, commitment</td>
<td>3</td>
</tr>
<tr>
<td>1. Working together, involvement, participation</td>
<td>4</td>
</tr>
<tr>
<td>2. Agreed Goals</td>
<td>5</td>
</tr>
<tr>
<td>7. Client understanding of problems changed</td>
<td>6</td>
</tr>
<tr>
<td>12. Outcome/progress and review</td>
<td>7</td>
</tr>
<tr>
<td>13. Exploration</td>
<td>8</td>
</tr>
<tr>
<td>15. Problem Management</td>
<td>9</td>
</tr>
<tr>
<td>9. Supportive and warm</td>
<td>10</td>
</tr>
<tr>
<td>11. Listening</td>
<td>11</td>
</tr>
<tr>
<td>3. Power Sharing - a sense of 'we' and importance of each role</td>
<td>12</td>
</tr>
<tr>
<td>8. Genuineness, honesty, congruence</td>
<td>13</td>
</tr>
<tr>
<td>10. Interested</td>
<td>14</td>
</tr>
<tr>
<td>19. Self-disclosure, ‘Willingness to be known,’ Humanity</td>
<td>15</td>
</tr>
<tr>
<td>14. Clarification</td>
<td>16</td>
</tr>
<tr>
<td>17. Challenging</td>
<td>17</td>
</tr>
<tr>
<td>16. Client Characteristics</td>
<td>18</td>
</tr>
<tr>
<td>18. Body Language</td>
<td>19</td>
</tr>
<tr>
<td>20. Technical Knowledge</td>
<td>20</td>
</tr>
</tbody>
</table>

Figure 2-1. Facets of the Relationship Present in all 24 Relationship Measures

When the three different perspectives were considered the first noticeable difference was that observer scales had the potential to record more components of relationship than those taking part in the interaction.
The observer rated scales had 18 component themes.

Of the nine observer rated measures three factors were present that were not seen in the other scales [Figure 2-2]. They were, body language [one measure], challenging [two measures], and client characteristics [one measure]. However, they occurred very infrequently and may, therefore, be unimportant. Body language, however, is a very powerful form of communication both of positive and negative affect and perhaps should not be discounted altogether. Researchers have found that the verbal component of face-to-face conversation is less than 35% and that over 65% of communication is done non-verbally (Pease 1997). Skilled observers may be able to detect this as they watch an interaction. However, for the people involved, it is often unconscious and they would be unable to rate it themselves.

Observer measures are extremely detailed and time consuming to use and require skilled researchers to code the interactions. The complexity of using an observer measure makes it unsuitable for use in the community and unlikely to be very useful in a practice situation outside the research arena.
Therapist and client rated scales used 12 analysed components [Figure 2-3, Figure 2-4] 

As the measures for client and therapist might be expected to be measuring the same construct, the relationship that exists between them, one might have expected that they would be very similar. However, within the 12 client-rated measures [Figure 2-3] four factors appeared that were not present in the therapist measures [Figure 2-4] i.e. genuineness, honesty, congruence [four measures]; supportive and warm [four measures], listening [seven measures] and self-disclosure, ‘willingness to be known’, humanity [five measures]. Likewise, in the three therapist-rated measures [Figure 2-4] four factors appeared that were not present in the client measures i.e. power-sharing, a sense of ‘we’ and the importance of each role [one measure]; exploration [two measures]; clarification [two measures] and problem management [three measures]. ‘Clarification’ was a factor only appearing in the therapist scales and may reflect the
importance to the process of helping of checking understanding of issues the clients bring. The client-rated facets of relationship are more concerned with the qualities of the therapist and her skill in listening whilst the therapist facets focus more on the technical processes involved in helping. Therapists are also asked to rate their own empathy and understanding which is inconsistent with studies that show that therapists ratings of empathy are seldom related to measures of patient outcome (Orlinsky et al. 2004). As a result one might expect that this factor would not be included in therapist-rated measures.

‘Listening’ appears to assume greater import in the client-rated measures [Figure 2-3] than in the observer-rated measures [Figure 2-2] appearing in seven of the 12 client-rated measures and in only one of the nine observer-rated measures. Therapists are not invited to rate themselves on how they listened to their client and yet this seems to be of relative importance in the client rated measures. Clearly listening is a therapist skill that helps to build the relationship and develop rapport. If both scales are measuring the same thing i.e. the relationship, then there appears to be a difference here that may mean that the same thing is not being measured at all.

From the charts presented, it is possible to see that the client [Figure 2-3] and observer-rated measures [Figure 2-2] are those that are most alike. Of the 12 client-rated measures focus was given to ‘empathy and helper understanding’, [12 measures] ‘mutual trust and respect’ [11 measures] and hope, enthusiasm and motivation, commitment [ten measures]. These are the top three most frequently occurring factors in the scales with ‘working together’ occurring in nine measures. The focus is again on the qualities of the helper and the characteristics of the relationship. The nine observer-rated measures [Figure 2-2] register working together [eight measures] and mutual trust and respect [eight measures] as the most frequently occurring factors in the scales followed by empathy and helper understanding [seven measures] and then hope, enthusiasm and motivation, commitment [seven measures]. Again, the focus is clearly on characteristics of the relationship and the qualities of the therapist.

Figure 2-5 overleaf shows the extent of the overlap between the sets of measures from the three perspectives of therapist, client and observer. These shared components were helpful for consideration of what would be useful in a measure that might apply to both the parent and HV.
Of the 24 measures retrieved there were eight shared factors between the therapist-rated, observer-rated and client-rated measures [Figure 2-5]: working together-involvement, participation [19 measures]; agreed goals [12 measures]; mutual trust and respect [20 measures]; empathy & helper understanding [21 measures]; hope, enthusiasm, motivation and commitment [20 measures]; client understanding of problems changed [12 measures]; interested [6 measures] and outcomes, progress, review [12 measures] [Figure 2-5]. Here, as in all the measures, there is obviously interplay between the characteristics of the relationship i.e. working together and mutual trust and respect; the skills of the helper i.e. empathy, hope, enthusiasm etc. and the process of helping, i.e. client understanding of problems changed. It appears when measuring the relationship this cannot be divorced from the interaction, which underpins it. How the process of helping is accomplished will be as important to capture in a tool, as this is the vehicle through which the relationship is established, developed and maintained.

There were only three shared observer/therapist components of the relationship, problem management, exploration and power-sharing [Figure 2-5]. Whilst between the client and observer
there were four such shared components; listening, supportive and warm, genuineness/honesty/congruence and self-disclosure. Between the client and therapist there were nine shared factors as can be seen in Figure 2-5.

As noted above, the helping relationship may be measured from three perspectives; the clients, the helpers or the observers. However, when considering all the research it is the client’s perspective of the relationship that is most accurate in predicting therapy outcome, followed by observers and then therapists (Horvath 2000; Summers & Barber 2003). Horvath (2000) explains this by theorising that the therapist comes to the relationship with theoretical knowledge and measures the relationship against these expectations. However, the client comes with no theoretical knowledge but with past experiences and measures this ‘here and now’ experience against these. This may well be the reason that the client’s view is the most accurate in predicting outcomes but it may also be a fault in the measures used as not all the literature is in agreement on this point. Fenton et al. (2001) examined the predictive ability of six working alliance instruments and found the observer tools to be the most accurate when highly objective outcome measures were used. Their results, however, need to be replicated in order to gain more credence.

The client’s knowledge and experience is subjective and entirely individualised. Horvath’s (2000) other explanation is that therapists may fail to be sensitive to the client’s experience of the relationship. If the therapist fails to notice that the relationship is not going well then there could be poor outcomes if steps are not taken to remedy the situation. Because the experience of the client is unique it will be important that the measure be flexible enough to capture this individuality but generalisable enough to be useful in practice to alert HVs to possible relationship difficulties being experienced by the parent.

2.4.3 Discussion
The tools developed thus far have all been used where treatment is the goal of the intervention and not in promotional and preventative interventions, where parent contact may be of much shorter duration. This means that the HV has to be very skilled in making positive relationships over a much shorter length of time than that given to therapy, especially where the parent may only be seen briefly to introduce the service. Furthermore, based on this introduction only, the parent may then be expected to access services if problems arise. If a positive relationship has not been formed at the beginning when services are introduced this is not likely to happen. The
idea that the relationship itself may be part of the solution to a client’s difficulty is not generally recognised within primary health service organisations but only more explicitly in the referral services of child and adolescent and adult mental health.

When community HVs visit parents at home it is not unusual for others to be present. This may happen for a variety of reasons, not least because the client feels vulnerable and may feel supported by the presence of a friend or relative (Jack et al. 2005). The tools developed within other professions do not consider this. The relationship has to be developed with whomever is present whether the parent alone, the child, and/or other friends, relatives or neighbours. This fact in itself might change how the relationship is established, and needed to be taken into account with the development of the new measure.

It is interesting to note that whilst the research indicates that it is the client’s perspective of the relationship that most clearly predicts outcomes the tools have seldom been developed in conjunction with the users of services. It is the client’s view of the relationship that is paramount. Tools developed need therefore, to take the views of clients seriously. Partnership, for the purposes of this study, is the relationship that most clearly defines the nature of health visiting. Furthermore, the measure needed to reflect a partnership approach throughout the study working in collaboration with parents.

The perspective of the parent is only one view of the relationship so it was necessary to measure the relationship from the view of the HV also. The relationship exists between them so a questionnaire for both parent and HV developed from the perspective of each was considered a useful approach. The development of such an instrument needed to be carried out in collaboration with the HVs also.

Finally, the helping relationships that are developed are unique to the individual dyad as each comes with their own constructs of the other and of the context and expectations of the meeting. Tools therefore needed to be flexible enough to capture the individuality of the parent/HV experience yet still provide a generalisable measure useful in research and practice.

2.5 Conclusions and Implications for research

The in-depth analysis of the scales so far retrieved adds clarity to the ways in which the construct under consideration, i.e. the helping relationship, has been measured. The clarity with which the
construct is conceived is the key to the validity of the tool. Within the research the developers have used different theories of relationship depending upon their professional background to help them develop their understanding of the components that need to be measured when considering the helping relationship.

When developing indicators the characteristics of the relationship or bond that HVs and their teams are aiming to establish, theories such as FPM, and Bordin's (1979) other two generalisable components of tasks and goals, needed consideration. Tasks and goals are clearly a part of the helping process [Figure 1-3] but relationship formation and development cannot be separated from the process itself because it is the foundation of the work that is done.

The measures reviewed contain facets of the relationship that are the skills or qualities of the therapist e.g. supportive and warm, interested, listening, challenging, hope, enthusiasm and motivation and commitment, empathy and helper understanding, body language, technical knowledge, self-disclosure. Yet other facets of the measures present are distinct parts of the helping process e.g. exploration, clarification, agreed goals, problem management, outcome/progress and review [Figure 1-3].

It is the combination of the variety of concepts included that makes them measures of helping relationships. How the health visiting process is negotiated and the relational skills that HVs use needed therefore, to be included in the new tool.

The design of an instrument to measure the parent/HV relationship needed to be grounded in the views of the parents and HVs and couched in their language. The TELER system of measurement appeared to be congruent with these requirements as it respects the individual and acknowledges the imperfect nature of measurement, which will only be as precise as the understanding of the phenomenon under scrutiny i.e. the parent/HV relationship. The foundations of the measurement tool are clinical knowledge and expertise brought to bear on that understanding as developed between practitioners and parents through interpretive inquiry. The statistical system of analysis appears appropriate to the level of data measurement and the clinical significance of the statistical analysis is valued. The TELER methodology is presented in Chapter 3 [3.3.1] along with the rationale for the choice of design and methods used within the study.
Chapter 3 Research Design and Methods

3.1 Introduction

This chapter describes the research design and methods used to formulate the TELER dichotomous questionnaires.

The objectives of this study, which this chapter addresses, are:

- To assess the feasibility, acceptability and suitability of the TELER methodology for use in health visiting by:
  - Identifying key processes used in the practice of promoting child health, specifically focusing on effective parent/HV relationships;
  - Developing and piloting indicators of that relationship using the TELER format working in partnership with parents and health visitors.

3.2 Rationale for the research design

Polit et al (2001) describe two paradigms in nursing research, the positivist and the naturalistic. However, this may be an oversimplification of these paradigms. Other authors (Weaver & Olson 2006; Bunniss & Kelly 2010) describe four such paradigms each with its own epistemology, ontology and methods; positivism, postpositivism, interpretivism and critical theory. For the purposes of this study two paradigms were employed; interpretivism and postpositivism.

Ontologically in the interpretive paradigm reality is seen as subjective, open to change and that there is no ultimate truth (Bunniss & Kelly 2010). Epistemologically there are multiple interpretations of reality and there is no ultimate way of knowing. Qualitative research methods are used. The researcher interacts with the research participants and the findings are a result of the interactive process with a focus on understanding. The individualised, holistic nature of the person in the context of their environment is important to the researcher who seeks to understand this complexity (Weaver & Olson 2006).

In contrast the postpositivist paradigm seeks an objective reality, believing that there is an overarching objective truth (Bunniss & Kelly 2010). However unlike positivism, there is an acknowledgement that reality can never be fully known and that attempts at measurement are
limited by understanding (Doucet et al. 2010). Postpositivists try to establish a ‘probable’ truth (Guba & Lincoln 1994; Bunniss & Kelly 2010). Quantitative methods are commonly used with goals of prediction and explanation. However, as with the positivist tradition, the researcher remains separate from the research participants and seeks statistical analyses that produce generalisations (Polit et al. 2001). Unlike positivists, however, qualitative methods are also used to provide confirmation of and depth to the quantitative methods (Doucet et al. 2010).

In this study, interpretive inquiry was employed in the service of designing a tool with the hallmarks of postpositivism in terms of finding an objective reality that could be measured. It was hoped that this approach would take into account the individual and holistic nature of relationships by providing valid and reliable indicators of the parent/HV relationship. This was the initial focus of the quest to formulate an instrument. However, it became clear during the course of the interpretive inquiry that these relationships could not be considered outside of the context of their organisations. These affected the abilities of HVs and parents to make relationships, resulting not only in the formation of relationship measures but also of an organisational impact measure to be used alongside.

Inevitably, trying to measure a relationship is difficult and striving for an objective tool may reduce the phenomena of the parent/HV relationship to an instrument that detracts from the deeper meaning of ‘relationship’. The ability to measure something as invisible and varied as this relationship predictably means that it will be reduced to a series of behaviours or tasks. However, these behaviours and tasks are only ‘indicators’ of something that is much deeper and felt at a personal level by the participants. The measure is not the ‘relationship’ itself but an indicator of the phenomena.

Clearly, each paradigm had its own contribution to make to the development of knowledge about parent/HV relationships. The interpretive enquiry concentrated on the parent and HVs subjective experiences of their relationships clarifying the details and processes present. An analysis of these factors enabled a synthesis, to distil common indicators to measure the relationship. In keeping with a postpositivist approach, the instruments were used with researcher observation methods to give added verification and confirmation to the findings. It is hoped that these questionnaires will be of use in both practice and research.
3.3 Study design

Figure 3-1 shows the design for the study and draws upon established questionnaire design procedures (Oppenheim 2001). The TELER method (Le Roux 1993) was chosen as one, which was particularly suitable for measuring relationships as it brings together both the interpretive and the positivist paradigms. The method produces quantifiable data generalisable to the group but not at the expense of clinically significant individual results. The TELER theory and philosophy are described in the following section.
Figure 3-1. Research Design
3.3.1 The TELER theory and philosophy.

In postpositivism, there is a belief in an objective reality that is observable. A criticism of this approach may be that it is reductionist by reducing a person to parts and not looking at the whole in context. In nursing research it has been seen as incompatible with the holistic approach characteristic of nursing (Weaver & Olson 2006) within which modern day health visiting has its roots.

However, the TELER philosophy respects the individual and acknowledges the imperfect nature of measurement, which will only be as precise as the understanding of the phenomenon under scrutiny i.e. the parent/HV relationship. The foundations of the measurement tool are clinical knowledge and expertise brought to bear on that understanding as developed between practitioners and parents during the interpretive inquiry.

TELER is an acronym for Treatment Evaluation by the Le Roux method (Le Roux 1993). A relatively recent development in the nursing (Browne et al. 2004) and physiotherapy (Mawson 1993; Mawson & McCreadie 1993) literature shows this to be promising as it has brought together practitioners, clients and researchers, collaboratively, in the quest for suitable measurement tools in a variety of areas. The TELER method is a structured system for making and presenting clinical notes for an individual receiving treatment or care (Le Roux 2003). These clinical indicators are used as a measure of the effectiveness of the treatment or care received. This method has already been piloted in the field of health visiting, to investigate decisions and judgements during a new birth visit (Newland 2004). It is therefore, feasible to use the tool in this way, its value as a research method to measure relationships between parents and HVs needs to be explored further.

The TELER method comprises three types of indicators; function, component and quiz indicators. The first two types of indicator trace change in a client over a given time period. However, the quiz style indicator is time independent, can be used when a client is seen only once (Le Roux 2003), and was therefore particularly pertinent to the way in which HVs often work.

Every measuring tool requires a translating medium. For example to measure heat mercury is inserted in a regularly calibrated glass tube and rises up the tube as it gets warmer. The mercury is the translating medium for heat. The translating medium of a TELER quiz indicator is a questionnaire, which provides the potential for a high level of objectivity (Le Roux 2003). The
level to which the potential is realised is determined by clinical knowledge and the questionnaire design. The knowledge can be from experts in the field, from literature and from specific research. The review of measures allowed an in-depth exploration of items researchers considered important to measure when assessing the client/therapist relationship. In this study specific research revealed what parents and HVs believed to be of importance in their relationships and this was compared with existing knowledge present in the measures of helping relationships. This synthesis of knowledge ensured the content validity of the questionnaires.

The questionnaire for the TELER quiz style indicator consisted of a series of statements rather than questions e.g. ‘The health visitor failed to do what she said she was going to do’. A response was required to each statement, all the statements were accompanied by the same set of alternative responses ‘yes, I agree’, and ‘no, I disagree’. A positive response to the statement implied that the participant acted in a way that enhanced the relationship between the parent and the HV. A negative response would indicate that the participant acted in a way that was not beneficial to the relationship.

The dichotomous questions present a number of advantages:

- It is easy for respondents to choose between answers.
- Respondents and researchers are likely to have similar interpretations of the options so that a well-constructed questionnaire can provide valid and reliable data (Mitchell & Jolley 2012).
- Tabulated responses to each alternative response gives easy access to what participants think of the issues presented.
- As there are only two options for participants to complete only a short time is required for completion (Polit & Beck 2008).

However, they also present disadvantages:

- Items are difficult to construct (Polit & Beck 2008).
- Respondents may find that their point of view is not represented and become frustrated with the questionnaire and not complete it (Mitchell & Jolley 2012).
- Respondents may feel that they are coerced into giving a ‘yes’ or ‘no’ response in order to complete the questionnaire and therefore compromise the reliability of the data by giving answers that are false.
The statements were difficult to construct and needed much consideration and deliberation. Endeavours were made to ensure that the items chosen were observable so were more likely to be answered correctly and easily with an affirmative or negative response.

Initially all the statements were formulated to require a ‘yes’ response that would be a positive indication of a beneficial relationship. Subsequently alternate statements in the original order were further developed and worded negatively to avoid errors and response bias (Oppenheim 2001).

The disadvantages of this type of questionnaire were overcome during the pilot phase 1 of the study. Any difficulties with the wording were rectified and there was no frustration on the part of the participants that their point of view regarding parent/HV relationships was not represented in the statements. They agreed that the questionnaire was easy to complete and represented what they would expect regarding their relationships with each other. As the statements to formulate the measure were distilled from the data collected from HVs and parents in the community during interviews, following their interactions with each other, this was as it should be. Further evidence supporting the selection of particular statements was also found within literature about health visiting and research on helping relationships, generally [Chapter 5].

Prior to beginning research in the community consideration needed to be given to the ethical issues that might arise and how participants might be accessed and recruited. These considerations will now be discussed.

3.3.2 Ethical Issues and Access

All research is carried out at some cost to the participants (RCN 1998). In this study the cost was in terms of the time involved in the qualitative interviews and completing questionnaires. The participants themselves received no direct benefit from participation although in the longer term it was hoped that the research would benefit the quality of health visiting practice. It was therefore important to ensure that the participants were respected and adequately protected. Home visiting parents alongside HVs can be very intrusive into the interaction and relationship. For this reason care was taken to give respect and protect the rights and dignity of all the participants in the research HVs, parents and their children, throughout.

The research was predicated on the ethical principles of:

- Beneficence;
- Non-maleficence;
- Respect for autonomy;
- Justice. (Beauchamp & Childress 1994)

3.3.2.1  Informed consent
In order to ensure that HVs and parents were fully informed of the aims and objectives of the study and were taking part with respect for their autonomy, the study was explained verbally and an information sheet provided. An example of the parent information and consent form is given in the appendix [Appendix 1 & 2]. A similar document was designed for the HVs. In this way all efforts were made to ensure that participation was voluntary. Consent forms were signed, dated and stored safely in a locked desk. Participants had the right to withdraw from the study at any time should they so wish and any relevant material destroyed demonstrating respect for their freedom to act.

3.3.2.2  Confidentiality
Parents and HVs taking part in the video stimulated recall part of the study needed particular assurance that the video recording was for viewing only by the researcher and by themselves and that it would never be seen by others. Participants were assured that their private details would remain confidential at all times.

Above all the researcher sought to allay anxieties in parents and HVs about being filmed and recorded and every effort was made to ensure that participation was purely voluntary and there was no undue coercion.

The identity of participants was protected throughout the study. Only the researcher was aware of participant identity. All video and audio recordings were stored on a password protected secure server at King’s College, London.

3.3.2.3  NHS ethics approval
This was sought and granted from the local research ethics committee following a request by them for further information and revision of some documentation. http://www.hra.nhs.uk/hra/
[REC reference number 06/Q0705/45] [Appendix 3]
Further ethical approval, constituting a substantial amendment, was sought from the committee regarding the participation of discussion groups in the early part of the research and this was also granted. The committee were approached again for permission to include the reporting of field notes made during the collection of the quantitative data. This was another substantial amendment and permission was granted.

The local Primary Care Trust [PCT] research and development committee also approved the study to be carried out in two local PCTs [RDSOU317]. This was later extended to two further PCTs [RDLSLG317].

Permission to access the HVs was granted via the PCT’s locality managers after the proposed study was outlined to them and their questions answered.

3.4 Study sites

Initially recruitment began in two PCTs in an inner city, urban environment with areas of high deprivation. These sites were purposefully chosen as the focus of enquiry was on ‘good’ relationships between HVs and parents. HVs in these PCTs were known to have undertaken the FPM training (Davis et al. 2002b) and therefore be familiar with the theory and skills of working in partnership with parents. Difficulties recruiting participants during the early part of the study led to expanding the areas from which participants were recruited to a neighbouring PCT.

Later in the study, in order to pilot the questionnaires as widely as possible, a further PCT was also included.

3.5 Samples and overcoming problems in recruitment

A recruitment meeting of HVs was held in each of the purposively chosen PCTs. Six parent/HV dyads were recruited for the qualitative enquiry into their relationships. Initially HVs who had been trained in FPM (Davis et al. 2002b) were asked to invite parents, with whom they had a good relationship, to participate. They explained to them what the study would entail and sought their permission for the researcher to accompany them on a home visit. Parents were also
approached through a local breast-feeding café and asked to recruit their HVs, if they felt that they had a good relationship with them.

The ideal location for the video recording and the interviews was thought to be the home as the parent and child might be more relaxed and at ease. However, three of the interactions and interviews took place in a clinic room where the parent and child had been specifically invited for a child developmental review [Appendix 7]. In the event there did not appear to be any qualitative difference in the interactions or data collection as the parents and HVs involved knew each other very well.

Three parents and seven HVs were also invited to take part in subsequent discussion groups to further validate the analysis of the qualitative data. This process of member checking is considered the most important technique for establishing the credibility of qualitative data (Lincoln & Guba 1985). It helps to ensure that the participants’ views are kept to the fore.

In phase 1 of the pilot of the newly designed questionnaires 11 HVs and 27 parents in the three PCTs participated. In the second phase of the pilot a snowballing approach was used with participants to recruit 15 HVs and 61 parents with a focus on families who were more vulnerable. These families proved to be more elusive due to their often-chaotic lifestyles but it was important to try to reach as many different types of families as possible. Gathering a variety of views on the parent/HV relationship in different circumstances helped to ensure the suitability of the questionnaires across the health visiting spectrum. Likewise, a variety of HVs were recruited to reflect the experience of the workforce, those who were newly trained, those who had several years experience and those with many years experience and were near retirement.

3.6 Qualitative Study of Parent/HV Relationships [2008/2009]

Although much knowledge of the parent/HV relationship had been gained from both the literature and the researcher’s experience it was important to obtain an up to date view from HVs and parents in the community. The aim of this part of the research was to identify key processes involved in effective parent/HV relationships. Drawing on a previously successfully method, video stimulated recall (Bidmead & Cowley 2005b), it was realised that these key processes could be
identified by accessing HV and parent constructs of their relationships after an interaction. The procedures and rationale for this decision are now described.

### 3.6.1 Stimulated Recall

Video stimulated recall was used in order to explore the HV and parent relationships. ‘Stimulated recall is an introspective method that represents a means of eliciting data about thought processes involved in carrying out a task or activity’ (Gass & Mackey 2000). There are two reasonable major assumptions on which the methodology is based:

1. That it is as possible to observe internal processes as it is to observe external events;
2. That human beings can access these internal thought processes and verbalise them to some extent.

It is a method that is particularly suitable for understanding complex, interactive contexts where there is uncertainty about processes and behaviour that are taking place at a cognitive level (Lyle 2003). A researcher may observe an interaction and see that a ‘good relationship’ has been established. However, what has been observed and heard does not necessarily provide an explanation of how the relationship has been achieved; in order to do that we have to ask the participants themselves for an explanation. As an observer the researcher can only report that of which they are conscious; they have no access to what is occurring on any other level. In order to know what the parent and HV are doing in the interaction they need, therefore, to be asked and to be able to verbally report what they experienced. All the parents in the qualitative study were able to express themselves when asked about their relationships with HVs as evidenced by the data obtained. HVs trained in the FPM approach (Davis et al. 2002b) had a wider vocabulary for expressing their relational skills than did those who had not. For example, HVs who were not trained in FPM emphasised much more their evidence-based knowledge as the foundation for their relationships [HVs 4 & 6 Appendix 7]. However, these were also the HVs who had most recently completed their Specialist Public Health Nurse training and were, therefore, more aware of their recently acquired knowledge.

A video recording of the interaction acted as a reminder to stimulate recall of the mental processes in operation during the event itself. The foundation of the stimulated recall approach is an information-processing approach whereby the use of, and access to, memory structures is enhanced, if not guaranteed, by a prompt that aids recall of information. The crucial assumption
behind the stimulated recall is the basic one of recall accuracy. Used extensively in second language research and other educational settings recall has been found to be 95% accurate where used a short period after the event [within 48 hrs.]. Accuracy declined as the time between the event and the recall lengthened. The method has advantages over simple post-event interviews in that the latter relies heavily on memory without any prompts. Quoting brain research evidence Gass and Mackey (2000, p.6) explain that ‘human beings tend to create explanations for phenomena, even when these explanations may not be warranted’. This finding is important when considering introspective methods because clearly there is a danger that individuals may create plausible stories for other descriptions of mental activity, without really knowing what is going on. Using a prompt such as a video recording makes this less likely to occur.

3.6.2 Video-recording

In this study, video recording was a secondary means of data collection used solely for eliciting detailed recollection from the participants of a parent/HV interaction.

There can be disadvantages to the use of video, however, as Roberts et al. (1996) report. They cite the cost of cameras, tapes, lighting equipment and a technician as possible drawbacks to this form of data collection. With the advancement of digital technology video equipment has reduced considerably in price, extra lighting has become unnecessary and the usage of video more commonplace so that the use of a technician has become obsolete. This has meant that as a source of data collection it has become increasingly acceptable. Video cameras are much smaller now and the editing and storing of data made easy via computers.

Even so the ‘Hawthorne effect’, which is the effect of the equipment and researcher presence on the data collected, needed consideration (Polit et al. 2001). The presence of the camera may influence the participants to interact in ways that would not be ‘normal’ for them. However, Coleman (2000) cites a study by Pringle & Stewart-Evans (1990) that studied the effects of video on General Practitioner [GP] consultations and whether the awareness of being videoed influenced their consulting behaviour. The study demonstrated that the awareness of video-recording did not influence the consulting behaviour of the four GPs studied. However, Coleman (2000) questions the generalisability of the findings because of the small number studied. The presence of the researcher in this study may have had some impact on the data collected. HV 6 reported,
there were lots of questions I wanted to ask but I didn't dare because you were there...’

This HV was not confident about her relationships with parents, which may have been why she felt the presence of the researcher inhibited her interaction with the mother.

As far as patients were concerned Coleman (2000) suggests that there is no evidence to imply that video recording influences patients’ behaviour. Furthermore, a study by Martin and Martin (1984) showed that 70% of patients who consented to video recording agreed on a post-consultation questionnaire that they ‘forgot’ about the camera presence during their consultation. In this study HV1 commented that she ‘forgot the camera was there after the first few minutes’.

As far as possible, the researcher tried to minimise the effect of the equipment by placing the camera in an unobtrusive position. The effect of researcher presence was minimised as far as possible by remaining quiet and sitting away from the direct eye line of the participants.

The fact that video recordings were to be made of the interaction may have influenced recruitment to this study. Those HVs participating may be different in some way from other HVs who did not volunteer and could possibly limit the generalisability of the research. An earlier study by Coleman (1996) found that GPs who agreed to be video recorded for research were more likely to work in training practices, to be members of the Royal College of General Practitioners and to have been qualified less than 10 years. The self-selecting HVs taking part in this study were recruited across a range of experience varying from 6 months to over 20 years post qualification. Apart from the fact that four of them had undertaken the FPM training (Davis et al. 2002b) they did not differ in any way from other HVs working in the area [Appendix 7]. It was noticeably easier to recruit HVs to the pilot phase when trialling the questionnaires when no camera was present.

Coleman (2000) also reports on whether patients taking part in video recorded research were in any way different from the general population. He concluded that those suffering from overt mental health problems and younger patients may be less likely to consent to video use. However, this finding was only based on three studies so further research is needed. In this study parents consenting to take part were from across the age range and one parent suffered from depression which would indicate that the parents may not have differed from the general population of postnatal mothers where 12.9% may be suffering from post-natal depression (Morrell et al. 2009).
A Lithuanian mother [Appendix 7, Parent 5] suffering from post-natal depression was hesitant about being video-recorded but agreed following reassurance of confidentiality. However, at interview she did not want to see the video so the researcher carried out the interview without this particular aid to recall. Her refusal to watch the video may have had something to do with her state of mental health. As the interview took place immediately after the interaction observed by the researcher, it was still possible for her to recall her thought processes at the time. The lack of video stimulation did not appear to affect the quality of the data collected with this participant.

3.6.3 Verbal Reporting

Following the video recording of the interaction between the HV and the parent an in-depth interview was carried out with each of the participants. At the beginning of the interview they were reminded of the focus of the research and thus of the interview. The video recording was played back to them and they were asked to stop the recording at any point that seemed significant to them in terms of their relationship with each other. If the parent or HV did not stop the recording then the researcher did so to ask, ‘What were you thinking at this point?’ or ‘What was important to you about the relationship at this point?’ [Appendix 4]. Lyle (2003) identified that questioning was a very important issue as,

‘inappropriate probing could lead to additional reflection and analysis’ (p864).

Some probing was necessary however, as participants tended to describe their relationship in terms that were too broad. Further explanation and detail needed to be sought by the researcher. An example of this sort of dialogue is presented below.

[P 1]…. she has got that really open way of making you want to you know open up and talk and sort of be honest and not kind of hide stuff ….  

[Researcher] ..... Have you got any idea about what it is that she’s doing that actually makes you feel like you can open up and talk?

[P1]… I think its ..... her questioning, maybe its all the open ended questions that makes me want to give a bit more than ere em than you would with other questions and stuff.

The interviews were audio-recorded and later transcribed. They were carried out on the same day as the video recording and usually within three hours of the interaction. This was to minimise the potential of participants to misremember their thoughts or create ‘explanations’ for their actions (Henry & Fetters 2012).
This type of verbal reporting is known as ‘self revelation’ or ‘think aloud’ (Ericsson & Simon 1987). The participant is asked to provide an ongoing report of her thought processes while performing a task e.g. ‘I was thinking, what should I say’. The term ‘process tracing’ is also applied to methodologies using verbal reporting.

In this study six dyads [i.e. six HVs and six parents. Appendix 7] participated in the stimulated recall interviews, which revealed rich data. Lyle (2003) suggests that, although there have been no formal research studies which compare the stimulated recall interviews with standard interviews, researchers who have used this method argue compellingly that stimulated recall interviews produce data with greater detail and accuracy than standard interviews.

3.6.4 Interview Analysis & Member Checking with Groups of HVs & Parents

The audio-recorded interviews were transcribed into the qualitative analysis software package NVivo [QSR version 8]. The aim of the analysis was to provide some structure and coherence to the data whilst retaining the original accounts from which it was derived to keep the participants language to the fore. The major goal was to describe and interpret the participants’ experiences of their relationships with each other. The analysis sought to detect, define, categorise, theorise, explain, explore and map the data.

In order to do this ‘framework analysis’, developed by Ritchie and Spencer (1994), was utilised. This analytical process involves a number of distinct though interconnected stages [Figure 3-2.]

1. **Familiarisation.** This followed a process begun with the transcription of the data. Listening and re-listening to the audiotapes for transcription purposes led to familiarisation with the data within each interview. Once transcribed the interview data were read and re-read with notes made of commonly recurring themes.

2. **Identifying a thematic framework.** Although it was important for the researcher to maintain an open mind when considering the data both she and four of the research participants were familiar with, and had been trained in the FPM (Davis et al. 2002b). This provides a model of parent/helper relationships generally [Chapter 1 Figure 1-2.] and suggested various headings that appeared to apply to the data from the notes made during the familiarisation process. This model formed the thematic framework of the
analysis. However, as the analysis progressed the model was adapted to incorporate new headings direct from the data. [Chapter 4 Figure 4-1]

3. **Indexing or free coding.** During this process pieces of data that corresponded to various themes were identified and taken out of the transcripts and put together under that particular heading. NVivo [Version 8 QSR] was extremely helpful in this process by maintaining a link to the place from which the data had come once extracted. This meant that it was always possible to return to the particular section or quote in the context in which it was said.

4. **Charting or Synthesis of data to ‘trees’.** During this phase the data now analysed into various individual themes were further analysed into overarching themes, or in the terms recognized by NVivo, [Version 8 QSR] ‘trees’ e.g. HV understanding became a branch of the tree that was HV qualities [Figure 3-3].

5. **Mapping and interpretation.** At this stage the researcher became aware of the defining concepts of the analysis and was able to build a model showing the range and nature of the relationship between parents and HVs. The concepts and associations were the product of the researcher and participant interaction and should therefore, reflect the participants true attitudes, values and beliefs (Srivastava & Thomson 2009).

The aim of using this method to analyse the data was to make the analytical procedure as well-defined and systematic as possible and to make it accessible so as to enable reworking of the ideas. This was to enhance the transparency (Meyrick 2006) and auditability (Koch 2006) of the data, which was necessary for the credibility of the findings.
Following the analysis, meetings were held with a group of three parents and seven HVs to further discuss and validate the findings. The aims of these groups were to:

1. Ensure that during the analysis the participants views remained to the fore rather than the researcher’s preconceptions and values (Meyrick 2006).

2. Explore a contradictory frame of reference i.e. what more difficult relationships might look like where relationships had broken down.

3. Identify behaviours consistent with building positive relationships.

The meetings were planned to meet the aims indicated above [Appendix 5 & 6]. The groups were scheduled to run for an hour and a half but in the event ran to two hours, as the participants were anxious to continue their discussions. It was expected that more parents would attend the group
but unfortunately, not all of the eight who were recruited were able to come on the morning due to their own unforeseen circumstances.

These discussions were audio-recorded, transcribed, analysed in NVivo and compared with the data from the individual dyad interviews. Common themes and language were identified for inclusion in the questionnaires.

3.7 Rigour of Qualitative Data

There has been much discussion as to what constitutes rigour in qualitative research (Koch & Harrington 1998; Murphy et al. 1998; Oakely 2000; Koch 2006; Meyrick 2006). This dialogue has been fired by criticism that qualitative research is subjective and anecdotal. Those working in the naturalistic paradigm have therefore sought to establish the validity and reliability of their data by means that draw on more positivist ways of operating, for example, by trying to demonstrate objectivity. The dichotomy between qualitative and quantitative methodologies has helpfully been bridged by the suggestion that the commonality for rigour in all research is the avoidance of error (Oakely 2000). This was the basis of a new framework for assessing rigour developed by Meyrick (2006). Following an extensive review of the literature and input from expert groups and practitioners, she built on two core principles for quality in qualitative research, transparency and systematicity.

Meyrick (2006) suggests that initially researchers’ theoretical and epistemological stance be made explicit. There is some relationship here to Lincoln and Guba’s (1985) notion that the credibility of research can be enhanced by investigator credibility as the researcher is not only the data-collecting instrument but also the person to analyse the data. Related to this is Koch’s (2006) assertion that for the research product to be credible the pre-conceptions of the investigator should be made explicit and should demonstrate reflexivity. The investigator, in this case, was experienced in the parent/HV relationship. She is a qualified HV with a counselling qualification who had also been working with HVs and other practitioners training them to relate to parents in the FPM (Davis et al. 2002b) over many years. The researcher, therefore, believed in the importance the parent/HV relationship and this will have influenced her data collection, analysis and reporting. Having worked for and with a number of different organisations during her health
visiting career she was also aware of the influence that different styles of management made to
the abilities of HVs to practice effectively.

Data credibility was also enhanced through the process of member checking with a group of three
parents and seven HVs following the initial analysis (Lincoln & Guba 1985). As the researcher
values and preconception will have influenced the data analysis this was presented to the
participants to ensure that their views remained at the centre of the interpretation of the data
(Meyrick 2006).

The fittingness or transferability of the data is achieved when the findings of a study can ‘fit’ into
contexts outside the study situation and when readers find the study meaningful in terms of their
own experience (Sandelowski 1986). This was striven for by providing a ‘thick description’ of the
interactions and processes observed during the research. However, for Meyrick (2006), the detail
of the group studied, and the context in which this took place is also important. The contextual
details of the participants in this qualitative study are provided in Appendix 7.

The auditability of the data refers to the ability of an independent auditor to follow the decision trail
of the researcher from the raw data through to the final analysis (Koch 2006). An example of this
is presented in Figure 3-3.
P. 5. I know that I can talk with her and she understands and she, she has like experience or at least understands me, how I feel, how it's like...

P1. I think it’s her manner as well she’s really kind of gentle

P6. I found her to be erm someone I could rely upon and, I think the most important thing in the relationship is someone that I trust and trusted very quickly you know and trusted her judgments for me because as a parent you really don’t know a lot of the time.

Figure 3-3. Examples of parent data: raw data to free nodes to trees [NVivo QSR version 8]

It was crucial that the qualitative data demonstrated credibility, as it formed the basis of the questionnaires. The validity of the questionnaires was therefore, dependent on this essential phase of the research. How the indicators were distilled from the data will be presented in the following section and in more detail in Chapter 5.

3.8 Distilling the Content of the Questionnaire Indicators

Parent and HV data were compared with each other and with the data from the analysis of the measures [Figure 5-1, Figure 5-2]. The qualitative findings were re-read and the major themes...
that were important to both HVs and parents identified. These themes were worded into simple statements to which the parent or HV could reply ‘yes I agree’ or ‘no I disagree’.

Following the findings of the qualitative research questionnaire, indicators were formulated for use by HVs and parents for a first meeting, an established relationship meeting, and to measure the influence of organisational factors on the relationship. From the discussion group data it was apparent that at a first meeting different processes were used by both HV and parents to those used in established relationships. The data also revealed that organisational factors affected the abilities of parents and HVs to use their different interactional qualities and skills. Each of the three sets of questionnaires formulated consists of one for the parent and one for the HV to accommodate their different perspectives on their relationships.

3.9 Piloting the Questionnaires [Chapter 6 & Chapter 7]

The questionnaires were piloted across three PCTs with a variety of clients and HVs. The aim was to assess the feasibility, suitability and acceptability of the TELER methodology in the field by:

- Ensuring the acceptability of the wording of the questionnaires.
- Ensuring that the statements were relevant to the many different types of relationships between HVs and parents e.g. between HVs and vulnerable parents, between HVs and those that were less vulnerable.
- Ensuring that the length of the questionnaires was acceptable.
- Ensuring that all items of relevance to parents’ and HVs’ relationships were included in the questionnaires.
- Inquiring as to the relative importance of items contained in the questionnaires so that the need for weighting any of the items might be identified.
- Identifying the circumstance under which it would not be suitable to use the questionnaires.
- Ensuring the instructions for completing the questionnaires were adequate and easily understood by participants.

The processes employed during the piloting will now be described.
3.9.1 Pilot Phase 1 [2010]

During this phase, the researcher visited 36 parents, with their consent, alongside the 11 HVs and observed the visit recording field notes on the interaction and the context in which it took place. The objective for this phase was to trial the questionnaires with a wide variety of families in order to continue the tool development, establishing their content and construct validity. Following each visit, the parent was asked to complete the questionnaire and was interviewed to ascertain its relevance using a semi-structured interview technique [Chapter 6. Table 6-1]. The parent’s comments were recorded in field notes. The HV was also asked to complete a questionnaire and she was then interviewed in the same way, and her comments noted.

A database of participants was constructed in EXCEL. All participants were logged and coded so that parent/HV dyads could be identified for future analysis. Field notes were also recorded on the HV’s team and working environment. The notes included observations of the parent/HV interaction, relationship and any particular problems experienced by the family.

Following this phase the wording of some of the statements were changed and some items removed whilst others were added to reduce item non-response and response bias [Chapter 6].

3.9.2 Analysis of Data – Phase 1.

The production of a measure of parent/HV relationship was attempted with one intended outcome, to be able to describe that relationship in numerical terms. This required the application of numeric codes to the data making the measurement level ordinal. As a result, non-parametric statistical tests were then used for analysis. This process was also piloted and initial results examined as reported in Chapter 6 [6.4].

The data were analysed manually according to the TELER method. This method was chosen so that when statistically analysing data not only would group level data be generated, but also of a more practical concern, data at an individual level would not be lost. This meant that the individual level data remained allowing the possibility that individual problems could be identified and potentially addressed. The researcher remained in contact with the data at all times so that interpretations could be made of the clinical significance of the findings at both the group and individual level. The data were ordinal so the non-parametric chi-squared test was chosen to
examine how much the sample differed from what might have theoretically been expected. The chi-squared test is a test of goodness of fit or a measure of association (Clegg 2001).

The proportion of participants noting a particular item on the questionnaire as a barrier to the parent/HV relationship was counted yielding interval level data. For this a t-test (Clegg 2001) was selected as suitable to determine which of the indicator statements on each questionnaire were statistically significant. These statements would suggest problem areas affecting the relationship between HVs and parents [Chapter 6, 6.4].

Finally a chi-squared test of association (Clegg 2001) was carried out to assess whether the HV and parent data showed similar perceptions of the relationship. [Chapter 6, 6.4]

3.9.3 Pilot Phase 2 [2010/2011] Questionnaire validation through hypothesis testing

It was hypothesised that the number of barriers to the parent/HV relationship identified in the questionnaires would indicate either a poor or a positive relationship. The greater the number of barriers the more problematic the relationship would be.

‘Hypothesis testing is based on a theoretical framework and indicates the expected direction of scores on the measure. Construct validity is supported if the scores reflect the framework as hypothesised’. (DeVon et al. 2007, p.157)

The aim therefore of this second phase of the pilot was to test the newly designed questionnaires to gain support for their construct validity. The processes and results of this are fully described in Chapter 7.

Consistent with the study aims, the questionnaires proved acceptable to 53 parents and 15 HVs; there were fewer comments relevant to the wording of the statements and parents and HVs found the questionnaires simple to complete.

Following home visits the HVs were given questionnaires to use with parents and return to the researcher in a stamped addressed envelope. The procedure for using them was clearly explained with a self-addressed envelope included for the parent. This meant that the parent’s copy was not given to the HV so that it remained confidential to the parent and researcher. Although every HV in the study was given these only four complete sets were returned. An
explanation for this may have been just lack of time on the part of very busy practitioners. For the study, it meant that the sample was smaller than it might otherwise have been.

3.10 Final Analysis of Data [Phase 2]

This followed the analytic procedures established in the phase 1 analysis. However, a new concept emerged as a result, that of clinical significance and how this might best be analysed. By careful comparison of the field notes and observations with the results of the analysis, it was possible to re-code the data for clinical significance rather than according to statistical theory. This final phase of analysis is fully described in Chapter 7.

3.11 Validity and Reliability of Questionnaires

The validity of an instrument is an overarching concept incorporating construct, criterion-related and content validity. Validity is a matter of degree and is therefore an ongoing process for newly formed instruments (Goodwin 1997). The journey towards validity and reliability for instruments developed through this study is begun here and is described throughout the creation of the tools.

3.11.1 Construct validity

The construct validity of the instruments may be defined as the extent to which the items in the questionnaires are an expression of the Parent/HV relationship. It incorporates face validity, the extent to which the questionnaires look as though they are measuring the relationship, content validity, the extent to which the questionnaires represent the range of indicators of parent/HV relationships, and criterion or concurrent validity, which is the extent to which the questionnaires correlate with an external criterion (Polit et al. 2001).

Initially a great deal of care was taken to build the indicators of good relationships from the qualitative data, HV literature and existing measures of helping relationships. The processes of distilling the indicators are explained in Chapter 5. Following this process, the questionnaires went through an initial pilot phase and then adjusted in line with HVs and parents comments. Throughout the pilot phases, parents and HVs were asked if the statements in the questionnaires reflected their thoughts about their relationships and if they wished to add or remove any statements. This process is fully presented in Chapter 6 [6.2.2].

A process of hypothesis testing, which is fully described in Chapter 7, demonstrated that the instruments were sensitive to differences in the parent/HV relationship. The number of barriers
identified through the questionnaires constituted the extent of relationship difficulties, thus proving themselves as measuring the relationship.

The t-test of the items on the questionnaire demonstrated their validity as suitable indicators of the parent/HV relationship.

### 3.11.1.1 Content validity

The content validity of the instruments may be defined as the extent to which the questionnaire measures the range of indicators of parent/HV relationship (Polit et al. 2001).

If the questionnaires show construct validity then it is likely that there will also be content validity. This was addressed throughout the pilot phases of the instrument development. Parents and HVs were interviewed following completion of the questionnaires and notes made of their comments [Chapter 6].

HVs and parents were asked whether they thought the measures were relevant to parent/HV relationships and their responses noted. At no time did any of the participants indicate that they thought that this was not so. Participants thought that the instruments were accurate in reflecting their relationships and did not wish any additions to the questionnaires.

### 3.11.1.2 Concurrent validity

The concurrent validity of the instruments may be defined as the extent to which the scores of the health visitors and parents’ questionnaires were correlated with and external criterion, in this case, observer notes.

The concurrent validity of an instrument is usually tested by using a comparison with a similar instrument (Oppenheim 2001). However, there are no measures of the parent/HV relationship in existence so this was not possible. During the pilot, the researcher was present at each of the interactions between the HV and parent and observed the behaviours of each participant. Where the researcher had noted difficulties in the relationship this was reflected in the questionnaire. A small number [four sets] of questionnaires were completed without the researcher being present so it is not possible to say whether this was 100% true for all the relationships measured.

### 3.11.2 Reliability

The reliability of the instruments may be defined as the extent of the accuracy with which the questionnaires measure the parent/HV relationship.
Although traditionally the reliability of an instrument was seen as a precursor to its validation and separate from it most authors now agree that it is a degree of its construct validity (Goodwin 1997). If an instrument has construct validity then it will be reliable. However, with any instrument it is a question of degree. Most of the questionnaire data were collected after observation of interactions between parents and HVs. This led to questioning the results of the statistical analyses and re-coding the data so that clinically significant relationship problems were not overlooked by over-reliance on statistically significant results. This is further explained in Chapter 7 [7.4].

The reliability of questionnaires was enhanced during the pilot phase by processes to reduce response bias and item non-response.

### 3.11.2.1 Response Bias

A number of steps were taken to avoid response bias. There was a balance of negatively and positively worded statements, and before during and after the pilots account was taken of parents' verbal comments on the wording of statements. This was done to ensure that the statements were easily understood (Oppenheim 2001). A non-judgemental attitude was adopted whilst collecting the data to try to ensure that the parents and HVs could be completely honest in their responses. The confidentiality and anonymity of the responses was guaranteed so that the parents and HVs need not be afraid to answer statements and respond openly.

### 3.11.2.2 Reducing Item Non-response

During the piloting of the questionnaires, any items that were confusing to parents or HVs were removed or re-worded. Care was taken to ensure the indicator statements had unambiguous meanings. If items were not universally applicable, they were excluded. Chapter 6 presents the detail of this process.

### 3.12 Conclusion

Bringing together the ontological paradigms of interpretive inquiry and postpositivism the study was able to develop parent/HV relationship measures that may be useful in practice and in research. Measuring something as invisible as a relationship presented challenges but through close working with HVs and parents it was possible to develop indicators of the relationship that were both visible and observable.
The research methods and design were chosen in accordance with the principles of questionnaire design (Oppenheim 2001). The qualitative research methods were chosen because of the expectation that they would yield the rich data sets and the ‘thick descriptions’ necessary for identifying the parent and HV constructs of their relationships with each other. The TELER method was considered the most effective means of measuring the parent/HV relationship because of its emphasis on retaining contact with individual participant data whilst allowing group level statistical inferences to be made. Findings are reported over the following four chapters, which describe the qualitative study, the development of the questionnaires, the piloting of the tools and the results of the statistical analysis.
Chapter 4 Qualitative Analysis

4.1 Introduction

This chapter reports the findings from data collected from qualitative, video stimulated recall interviews with six parent/HV dyads. The HV and parent interviews provided data sets from which to identify indicators relevant to both sets and to each separately. The analyses of the findings from the interview data were further discussed with a group of seven HVs and separately with a group of three parents. The results of the analysis of both the interview and group data are presented here.

The FPM (Davis & Day 2010) – a generic way of conceiving helping relationships – formed a framework for the analysis of the data [Figure 1-2].

As the analysis progressed, a different model evolved which more clearly demonstrated parent/HV relationships [Figure 4-1].

Figure 4-1. A Model of Parent/HV Working Relationships
The five themes that were identified from the data were:

1. Organisational factors
2. Parent qualities and relational skills
3. HV qualities and relational skills
4. Parent/health visitor relationship
5. The health visiting process.

The service or organisational factors head the list as they were not just the context for service delivery – as in the FPM - but were found to have a direct influence on the ability of HVs and parents to use their qualities and skills to form positive working relationships. Parents were also found to have their own relational qualities and skills, which fed into the parent/HV relationship. In FPM, parents are identified as having particular characteristics but their qualities and skills are not identified. Positive working relationships were found to be crucial to the work of health visiting. Outcomes in health visiting fed back into the relationship and became part of the health visiting process. For example if a parent received sound advice from the HV this fed back into the relationship, building trust for further issues or problems to be explored.

4.2 Organisational factors

This section of the chapter reports and discusses the findings around the theme of organisational factors. To both HVs and parents, these were important because they obstructed parent/HV relationships [Figure 4-2]. Parents wanted continuity of care from one HV and preferred to be home visited rather than attend busy, often crowded clinics. HVs were also concerned about caseload sizes, and the business of clinics, which affected their ability to provide continuity of care. However, they also worried about other issues such as record keeping, and clinical supervision. The HV group added further information to the data reporting the effects of unsupportive management and working in skill mix teams.
Research into organisations has demonstrated that they can be highly influential in promoting worker well-being or stress and burnout. Three core features of successful organisations have been identified: worker involvement, management commitment to shared values and a supportive organisational culture (Murphy 1999). The data in this study revealed that many of these core features were absent from the PCTs involved.

The following themes, which emerged from the data under the heading of organisational factors, will now be explored:

- Clinical supervision
- Continuity of care
- Home visiting versus busy clinics
- Record keeping
- Lack of management support
- Working with other agencies
- Skill mix
- Caseload size

### 4.2.1 Clinical Supervision

This was only mentioned by one HV and not by any of the parents interviewed. The HV concerned was qualified two and a half years and considered supervision very helpful but something that she had to seek out and find for herself. It appeared to confirm her in her practice and as a result, she felt more confident.

[HV6] I'm one person here who gets clinical supervision on a regular basis because I am the baby in the family whatever they say, I've only been a health visitor for two and a half years and I feel that I need regular supervision so I've found someone to
supervise me and she's been a health visitor for a long time..... she says that it seems to her that ... I'm doing the right thing......

4.2.2 Continuity of Care

HV's and parents valued the fact that they were able to meet each other on a regular basis. When a person who was unfamiliar was encountered then there was reticence on the part of the parent to share how she was really feeling, or perhaps ask questions that she had.

[P2] Once when I've been there was someone else. and that's strange because you feel less inclined to talk to someone you've not talked to before, because there is a degree of relationship that's built up over the last three or four months, I suppose, and then when you're faced with someone you've never met before there's a definite element of 'yes everything's fine'. Maybe it is fine, maybe you've nothing to talk about but I'm sure if it was someone you had known before you'd be more likely to ask.

A parent complained about the number of different HVs who visited her at home [3] and found that she could not establish a relationship with any of them.

HV's too, spoke about the importance of being able to see the same client and build relationships with them over time. Because this no longer happened, the relationship did not have sufficient time to become established and the work with the families suffered from an inability to raise difficult issues.

[HV grp K] Well it's difficult to form relationships with clients in the [HV locality] team. Most clients are lucky to get one visit the new birth visit and follow up visits have now gone and also parents now visit a different child health clinic to the one that you work at so in effect you may never see those clients again.

This was in stark contrast to the service that the HVs felt they were once able to provide where they were able to visit more frequently particularly in early parenthood.

Reminiscing about a parent with whom it had been difficult to establish a relationship a HV suggested that in order to access some of the more vulnerable parents it was important to have the time to continue visiting even though the parent was not in or did not answer the door. In the discussion group, HVs agreed that just being persistent might be enough to help establish a relationship.

HV's described ways in which they tried to reach out to those with whom it was more difficult to establish relationships. They did this by relating to the children, admiring a baby and making positive comments in order to build parental confidence.
Where HVs were moved to a smaller team covering just one geographical ward, instead of two, they found it easier to maintain relationships with parents. They did this by deciding that, as a team they should remain linked to the parent they had seen at the new birth visit. There was also a greater chance of seeing the parent in clinic.

4.2.3 Home Visiting versus Busy Clinics

For HVs, home visiting was a preferred way of meeting parents and establishing the relationship that was important for continuing work. It not only allowed them insight into how families lived but also they found the parents more receptive and more likely to respond to their requests for personal information.

The clinic environment was not the place to deal with sensitive issues or to help distressed parents, ideally home visits were deemed more appropriate in these cases.

[HV5] I think … she was really, upset in the clinic, and we were in one room, and I saw that I couldn't really let her go because I could see that she was on the verge of tears, actually, and I took her into another room, she had to wait a little bit for me whilst I dealt with something briefly with somebody else, …we had more privacy and then I remember saying to her, 'I think we haven't got enough time to deal with everything here', it was a baby clinic, and 'I'm happy to come home and see you'.

HV5s were more likely to home visit for problems, particularly for postnatal depression. The GP surgery waiting rooms in which some baby clinics were held could be unsuitable affording little privacy or time. In community clinics, some HVs went out of their way to make the environment as sociable as possible helping parents to feel at ease and introducing them to each other. The majority of parents preferred home visiting as well as they felt more able to divulge issues that were difficult for them.

[P2] Because [HV2] comes into your home to see you, you feel you're much more able to speak freely.

However, when a parent was unable to establish a relationship with a HV due to lack of continuity of care during home visiting she preferred to attend clinic.

Parents also found clinics difficult. Clinic HVs, were unknown to the parent, and were not readily recognisable among other members of staff and this led to parents not knowing whom to ask about the baby's health. With the busy atmosphere of the clinic, they found it impossible to discuss their worries even though eventually they may identify someone with whom they could relate. Parents were just left standing, waiting.
One time there was quite a nice lady but the baby was sleeping and I wanted to ask something but I forget in this moment. OK, OK people are waiting, ‘so you wait there, and when you remember you can ask me later’. And then I waited outside and she was talking to somebody else outside and then I just waited outside, but you can’t talk like that.

4.2.4 Record Keeping

HVs reported that they were hampered in their efforts to relate to parents by new technology that was intended to help them. Computer systems intended, among other things, to speed up the process of record keeping could intrude on parent/HV relationships particularly in the clinic situation where HVs felt that the emphasis on recording parents’ attendance interfered with eye contact and the flow of conversation.

[HV3] Yeh, computerized recording system. All the babies have to go on to there and comments written for attendance which takes a really long time… but I didn't really want that to interfere with the service that we provide, you know. In some places they have reduced the numbers or not doing it but I think … if we start concentrating on that record keeping and those kind of aspects then we lose that personal communication and that's what it's all about.

Record keeping was considered a huge pressure generally in the HV group as a new system of computerised recording was being implemented and so a dual system of electronic and paper records was in use. The time needed for this impinged not only on their face to face work with parents, but also on their ability to take the breaks required for maintaining optimum mental health. Increases in record keeping were also due to the involvement of other agencies; for example the HVs were expected to complete forms for children’s centres, which added to the time spent at a new birth visit not relating to the parent but form filling.

4.2.5 Lack of Management Support

HVs were particularly concerned about lack of management support, for sufficient time to establish relationships with parents. Management, it was felt did not value this way of working.

[HV grp. C] The other thing is, our managers are touting about, when you argue about relationship building, they just say it doesn’t matter, ….that the client should be able to go and see a health visitor and get the same service from every health visitor they ignore the argument.

This was exemplified by what the HVs called ‘scope creep’. By this they meant that managers seemed to undervalue HVs role by extending it whenever they felt it necessary. One, possibly controversial, example concerned the requirement of HVs to undertake two days training and then act as triage nurses in the local hospital during the swine ‘flu epidemic. The HVs considered that
this devalued what they were already doing in the community, but of relevance to this is the way it affected the time they were able to give within their already oversized caseloads; giving time to parents had been identified as key to building relationships with them [4.6.3.5].

4.2.6 Working with Other Agencies

The involvement of other agencies with the work traditionally done by HVs was not always seen as a positive development. Particularly relevant to this was the involvement of Children’s Centre staff with more vulnerable families. They were seen as a relatively low-level intervention because they did not have the skills required to work with families that were more complex.

[HV grp. C] I think the other thing is about the impact of children’s services because from my experience in Sure Start they were fine at low level intervention but anything more complex was sort of out of their league, out of most people’s league, and it does actually need to go to social services but I think there is a naïve expectation of some of the workers in the children’s centres’ that they, you know, have more skills than they actually have.

Children’s Centres were also seen as part of a fragmentation of services that was unhelpful for parents.

[HV grp. K] It's not [an integrated service] they’re [children’s centre staff] making decisions on behalf of the centre and we’re making decisions in isolation as well and there’s confusion and fragmentation for everybody.

Other health services, also under pressure, seemed to be closing their doors. Particularly highlighted was the midwifery service where shortage of midwives now meant that mothers had to attend the hospital to see the midwife rather than receive a home visiting post-natally. In addition, the local Child and Adolescent Mental Health services (Department for Children, Schools and Families & Department of Health 2008) were under mounting pressure and had closed their local community service.

Whilst families seemed to be increasingly complex there was an anxiety that other services would not take referrals of families in need because the threshold for acceptance was set too high. This was particularly true of Social Services where the need to refer was something that the HVs were doing more regularly. Previously they felt that they could get to know and support parents and that this may have prevented referrals. Because of the amount of time spent on child protection issues there was felt to be no equity of service delivery to parents. There was anxiety about health needs being missed in the ‘big uncharted pool,’ reflecting the pressure on the role of HVs...
to provide a ‘universal service’. There was also the concern that other services, particularly adult mental health services, might not be aware of children’s needs.

### 4.2.7 Skill Mix

The HVs were adamant that the pressure on their time meant that their work had become restricted to dealing with safeguarding issues rather than providing a universal preventative and health promotional service. This was now being provided by staff nurse members of the team leaving HVs with a lack of job satisfaction.

[HV grp. N] I think if you think of all the things we used to do like weaning, feeding, you know all of those things we’re just skimming the surface now. [HV grp. D] One of the staff nurses here said to me this morning, we were talking about her doing her health visitor training. She said, ‘Oh but really why would I because all the things you used to do I can do as part of my role now, that’s what I really enjoy because what you’re left with is safeguarding’, which is very true isn’t it? [HV grp. N] But that’s what I want to do actually, I want to be a staff nurse and feeding and weaning and…

### 4.2.8 Caseload Sizes

In this inner city area of urban deprivation the size of the HV caseload was a very important factor influencing the ability of HVs to establish relationships with parents. Caseloads for all the HV teams were all well above the recommended levels (Cowley & Bidmead 2009a). This is not unusual in England and caseload sizes are generally extremely variable and not linked to areas deprivation (Cowley et al. 2007). HVs could not readily say how many were on their caseload as they worked as a team typically covering two wards. However there was general agreement that unless they had a specialist role e.g. for the homeless then the size of the caseload was unmanageable [typically in excess of 400 under-fives to one fulltime HV]

[HV grp. D] Our caseload is much smaller than….the other corporate teams, because of the nature of them being in hostels and so you do find that you can keep, even though we’ve got travel because we cover the [Locality] as well, but you can make relationships, but because you have a smaller number of people, so it is quite interesting doing the corporate working, you can do it but we do have probably about a third of probably what the other teams have so you can do it with that number but certainly not with the sizes other people are having to work with.

### 4.2.9 Discussion

The data analysis revealed that HVs were working under pressure because they valued their relationships with parents and were trying to maintain them even though organisational constraints on their practice were making this very difficult. They were keen to provide a good quality service to parents in spite of the problems encountered. However, the way in which organisations manage services in primary care is known to affect the quality of care (Bower et al.
There is also a link between hospital organisation and the quality of patient care (West 2001). Although there is little research in this area in health visiting, it is likely that there is a link between the organisation of health visiting services and outcomes for parents and children. This is not a new idea, as Chalmers (1992) in her theory of HV practice suggested, that ‘the availability of referrals to resources such as health and social services, the time the HV has available for client work and material resources would influence what the HV perceived she could offer clients. When resources are limited, the HV may feel she has little to give to address clients’ needs and clients may respond by not receiving any HV offers’ (p.1324).

The time available for parent face-to-face contact and the availability of referrals to other resources were found to be severely compromised in this present study. This was an ongoing source of worry and concern to HVs.

Apart from child protection supervision regular supportive clinical supervision was not provided in health visiting; yet high levels of stress have been found to be amenable to sessions of restorative supervision (Wallbank & Hatton 2011). Social services research on supervision, found that there was a significant impact on workers themselves with respect to reduced anxiety, depression, somatic complaints, burnout and turnover (Barak et al. 2009). Clinical supervision has also been an integral part of successful interventions in health visiting (Barlow et al. 2003; Brocklehurst et al. 2004; Davis & Tsiantis 2005; Barnes et al. 2011). A review of clinical supervision literature between 2001 and 2007 concluded that organisations had a responsibility to ‘sustain and develop’ clinical supervision and that there were potential benefits on patient outcomes (Butterworth et al. 2008). Such benefits have been demonstrated in psychotherapy research where supervision has been shown to be effective for the working alliance, symptom reduction and treatment retention (Bambling et al. 2006). The provision of regular clinical supervision for HVs should be part of the supportive organisational culture mentioned at the beginning of this section.

HVs, in this study, found that their ability to give continuity of care to parents was severely hampered, due in part to the high numbers on their caseloads. In 2006, Netmums carried out a survey of 6,000 parents. 70% of parents said that they would like to have one dedicated HV, who knew their family, rather than being seen by different individuals from a team (Russell 2008). Moreover, a recent systematic review of the association between continuity of care and outcomes found that increased provider continuity is associated with improved patient outcomes and satisfaction (Van Walraven et al. 2010). As well as parents, HVs, in this study, would also prefer
to give continuity of care. This was of paramount importance and nearly all of the other factors identified influenced continuity by affecting the amount of HV time available. From the characteristics of home visiting interventions that led to improved client health outcomes, it is known that consistent contact with one nurse is important (Olds 2006). If health visiting practice were based on this evidence then the aim would be to carry out six to 12 home visits per family spread over a minimum of a year within a multifaceted programme designed to promote family wellbeing and prevent child abuse (Macleod & Nelson 2000; Bull et al. 2004). The size of caseloads and the time spent on record keeping and attending meetings means that this is rarely, if ever, achieved.

In this study, HVs regretted that many of the parents that they visited at home were not seen again in the clinic setting. They were unable to develop relationships with parents through clinic contacts. Clinics were experienced by HVs and parents as busy, rushed environments where HVs did not know the parents and parents could not easily identify a HV. Mothers in the Oxford intensive home visiting study also found clinics unsuitable for anything more than a general conversation with the HV (Kirkpatrick et al. 2007). The Netmums survey (Russell 2008) also found that clinics were unsuitable places for parents to talk privately about their problems with the HV seemingly rushed off her feet.

The size of teams and the allocation of tasks within the team were issues that the HVs in this study found difficult. Recently Griffiths (2011) warned against the introduction of skill mix in nursing without a rigorous assessment of patient needs. As he points out, the prevailing management ethos of ‘faster, better, cheaper’ may not always lead to positive patient outcomes. In health visiting, skill mix has been introduced without the required rigorous assessment of need or evidence of what works best for child and parent outcomes in this regard. Moreover, it is clear from survey evidence of parents that they would prefer to have parenting support and child health advice from a trained and up-to-date health visitor (Family and Parenting Institute 2007). The introduction of skill mix team working in this study meant that HVs were not always able to maintain contact with the parent that they home visited at the new birth. However, on a more positive note there is evidence to suggest that the presence of nursery nurses in HV led teams is associated with more group work, whilst adequate administrative support is associated with a more comprehensive and multifaceted health visiting service (Cowley et al. 2007). Where skill mix teams have been introduced training, support and supervision by HVs have been considered
essential (McIntosh & Shute 2006). However, the effect on HV loss of face-to-face contact with parents as a result needs to be accounted for when determining caseload sizes as this will result in less HV time being available for establishing and maintaining relationships with parents.

HVs in this study experienced their managers as unsupportive of their relational work with parents. Whilst HVs valued the ability to establish and maintain relationships with parents, they felt that managers did not. In effective organisations there are shared values with a shared commitment to organisational goals (Murphy 1999). It is interesting to note that a positive, transformational style of leadership in nursing has been demonstrated to be linked with increased patient satisfaction and reduced adverse events (Wong & Cummings 2007). If managers and HVs have a shared view that parent/HV relationships are important to child and parent outcomes then perhaps organisations might be experienced as supportive and thereby more effective.

The organisational issues identified by parents and HVs highlighted the need for parents and HVs to have time to develop relationships in an unhurried atmosphere. They needed to be able to see parents on a regular basis and home visiting was the preferred method of doing this as clinics were identified as rushed and often not providing the same continuity of care that was ideal for creating trusting relationships. Seeing the same person on a regular basis was the foundation for the parent to be able to relate their worries.

Table 4-1 below, identifies the organisational facilitators and barriers to relationship building in health visiting. It is clearly necessary for management to value this approach to health visiting so that organisations might facilitate a structure that supports practice and the desire of HVs to provide a universal service built on the foundations of partnership with parents.
Table 4-1. Organisational Facilitators and Barriers to Relationship Building in Health Visiting

<table>
<thead>
<tr>
<th>Facilitators for Relationship Building</th>
<th>Barriers to Relationship Building</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Continuity of care</strong> (Russell 2008; Van Walraven et al. 2010)</td>
<td>No continuity of care</td>
</tr>
<tr>
<td><strong>Home visiting</strong> (Bull et al. 2004)</td>
<td>Intrusive home visiting</td>
</tr>
<tr>
<td><strong>Clinics with staff continuity</strong> (Bowns et al. 2000)</td>
<td>Busy clinics (Kirkpatrick et al. 2007) with no staff continuity</td>
</tr>
<tr>
<td><strong>Smaller caseload sizes –small teams</strong> (Bower et al. 2003)</td>
<td>Corporate working- Large teams</td>
</tr>
<tr>
<td><strong>Management support</strong> (Wong &amp; Cummings 2007)</td>
<td>Lack of management support</td>
</tr>
<tr>
<td><strong>Working in partnership with other agencies</strong> (Evans &amp; Killoran 2000)</td>
<td>Fragmentation of services</td>
</tr>
<tr>
<td><strong>Equity of service</strong></td>
<td>No equity of service</td>
</tr>
<tr>
<td><strong>Clinical supervision [individual interview data only]</strong> (Butterworth et al. 2008; Barak et al. 2009; Wallbank &amp; Hatton 2011)</td>
<td>Skill mix</td>
</tr>
<tr>
<td></td>
<td>Record keeping –dual system</td>
</tr>
</tbody>
</table>

Organisational factors influence parent/HV relationships; they cannot be ignored and should be included in any consideration of the indicators of good relationships. HVs and parents may have good relational qualities and skills but if they cannot meet on a regular basis then a basic requirement enabling their relationship development is not being met, giving them little chance to exercise those same qualities and skills. Indicators of parent/HV relationships cannot be considered in isolation from the organisational factors that may diminish the exercise of those qualities and skills. This chapter now continues to identify what the relational qualities and skills of parents and HVs might be.

4.3 Parent Qualities

There has been a tendency in studies on nurse/patient relationships to focus on nurse communication skills (Jarrett & Payne 1995) and this has also been the trend in health visiting research. Little has been written about the parent’s contribution to the relationship. Jarrett and Payne (1995) suggested that future research consider not only the nurse contribution to the relationship but also the patients.
In the present study, HVs and parents identified parental qualities and skills that were deemed to enhance their relationships with HVs. This section of the chapter will consider the parental qualities.

HVs identified three qualities that parents contributed to the relationship, interest, friendliness and respect. Parents and HVs shared the opinion that trust in the HV along with openness, honesty and genuineness were important qualities that enhanced the parent relationship with the HV [Figure 4-3].

![Figure 4-3. Parent Qualities. Comparison of HV and Parent Themes](image)

Overall five parental qualities were identified:

- Friendliness
- Trust
- Openness, honesty and genuineness
- Interest
- Respect.

Parent qualities may be seen as the internal resources that they bring to the parent/HV relationship. They may be resilience factors that can be utilised when parents are facing difficulties. The ability to trust for example is an essential ingredient of a positive and productive relationship without which the work of health visiting would not be able to proceed (Jansson et al. 2001).
4.3.1 Friendliness

The friendliness of the parent towards the HV enhanced the way that the HV felt about the parent and thus enhanced the trust in the relationship. When it was present, HVs were more likely to trust parents to find help when they needed it.

[HV2] I think she appreciated my input and I can trust her to come to me if she needs something, I think, and she’s very friendly and very affable.

However, the ability of the parent to be friendly depended on the parent’s constructs or perceptions of HVs. When parents first encountered a HV their perceptions could be coloured by previous experiences of health professionals and other authority figures. This influenced their behaviour and had consequences for the parent/HV relationship.

[HV grp. D] With the younger ones, they have this idea about authority figures, don’t they? And they have a stereotype about us just as much as we might, you know, and I think it’s about trying to break that down, isn’t it? And make them realise that we’re not necessarily how they think we’re going to be.

However, this did not mean that parental perceptions of the HV could not be changed. By working hard to ensure that parents had a good experience HVs sought to encourage the parent to maintain a link with the service. The parent constructs of HVs influenced their ability to trust them fully.

4.3.2 Trust in Health Visitor

HVs identified the parent’s trust in them as crucial to the relationship. When HVs were experienced as going out of their way to help a parent - for example, arranging a home visit for a distressed parent attending clinic - the parent felt more in control of the environment and was more able to tell her story; this helped to build the trust in the relationship. This ability to give continuity of care also aided the development of trust.

[HV5] When I did go home she found, I think she found, there was no threat from telling me the stuff that she needed to hear and iron out in her own mind. erm... That, I think, she kind of developed that trust and she did allow me very freely to come back the second visit and again another visit......

Parents identified that their ability to trust the HV was dependent on the HVs’ reliability, their ability to be non-judgemental and to give sound, effective advice. HVs demonstrated reliability by returning telephone calls and giving helpful suggestions about child health care issues.
The parent’s ability to trust the HV had a bearing on their ability to be open and honest.

### 4.3.3 Openness and Honesty

The HVs identified openness as a key quality of the parent; it enabled health needs to be identified and appropriate services mobilised as necessary. If the parent was open and there was a lack of defensiveness then they were more likely to use the service. This receptivity was helpful to the relationships that they had not only with HVs but also for relationships with and access to other services.

Parents felt that their ability to be open and honest was to do with the way in which the HV did not judge them or make them feel ‘silly’.

> [P3] I don’t think there’s anything I couldn’t say to her. When he had the eczema for example I sent her a text saying maybe it’s an allergy. I was in a panic thinking about what it could possibly be and she never made me feel silly.

It was important that parents felt that they could talk freely to their HV; the fact that she was outside their immediate circle of friends and family made it easier to speak their minds and even at times to disagree.

The parent’s group data indicated that they were only able to be honest and open when the relationship became established; for some this would not be at the first visit. Time was needed for relationship development and only then would the parent feel comfortable enough to be really honest.

> [Parent grp. A] I guess, especially the first time, that sort of, you answer questions half-heartedly, not being completely honest, because it's such a new relationship and now I'm probably much more honest because I feel more settled in myself and I'm now at the point where it's ok to ask for help whereas in the first week or so you want to be that maverick of ‘I can do this’.

However, this could only happen, if the HV was experienced as a non-threatening presence, maintaining a non-judgemental attitude and open to the parent’s experience.

> [Parent grp. C] I think certain questions that the home visitor might have asked me I wouldn’t have answered honestly I would’ve said anything that I thought they wanted to
hear because of how they were with me….I think if we had had a better relationship I would have asked and said that I’m finding it quite upsetting when the baby’s upset…

4.3.4  Interest

When establishing the relationship HVs found it helpful if parents demonstrated an interest in the service that she provided. When parents were able to do this then HVs felt the relationship was valued and appreciated. They were then able to trust that the parent would attend the clinic. For HVs this was a good indicator of the fact that the relationship was well established.

[HV2]  Well, because I knew she would attend because mum and dad were interested, when I've been round and seen them both, they're interested in the service, interested in the red book, interested in what I was saying and asking the right questions you know and showing insight into how S [baby] was and services as well, the midwifery services.

4.3.5  Respect

When the HV felt respected by the parent and her opinion valued then this had an effect on the service provided by the HV. The HV was more likely to put herself out to do as much as she possibly could to help the family. Although the HV was at pains to explain that she always did her best for families, the fact that a parent was able to demonstrate respect made it easier for her to establish a relationship and provide a service.

[HV2]  She just seemed to be respectful of my opinion as well…so I guess it goes both ways doesn't it…I try to do my best for parents so I will put myself out to do as much as I can to help them.

4.3.6  Discussion

This study found that the qualities that parents bring to their relationships with HVs were an important factor and may influence the level of service offered by the HV. There is little existing research in this area. There is more regarding the patient characteristics within psychotherapy literature that may also throw some light on the difficulties that HVs sometimes encounter when trying to establish relationships with parents in the community. In psychotherapy correlations have been established between social support, complexity of mental health problems, disturbances in social and work relationships, coping style and treatment outcomes (Beutler et al. 2002); treatment outcomes are highly correlated with the quality of the working alliance (Lambert & Barley 2002).

The findings regarding parental qualities in the present study are a reflection of existing research within public health nursing and health visiting. For example parental friendliness was something
that Jack et al. (2005) found to be important to parents as a mechanism to reduce the formality of visits by encouraging social exchange and limiting family vulnerability. Parents sought mutuality by scheduling visits at times when there were few distractions and often offering refreshments. In the Jack et al. (2005) study parents appreciated public health nurses who were caring, empathetic and respectful. They responded to them when conversations were friendly and filled with humour, with a mutual exchange of ideas.

The ability of the parent to be friendly depended on her existing preconceptions or constructs of HVs. These constructs have been formulated through previous encounters with authority figures, other health professionals, and social care providers. This may influence parental interest in, and receptivity to the HV and her offer of a service (Chalmers 1992). Parental negative constructs however, can be overcome when HVs demonstrate an approach that is friendly and warm (Kirkpatrick et al. 2007).

The ability of parents with young children to trust is essential in establishing a positive and productive relationship, without which the work of health visiting could not proceed (Jansson et al. 2001). As in the Oxford intensive home visiting study it took time for some parents to establish relationships with HVs and develop this trust (Kirkpatrick et al. 2007). They did not feel that they could be completely open and honest during a first encounter, particularly where the HV communication skills were poor. When parents felt uncomfortable with the HV there was a lack of honesty as also reported by Jack et al. (2005). The parents controlled the interaction and amount of information that they would give thus blocking HV entry into their situation more fully (Luker & Chalmers 1990).

In the present study where parents were friendly and able to trust the HV, they could be open and honest but only if the relationship was allowed to develop over time; openness and honesty were difficult to achieve for some during a first encounter. The qualities that a parent uses in relating to the HV may be an important indicator of the ability to maintain the relationship and may influence the offer of service that the HV provides. Future research on parent/HV relationships needs to consider the parent’s contribution more fully and the influence that this may have on the identification of needs and the level of service offered.
4.4 Parent Relational Skills

This section of the chapter considers the relational skills that parents bring to their encounters with HVs. Hunt and Meerabeau (1993) in their paper, exploring the expression of emotion, show that patients often use communication skills to control the flow of the conversation, keeping it ordinary in spite of an emotionally charged situation. As already mentioned in the section on parental qualities, other researchers have also identified that parents may control the interactions with HVs (Luker & Chalmers 1990; Jack et al. 2005). However, they do not specify the skills that they use to do this.

In this study, only HVs identified the first two skills but both parents and HVs identified the third.

- Good communication skills
- Information seeking
- Reciprocity

![Diagram](image.png)

Figure 4-4. Parent Relational Skills. Comparison of HV and Parent Themes

4.4.1 Good Communication Skills

The ability of the parent to explain and talk about their problems worries or concerns affected not only their relationship with the HV but also the service offered. It was appreciated by the HV when the parent was able to do this as it facilitated the work allowing her to identify possible health needs.
4.4.2 Information Seeking

The ability to ask for help and look for answers to questions was important to parents’ relationships with the HV. The HV appreciated the enquiring mind of the parent.

[HV3] She’s questioning, looking for information, which is good.

The parent group data showed that although parents needed to ask questions, this was clearly linked to an overall lack of confidence rather than parents exerting their power and taking control of the interaction.

[Parent grp. L] Erm, I think maybe, especially when it’s your first baby, I think you might feel silly asking things, it might not be but you forget and feel a bit…. you might not have the confidence to ask questions that you want to ask.

In the clinic situation, the HV was keenly observed and listened to by the parents. Her skill in dealing with others inspired confidence in new parents giving them the ability to ask questions and get the information they needed.

[Parent grp. A] Hearing other people asking questions and no matter how trivial they seem, it builds confidence in me, as well because I can see how they [the health visitors] respond to other people’s questions and it makes me feel confident in asking my own silly questions.

4.4.3 Reciprocity

The parents were at pains to demonstrate that they were ‘trying hard’ and seemed to feel that unless they did then the HV would not necessarily be as helpful as she might otherwise be. Parents in the parent group were all breast-feeding their babies and wondered if they would have as much HV support if they were bottle-feeding.

[Parent grp. L.] Yes, they’ve got to see that you’re trying hard otherwise why should they make the effort if you’re not.

Interestingly the HV interview data reflected this theme seeming to agree with this point that when the parent was respectful of her opinion she was more likely to put herself out for the parent to help them as much as she could [p.108.]. When this interpretation of the data was presented to the HV group, they refuted the idea that the quality of the relationship with the parent was an indicator of the service that was offered. They tried hard to provide an equitable service in spite of difficulties with relationships.
[HV grp D]......You have to do your job in a way that is professional, that is respectful of them regardless of how they might behave and to do that, but ultimately, I don’t think you can because they won’t have characters that allow them to be like that because they’re damaged in many ways aren’t they? But I don’t think that means that you shouldn’t actually you know deal with them at the same level …the same level of care and support and style even though it’s very difficult at times.

4.4.4 Discussion

It was clear from the data analysis that parents did exercise control over their interactions with HVs. However, their inability to give information to, or seek information from the HV may not have been entirely governed by their need to control the conversation but may have been due to a lack of confidence. Parents appreciated being given information that they needed without requesting it especially during the initial contact with the HV. On the other hand asking questions may be a way in which parents can exercise their control in their interactions with HVs, keeping the lead in the conversation to ensure that their needs are met (Kettunen et al. 2002).

‘Giving and receiving’ is a well-documented way of conceiving the health visiting process (Chalmers 1992). HVs and parents control the interaction by regulating what they offer and receive from each other. This was clearly expressed in this study with the HV’s perception of respect for her opinion defining the service that she might offer [p. 108]; whilst the parent ‘tried hard’ in order to show that she was worthy of the HV’s efforts [p.111]. Although the HV group disputed the idea that the way that the parent related to them had any bearing on the service offered there was some evidence in the interview data and from the parent group to support this idea.

If the relationship developed in health visiting is a two-way process of partnership, the contributing factors of the parent cannot be denied. The constructs that parents have of HVs will affect the parent’s use of their qualities and skills. Clearly, it is not sufficient to consider the HV input alone or to ignore the organisational impacts on that relationship. Both will affect the relationship and possibly the offer of service by the HV and receptivity of the parent. The extent to which parents feel able to use their relational qualities and skills are indicators of the extent to which the relationship with the HV has developed. This in turn may be dependent upon the use of HV qualities and skills.
### 4.5 Health Visitor Qualities

The qualities and characteristics of helpers generally have been outlined in the literature about helpers (Rogers 1959; Egan 1998; Carkhuff 2000; Davis & Day 2010). Davis and Day (2010) highlight, respect, genuineness, empathy, humility, quiet enthusiasm, personal integrity and technical knowledge and expertise as crucial qualities and characteristics of helpers. Carkhuff (2000) particularly emphasises the importance of empathy whilst Rogers (1959) focuses on respect or unconditional positive regard and congruence or genuineness as important qualities.

This section of the chapter reports the findings of this study regarding the HV qualities and characteristics. Whilst some of those mentioned in the literature were evident, others were not. Personal integrity, quiet enthusiasm and humility were not mentioned by HVs or by parents although ‘caring with motivation to help’ might mirror Davis & Day’s (2010) quiet enthusiasm.

Not all the qualities identified by HVs were identified by parents and not all the qualities identified by parents were identified by HVs. However, there was some overlap between the two [Figure 4-5].

![Figure 4-5. HV Qualities. Comparison of HV and Parent themes](image-url)
HVs and parents identified nine qualities between them necessary in a HV for the building of a good relationship. They were:

- Knowledge and experience
- Empathy and Understanding
- Availability & Approachability
- Honesty & Genuineness
- Respect – reliability, politeness, punctuality, encouragement and flexibility non-judgemental attitude, interest
- Trust in parent
- Calmness and gentleness
- Caring with motivation to help
- Friendliness, sense of humour.

4.5.1 Knowledge and Experience

This characteristic of HVs was of paramount importance to both HVs and parents. HVs were valued by parents for their knowledge, which they recognised as being evidence-based. HVs too valued their evidence-based knowledge as being part of their professional role that made their advice different from the advice sought from family and friends.

[HV4] When we started to talk about weaning ........ she'd obviously been having some discussions with them [family] and often that is a topic where clients have had input from family and friends but we're [HVs] able to bring more recent and up to date research based advice and so ...... I find I'm often different ....That is an example of where I would see health visiting being different because of that evidence based knowledge.

Parents valued not only the HV’s knowledge but her experience also. Moreover, when good advice was given by an experienced HV the relationship was strengthened, building trust not only in the advice but also in the HV herself.

HVs also valued their experience as they realised the impact it could have on the lives of the parents and children. They realised that what they told parents would carry a lot of weight as they were perceived as professional and experienced people.

4.5.2 Empathy and Understanding

Carkhuff (2000) presents ‘empathic understanding’ as an important quality in helpers. On the other hand, Davis et al. (2002a) defined ‘empathy’ as ‘trying to understand’. This definition allows for the fact that helpers may never really understand another’s reality but the effort of ‘trying’ to understand may be all that is required. When faced with parents from other cultures whose first language is not English, HVs may struggle to comprehend a parent’s story. This
element of ‘trying to understand’ was only identified as a theme in the HV data, which seemed to imply that the parent might not have been aware of the HV’s struggle.

[HV5] I have to really try hard to listen and to understand and not to be distracted by the language really and by putting it together.

Only one HV actually named empathy as an important quality but others showed empathy whilst discussing and explaining parent’s concerns and difficulties. They demonstrated this by their facial expressions and by the words that they used. Even when the HV group were discussing parents with whom it was difficult to establish a relationship their understanding of the difficulties that these parents, who were young teenagers, might have was evident. They spoke of the teenage parents poor experiences with other authority figures and of the fact that some may have been in care and find it difficult to relate.

Parents were very appreciative of the HV’s empathy, which was spoken of as their ‘understanding’. They found it a relief to talk because they felt understood.

[P1] You’ve had a bit of weight lifted off because you’ve talked to someone who obviously understanding what you’re going through.

4.5.3 Availability and Approachability

The fact that the HV was available by telephone and could be contacted easily was important to both HVs and parents especially at the beginning of the relationship when parents felt less confident.

[HV6] I was always there when she needed me, ok, always available for everything, helping her out, and all the rest of it at the beginning.

Parents particularly appreciated this aspect of health visiting practice so that when questions arose they would feel comfortable to contact the HV by phone. Not only did the HV have to be available but also approachable.

[P4] Now I'm seeing her again and she's gave me her phone number so I could speak to her if I've got any questions, I could phone her up and that, which is good because I do feel like I could actually phone her.
4.5.4 Honesty and Genuineness

HVs felt that they needed to be honest with parents about the service organisational constraints that might affect their relationship. One HV was careful to explain to parents that they would not see her at the clinic that they attended.

[HV4] I suppose being clear about the system and not raising their expectations that they're going to see me but making it clear immediately.

The work of trying to be honest and open with parents was discussed in the HV group where it was admitted that they were not always as honest as they might be. It was felt that by trying to have a non-judgemental style of relating and trying to be very supportive meant that sometimes the honesty became a 'bit lost'. Moreover, this style of relating meant that dealing directly with people became difficult with detrimental consequences for relationships with parents that were more vulnerable.

Parents too needed a relationship with the HV where they felt that they could be 'brutally honest'; the fact that the HV was outside their normal circle of family and friends was felt to make this possible.

[P2] You need somebody who's slightly removed but has your interests at heart and you can be brutally honest.

One parent explained that it made it easier for her to tell the HV when she did not agree that a particular piece of advice was going to work for her and her baby.

Alongside the quality of mutual honesty sits genuineness, which may be defined as the effort that one makes to be sincere, not to play a part, and to be real and consistent (Davis et al. 2002). Parents seemed sensitive to the genuineness of HVs concern and remarked on the fact that HVs seemed 'genuinely interested' in them and their babies. They really appreciated this, as it seemed to help them feel that HVs were alongside them in their 'current adventure'.

4.5.5 Respect

Respect may be defined as a valuing of the other, thinking positively and constructively about them no matter their problems, background or present circumstances (Davis & Day 2010). For HVs and parents, this notion of respect incorporated a non-judgemental attitude, interest in the parent, politeness, praise, punctuality and flexibility of approach.
Of all the factors that go to make up respect a *non-judgemental attitude* was considered the most important. This particular quality differentiated HVs from friends and family. It was of paramount importance to enabling the parent to feel comfortable enough to express her needs. For example, one parent reported that with her first child she had post-natal depression but that she could not reveal this to anyone. With the second child she was determined it would be different. The non-judgemental approach of the HV was crucial to her being able to get the support she needed.

[P4] ….it’s important that you don't feel like you're being judged and that they're there to help you rather than to criticise, which is really good.

Although respect goes beyond *interest*, it was nonetheless important to parents that HVs were interested in them and their families. The fact that the HV expressed an interest in the parent and the wider family and not just the baby ensured that the parent felt important helping to raise their self-esteem.

[P1] She’s asking about my husband as well and when I mentioned that my mum was coming as well next week it was like, it was all kind of, you know, she was interested in me rather than just the baby.

HVs respected parents for the struggles that they had to face and also their views and opinions.

[HV6] I hope [that she] trusts me, to feel safe because you know …. It’s about safety and confidentiality and respecting her as a person and her views.

For example, when a Lithuanian mother was struggling with postnatal depression and social isolation along with visa problems the HV expressed her admiration of her ability to care for her son as well as she had.

Although parents did not speak about the HV respecting them, one parent spoke of the HV’s *politeness* as being important in her ability to be open.

[P4] It's helpful if people are polite and that it does it really makes a difference to me…I wouldn't be able to speak to somebody properly and open up and want to talk to them if they wasn’t friendly and polite like.

This theme of politeness was only present in the parent data. The fact that the HV was polite meant that the parent was more able to be open in her discussions with the HV. When this theme was discussed in the parent group, the parents identified some aspects of more difficult relationships where this aspect of the HV approach seemed to be absent. HVs failed to introduce themselves and there were difficulties around *punctuality*. For example, when there was a
disagreement about the timing of an appointment and the HV was disrespectful then the relationship had the potential to break down.

On the other hand, HVs demonstrated respect by being reliable, returning phone messages and doing what they said they would do.

[HV 3] Any time she's made calls or left messages for me to contact her I've always followed things up I've always tried to follow up whatever is necessary for her and see that through and that way you know shows a reliability so then she knows that she can trust me I think that if you let her down by not following on that would have an effect on the relationship.

This also built trust in the relationship and parents felt secure in the knowledge that if they had a problem then they could leave a message and they could be sure that the HV would return their call.

The HVs demonstrated great respect for parents by trying to be flexible about the arrangements for home visiting, trying to visit at a time convenient to the parent. They tried to use professional judgment as to the level of support needed in spite of organisational constraints about the number of visits they should be delivering in an area of high need. They also demonstrated flexibility in the advice that they gave trying to affirm and respect the parent’s decisions. Adopting a non-judgmental stance, they were willing to compromise unless there were clear adverse effects on the child.

When HVs offered praise to a parent for the care that they were taking of their child, they felt respected by the HV. It helped to build their confidence and feel that they were ‘doing a good job’. Moreover, they felt that the HV trusted them with their child.

4.5.6 Trust in the Parent

HVs felt it was important to the relationship to be able to trust the parent; moreover, parents were aware of the HV’s ability to trust them or not.

[HV2] Well, I suppose, because I felt she was taking on board what I was saying I knew she would come back, I knew she wouldn't just drop out of the system so ‘cause that's another thing I'm always thinking about. Can I trust this person to come to the baby clinic and get the six weeks check done and the immunisations? So there's trusting in there.

By way of contrast, the HVs in the group also spoke of their lack of trust of some parents. HVs found some parents, particularly those that had mental health issues or child protection issues,
difficult to trust. They realized that their lack of trust in the parent had the potential to damage their relationship and this could cause the HVs difficulties. For example, knowing that the HV did not trust her, a mother avoided her by attending different clinics; lack of HV trust also caused the father of the child to be aggressive towards the HV at home visits. When this occurred, it was very hard to continue to offer a service.

[HV grp. N.] I had one where social services came to the team of about two years ago and the child was being neglected and was actually starving and I referred him to the hospital and ever since then I've had a really difficult relationship with her and the family and I always feel that the mother’s coming to one clinic and she moved the clinic she came to another clinic as well, so there’s a lot of avoidance there and because they're a child, you know, a child in need and I have to visit at home and the father is quite aggressive towards me so that damages the relationship and my ability to offer more support as well, you know, and the child is in the middle of all this as well.

4.5.7 Calmness and Gentleness

These qualities in HVs are central for parents to feel that they can talk freely.

[P1] And I don’t think anything would faze her and she’s just completely calm and that whole kind of personality just makes me think that it’s ok I can say anything. I think it’s her manner as well she’s really kind of gentle.

A calm and gentle approach seemed to relax the parent so that she could speak easily of her difficulties. It helped the parent to feel unafraid to express her concerns.

4.5.8 Caring

Parents identified this quality in HVs as essential in the relationship.

[P6] She obviously takes good care of you and the situation you’re in.

It was not only the fact that the HV cared for the parent but that they also had a wider perspective of the whole situation in which the parent found herself. For example, this might include the other family members, and the amount of social support available to the parent through friendships or local community groups.

HV s demonstrated their care of parents speaking about their motivation to help them in any way that they could. It seemed as though it might be a pressure felt by HVs, as they were listening to the parent’s story that they needed to provide a solution to a difficult situation.

[HV1] I really wanted to do something for her to sort of sort this baby who was crying a lot and who is… I wanted to help her in some way. I wanted to do something positive for her that she could go away with today that would help her through the next week.
4.5.9 FRIENDLINESS

Parents wanted HVs to be ‘friendly’ towards them.

[P4] I think it just that she's friendly as well which is nice like cause you can get some people that come and they're just doing their job and they're not really there for any other reason than they... But I feel that she was trying to make you feel better...

HV's, on the other hand, spoke about trying to make themselves ‘approachable’ so that parents would contact them if they needed help.

4.5.10 DISCUSSION

HV's and parents identified nine qualities or characteristics that were of importance to the parent/HV relationship. Although many of these qualities have been found in the literature some were not. In this study, the HV's calmness and gentleness were important, as were her friendliness and sense of humour and trust in parents. Although the building of trust in the relationship has been written about this usually refers to the client's trust in the helper rather than the other way round. In this study, which focused on the good relationships HVs had with parents, there was mutual trust between the participants in the interactions.

Bidmead & Cowley (2005a) in their concept analysis of partnership working within the context of health visiting drew attention to the qualities of, respect, genuineness, humility or acknowledgement of one’s own limitations, warmth, quiet enthusiasm, empathy, friendliness and approachability. Most of these were confirmed by this present study with the exception of humility and warmth, which were not mentioned explicitly.

The HV’s knowledge and experience were the overriding characteristics of HVs that parents valued the most. The knowledge that the HV had was both experiential and professional and confirms previous research findings in this area (Collinson & Cowley 1998). That the HV ‘knew what she was talking about’ was also central to the findings of parental perceived support from the HV in a study by Plews et al. (2005). Parents felt that the HV knowledge and advice was unavailable to them anywhere else so her expertise was highly valued. This reflects the findings of Russell and Drennan (2007) in a survey of over 4,000 parents.

The respect that a HV has for the parent was demonstrated by being punctual, trying to arrange visits at the parent’s convenience, being polite, praising and encouraging the parent in their decisions. However, being non-judgemental was the essence of demonstrating respect for the
parent. This has been identified in previous research into HV relationships with parents (Normandale 2001; McIntosh & Shute 2006). Moreover, in a study of Canadian public health nurses many mothers were ambivalent about receiving public health nurse visits at home for fear that they would be judged as failing or inadequate mothers (Jack et al. 2005). They felt that they needed to ‘measure up’ to the nurse’s expectations and nurses were coming to ‘check up on them.’ Similarly, in the Oxford intensive home visiting study parents thought that HVs were only there to check that ‘you are keeping your kid properly fed’, (Kirkpatrick et al. 2007).

Support for parent decision making was also a critical factor in demonstrating respect for the parent. This reflects findings in previous research that respect is key in helping parents feel more confident and empowered (McNaughton 2000). Similarly, being respectful of parents needs for autonomy and control, being polite, praising them for things that they did well and arranging visits at the wishes of the parent have been identified as being instrumental in gaining access to parents (Luker & Chalmers 1990).

Reliability was particularly important and was demonstrated by the HV returning telephone calls. Reliability was also a factor in the development of trust in the study by Jack et al. (2005). In this present study, the parent’s ability to trust was also affected by the ability of the HV to home visit when necessary, the continuity of contact, the HV’s reliability, her ability to be non-judgemental and to give sound effective advice. The importance of trust in a relationship has been explored in health visiting literature but there has been little written about the HV’s ability to trust the parent.

HV’s ability to trust parents and to be friendly could possibly be coloured by their constructs or perceptions and stereotypes that may be at the forefront of their minds when faced with a particular kind of parent, for example, a teenage mother [p.106]. Previous experiences of encounters with teenage mothers may replay themselves in their minds and unconsciously influence not only the relationship but also the offer of service that they make (Chalmers 1992). HVs in this present study were aware of the possibility of taking a stereotypical approach to relating to a parent and tried hard not to let this influence them.

When parents experienced the HV as interested not only in babies but in themselves as well, then they felt respected, important and their self-esteem grew. This confirms the research of Kirkpatrick et al. (2007) who found that if the HV was interested in the mother and not just the baby this too led to the building of positive relationships with the parent.
If the HV was gentle and caring then the parent felt able to speak freely. The need for the HV to demonstrate a caring approach during the early months of parenting was also found in the work of Pearson (1991). As time progressed and the mother became more confident then the HV withdrew. The majority of parents in this study were in early parenthood so had indeed experienced the HV as caring. This caring approach was also found by Cowley (1991) to be crucial to the ‘opening up’ of otherwise ‘closed’ conversations.

The HV needed to be honest and genuine in her dealings with families demonstrating interest and caring. She needed to adopt a non-judgemental attitude in order that parents might find her someone in whom they could confide. Parents learnt to trust the HV especially if she demonstrated reliability by returning telephone messages and being easily available should problems arise. The relationship was enhanced where the HV could trust the parent, although this may not always be possible. Her friendly approach and calmness, empathy and understanding were all qualities that parents greatly appreciated.

4.6 Health Visitor Relational Skills

Helper qualities and characteristics can be demonstrated through a large set of relational skills. These have been described in the helping literature generally (Rogers 1959; Egan 1998; Carkhuff 2000; Davis & Day 2010). They agree on the importance of active listening and on demonstrating respect or unconditional positive regard and empathic responding. Davis & Day (2010) and Egan (1998) give the detail of the skills involved in active listening and consider the micro skills of attending and the helper’s nonverbal communication. Rogers (1959) focused on unconditional positive regard or respect and genuineness or congruence as crucial to client wellbeing. Carkhuff’s (2000) main focus has been on the skills involved in expressing empathy whilst Davis and Day (2010) also focus on the skills needed to help people change.

The data in this study identified four main skills that HVs used in their efforts to engage in positive relationships with parents they were:

- Active listening
- Remembering
- Exploring, using:
  - Open questions
  - Silence
  - Encouragement
  - Following the parent lead
  - Giving the parent time
Figure 4-6 below shows the themes emerging from the data pertinent to HV skills. The HVs were able to say in more depth than the parents what skills they were using although there was some overlap between the data. The HV skills of ‘listening’, ‘remembering’ and ‘giving individual attention’ were the themes where there was consensus between parents and HVs about their importance.

4.6.1 Active Listening

In terms of the importance of the skills identified, it seemed that listening was the most valued skill for both HVs and parents. HVs were clear that listening was crucial to the help they were able to give to parents.

[HV1] It was the listening that was helping her and that maybe not advising her on every single thing that she was saying, I think, to let her continue to talk as long as she wanted to really.

Parents were equally clear that having someone listen to them was what was necessary.

[P5] My partner he doesn't care to listen I told him, I told him he talks and I don't talk and he talks too much and I can't say everything that I want ……[but with HV] I can
say what I want and she doesn’t say what to do? She can listen and another person can’t……. Like I talk with my sister and she doesn’t want to listen.

The ways in which HVs responded to parents demonstrated their attentive listening and this was also reflected in the parent group data.

4.6.2 Remembering

For parents it was important for the relationship that HVs remembered who they were and seemed to be linked to HVs being attentive.

[P1]…she seemed to kind of remember me and what I told her last week and she knew that I had seen a cranial osteopath last week. She remembered some of the problems that we’d had with the feeding, like with L’s permanent feeding and I think that’s a really kind of important attribute actually is that you can remember people’s stories because then, because I know health visitors must see so many people…….but it almost makes me feel more kind of like they remembered you and that’s really good because it’s a time specially when you can be floundering a bit and feel like no one really understands what you’re talking about and it does feel good that she does remember a lot of our particular issues as well.

HVs too thought that this was a crucial skill in maintaining their relationships with parents. Whilst one HV tried hard to address parents by name in the clinic, so that they might not feel that they were ‘just a number’, others worried that because of decreased contact time with parents they would easily forget them, they therefore, openly addressed this possibility with parents.

[HV grp. B] But I could visit today and I would not ….I would pass them on the street. And I say it to them, ‘now please say hello if I see you on the road and don’t acknowledge you because we don’t see so much of you, it’s not being rude.

They were keen to give parents a sense of continuity of care by remembering who they were even though they sometimes found it a struggle. They believed it important to try to give parents the feeling that they were individuals that mattered and that the attention they received was for them alone.

4.6.3 Exploring Skills

Both HVs and parents identified some skills of exploration, although not the same ones. Enabling parents to tell their story is a key health visiting skill essential to building the parent’s sense of self-efficacy. Parents spoke about the HV’s use of ‘open questions’ and ‘silence’. HVs did not identify these basic skills but spoke of the skills of, ‘encouragement’, ‘following the parent’s lead’, ‘giving parents time’, ‘observation’ and ‘body language’.
4.6.3.1 Open Questions
The parents identified this as a key skill in the HV’s ability to help them to talk about their problems. They found that it made them want to reveal more about themselves.

[P1] It's her questioning; maybe it’s all the open-ended questions that makes me want to give a bit more than you would with other questions and stuff.

4.6.3.2 Silence
For another parent it was the silence between the questions that she found useful in helping her identify her concerns.

[P2] I suppose in some ways it's the silence between the questions and the asking if you're ok that you're then able to fill with your own concerns.

4.6.3.3 Encouragement
HVs actively encouraged parents when they were talking by being positive about what they were doing, nodding and listening carefully.

[HV1] I hope that I was encouraging her to keep going if she wanted to.

4.6.3.4 Following the Parental Lead
HVs were also aware that because they do a great deal of routine work they might repeat the same information to parents without paying attention to the individual needs presented at a particular time. One HV was very aware that this might happen when carrying out a routine eight-month developmental assessment and felt that by following issues that the parent raised she was more likely to avoid this pitfall.

[HV3] I was very aware of the fact that I do an eight-month check so often not to kind of give spiel about eight month but to do it in a systematic way and go along with the mother and baby and whatever she comes up with, you know.

4.6.3.5 Giving the Parent Time
HVs were cognisant of the fact that parents needed time to be able to tell their stories and that this was difficult to provide especially in a busy clinic situation. However, in spite of busy caseloads, they tried to arrange their work so that they could give time, where they identified that this was necessary, and make a home visit. When parents were dealing practically with their babies HVs also felt that it was necessary to allow parents to work at their own pace and not to rush them.
[HV3] I don't interfere with what they're doing or try to rush her because ..., I feel, you know, it makes her nervous and erm whatever speed they do it in, not rush her, so I just chatted to the baby whilst she was doing that, rather than just in silence standing back waiting, which would make her even worse and more nervous, I guess. So yeh, just waiting and I'm not, I don't interfere with the way she undresses; I just let them do it.

4.6.3.6 Observation Skills

HVs were not only alert to what parents told them about their babies but also observed for themselves what was happening during the parent/child interaction. The HV’s observation skills were not restricted to the parent/child interaction; they were also in use whilst she was interacting with the parent noticing the parent’s body language, particularly her facial expression.

[HV1] She was explaining that very well and she likes that, I think, by the expression on her face, she does lighten up a little bit when she says that.

4.6.3.7 Body Language

HVs were also aware of the way in which their body language conveyed information to the parents and children. They were aware that they needed to make eye contact with parents to indicate that they were listening to them. One HV bemoaned the fact that she always had a lot of form filling to do at the new birth visit and so felt that this detracted from giving her full attention to the parent at a time when she was trying to get to know them.

[HV grp. D] You don’t actually know your clients and it’s impossible to do a full assessment at that new birth visit because of the bureaucracy, you know the forms to fill in, the children’s centre form so you’re hardly making eye contact at times you know and erm...

The parents’ group added detail about what was necessary for the HVs body language in order for the relationship to be positive. Where the HV appeared on edge and not quite relaxed the parent was not able to build a relationship with her; the HV’s body language set the parent ill at ease and made her feel uncomfortable. Her tone of voice was also of particular importance.

[Parent grp. C] ...you want it to be confidential, to be friendly, if someone’s barking information at you or asking things in a pitying way because you look a bit distressed because you just had a baby you get a bit fed up.

4.6.4 Challenging

This theme was identified in the HV group data. HVs described how a relationship with a parent, built up over time, allowed them to explore more sensitive issues which could not be covered in a first meeting. They expressed great concern about the inability to meet with parents on more than
one occasion. This, they felt, affected their work. It was a particular difficulty when asking parents about sensitive issues such as domestic violence.

[HV grp. K] I think sometimes that’s part of the problem with not being able to do offer the follow up because some of the things you see at one visit you want to address but you know a lot of the time you would try and address that later on down the line wouldn’t you? Because you cannot do it all in one visit and it’s not fair to the clients either and it would seem very critical again so that suffers because you can’t offer more of a long term relationship because it’s about working with them with lots of issues over a period of time and I think that’s what we’ve lost really haven’t we?

Giving information was one of the simplest ways in which HVs invited parents to change. If it was personalised to meet their particular needs it was not perceived as a challenge. The parents identified this as highly important in their relationships with HVs.

[P3] When he had the eczema, she was very specific about him she wasn’t reading from a sheet you know none of your bog standard stuff it was very specific to him and I had her attention and she followed it up.

When speaking with parents, especially when addressing something that might be seen as challenging, HVs tried to remain respectful of the parent’s choices.

[HV grp. N] If they have a problem and they are doing something which is not too correct it’s how you address that without putting them down, you know it’s about going around and saying how can we do it this way or something. You know you approach it without undermining them.

4.6.5 Discussion

In this study HVs demonstrated a range of relational skills that helped them establish relationships with parents, explore their needs, and to change as necessary. They understood the value of allowing parents to tell their stories and listening closely not only to content but feelings that may have been expressed non-verbally. Active listening where the HV not only hears what the parent says but responds to the meaning, content and feelings expressed helps the parent to feel valued and respected (Kirkpatrick et al. 2007). Not only does this facilitate the parent’s exploration of their health needs as they see them, but also has the added function of building a relationship based on trust and respect. Moreover, it facilitates a deeper exploration of the parent’s world and consequently there is more likelihood of developing a shared understanding of their problems, goals and aspirations. The findings of this study with regard to active listening reflect the findings of other authors on this subject (Cody 1999; Bidmead & Cowley 2005a; Bidmead et al. 2002; Russell & Drennan 2007)
The ability to give parents time may well be linked to how well HVs listen to parents. This giving of time was important in the building of the relationship to the women in the Oxford intensive home visiting study (Kirkpatrick et al. 2007). In this present study, HVs found that they could only give time, away from the busy clinic, in the home environment. More often than not they gave parents more time than their organisations stipulated because they felt their work would suffer if they did not; a strategy that has been found in other recent research (Condon 2011).

When engaged in exploring the parent’s situation HVs tried to be led by the parent. The studies by Machen (1996) and Normandale (2001) revealed that parents find HVs most acceptable when they are most responsive to parent determined need and are prepared to engage in relevant discussion. Trying to impose their own agenda particularly by using health assessment tools has been found to be unhelpful in this respect (Mitcheson & Cowley 2003).

Body language is an important element of any interaction and accounts for about 65% of communication (Pease 1997). This is particularly true for the communication of empathy (Caris-Verhallen et al. 2000). The importance of the way in which HVs use their body language was also identified by Jack et al. (2005). The public health nurses in their study needed to nod their heads in encouragement, smile, and give parent’s time thus beginning to create an atmosphere where both visitor and parent could be completely open with each other. In this present study, HVs were aware of their own body language and what it may be communicating especially when they felt their ability to make eye contact was compromised. However, during home visits they were able to focus their attention on the parent’s body language - particularly the parent’s facial expression - and add the information to their knowledge of how a parent might be feeling echoing the findings of Zerwekh (1991).

Home visiting has the propensity to create the right environment in which difficult issues can be discussed and may lead to the identification of needs (McIntosh & Shute 2006). However, Peckover (2003) has shown that even where the HV is a regular home visitor and relationships are positive domestic violence may not be revealed. Moreover when domestic violence has been revealed it has been in the context of a home visit and a good relationship with the HV. HVs in this study found that it was hard for them to raise the issue of domestic violence at a first visit because they felt it to be too early in the relationship. Other difficult issues may also not be addressed because of lack of time and the inability to do more than one visit.
Giving advice and information that does not undermine the parent is a skill of challenging parents to change. When infant care is less than optimal the HV needs to address this and inevitably puts the relationship at risk as directive approaches have been shown to have a negative impact on relationships (Elkan et al. 2000b; McIntosh & Shute 2006). It is often the families who are most at risk with whom the HV has to make the greatest efforts at making a connection (Marcellus 2005) and yet if the relationship is strong enough it can even survive a referral to social services (Kirkpatrick et al. 2007). In this study, HVs demonstrated their avoidance of the ‘stereotyped advice’ identified by Kendall (1993) by tailoring the information that was given to the specific family needs. They also avoided giving the ‘unsolicited advice’ identified by Mitcheson and Cowley (2003) by listening carefully and following the parent’s agenda.

In spite of some of the organisational problems good relationships can be established when the combined parent and HV qualities and skills come together to form the helping relationship. Working with the parent to address their perceived needs rather than taking a top down directive approach appears to enhance the relationship. HVs use their qualities and skills in a way that helps the parent build trust and confidence in the HV. This can only happen if the HV has sufficient time to devote to the, sometimes time-consuming, activity of building relationships with parents.

4.7 The Parent/HV Relationship

Positive helping relationships have been designated as a partnership (Davis & Day 2010), patient-centred (Little et al. 2001b), client-centred (Rogers 1959), caring (Watson 2002), a working, therapeutic or helping alliance (Allen et al. 1985; Alexander & Luborsky 1986; Horvath & Symonds 1991).

In health visiting a positive relationship with the parent has also been identified in various ways: a friendship (Davies 1988; De La Cuesta 1994), a partnership (Normandale 2001; Bidmead & Cowley 2005a; Bidmead & Davis 2008), purposive befriending (Coles 2000), therapeutic (Cody 1999; Cowley 1995) and alongsideness (Pound 2005). This section of the chapter reports the analysis of the themes arising from HVs and parents when asked how they would describe their relationships in the context of the present constraints on the health visiting service, as described in the section on the organisational factors.
HVPs spoke about their relationship with parents as being either easy or difficult and of their relationships with babies, children and fathers. Parents on the other hand emphasised not only the closeness of the relationship – describing the HV as a ‘mother figure’, ‘extended family member’ or ‘wise friend’ – but also of the more distant type of relationship indicated by the terms ‘professional’ and ‘distant’ [Figure 4-7]. There were also commonalities in the HV and parent data of professionalism, support, advocacy and therapy. The following were the terms used by both HVs and parents to describe the parent/HV relationship:

- Professional
- Supportive, ‘someone to take you by the hand’
- Equal, woman to woman
- Therapeutic
- Informal and easy/difficult
- Relationship with father
- Relationship with baby
- An advocate or ‘someone on your side’
- Mother figure, a wise friend, or extended family member

Initially consideration will be given to the elements of the relationship where parents and HVs had shared views. Moving on from this, the views expressed by HVs alone will be presented followed by those of the parents.

Figure 4-7. The HV/Parent Relationship. Comparison of HV and Parent Themes
4.7.1 Professional Relationship

Parents had very individual ways of describing similarities to their relationships with HVs; for example, ‘a wise friend’ an ‘extended family member’, ‘someone on your side’, a ‘mother figure’ but in contrast to the closeness indicated by these terms, they agreed it was also a ‘professional’ relationship. ‘Professional’ meant to them not only that the person was employed in a particular role and therefore more distant, but also that they were knowledgeable.

[P6] … the relationship is like that kind of obviously professional and doing their work and their job and you know but also providing you with a huge amount of helpful information and tips.

HVs too, were aware that parents saw them as being in a ‘professional’ relationship as distinct from the relationships parents had with friends or family and that this was because of their knowledge and experience.

4.7.2 Supportive Relationship

HVs tried to be supportive to parents especially in the early weeks when parents may be lacking in confidence. Their primary method of doing this was by being available with information.

It was important to parents that they felt the relationship to be supportive. One parent graphically described it as ‘someone to take you by the hand’. A non-judgemental attitude was crucial to this as demonstrated in the quote.

[P2] I think it's a unique relationship because you genuinely …… know that they are there to help you they're not there to give you an opinion on how you are doing they're there to help you do as well as you can and to feel supported as opposed to telling you, you are doing it wrong or that's a disaster or whatever.

4.7.3 Advocate, ‘Someone on your side’

Although the HV discussion group added little new data to the interview data on the topic of relationships HVs did identify it as, on occasions, being one of an advocate for parents.

[HV grp D] It's about being an advocate for people isn't it? Because, this morning I heard that a GP practice were totally blocking her appointment and things and I think being very difficult with her and you know it's sort of like trying to facilitate people into the system because the system should not actually be difficult.

Parents also identified this advocacy role in HVs as very helpful. For example, a parent suffering with mastitis with a jaundiced baby was unable to obtain a doctor's appointment for herself and the baby, the HV intervened and insisted that the parent and baby be seen. The parent found this
most helpful as she was feeling too physically and psychologically frail to insist on her need to have an appointment.

4.7.4 An Equitable Relationship

Where the relationship was working well the parent felt as though they had an 'equal' role with the HV. They could speak freely, share information and work with the HV to resolve their difficulties. Both HV and parent had power within the relationship – the HV from her professional role, knowledge and expertise, the parent from the knowledge of her baby and her ability to share or withhold information and allow entry into her world. Although parents and HVs used the term 'equal' in their explanations of the relationship the word 'equitable' might seem more appropriate as each have power and each may lead in the interaction at different times. In order to achieve equity differential treatment of unequals is required (Almond 2002). Within the parent/HV relationship, there was inequality in the relationship due to unequal expression of needs. This required differential interaction by the HV in order to reduce professional power so that the relationship at least 'felt' equal.

The HV in the example below was successful in achieving this as the parent described her relationship with the HV as 'woman to woman' so there was a clear feeling of equality.

[P1] I don't sort of see with her that she's someone on a different level.

HV3 tried to ensure that there was equity in the relationship by the way in which they worked - trying to reduce their professional power - so that the parent remained in control and the HV did not become an authority figure. .

[HV3] It doesn't become er well in a way a thing imposed by the professional on to her … I can see a certain attitude in clients or when they come to us often almost like fear of authority or they see me in a particular role ..... What I see is her baby and how much it means to her … emotionally that she needs to have that control.

A good example of the sort of working together that showed this partnership with involvement and participation of the parent was given by a HV who was newly trained in baby massage where she described working alongside the mother on the kitchen table with her doll as the mother worked with the baby.
**4.7.5 Therapeutic Relationship**

The parent’s relationship with the HV of itself may be helpful to parents. From psychotherapy research, it is known that the client’s relationship with the therapist is fundamental to achieving positive outcomes as the therapist makes a deliberate use of the self to influence client behaviour (Horvath & Symonds 1991).

Some HVs deliberately strove for a therapeutic relationship with parents. The example given below shows that the parent concerned, experienced the HVs attempts at this way of working was successful.

[HV1] I hope that she finds it therapeutic … that she can say to me whatever has been going on and we’ll probably try and tease it out and get her to find her solution towards it … with a few hints here and there.

[P1] I can imagine that it’s a bit like going to therapy. It’s a similar relationship, I think, in the sense that you’re going for your own benefit it’s for you, it’s for your welfare and obviously the welfare of your child.

The following descriptions of the relationship were given only by HVs.

**4.7.6 Informal and Easy Relationship**

HVs strove to have an informal and easy relationship with parents. However, one HV sometimes worried that relationships might have overstepped the boundaries of a normal HV/parent relationship.

[HV6] A not a very formal relationship. …Sometimes I wonder if it is a health visitor and client relationship, whether it’s gone a bit further than that because I know her so well.

For example, she expressed some concern that there were some parents she embraced when they meet. She had sought guidance about this in clinical supervision, which she had found helpful.

Another HV showed that the relationship can be mutual and was as much to do with the parent’s approachability as her own was.

[HV1] It feels like an easy relationship… I kind of feel I wouldn’t mind meeting her again and we would explore her issues … about feeding or about any other part. I think we are both approachable for each other….
4.7.7 A Difficult Parent/HV Relationship

However, not all relationships were easy. HVs in the HV group spoke of relationships that were more difficult particularly where there were mental health issues such as post-natal depression, where there were child protection issues or where they just did not share the same values as the parent.

One HV described how she had to be more directive with a teenage parent and how subsequently she had difficulty in accessing her, which may have been indicative of a poor relationship.

[HV grp C] I’ve got a teenager at the moment and she's just pushing everybody away and so the child’s going to end up on the child protection register and ….. she’s just challenging when you see her, she’s saying, ‘well why are you saying I’ve got to do this and why have I’ve got to do that?’ so she’s difficult in that sense and she’s difficult to access…….. Because we’re telling her things she doesn’t want to hear…. she’s got a history of being in care herself.

Although the parents in the interviews did not speak about difficult relationships with HVs, one parent did describe her difficulties in relating to a HV who was not her named HV, when she visited the sleep clinic with her baby. Although she had met her before at home when her regular HV was on leave, she described it as a more distant relationship.

[P6] S [HV] does know my history and A’s [child] history but I guess she doesn’t know all the detail and no it is different it’s a more… distant relationship not that she’s cold and she was really helpful and everything and I appreciated everything that she did but there isn’t that same link.

This perhaps reflects the experiences of parents who in this study often did not meet their named HVs in the clinic situation.

4.7.8 Relationship with the Father

HVs form relationships not only with mothers but also with fathers. One father felt uncomfortable in the mainly female environment of the baby clinic. The HV was aware of this and tried to make him feel more at ease.

[HV3] Yes he does come which is great but I have to say, 'is Tom here?' ‘yeh, he's outside' and I’ll say well ask him to come in and invite him in and make him feel comfortable.

Not only does the HV form relationships with other family members but also with the baby.
4.7.9  Relationship with the Baby

The child is the centre and focus of HV work. Some HVs strove to make this clear at an initial contact explaining that they were interested in the parent’s health and that of the family because they were aware of the influence this could have on the baby - the well-being of the baby was their prime concern.

However, the relationship with the baby served more than one purpose; it could help to build the relationship with the mother. The HV group data illuminated this further particularly in relation to more vulnerable parents who may be hard to reach.

[HV grp B] Very often, you can reach them through the children, … by just talking to the children, admire the children, saying good things about the child, picking out the little bits of good they're doing and building confidence in themselves and making them feel a bit good ...I have found that helps.

One HV took a particularly respectful approach to the presence of the baby and spoke of how important it was to acknowledge the baby as a person who was present and to involve them.

[HV3] I think the communication is not just with mother but is with baby as well, whatever age, …… so if I'm talking about a baby it's wrong just talking to mother when there is another person sitting there, so every now and then, just make contact with the baby so I think that they are all involved and also I feel that I develop a relationship with the baby as well right from birth really you know smiling or getting a few minutes talking to the baby and then go back to mother.

Finally, themes about the relationship that were identified only by parents will be considered.

4.7.10  A Mother Figure or Wise Family Member, a Wise Friend

A parent spoke of her HV as a ‘wise family member’, which was linked with the HV’s knowledge and experience.

[P6] I said she's a wise family member and what I mean is that she's got all this knowledge and all her experience that she's bringing to your situation so she was very linking everything up really but not leaving out the other parts like the personal aspects of mothering.

The same parent also used the term ‘wise friend’ and included the HV as someone in her friends and family group. However, HVs in the follow-up group discussion admitted that parents could be confused by the relationship that seemed to them like friendship.
Parents acknowledged that the relationship with the HV was like talking with their mother. One parent did not have a good relationship with her own mother but wanted it to be different for her son.

[P5] …or for me it can be like how I feel … I can't say Mum, but she was there when some things sensitive come. My Mum ……. didn't say to me, never, 'I love you or anything like that' and I think now I have him I want to be with Mum and that I feel I can get that advice and that experience and that parenting thing [from HV] as well and that's important for me as well.

It seemed as if HVs could be whatever parents needed them to be at the time whether it be a mother figure, an extended family member or just a 'someone to take you by the hand'. This flexibility of the HVs relationships with parents seemed important to the parents.

### 4.7.11 Discussion

Table 4-2 below shows a comparison from the findings of the literature and HV relationships as defined by parents and HVs in this study.

<table>
<thead>
<tr>
<th>Helping relationship literature</th>
<th>HV relationship literature</th>
<th>HV relationships in this Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnership (Davis &amp; Day 2010)</td>
<td>Partnership (Normandale 2001)</td>
<td>Equal/Equitable</td>
</tr>
<tr>
<td>Patient-centred (Little et al. 2001b)</td>
<td>Friendship (Davies 1988; De La Cuesta 1994)</td>
<td>Professional</td>
</tr>
<tr>
<td>Purposeful befriending (Coles 2000)</td>
<td>A mother figure, wise family member/wise friend</td>
<td></td>
</tr>
<tr>
<td>Client-centred (Rogers 1951)</td>
<td>Alongsideness (Pound 2005)</td>
<td>Advocate 'someone on your side</td>
</tr>
<tr>
<td>Supportive (Plews et al. 2005)</td>
<td>Supportive</td>
<td></td>
</tr>
<tr>
<td>Informal and easy/difficult</td>
<td>Includes relationships with other close family members. e.g. father/grandparents/child</td>
<td></td>
</tr>
</tbody>
</table>
It is interesting to note that in this research, neither parents nor HVs used the term ‘partnership’ to denote their relationship [Table 4-2]. Indeed Roche et al. (2005) has made the point that if parents do not think of themselves as partners then they are unlikely to relate in this way. However, in spite of the lack of the explicit use of the term, parents experienced its essential element - the equity of the relationship; HVs were at pains to ensure that they did not use their power in an undermining way. Partnership, however, whilst a meaningful concept in the research and literature, may not be the way in which parents and HVs conceptualise their day-to-day relationships.

‘Friendship’ as a designated title for the relationship was not used exclusively on its own in this study [Table 4-2]. That the relationship was ‘friendly’ was without doubt but the parents realised that the HV was not a ‘friend’ in the normal sense of the word. It was a ‘professional’ relationship as well. Parents seemed to tussle with the two ideas. This quote was from the parent who had called the HV a ‘wise friend or family member’

[P6] I know she’s a health professional and but to describe the relationship I think that's what the relationship is and I don't know a good word for someone who comes with that amount of wisdom

A ‘friendship’ usually entails some give and take particularly on an emotional level and whilst a parent may very well share her emotions, it is unlikely that the HV would reciprocate. HVs were aware of the dangers of over involvement with parents and with the difficulties that some parents may have in distinguishing between someone who was a friend and the professional relationship that they had with the HV.

The closeness of the relationship was very apparent in this study as the HV relationship was described not only as intimate as a ‘wise friend’ but possibly also as a ‘family member, e.g. mother’ [Table 4-2]. Yet some parents refuted this explaining that they found the HV’s position outside their family circle facilitated their ability to be honest in their disclosures [p.116]

The realisation that the HV was an employed professional seemed to keep the relationship in a more real place; she was not a friend or a family member. For both HVs and parents ‘professional’ seemed to describe not only the HVs employment but also her knowledge. The ‘knowledge and experience or wisdom’ set her apart from friends and family.
This carries the danger that the HV may be experienced as an ‘expert’ with a superior role in the relationship. When parents and practitioners approach a relationship with this expectation, with the professional taking control of the interaction and exerting her professional power, the parent may feel undermined and assume a passive role (Mitcheson & Cowley 2003; Davis & Day 2010). This, however, was not the experience of the parents in this study who, when designating the role as ‘professional’ seemed to see this in a positive light, relating it to the HV training and knowledge. Hence the relationship was ‘easy and informal’ with mutual ‘approachability’.

However, not all HVs found relationships with all parents ‘easy’. Sometimes the HV found that she had to assume a more directive approach with parents who did not have insight into their own vulnerabilities. This in turn could lead to difficulties with the relationship, as the parent experienced the HV working from her own agenda and using the power of the state, especially if social services were involved. The involvement of social services, however, does not mean that the relationship will always be difficult, as Kirkpatrick et al. (2007) have shown. In this Oxford intensive home visiting study, the fact that the HV had established a trusting relationship with the parent made the referral to social services easier. It was only where the home visitor was perceived as not being completely open about the referral process that the relationship was experienced negatively. HVs have to exercise considerable skill to maintain relationships with parents when child safeguarding issues are identified.

The majority of parents experienced the HV as ‘someone who was on their side’ [Table 4-2]. This reflects the findings of Pound (2005) who designated the relationship as ‘alongsideness’. Kirkpatrick et al. (2007) and Plews et al. (2005) found that parents appreciated having somebody ‘there for you’. This also links with the advocacy role that HVs have, and that was demonstrated in this study. Both ‘advocacy’ and ‘alongsideness’ can be seen as part of the ‘support’ relationship that the HV has with the parent; they may also be reflected in other designations of the relationship, e.g. partnership. Support in this study was linked with the HVs knowledge and ‘wisdom’ reflecting the findings of Plews et al. (2005). However, the ‘expert’ relationship may sometimes be experienced as supportive if the parent always accesses the HV for the advice that she needs, and this may undermine her own decisions and confidence (Davis & Day 2010). Although there was no evidence of this in this study it is important to bear in mind that ‘support’ of itself is not necessarily an indication of what may be considered the ‘ideal partnership relationship’ proposed by Bidmead and Cowley (2005a).
There was agreement in the literature and in this study that the parent/HV relationship may be therapeutic [Table 4-2]. A therapeutic relationship is usually encountered in cases where there is a problem, physiological or psychological, that requires treatment. The therapy also may be physical or psychological. Although there may be evidence that the therapist is important to the outcomes, it is only in psychotherapy that there is the explicit therapeutic use of the self by the therapist to effect client change. The question arises as to whether HVs explicitly use the relationship to affect change in the parent – for instance when they carry out listening visits to mothers suffering with post-natal depression [PND]. There have been a number of studies that show that HVs are able to have a positive effect on the course of the illness (Wickberg & Hwang 1996; Seeley et al. 1996; Morrell et al. 2009). There is also some emerging evidence that when mothers do not have PND the therapeutic relationship established by the HV can have a preventative effect (Brugha et al. 2010). It has been argued in the past that HVs should develop their therapeutic skills further (Cody 1999). However, not all HVs use a therapeutic approach and those that do may not use it all the time. The HV role may demand that she will at times need to be more challenging and give advice whereas a therapist may not engage in these skills, seeking to remain non-directive (Obeid & McGee 1996).

Perhaps one of the most intriguing things about the parent/HV relationship is that parents experienced HVs as they needed them to be for their particular situation. There was variety in the ways in which parents spoke of the relationship with HVs and it appeared that one of the major relational skills of the HV was to know how to respond to each parent’s need in their particular circumstances. This was first identified by Cowley (1991) but was also apparent in the present study. HVs felt that the relationship with the parent was central to their work and that without this professional, supportive, therapeutic and equitable relationship they would not be able to do their work. Moreover, although the relationship with the mother was important, HVs also sought to relate to fathers, babies and children too.

4.8 The Health Visiting Process

Both HVs and parents bring their qualities and skills to the relationship, which is crucial for them to be able to work through the health visiting process. This requires that both engage using additional skills. Cahill et al. (2008) identified three stages of the relationship built between therapists and clients; establishing a relationship, developing a relationship and maintaining a relationship [Figure 1-1]. These stages of the relationship allow the dyad not only to work through
the helping process but also to continue to invest in the relationship. Similar stages can be found in the relationships that HVs have with parents and link to the helping process [Figure 1-3] in the FPM as defined by Davis & Day (2010) and adapted with evidence from this present study as the health visiting process [Figure 4-8]

<table>
<thead>
<tr>
<th>Establishing the relationship</th>
<th>Parent Health Visitor Relationship</th>
<th>Developing the relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Putting parent at ease, Parent expectations, Ground rules, Explanations, Talking at parent’s level, Knowledge of the health visitor role</td>
<td></td>
<td>HV relational skills [see section 5.6] Open questions, Silence, Encouragement, Following the parent lead, giving the parent time.</td>
</tr>
</tbody>
</table>

![Health Visiting Process and Themes from Data](image)

**Figure 4-8. The Health Visiting Process and Themes from Data**

Cahill *et al.* (2008) did not include ending relationships between therapists and clients presumably because there were no measures that sought to link this stage with outcomes for clients. However, HVs do think about and plan endings of relationships with parents when a particular episode of care is complete e.g. a parent recovers from post-natal depression. Very often,
though, they have long-term relationships with parents [children aged 0-5 years] and at times, they are more intensive than at others depending on family needs.

Some of the themes emerging from the HV and parent data clearly related to the health visiting process, particularly building the relationship. All the data relating to the process of exploration was included in the HV relational skills section [p.124].

Although there was some overlap between the two sets of data HVs were more aware of the processes involved than the parents, which might be expected as many of the HVs were trained in the FPM (Davis et al. 2002b).

![Figure 4-9. The Health Visiting Process: Comparison of HV and Parent Themes]

The themes from the data are presented as parts of the health visiting process.

4.8.1 Establishing the Parent/HV Relationship

4.8.1.1 Introductions

The normal politeness of the HV introducing herself was highlighted in the parent group discussion as being very important and was only really noticed when it was absent. Not only did the HVs fail to do this but they also wrote illegibly in the parent held record so that the parent could not read the signature and did not know who had been to visit her.
And the second one who came to the house didn’t even introduce herself. I don’t know her name and everything that she wrote down is illegible so I wouldn’t be able to tell from that what her name is either.

It was essential that parents knew who was visiting them and how they could contact them. If normal courtesy was absent it was unlikely that the parent would wish to make contact in the future.

4.8.1.2 Putting Parent at Ease, Making them feel Comfortable

This was a recurring theme in the data. Parents spoke of how they felt comfortable and at ease with the HV and HVs spoke of their efforts to help parents feel comfortable and at ease. Some HVs made particular efforts to make everyone welcome and at ease in the baby clinic even though, or perhaps because, they were often busy and difficult places for parents to be, as has been noted previously. One HV spoke of trying to imagine that she was inviting parents into her living room, encouraging them to relax in the surroundings and to chat to one another.

At home visits too, HVs tried to engage the parent in neutral conversation to help them to feel comfortable. For example, they might engage the parent by commenting positively on the décor, or a pet, accepting a cup of tea offered by the parent, and chatting easily about inconsequential things. Parents particularly appreciated the efforts that HVs made to put them at ease. This facilitated being able to talk about issues that were more important.

[P4] When S [HV] came up the first time my sister was with me and she made us feel really comfortable just chatting about anything like I was talking about other things as well though it made me feel more comfortable it’s … quite good actually.’

4.8.1.3 Eliciting Parental Expectations

At the beginning of the relationship, parents came with expectations of the HV role and service that needed to be ascertained. For example, HVs were concerned about the parent’s expectations for finding solutions to problems.

[HV1] She has an expectation by telling me this that something’s going to come from me so there’s and expectation there and that’s, I feel why she’s going into detail about the feeding and about the length of time which is extraordinarily long for her, three or four hours at one sitting. It’s very long. So I think there’s an expectation……’

Parents might also harbour false expectations about the kind of service that they would receive and HVs sought to clarify this at the outset explaining the constraints on the service and HV availability. Similarly, HVs realised that they might have unrealistic expectations of parents and
that this might interfere with the process of establishing relationships. If they failed to consider the parent’s background and take into account their lack of confidence as new parents then there was every possibility that the relationship would not become well established.

4.8.1.4 Knowledge of the HV Role

One of the ways in which HVs dealt with the parents' expectations was to give information about the HV’s role.

[HV4] I suppose in the new birth, which is often the first contact we have, then there is an explanation of health visiting and that is discussed that our interests are in the children under five and we have an interest in working with families with an emphasis on the children and protecting their well being.

Although parents had some knowledge about this, there was need for clarification. Parents particularly valued the explanation of the fact that the HV was concerned about the whole family and about the mother particularly. They were often pleased and surprised by this information.

4.8.1.5 Establishing Ground Rules

As parents did not always understand the constraints under which the services operated HVs needed to establish some working ground rules with parents. They tried to do this in a way that did not impose on the parent.

[HV4b] It’s the whole thing of how you manage the time that you’re there with her and the fact that we have an appointment ….. would be respected by me and I hope it will be by her and so we’re setting some ground rules, almost without calling them that though, about how we do things.

Linked with this was the explanation of the limits of the confidentiality of the relationship. This had to be done with care and skill. One parent in the parent group reported that the HV, who came to her soon after the baby was born, was more than a little clumsy in her explanation of how, when a child is at risk, she would have a duty to report this to social services. This had disastrous implications for her relationship with the parent as it meant that she was not happy to have HVs in her house.

4.8.1.6 Explanations

Initially there were explanations made to parents by HVs about what was going to happen at the visit with the aim of involving them more fully. Although some of the work that HVs did was routine – for example, eight-month developmental assessments – the HVs explained the kind of development that could be seen in the baby and what the parent could anticipate would be the
baby’s progress. HVs and parents highlighted the skill involved of speaking at the parent’s level so that explanations were fully understood.

[P3] She speaks to you at the same level; she's not blinding you with science. She’s just very down to earth and natural.

4.8.2 Understanding and Clarification

Provided HVs listened well parents often told long and complex stories of their experiences or worries. HVs needed to ensure that they had grasped the full meaning of what was happening and often summarised what had been said.

[HV1] I was also getting her to re-phrase what was happening to clarify what was happening.

They also encouraged parents by asking open questions about their concerns helping the parent clarify their meaning. This process was particularly complex where the parents first language was not English.

Parents identified how much they appreciated the HVs understanding or empathy.

[P grp L]... she knows what it’s like to be a first time mum and 10 or 12 days into it, what issues are going through a first time mum’s mind, which she understands, the issues along the way with everything else.

4.8.3 Aims and Goals

Having clarified the parent’s concerns the HVs sought to negotiate and agree with the parent what she wanted to achieve. In the example given below the HV not only identifies the aim ‘to not feed so frequently’ but also suggested a strategy that the parent might use to achieve the aim.

[HV1] Her mum or somebody said that you should do this or you should do that and you know and that was to do with sitting down and feeding the baby for about three hours at a time and although I didn’t directly say that, I did eventually come to some idea, some agreement with her, that it might be worth trying to feed frequently but not for that length of time and to go out and have a walk or something like that and she seemed to accept that.’

4.8.4 Strategy Planning

4.8.4.1 Giving Information and Advice

Once the aim or goals have been agreed with the parent then they started to plan how this might be achieved. At this point there can be conflict within the HV of whether it is in the parent’s best interests to give advice about a particular strategy or whether it is better for the parent to work it
out for themselves. There were occasions when a HV would hold back on advice giving so that the parent developed confidence in her own decisions.

Parents found advice from the HV useful and compared it to other suggestions that they had received.

[P1] She’s kind of suggesting it you know and not ‘leave him for three hours while he screams’ No, no give it an hour, an hour’s quite a … because he’s sort of with three hours which was what other people had suggested, changing his nappy well that takes ten minutes, and then take him for a walk and that’s two and a half hours, that’s almost impractical, but what she’s saying is, just give it an hour between feeds at first and see what happens and an hour in my mind I can kind of cope with. So I think I am definitely going to take up what she says and try it.

They recognised that they could easily fall victim to conflicting advice as they realised that there was so much information available to them from the internet, family and friends but found that the HV was a good starting place and could use these other sources to supplement their knowledge.

One parent particularly appreciated a range of options being put forward by the HV so that she had choice.

One of the key factors in maintaining the relationship was that the HV gave information that was necessary. However, the skill with which the HV does this is of paramount importance. One parent in the parent group, who had a poor relationship with a HV, highlighted this by saying that the HV told her what to do as opposed to ‘asking her’. She disliked this directive approach.

4.8.5 Implementation

HVs might support parents with the implementation of their strategies or plans. However, the HV may not know if the parent would do as planned. For example, a parent who had post-natal depression promised to attend her GP and the HV considered phoning her to see if she had actually done this as she felt it to be crucial for the mother and the baby.

[HV6] She’s admitted that she needs help, she’s finally admitted that she needs to see her GP and I’d actually got her to agree to see her GP when I left but then that was two weeks ago and I haven’t actually phoned her to see if she’s actually done that important thing but when I did speak to her a couple of days later after that visit and she said yes definitely she had an appointment with her GP that day and she was definitely going.

4.8.6 Reviewing and Planning Endings

Endings were important to the parent and HV. Either leaving the door open for further contact if necessary or referral of the parent or child to another professional may be necessary. However, the relationship may just end with the agreement of both parties. The decisions about these
various options have to be taken in negotiation with the parent. HVs reflected on their relationships with parents and tried to decide how best to proceed. For example, what happened next, in the case where a HV was visiting for post-natal depression, would very much depend on how helpful the parent found the HV’s intervention.

[HV5] It [relationship with HV] does seem to be important to her because … each week she has continued to talk, I mean we're three weeks into these sessions and she's continued to talk and she's never said, ‘oh I'm fine now I don't need it any more’. However, today … I did also suggest about going back again so that we could either finish it off and decide that she needs to go somewhere else for therapy, if it's not sufficient for her, …. so next week will be quite telling, what she has to say then.

4.8.7 Outcomes

The establishment, development and maintenance of the parent/HV relationship continue throughout the health visiting process and focuses on positive health outcomes for the parent and child. If the HV and parent are successful in achieving these outcomes then the relationship develops as one of trust where further problems are discussed and information sought.

Parents defined the outcomes as feeling more confident and reassured, reflecting the safety net effect reported by Plews et al. (2005). In some cases their construct of HVs had been changed from one that was unfavourable to one where they felt that HVs were helpful.

[P4] It's just... most people I know don't like health visitors and don't like them coming around because you just feel like people are coming around to watch you with your baby. It's like people are making sure you're ok and I had that feeling from J [baby 1] … and that never went away until now up until I had J [baby 2] I just thought health visitors just come around to watch but she has actually changed my opinion on health visitors which is a good thing because I wasn't too great on health visitors and that so she's managed to change my opinion on it so that is good news.

HVs may have a problem in gaining entry to a home where the parent has had a previous poor relationship with them (Luker & Chalmers 1990). They may have to work hard to overcome such resistance in order to gain entry even on the doorstep! This will involve a process of gently challenging the parent’s constructs to help the parent to see that not all HVs are necessarily going to behave in the way that was previously experienced. Access to services is thus promoted.

As a result of their relationship with the HV the parents felt inspired, motivated and encouraged and their self esteem was raised.

[P1] It makes me feel… that you’re kind of as important in the whole thing and that I’ve not just come here because I’ve got problems breast feeding L [baby] but I’ve come here because I’m having a few problems with it as well and it makes me feel that you’re kind of important.
Where peer support had been encouraged by the HV parents felt that they were able to learn from other parents.

[Parent grp. L] I just think how they interact with other people as well they build the right environment within this group that we can all ask questions and I’m learning listening to the questions you’re asking I’m learning and I’ll probably retain that for six months time and that sort of thing.

Maternal and child health outcomes were only raised in the context of considering a poor relationship with a HV and then only in general terms.

[Parent grp. C] ... I know a lot of the information and advice I've got had been invaluable to me that I've got from here and I don't know, there's a lot of stuff that you'd miss out on if you didn't have a good experience with them so...[Parent Grp L.] And your baby could suffer as a result.

HVs, by trying to boost parents' confidence through reassurance and helping them get to know each other, were trying to promote parental autonomy. They wanted parents to enjoy their babies and sought to promote child development and ensure that parents had access to services.

[HV3] The whole way of interacting, working I find in the first year, there is a lot of intensive contact up to a year but all the time I am working towards making sure the mother is becoming independent, autonomous and then you find that they move away so that relationship that friendliness is there but they see you less and less moving away more and more...

4.8.8 Discussion

The health visiting process that has been described here builds on the work of Bidmead et al. (2002) and Davis and Day (2010); they explained the helping process within a partnership framework [Figure 1-3].

The health visiting process differs from the helping process in that HVs may not always need to 'help' as problems may not be presented by families. The role of the HV then may be purely promotional and preventative. HVs may not work through the whole process with a parent or family and the interaction may not always follow the steps laid out [Figure 4-8] in the order presented it is not a linear process. However, where problems presented themselves HVs worked through the process carefully exploring the parent’s perceptions and difficulties before summarising and bringing further clarification to the story. Finding out what the parent wanted to achieve was key to the HV and parent working together to find strategies to resolve the issues that had arisen. Parents went away motivated and inspired to try out new ideas knowing that the
HV was available should they need her. Parents interviewed felt well supported by HVs in this study in spite of the prevailing organisational problems.

The qualities and skills of the parent/HV determine their relationship when they come together to begin to discover health needs and their resolution. The ways in which they approach each stage of the health visiting process, not only determines the outcome of that stage but also determines how the relationship is established, develops and is maintained, until its conclusion.

Where HVs have established good relationships with parents, they are at pains to ensure that parents have understood their role. This is important as Collinson and Cowley (1998) found that a lack of explanation of the role and service can lead to its under-utilisation or inappropriate use. Some women may not be aware that HVs are trained nurses (Kelly 1996) and the name health ‘visitor’ may lead some parents to expect home visits more often than are provided. These unrealistic expectations are then connected with the parent’s perceptions of a service failing to meet their needs (Collinson & Cowley 1998). This echoes the work of Pearson (1991) where there seemed to be a mismatch between what parents expected to receive in terms of help or advice and what the health visitor was actually able to offer. The aim of the HVs in this study was to ensure clarity around the parent’s expectations of the service and the role of the HV.

Cowley (1991) explained the process of relationship building as one of ‘getting to know’ a parent, as at the same time ‘getting known’ by them. This relationship was based on openness and agreement about the purpose of the service, which would differ according to the perceived needs of each client.

De la Cuesta (1994) noted that HVs often ‘adjusted their approach, their physical appearance and language’ in order to convey messages of being ‘innocent and useful’. Although in the present data the HV showed the same adaptability to parents by ensuring that explanations were given at the parents level, it was more to do with ensuring that the parent was able to fully understand what was being explained rather than appearing ‘innocent and useful’.

HVs were skilled in helping the parent to feel comfortable and at ease. This was also identified as important for the relationship by Kirkpatrick et al. (2007). In their Oxford study of intensive home visiting, young, vulnerable parents spoke of the fact that they needed time for the relationship to develop to a stage where it was ‘comfortable’. This sense of being comfortable was essential for parents to be able to raise difficult issues and begin to trust the home visitor.
The HVs in this study were skilled in giving information and advice. They did not tell parents what they should or should not do; instead, they offered parents’ options and allowed them to choose a strategy with which they were comfortable. When HVs were directive, this had a negative effect on the relationship. Many sources of information [e.g. websites, other parents, their own parents, magazines] are open to parents who may show their lack of trust by checking out its reliability with secondary sources (Jack et al. 2005). These may or may not give correct information but HVs need to be alert to the fact that parents seeking information, may not just ask the visiting professional and so should be prepared to pre-empt conflicting advice by open discussion of the topic (Bidmead & Cowley 2008). This was the practice of HVs in the present study.

HVs spoke about identifying health needs of families and sought to do this in a collaborative way with parents using their relational skills to explore issues. The use of a more structured approach using various tools has been found to be disempowering for parents (Mitcheson & Cowley 2003). It is the ability of the HV to convey a ‘caring, interested stance rather than a judgemental and inquisitorial attitude’ that is key to the search for health needs (Cowley 2000). Appleton (1997) too, suggests that professional judgement based on getting to know the family is a more successful approach to eliciting health needs than following clinical guidelines.

Gaining entry to a home where the parent has had a previous poor relationship with HVs can be a problem (Luker & Chalmers 1990). HVs may have to work hard to overcome such resistance in order to gain entry. This will involve a process of gently challenging the parent’s constructs to help the parent to see that not all HVs are necessarily going to behave in the way previously experienced. Access to services is thus promoted.

Contact with the HV was often more intense during the early weeks and months. Pearson (1991) found that HVs tended to withdraw at the end of the child’s first year so the promotion of parental autonomy is paramount. When a positive relationship with the parent was achieved then the parent was able to accept less external control (Pearson 1991). HVs in the present study also found that by building the confidence of the parent in their own decisions that they would be less needed as the months went by.

In a study of health outcomes in health visiting (Almond 2001) found that although parents seemed to be able to articulate the consequences of their use of the health visiting service HVs were less able to do so. The present study found that both HVs and parents were able to give
explanations of what they thought were the outcomes of their work together but only in general terms. However, the focus of this study was the parent/HV relationship and was not explicitly about the outcomes of that relationship. They were included here as valuable indicators of a successful parent/HV relationship.

This study throws further light on the skills HVs and parents use when engaged in the health visiting process together. Although much of the detail can also found in health visiting literature there appears to be new evidence here about how HVs help parents with the processes involved in problem solving i.e. agreeing goals, planning strategies, implementation, reviewing and ending. It also highlighted that these things could not be achieved without the high level of relational skills displayed by the HVs in this study.

4.9 Chapter conclusion

The themes arising from the interview data throughout this chapter provide important indicators of the parent/HV relationship. As can be seen from the presentation of the figures in each section different themes were important to HVs and parents; each group had their perceptions of what was of importance in the relationship, although there were overlapping themes as well. These themes are the indicators of positive relationships between HVs and parents.

These indicators can now be identified and used to formulate questionnaires for parents and HVs separately to measure their relationships. The next chapter describes the formulation of the questionnaires from the data presented in this chapter.
Chapter 5 Distilling the Content of the Questionnaire Indicators

5.1 Introduction

This chapter explains the process of identifying and formulating the questionnaire indicators of parent/HV relationships [see Chapter 3 for methods]. Initially findings from the interview data [Chapter 4] and the analysis of relationship measures [Chapter 2] will be presented lending weight to the argument for a profession-specific measure of the relationship. This is followed by an overview of the pilot questionnaires with the evidence for each indicator that was utilised.

5.2 Qualitative Data Analysis Compared with Relationship Measures

The analysis of the measures of relationship [Chapter 2] is now compared with analysis of the qualitative data [Chapter 4]. Initially, the client measures [Figure 5-1. Box A] and the results of the analysis of the parent interviews will be compared [Figure 5-1. Box B] followed by a comparison of the therapist measures [Figure 5-2. Box A] and the results of the analysis of the HV interviews [Figure 5-2. Box B].

5.2.1 Comparison of parent interview data analysis & client relationship measures

The comparison of the parent interview data and the client relationship measures analysis revealed many differences. Most striking was the emphasis in the interview data that parents put on the HV’s experience and knowledge. HVs were a useful source of advice and were valued by parents because of this. However, the HV also had to be non-judgemental, caring, friendly, and able to put parents at their ease. None of these qualities or skills was seen in existing client measures where clients were asked to rate their therapists or social workers, or patients their doctors or nurses [Figure 5-1. Box A]. The relationship measures used in other professions were, therefore, inappropriate for use in parent/HV relationships.
Figure 5-1. Item Comparison: Parent Qualitative Data and Client Measures reviewed Ch.2

There was congruence between the parent interview data and the client measures concerning empathy and understanding, listening skills, honesty and genuineness, trust, support, and therapist or HV interest in the client/parent [Figure 5-1. Box C]. Two items common to both sets of data was a focus on outcomes and the ability to motivate and inspire the client/parent; these may be important to include in a new measure of parent/HV relationships.

The parent interview data also identified various organisational factors that affected the ability of HVS and parents to build and maintain their relationships with each other. Continuity of care and home visiting were found to be important. However, these factors were absent in the measures as clients may always see the same therapist and home visiting may not be their usual method of service delivery.
5.2.2 Comparison of HV interview data analysis and the therapist relationship measures

Further exploration of the facet analysis of the therapist measures and the results of the analysis of the HV interview data revealed that some qualities and skills overlapped [Figure 5-2. Box C]. Congruence between the measures and interview data was apparent, with the qualities of empathy and understanding, interest, trust, respect and motivation to help along with the skills of exploration, being present in both sets of data.

A variety of other factors came into the equation when HVs were relating to parents. This particularly included their knowledge and experience in relation to child health and development. Moreover, although the HVs prime relationship was with the mother, the HV also needed to relate to children as well as to the father, if present. The therapist/doctor/nurse/social worker measures do not take into account the fact that other people may be present. The interview data were also able to show some of the detail of the health visiting process; for example, how HVs build relationships with clients by putting them at their ease [Figure 5-2. Box B]. These details were considered necessary for a new, objective measure of parent/HV relationship.
Both the HV and parent interview data identified the parent relational skills however, only the HV interview data revealed the parent qualities of openness and honesty, friendliness, interest and trust and respect for the HV. Neither the therapist nor the client measures mentioned the client contribution to the relationship [Figure 5-1, Figure 5-2]. However, this was considered important by HVs and therefore necessary for inclusion in the new measures.

5.3 Explaining the Questionnaire Design

For accuracy of measurement, it was decided that the questionnaires needed to be as objective as possible. A simple statement followed by a ‘yes, I agree’ ‘no I disagree’ answer was used. Subjective statements were avoided to enhance the objectivity of the responder and to make it
possible for a ‘yes’ or ‘no’ answer. ‘Feeling’ statements, which were common in some relationship measures reviewed, were omitted and in their place were put observable characteristics, for example, not ‘I felt the parent was unhappy to see me’ but, ‘The parent’s facial expression indicated that she was unhappy to see me’.

Approximately half of the statements on each questionnaire were worded negatively so that a ‘no I disagree’ answer would be positive for the relationship. This meant that the parent or HV needed to read the statement carefully and give a considered response rather than just working down the page ticking all the positive or negative answers, thus avoiding response bias.

The statements on the parent versions of the questionnaires include the parents’ perceptions of the HV’s contribution to the relationship. Likewise, the statements on the HV versions of the questionnaires include the HVs perceptions of the parent contribution to the relationship. These differing perspectives were ascertained from the interview and group data found in chapter four.

As it was anticipated that the questionnaires would be completed at the end of a parent/HV meeting in which young children and/or babies may be present, the questionnaires were kept as brief as possible to maximise ease of completion within a short time frame.

5.4 Explaining the indicator domains

The interview data focused on positive and established parent/HV relationships so that indicators of good relationships could be identified. However, in the course of discussing the interview findings with parent and HV groups it was obvious that sometimes relationships were not easy and when they were more problematic they had potential for difficulties from the very first meeting [4.8.1.1]. The decision was taken therefore, to devise a set of indicators for parents and HVs not only for when relationships had become established but also for a first meeting.

It also appeared from the parent and HV interviews that the role organisations played in supporting the development of relationships was crucial. As this was a variable that may also affect the measurement of the relationship, it was decided to formulate not only the relationship measures but also measure of the organisational factors that may affect relationship development.

Overall, two versions of the questionnaires were devised, one for parents and one for HVs for each of the three areas under consideration i.e. a first meeting, an established relationship [at
least 3 months] and organisational factors. Each set of pilot questionnaires will be considered in turn and evidence presented for the inclusion of each of the indicators. Initially evidence from this study will be presented and where necessary, will be cross-referenced to chapter four. New evidence from the qualitative data analysis will also be included where not included in chapter four. Wherever available evidence from existing literature will then be added. The next chapter [Chapter 6] will explain the piloting procedures and the changes to the indicators that were made as a result.

5.5 First visit questionnaire [Parent version].

The first visit to the home by the HV was critical for establishing the relationship with the parent [4.8.1.1]. HVs were under increasing pressure, due to falling numbers so the first visit could be the only visit and therefore the only chance that the parent had to find out about the service and establish a relationship with the HV. This ‘entry’ work was also identified by Luker & Chalmers (1990) as being a crucial to beginning the process from which client’s needs are identified. Where the parent perceived the offer of a service or advice as unhelpful then they were more likely to control the HV’s attempts to explore issues more fully and did not respond to the HV’s invitation to ‘open up’. They were less likely to accept any advice the HV gave, fail to attend appointments or allow the HV into their home (Chalmers 1992).

Table 5-1. The First Visit Questionnaire [Parent Version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The advice/information the health visitor gave me made sense in my situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>The health visitor played with/examined my baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>The health visitor ignored my baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The health visitor complimented me on my baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>The health visitor introduced herself.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>The health visitor gave me time to talk about my situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>At the end of the meeting I still had questions that I had not been able to ask the health visitor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>I knew by her facial expression that the health visitor did not understand me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>The health visitor did not look at me when I was talking.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>My future contact with the health visitor is unclear.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>The health visitor’s explanation of the circumstances under which she would share information with other services was unacceptable to me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>I knew by the words that she used that the health visitor understood me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>The role of the health visitor is unclear to me.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The indicators at the first visit for the parent questionnaire focused on what the HV did to establish the relationship [7 Statements 2, 3, 4, 5, 10, 11, and 13. Table 5-1] and the skills she used of exploration, listening, empathy and advice giving [6 Statements 1, 6, 7, 8, 9, 12. Table 5-1].

5.5.1 Establishing the Relationship
[Statements, 2, 3, 4, 5, 10, 11, 13. Table 5-1]

Initially consideration is given to the evidence for the indicators for the tasks and skills that HVs use to establish relationships with parents and is presented under the three headings:

- The HV introduction, role and future contact
- The HV’s explanation of the circumstances under which she would share information with other services and
- The HV relationship with the baby.

5.5.1.1 The HV introduction, role and future contact.
[Statements 5, 10, 13. Table 5-1].

Introductions are the first part of the health visiting process contributing to the building of a relationship with the parent. From the group interview data, it was clear for the parent that had had a poor experience of interaction with the HV the introduction was very important. Because the parent did not know the name of the HV, she had no idea how to contact her [4.8.1.1], access the service or continue to relate to her. The evidence from the HV literature was discussed previously in Chapter 4 [p. 147].

5.5.1.2 The HV’s explanation of the circumstances under which she would share information with other services.
[Statement 11. Table 5-1]

Openness and honesty are traits that the HV needs to build into the relationship so that there is trust between herself and the parent. The relationship might flounder if a parent perceives less than open practice with reports made to social services without prior discussion. However, how the HV explains the boundaries of confidentiality is vitally important. Cowley (1991) suggests that HVs do not need to be ‘brutally honest’ but can operate within a ‘closed awareness context’ in order to avoid dissonance during interactions. This mother’s experience at her first meeting with her HV meant that she was not happy to have HVs in her house.

[Parent grp. C] The first lady within a few minutes of being in the house felt the need to explain to me that if there were any issues, if anything arose the police are contacted all
the records are kept between the police, doctors, hospitals so er, yeh, I was a bit on edge because I didn’t know why she was telling me this. She did say in a speech, like she would if she went into any house, so I didn’t feel that it was personal but it did make me uncomfortable I didn’t feel that it was necessary to tell me that it would be put on a police database and my partner’s a policeman so I knew all this because of him but it felt very strange to have that.

However, explanations about the boundaries of confidentiality, when made sensitively, can help the parent understand the limits of the relationship; that it is a professional relationship.

[P6] The relationship is like that kind of obviously professional and doing their work and their job.

5.5.1.3 The HV relationship with the baby.

[Statements 2, 3, 4. Table 5-1]

For HVs, the child was the centre and focus of all their work and they tried to make this clear at the initial contact. They were interested in the parent’s health and that of the family because they were aware of the influence this could have on the baby. However, the interview data showed that the HV’s direct relationship with the baby was crucial for the relationship that was made with the mother.

[HV3] Every mother's baby is individual to them, you know I might see 50 babies a week but for them that baby is special and I think it gives them a lot of pride or joy about it as well which I think is important to let them experience that about their own baby especially as I am always positive about baby and what they're doing, you know smiling and I can see by their face it makes them really happy to hear that.

The HVs in the group also acknowledged that with parents who found it difficult to relate to them it was usually possible to establish the relationship by relating to the baby [4.7.9. HV grp B].

These interactions with the baby or child have been described previously as strategies or ploys that HVs use to influence parents and maintain their co-operation (Cameron 1992). Also in the Jack et al. (2005) study of Canadian public health nurses, mothers felt disconnected from the public health nurse if she 'did not spend time with the child....engaging in some social conversation'.

5.5.2 HV relational skills - exploration, listening, empathy and advice giving

[Statements, 1, 6, 7, 8, 9, 12. Table 5-1. ]

The evidence for the indicators of the HV relational skills is now presented under four headings:
5.5.2.1 Listening skills.

[Statement 9. Table 5-1]

Listening is most often indicated by eye contact. If the HV is not making eye contact then she is unlikely to be really attending and listening to the parent. ‘The person listening looks at the person who is talking most of the time’ (Davis et al. 2002a). Moreover, active listening where the HV not only hears what the client says but responds to the meaning, content and feelings expressed helps the parent to feel valued and respected (Kirkpatrick et al. 2007).

The most important skill identified by both HV and parents was listening. It was fundamental to the building of the relationship [4.6.1]. Similarly this skill and being receptive to the family's situation and needs was found to lay the foundations for a positive reciprocal relationship by Swedish public health nurses with a similar role to HVs (Jansson et al. 2001).

5.5.2.2 Pacing and exploration.

[Statements 6, 7. Table 5-1]

The HVs appeared very aware of the need to provide time for parents, particularly if they were distressed, agreeing to meet them in their homes away from busy clinic environments [4.2.3]. This was also found to be important in a study by Collinson & Cowley (1998) where the fact that HVs appeared to have time for parents was greatly appreciated. Needing time was also identified as essential for building relationships in Jansson et al’s Swedish study (2001). Within the context of service quality, timing (Cowley 1991) and ‘insufficient time’ (Williams 1998; Terov & Akselsson 2005) have been identified as important constituents.

The ability of the parent to ask questions of concern to her and to have the HV respond was important [4.4.2]. This is part of the process of identifying health needs, a key skill of health visiting; however, the profession appears to be divided as to the best way of doing this. Although some advocate the use of an open agenda (Labonte 1994; Davis et al. 2002a) at times assessment tools or guidelines have been implemented to standardise the process (Appleton 1997). However, the literature identifies that HVs may then control interactions and not allow
parents to tell their stories in their own way (Mitcheson & Cowley 2003). This has a reported negative impact on client relationships (Sefi & Macfarlane 1985; Abbott & Sapsford 1990; Foster & Mayall 1990; Kendall 1993; McIntosh & Shute 2006). More open styles of communication are however, associated with more positive parent views (Machen 1996; Collinson & Cowley 1998; Almond 2001; Normandale 2001).

In the context of using structured needs assessment however, Mitcheson and Cowley (2003), found that HVs often gave the parent no opportunity to ask questions until the end of the encounter when it was clear that the business of the meeting, as determined by the professional, was at an end. This was found to be a barrier to relationship building.

5.5.2.3 Giving information and advice.

[Statement 1. Table 5-1]

Parents valued the HV’s knowledge and experience [4.5.1, 4.8.4.1]. It was the way in which the HV used her knowledge that was important to parents. Specifically they valued advice and information that was tailored to their situation.

[Parent grp C] I think a lot of the advice we get is from commercial entities like. [tape blurred] And the health visitors are impartial they’re medical they’ve got everything at their fingertips and a lot of the stuff that ...., that I’ve been told, the advice it’s not gospel, they’ll tell you if something isn’t the one answer you should work by they’ll say, they’ll give you two different types of advice and whichever you think is right for your baby, then you feel you are getting the right advice for your child not, ‘this is the textbook, work by it.

This echoes the findings of a study of public health nurses in Sweden which found that giving individualised advice was important (Jansson et al. 2001).

That HVs are knowledgeable was found to be important to service quality in the Hanafin & Cowley study (2006) and had been recognised in other studies. Reutter & Ford (1996) found that public health nurses needed to have expertise, they needed to be competent (Jansson et al. 1998), have appropriate qualifications (Cowley 1995) and to be informed and credible practitioners (Collinson & Cowley 1998).

In the Mitcheson and Cowley (2003) study, information giving was identified as an integral part of the process of identifying needs. However, their data showed many examples of HVs giving unsolicited advice that was not in response to an issue that was raised by the parent. Earlier work by Heritage & Sefi (1992) also found that HVs tended to initiate information/advice
regardless of the response. Far from working in partnership with parents, this reduced the ability of the parent to participate fully in the interaction and may have had serious consequences for the relationship.

5.5.2.4 Empathy and understanding.
[Statements 8, 12. Table 5-1]

Empathy has been defined as an attempt by the helper to understand the world from the viewpoint of the client (Davis et al. 2002a).

The HVs thought empathy important and parents were very appreciative of this HV skill identifying it as their ‘understanding’. Parents found it a relief to talk because they felt understood [4.5.2]. This supports other research where the feeling of being understood, which was shown by ‘attitude’ and ‘body language’ conveyed the HVs enjoyment of what she was doing rather then it being ‘just a job’ (Kirkpatrick et al. 2007). Previously, Carl Rogers (1959) identified this as a major quality essential to relationship building but more recently, Jack et al. (2005) identified empathy as one of the characteristics of public health nurses that influence the parent’s ability to trust.

Empathy and understanding were also important factors included in the observer, therapist and client measures reviewed but because helpers demonstrate empathy both by what they say and by their facial expression (Davis et al. 2002a) both of these observable indicators were included in the new measure.

5.6 First Visit Questionnaire [HV Version]

Parents make an important contribution to the relationship and interaction and their involvement should not be neglected (Jarrett & Payne 1995). Indeed there is a Finnish study that suggests that clients definitely exercise their power over visiting public health nurses during home visits (Kettunen et al. 2002) and this is supported by studies of public health nurses in Canada (Jack et al. 2005). Trust in the home visitor depends on her characteristics or qualities such as her reliability, genuineness, warmth and ability to be caring and empathetic (Jack et al. 2005). The HV version of the first visit questionnaire therefore includes HV perceptions of the parent contribution to the relationship as ascertained from the interview data presented in Chapter 4. The parent contribution to relationships has not been well researched so the indicators are
designed to measure this rely heavily on the new knowledge distilled from the analysis of the qualitative data in chapter four.

Table 5-2. First Visit Questionnaire [HV Version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The parent took no interest when I spoke to and/or played with/examined her baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>The parent’s facial expression indicated that she was unhappy to see me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>The parent indicated by nodding, repeating it back or asking further questions, that she/he was interested in what I was saying.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The parent looked through the red book when I gave it to her.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>The parent spoke in detail about her situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>The parent failed to ask questions and initiate topics for discussion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>I did not speak to/play with/examine the baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>The parent indicated by what she said that she is planning to do the best she can for her baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>The parent and I agreed a way forward for future contact.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>The parent welcomed me into her home [e.g. offered me refreshment, showed me where to sit].</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>The parent indicated by what she said that the information/advice I gave her was irrelevant to her baby/situation.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There are 11 statements on the first visit questionnaire for HVs, five pertaining to establishing the relationship and six to the parent qualities and skills.

5.6.1 Establishing the relationship

[Statements 2, 7, 8, 9, 10. Table 5-2]

There were four indicators identified as important to establishing a relationship:

- Parent friendliness
- HV facilitation of mutuality and parent interest
- Working together
- HV trust in the parent.

Each will now be presented below.

5.6.1.1 Parent Friendliness

[Statements 2, 10. Table 5-2]

HVs spoke of how relationships with parents were easier and more comfortable where the parent was welcoming and seemed pleased to see them [4.3.1]. Parents too spoke of how they tried to make HVs feel welcome.

[P4] I try to be friendly and make people feel at ease as well.

- 162 -
A measure of parent friendliness may help the HV ascertain how hard she may have to work at establishing the relationship with the parent. In the Canadian study (Jack et al. 2005) mothers sought to create an environment that would enhance their ability to ‘open up’ and ‘speak from the heart’. They were more able to do this in an atmosphere of mutuality.

5.6.1.2 Health visitor facilitation of mutuality and parent interest

[Statement 7. Table 5-2]

It was important to HVs that they demonstrated interest in the baby or child. This was often a way in which they were able to establish relationships where the parents seemed less trusting of health professionals [4.7.9]. The baby was also the joint focus of the parent/HV interaction creating a mutual point of interest and discussion [4.7.9, HV 3].

5.6.1.3 Working together

[Statement 9. Table 5-2]

In the parent group interview data, there was evidence that HVs may not always seek the parent’s views on whether they should or should not meet in the future and where this was unclear the parent/HV relationship was not good and the parent felt disconnected from the service.

[Parent grp. C] I don’t know her name and everything that she wrote down is illegible so I wouldn’t be able to tell from that what her name is either. …..I don’t know who to phone to ask for someone different because I've been given no contact details.

5.6.1.4 HV trust in parent

[Statement 8. Table 5-2]

HVs felt that the relationship with parent was better where they felt that they could trust the parent [4.5.6]. When there was a lack of trust in the parent relationships were more difficult. Parents were aware of whether or not HVs trusted them and where this was absent the lack of trust could be mutual.

5.6.2 Parent relational qualities & skills

Demonstrating interest, good communication skills, receptivity, and trust in HV [Statements 1, 3, 4, 5, 6, 11. Table 5-2].

Three indicators of parental relational qualities and skills were identified:
- Parent communication skills
- Parent interest
- Parental receptivity.

Each will be presented below.

### 5.6.2.1 Parent communication skills and trust in HV

[Statements 6, 5. Table 5-2]

When the parent was able to articulate her problems well this positively affected the relationship with the health visitor [4.4.2, HV2, HV3]. Because parents sometimes lack the confidence to ask the questions this statement may also reflect the HVs ability to put the parent at ease. How well the parent communicates may also be influenced by the HVs facilitative listening and friendly manner.

### 5.6.2.2 Parent interest

[Statements 3, 4, 5. Table 5-2]

Parental interest in the health visiting service was highlighted by HVs as one of the indicators of the development of a positive relationship. When parents were interested then HVs felt valued and appreciated. [4.3.4, HV2]

### 5.6.2.3 Parental receptivity

[Statement 11. Table 5-2]

The HV used similar but different sets of skills when visiting a parent that they already knew and with whom they had a good relationship. They did not feel the need to introduce themselves and explain the service for example, but instead they needed to remember the parent and have demonstrated reliability. Parents, for their part, were less reserved and more able to express their concerns.

Where parental relationships with HVs are well-developed, parents may trust the HV demonstrating their receptivity by acting on the information and advice received (Jansson et al. 2001) [4.8.4.1]. This statement may also be indicative of the ability of the HV to give individualised advice and information particularly relevant to the family. Mothers who feel that their needs are not being met are more likely to withdraw from home visits (Jack et al. 2005).
5.7 An Established Relationship Questionnaire [Parent version]

This section of the chapter continues with an overview of the questionnaires for an established relationship used when the parent had known the HV for at least 3 months. The indicators in the parent version cover HV skills, qualities, and health visiting process.

Table 5-3. An Established Relationship Questionnaire [Parent Version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The health visitor's responses indicated that she did not understand me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Decisions that I make for my baby/child/family/situation are not encouraged by my health visitor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>When I saw my health visitor she remembered me and called me by name.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The health visitor failed to do what she said she was going to do.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>The health visitor gave me information/advice which was not relevant to my situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>The health visitor returned my phone message.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>The health visitor's facial expression let me know that she understood me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>When the health visitor visits me she is often late without letting me know.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>When I spoke to the health visitor she made eye contact that did not make me feel uncomfortable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>When I met the health visitor she had forgotten details of my situation from the previous meeting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>When we met the health visitor gave me time to talk about my situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>When the health visitor visited me at home she was punctual.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.7.1 HV punctuality, reliability and respect.

[Statements 8, 12, 6, 4. Table 5-3]

HV punctuality [8 & 12] was important for parents and for HVs. Where the parent/HV relationship was poor there was confusion around the time of the visit [Chapter 4, 4.8.1.1].

[Parent grp C] The second health visitor that came round erm the appointment was at one o'clock and I was at my Mother-in--laws and got home at five to one and she was waiting outside and I got in and I had an answer machine message and it was her from outside saying, ‘I notice that you can’t be bothered to turn up so I’d like you to re-arrange and next time you should be at home when you say you are going to be’, so… which again felt like I say, I appreciate that it’s your time and I should be here but I am and so every time they came around it felt like they got off on the wrong foot straight away.

One of the parents also affirmed that when the HV was punctual that this demonstrated respect for the parent.

[Parent grp A] I think being punctual is one [way that they demonstrate respect] and they deliver on what they say they’re going to do …

This finding was unsurprising as Bowns et al. (2000) found that poor punctuality was a reason for dissatisfaction with the health visiting service. Furthermore this was linked to the HV being reliable
and doing what she said she would do [statements 6 & 4]. When Canadian public health nurses demonstrated reliability the parents were able to be more honest and share personal aspects of their lives (Jack et al. 2005). It was therefore important not only for the relationship but also for the identification of health needs.

5.7.2 HV empathy and understanding
[Statements 1, 7. Table 5-3]

The ability of HVs to demonstrate empathy and understanding was important to parents [4.5.2]. Carkhuff (2000) and Davis et al (2002a) both identify empathy as hugely important in helping relationships. Empathy is often expressed through body language initially, through facial expression, as 65% of communication is non-verbal (Pease 1997). However, HVs also needed to respond verbally not only to the content of what was said but also to the feelings expressed so that the parent felt understood. Parents were highly appreciative of HV’s understanding of their situation [4.5.2].

5.7.3 HV ability to remember
[Statements 3, 10. Table 5-3]

Parents were appreciative of being remembered by the HV. It made them feel important and known by the HV [4.6.2]. HVs realised this and made efforts to ensure that they remembered details about parents that they met. They often worried that because of increasing time pressures that they may not actually remember parents and appear disrespectful [4.6.2]

5.7.4 HV listening/pacing skills
[Statements 9, 11. Table 5-3]

Parents were very clear that the HV’s listening skills were of paramount importance [4.6.1]. Listening has been identified as an important skill crucial to the identification of health needs and the building of empathic relationships with parents (Normandale 2001). One of the key indicators that a person is listening is their eye contact or gaze (Davis & Day 2010). This indicates interest in the conversation and attention to the person. It is part of the listener’s facial expression and as such should not be a fixed stare that could make the other person feel uncomfortable.

Giving time was identified by HVs as an important part of allowing the parent to feel comfortable enough to tell their story [4.6.3.5]. However, there is evidence in health visiting research that
parents have not always been given the time to talk about the things that trouble them (Normandale 2001; Mitcheson & Cowley 2003).

5.7.5 HV skills of giving information/advice

[Statement 5. Table 5-3]

Where parent/HV relationships were well developed HVs worked hard to respond with information to the parent’s expressed needs [4.6.4 p.126]. Similarly, Jansson et al. (2001) found that where public health nurses had built good relationships with clients they were more likely to give individual advice.

Giving unsolicited advice that was not pertinent to the parent’s individual situation was identified in the study by Mitcheson & Cowley (2003) as counterproductive. Kendall (1993) also found that ‘stereotypical’ advice that was not tailored to the parent’s specific needs was not helpful. Likewise, Bowns et al. (2000) found that inappropriate advice was a cause of dissatisfaction with the health visiting service.

5.7.6 HV ability to help parents develop self-confidence and autonomy

[Statement 2. Table 5-3]

Parents felt that because of their positive relationships with HVs they were more confident [4.8.7]. HVs tried to encourage parents in the decisions that they made for their children. This reflects the findings of Pearson (1991) who found that when there was a positive relationship with the HV over time then the parent would be happy to accept less external control from the HV. They were more likely to rely on their own decision-making skills as confidence developed over the baby’s first year. A Finnish study of public health nurses (Vehvilainen-Julkunen 1992) found that the relationship was needed to support the parent’s self-confidence and more recently Kirkpatrick et al. (2007) found that HVs encouraged parents to have confidence in their own ideas.

5.8 An Established Relationship Questionnaire [HV Version]

The HV version of the established relationship questionnaire covers indicators that relate to HV skills, parental communication and trust, and the health visiting process.
Table 5-4. An Established Relationship Questionnaire [HV Version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I could not remember the parent when she came to clinic.</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
<td>In the last three months the records show that the parent needs constant advice from me and does not make her own choices/decisions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>The parent is at home when I call.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The records show that the parent acts in a way that disregards the information I have given her.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>The parent regularly seeks out information in the interests of the child/baby by asking me questions when we have contact.</td>
<td></td>
<td></td>
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<tr>
<td>6.</td>
<td>In the last three months the records show that the parent has acted positively in her child’s best interests.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>The records show that the parent contacts me if she has a problem.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>The parent said little about her/his situation.</td>
<td></td>
<td></td>
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<tr>
<td>9.</td>
<td>In the last three months the records show that the parent has not accessed or used other services e.g. children’s centre, GP, speech and language, hospital, CAMHS, social services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>The parent is often not at home when I call.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>I was able to comment to the parent on her growing confidence in the management of her situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>The parent attends clinic to see me regularly.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.8.1 HV remembering

[Statement 1. Table 5-4]

As stated above [4.6.2] the ability of the HV to remember parents by name was important in the relationship not only to the parents but also to the HVs. They wanted to be able to remember the parents and children with whom they were in contact, worried that because of pressure of work, and time that they would be unable to do this [4.6.2]

5.8.2 Parent Confidence

[Statements 2, 11. Table 5-4]

Parental self-confidence was important to HVs and to their developing relationship. They hoped to see parents’ confidence increase and according to Pearson (1991) use this as a measure of the parents’ ability to become more autonomous and need less HV involvement. This links to the statement on the parent version of the questionnaire [statement 2 Table 5-3]

5.8.3 Parent attendance

[Statements 3, 10, 12. Table 5-4]

According to the interview data, when the parent/HV relationship was poor, parents were unsure about receiving home visits.
I feel a lot more comfortable with the clinic visits simply because they’re down to me. I personally haven’t had a great experience with both of the health visitors who visited me at home. I felt really intimidated and threatened so I prefer it being on my terms when I choose to come to the clinic and the health visitors I’ve met here have been really helpful and friendly so it’s made me feel a lot more welcome erm whereas I felt a bit…the health visitors I had were a bit like social services knocking at the door to take the baby away and I actually had to prove to them that I was good enough.

This finding is supported by Jack et al. (2005) who found that when parents are unable to overcome their fears and develop a trusting relationship with their home visitor they may demonstrate this by cancelling or not being present for scheduled home visits without giving an explanation. The parent not being home on more than one occasion without explanation is indicative of the lack of a positive relationship with implications that could be far reaching.

5.8.4 Parent information seeking and receptivity

Parents with positive relationships with HVs sought out the HV when they had a problem indicating that they found her a reliable and trustworthy source of information and advice [p.144]. In the Oxford home visiting study women who had developed positive relationships with their home visitor also spoke very positively about the advice and information they had received (Kirkpatrick et al. 2007).

5.8.5 HV trust in parent

Mutual trust is important in relationships. The literature however, tends to focus on the ability of the parent to trust the HV but in this study HVs also needed to be able to trust the parent [p.118]. Parents seemed to be aware of the HV trust in them too.

5.8.6 Parental communication and trust

Parents found it difficult to be open and honest and really trust the HV until they knew her [4.3.3.]. This supports the finding by Jack et al. (2005) who found that as the parents trust in their public health nurses increased they were more willing to discuss personal, sensitive issues. However, if
they were unable to overcome their fear they chose not to fully disclose information during individual and family assessments.

5.8.7 Ability of parent to use other services

[Statement 9. Table 5-4]

HVs hoped that when they worked with parents they would as a result be able to access other services more easily.

[HV grp C] [I hope] …that they’ll be able to use the services properly and that sort of thing even if you’re not around.

In the Jack et al (2005) study parents who had established trusting relationships with their nurses showed no problems in accepting referrals to the family visitor. The reason for this was said to be because the women trusted the public health nurse and perceived her interventions as helpful and genuine. If the relationship is strong enough it can even survive a referral to social services (Kirkpatrick et al. 2007).

5.9 Organisational Questionnaire [Parent Version]

This section of the chapter will consider the organisational questionnaires and will present the evidence for the indicators chosen for both the HV and parent versions.

In the acute sector of the NHS it has been recognised that poor organisational cultures erode the ability of nurses to care for their patients compassionately (Ross 2010). Indeed the King’s Fund Point of Care programme aims to improve patient experience of care in hospital by improving the staff experience as employees (Cornwell 2009). Raleigh et al. (2009) found evidence of associations between positive staff feedback and positive patient feedback in the annual NHS patient and staff surveys. Where staff have a good experience then, it seems so do patients. From the interview data collected in this study it appears that HVs agree this may be so in primary care, working in the community in the family home.
Table 5-5. Organisational Questionnaire [Parent Version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I have been visited at home by different health visitors.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>The health visitor writes clearly in the red book the things we have discussed.</td>
<td></td>
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<tr>
<td>3.</td>
<td>At clinic the health visitor has time for me if I need it.</td>
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<td></td>
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<tr>
<td>4.</td>
<td>When I attend clinic I usually see the same health visitor each time.</td>
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<tr>
<td>5.</td>
<td>At clinic it is difficult to identify the health visitor amongst other team members.</td>
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<tr>
<td>6.</td>
<td>At the clinic where I see my health visitor I am able to meet and get support from other parents.</td>
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<td></td>
</tr>
<tr>
<td>7.</td>
<td>The health visitor I see at clinic is a stranger to me.</td>
<td></td>
<td></td>
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<tr>
<td>8.</td>
<td>At clinic I can ask the health visitor any questions that I have.</td>
<td></td>
<td></td>
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<tr>
<td>9.</td>
<td>At the clinic the health visitor rarely smiles at people or greets them by name.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>I cannot see the health visitor in clinic without an appointment.</td>
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</table>

The organisational factors that affected parents were to do with issues that affected continuity of care and their experiences of attending child health clinics. The statements on the questionnaires reflect these two areas of concern.

5.9.1 HV continuity of care

[Statements 1, 2, 5, 10. Table 5-5]

Parents wanted to see the same HV for home visits and ideally see this same HV in the clinic situation [Chapter 4, 4.2.2.]. The statements cover both the home visiting situation as well as the clinic visit. This parent compared the continuity of care that the HV had managed to provide with that of the midwives.

[P2] At first because I had an elective cesarean because I had a low lying placenta I saw her every week for the first two or three weeks and then I saw her at the baby clinic. She comes to the baby clinic so I got to see her there and that was like every couple of weeks, but now it’s about every month when I go and get him weighed but it’s more when I go to the clinic

[P2] I think with the midwives I could have been suicidal with the midwives and they wouldn’t really have known, erm, and in some ways I couldn’t really wait for them to leave when they came it was often, I felt quite, because he was jaundiced I had a different midwife each of the three visits I did get a different one every time so nobody could tell me whether they thought he was more yellow than he was before and it was all on my shoulders, ‘well you’re his mother’ Well I know I’m his mother but at this point in time it would be nice to have some reassurance that ‘yes he’s getting yellower or no he’s not.

When the health professional is able to see a family over time not only is there a chance for the development of a supportive relationship but also changes in health status become obvious to the observer. This continuity facilitates prompt resolution of evolving problems and difficulties and the
promotion of positive health and child development. This ‘relational continuity’ has been found to be of importance in primary and mental health care (Haggerty et al. 2003).

‘Informational continuity’ is provided by HVs in the UK with the child health record also known as the ‘red book’. Parents in this study who had a poor relationship with their health visitor also suffered a lack of informational continuity, as the writing in the red book was illegible [4.8.1.1]. In general practice, ‘informational continuity’ may be the only type of continuity that is provided with patients expected to see whichever GP is available. Patients, however, do not recognise this as continuity of care (Boulton et al. 2006). HVs may not be able to achieve relational continuity but strive to provide informational continuity. This form of continuity, however, is not what the majority of parents want as evidenced in the Netmums survey where 70% of 6,000 parents stated they wanted to be seen by one dedicated HV who knew their family (Russell 2008).

In the Trusts involved in the present study, it was usual for there to be no appointment system at a child health clinic. Parents attended whenever they wished over a two-hour period. Frustration with this system was expressed in the study by Bowns et al. (2000) and was a cause of dissatisfaction with the health visiting service.

5.9.2 Experiences of Child Health Clinics

[Statements 3, 4, 6, 7, 8, 9. Table 5-5]

Not only may parents not be seen by the same HV at home visits they may also experience a variety of practitioners when they visit the child health clinic. HVs as well as parents spoke of clinics as busy rushed environments. Parents were confused by the numbers of health professionals who may be present and who they were [4.2.3]. Furthermore, it was difficult for them to ask questions and get their needs met [ 4.2.3.].

Because HVs had to record clinic attendance on the computer they found they had little time to make eye contact with parents. They were often unable to greet parents by name, as they did not recognise them. This aspect of remembering parents and their names was important to both parents and health visitors [4.6.2]

Some HVs strove to make clinics pleasant places where parents could meet not only the HV but also other parents in similar circumstances [4.2.3].
Kirkpatrick et al. (2007) found that parents frequently saw different HVS in different clinics, which resulted in a feeling that HVS never really got to know the parents properly. Mothers in this study also found that the clinic environment was unsuitable for anything more than a general conversation.

5.10 Organisational Questionnaire [HV Version]

The areas of organisational concern were more varied for HVS than for parents. Their issues were about:

- Team working
- Workload
- Clinical supervision and
- Barriers to parent contact.

The statements reflect these areas of concern and are presented below.

Table 5-6. Organisational Questionnaire [HV Version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>My workload is such I cannot carry out follow-up visits to clients who are in greater need.</td>
<td></td>
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<tr>
<td>2.</td>
<td>I lead a team who are able to help me meet the client's identified needs.</td>
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<td></td>
</tr>
<tr>
<td>3.</td>
<td>The HV team that I work with is small enough to get to know each other and meet together weekly.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The time spent on record keeping does not reduce routine face to face contact with clients.</td>
<td></td>
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<tr>
<td>5.</td>
<td>Attending meetings interferes with my routine face to face contact with clients.</td>
<td></td>
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</tr>
<tr>
<td>6.</td>
<td>I do not receive helpful clinical supervision regularly.</td>
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<tr>
<td>7.</td>
<td>Working in a skill mix team prevents me developing relationships with clients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>The clients I visit at home I do not see in clinic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>My caseload meets CPHVA guidelines i.e. 250 children in affluent areas or 100 children in deprived areas.</td>
<td></td>
<td></td>
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<tr>
<td>10.</td>
<td>I can use my professional judgment to decide which clients to see on a continuing basis.</td>
<td></td>
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</tr>
</tbody>
</table>

5.10.1 Team working

[Statements 2, 3, 7. Table 5-6]

Statements 2 and 7 refer to the skill mix element of team working and statement 3 to the team size.

The findings in this study, and others (Cowley et al. 2007) were that the team was led by a HV or corporate group of HVS who delegated tasks to more junior staff. Although the HV remained accountable and was responsible for the supervision of less qualified members of the team she
remained disconnected from the parent. This was reflected in the finding that this way of working was associated with less home visiting (Cowley et al. 2007).

Skill mix is a particular way of team working and can be defined as a way of connecting the 'needs' of families with the skills available amongst the professionals in a particular working environment (Fisher 2009). It has been associated with a greater availability of group work for post-natal support, parenting and infant massage (Cowley et al. 2007).

However, there is a subtle difference between teams where skilled staff are sought to meet identified needs and where there is grade mix or skill substitution.

[HV grp B] It's not skill mix though it's grade mix. It's staff nurses from the hospital with the training. It's not like somebody whose come in whose great on, I don't know, breast feeding or whose great on depression or whatever we needed. It's certainly not on skills.

There was evidence that the variety of staff available in clinics was confusing for parents and they had trouble in identifying the HV.

[P5] Ok, ok and just somebody standing there I don't know whose there and ok, ok and then I think maybe it's a health visitor or maybe its not.

Team size was important to the HVs.

[HV grp K] I've noticed that since we moved from a bigger team covering two geographical wards to a smaller team covering one geographical ward it has been slightly easier to maintain a relationship and as a team we are able to follow up new births and to make a team decision and in order to establish the relationship remaining linked to them and we have been able to do that because we are a smaller team covering a smaller area and probably there's a greater chance for us to see people in clinic as well and I think that's been hugely vital because I know when we worked in X locality it was impossible.

In a review of the literature of teams in primary and community care, Xyrichris and Lowton (2008) also found that smaller size teams correlated significantly with team effectiveness whilst larger teams showed lower levels of member participation.

The introduction of corporate teams of HVs with a grade mix team was viewed as unhelpful to the continuity of care that HVs wished to give as it meant that it was often not possible to see the parents they home visited in the clinic situation, nor on a continuing basis [4.2.2]. This echoes the finding of Wright (1998) who found that skill mix increased the HV's workload due to the need to monitor and support staff and thus decreased their client contact time.
Teams may be useful as they allow the achievement of an aim or goal that would not be possible with a single practitioner working alone. Nevertheless, team-based structures need to allow for mutual support as individuals involved carry out complex and demanding tasks (Carter & West 1999).

5.10.2 HV Workload

Statements 1, 9, 10. Table 5-6

Getting the HV workload right, was cited by HVs as being crucial to their ability to forge relationships with families [4.2.8]

According to Cowley & Bidmead (2009a) the optimum size of a health visiting caseload is a controversial issue and there is great variation across England (Family and Parenting Institute 2007). Moreover, different sized caseloads are not automatically linked to areas of deprivation (Cowley et al. 2009) and lack a logical basis. In this study the caseload size impacted on the ability of HVs to provide continuity of care to families and they struggled to visit families in greater need. Management could be prescriptive about how many home visits could be made by the HV. However as Jack, et al. (2005) pointed out, it is important that managers recognize the necessity of allowing flexibility in deciding how many visits are needed in the early stages of building the relationship.

In this study, HVs were working across three PCTs with wards that fell into the some of the most deprived in England according to the Index of Multiple Deprivation. In these areas, in the view of Cowley and Bidmead (2009a), caseloads should be one whole-time equivalent HV to 100 children aged under five. Although sometimes these wards bordered on areas that were more affluent there seemed to be little discrimination in the allocation of HV resources. According to the Community Practitioners and Health Visitors Association (Cowley 1997) average caseloads should be no more than 250 children per full-time HV in order to allow HVs to make relationships with families and assess health needs adequately (Unite/CPHVA 2009).
5.10.3 Clinical supervision

[Statement 6. Table 5-6]

Although in this study, only one HV mentioned clinical supervision as being important to aid her reflection on relationships with parents, there was evidence to suggest that this was very helpful to practitioners and has been part of successful interventions in health visiting [Chapter 4, 4.2.1]

Clinical supervision has been shown to be beneficial for workers (White & Winstanley 2010; Wallbank & Hatton 2011) and possibly for patients (Bambling et al. 2006; Butterworth et al. 2008; White & Winstanley 2010) and their relationships with professionals (Bambling et al. 2006)

5.10.4 Barriers to Parent contact

[Statement 4, 5, 8. Table 5-6]

HV s reported difficulties in record keeping and felt that it hampered the amount of face-to-face contact with parents [4.2.4]. They also reported that they were expected to attend an increasing number of different meetings about families that were subject to a child safeguarding plan or designated a child in need.

[HV grp F] We spend all our time attending meetings where the same things are discussed about the same families very officially and yet there’s this huge pool of families that aren’t getting any services whatsoever so there’s one percent of families getting a huge amounts of different services and everybody’s having endless meetings about them and yet there’s this big uncharted pool.

HV s were unable to see parents that they visited at home in the clinic setting. This was not only because of the sheer numbers of parents to be seen but also because of the ways in which clinics were organised [4.2.2].

5.11 Conclusion

This chapter has presented the evidence for the indicators chosen for the pilot questionnaires. They were distilled from a synthesis of both the qualitative data gathered through the stimulated recall interviews, existing literature and commonalities with other measures of relationships. The next chapter will consider the processes involved in the piloting of these questionnaires, the changes made and the reasons for these.
Chapter 6 Establishing the Content and Construct validity of the Questionnaires

6.1 Introduction

This chapter explains the methods used to pilot the TELER dichotomous questionnaires described in Chapter 5. It will detail the adjustments and refinements made to the questionnaires as a result of the comments made by HVs and parents in the community and go on to describe the statistical tests used to analyse the results.

During the formulation of the questionnaires, it was ensured that the questionnaire statements were valid by the processes described in Chapter 5. However, a pilot phase was necessary to test them, with HVs and parents, for construct and content validity. Validity was a particular focus of the pilot. The statements used as indicators of the relationship needed to be unambiguous to meet the requirements of measurement theory and measurement scales (Hand 2004).

6.2 Methods

6.2.1 Sample

Two inner city PCTs were purposively chosen from which to recruit HVs and parents to the pilot study. The PCTs had a history of training their HVs in the FPM (Davis et al. 2002b) so HVs would be expected to be familiar with the concept of needing to establish and maintain relationships with parents. Eleven HVs volunteered following meetings where the rationale for the study was presented along with and explanation of the eventual outcome; the formation of new instruments to measure the parent/HV relationship.

All the HVs worked in skill mixed teams covering health visiting services for the under-fives in various wards of the borough. The teams varied in size and composition from four HVs working with two nursery nurses, two staff nurses and clerical support to two part-time HVs working with one nursery nurse and clerical support. The HVs experience varied from one year to 26 years [Figure 6-1].
The HVs were asked to take the researcher to visit as many different kinds of families as possible having previously sought their permission. Heterogeneity of the sample was important so that the instruments developed might be applicable to many types of families that usually comprise a health visiting caseload. The views of these families on the developing questionnaires were needed to establish the validity of the constructs across diverse communities. The families varied in their circumstances and backgrounds. The HVs were asked to recruit families where English was spoken however, for twelve of the families concerned English was not their first language; for example, this included families from, France, Spain, Russia, Lithuania, the Cameroons, and Sierra Leone. Other families came from the West Indies, New Zealand, and Ireland. Parents were asked their age on the front sheet of the questionnaire along with their contact details and research coding [Appendix 8] On reflection it was also felt that the number of children in the family may also be important data to collect again to ensure that a wide variety of families were included in the research. Following the pilot, this information was collected along with the parental age on the front sheet of the questionnaire.
6.2.2 The Process of Piloting the Questionnaires

Visits were made alongside the HV and were observed with field notes recorded concerning the interaction and relationship. These notes were complemented with notes of the context of the visit, for example the family circumstances and the organisational background of the HV. At the end of the visit, the HV left and the parent was given the questionnaire to complete. Following completion the parent was asked a series of questions about the questionnaire. An interview guide [Table 6-1] was used as an aide memoir for the semi-structured interviews, and notes were made of the parent’s comments. The use of this technique was a useful way of ensuring that all the topic areas are covered (Polit et al. 2001) for each of the participants.

Table 6-1. Interview Guide

<table>
<thead>
<tr>
<th>Number</th>
<th>Questions</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Are the statements relevant to your relationship with HV? Yes/No</td>
</tr>
<tr>
<td></td>
<td>Which are not? Numbers</td>
</tr>
<tr>
<td></td>
<td>Why are they not relevant?</td>
</tr>
<tr>
<td>2</td>
<td>Are any of the statements more important in terms of your relationship than others? Yes/no</td>
</tr>
<tr>
<td></td>
<td>Which ones? Numbers</td>
</tr>
<tr>
<td></td>
<td>Why?</td>
</tr>
<tr>
<td>3</td>
<td>Do you think anything important has been left out and should be added? Yes/no. What should be added? Why?</td>
</tr>
<tr>
<td>4</td>
<td>Should any of the statements be removed? Yes/no</td>
</tr>
<tr>
<td></td>
<td>Which ones? Numbers</td>
</tr>
<tr>
<td></td>
<td>Why?</td>
</tr>
</tbody>
</table>

Figure 6-2. Age and Number of Parent Participants
The HV was given a questionnaire as she left the parent's house and was subsequently interviewed according to the above guide but with the word ‘parent’ substituted for the word ‘HV’. Notes were made of the HVs’ answers.

The 11 HVs were accompanied on 13 first home visits and 14 visits to where the relationship had been established for at least three months. Questionnaires were completed for both the HV and the parent at each visit and post-visit interviews carried out.

6.3 Results

The six pilot versions of the questionnaire proved acceptable to parents and HVs. They were easy to complete within a short space of time. HVs and parents agreed that the statements reflected items that were important to them as indicators of their relationships with each other. There were some instances where the wording of items needed changing and some overlapping of items required amalgamation or removal from the questionnaire.

Consideration will now be given to each of the questionnaires in turn to explain the participants' comments and show how the items were altered as a result. Initially the pilot questionnaire is presented followed by a list of the changes made and the reasons for these. The final questionnaire is then presented.

6.3.1 First Visit Questionnaire [Parent Version]

Table 6-2. Pilot version of First Visit Questionnaire [Parent version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The advice/information the health visitor gave me made sense in my situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>The health visitor played with/examined my baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>The health visitor ignored my baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The health visitor complimented me on my baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>The health visitor introduced herself.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>The health visitor gave me time to talk about my situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>At the end of the meeting, I still had questions that I had not been able to ask the health visitor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>I knew by her facial expression that the health visitor did not understand me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>The health visitor did not look at me when I was talking.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>My future contact with the health visitor is unclear.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>The health visitor’s explanation of the circumstances under which she would share information with other services was unacceptable to me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>I knew by the words that she used that the health visitor understood me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>The role of the health visitor is unclear to me.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Although neither parents nor HVs commented about the order of the statements, when changes were being made to the questionnaire, it was felt to be more logical to put the statement about the HV’s introduction at the beginning of the questionnaire.

**Statement 3. The health visitor ignored my baby.** [Table 6-2]

This statement was removed as it overlapped with statement 2. The health visitor played with/examined my baby and 4. The health visitor complimented me on my baby [Table 6-2]. The analysis of the response profile [Appendix 9] of the First Visit [Parent Version] questionnaire for these statements showed that no mother marked statement 3 [Table 6-2] negatively meaning that the HVs evidently, responded to every baby. However, four out of the 13 parents completing the questionnaire indicated that the HV did not examine or play with the baby. Only one HV failed to compliment the parent on her baby. Although there was overlap in the statements, it appeared that HVs do not ignore the baby completely so the removal of this item was justified.

Statement 2, ‘The HV played with/examined my baby’ and statement 4, ‘The HV complimented me on my baby’ [Table 6-2] were considered irrelevant to a parent whose baby was asleep at the time of the visit. However, it was important to include these two statements as it is part of the HV role to, at the very least, see, if not examine the baby, at the first visit. Practice seemed to vary greatly on this point from a complete head to toe examination to barely a glance by the HV in the baby’s direction. Perception of the role of the HV was influenced by HV management her interaction with the infant. When the HV did not examine the baby, one parent felt that it was not the HVs role to do this, which may have had consequences for the relationship between mother and HV at a later stage of the child’s development when this would become necessary.

**Statement 11. The health visitor’s explanation of the circumstances under which she would share information with other services was unacceptable to me.** [Table 6-2]

The wording of this statement was changed for simplification following parents’ comments. None of the HVs observed at the first visit, explained the circumstance under which she would share information with other services. However, the parents all ticked the ‘no I disagree’ box and did not indicate the absence of an explanation. The researcher was listening for some reference to social services by the HV. However, the parents were not expecting this and heard instead the HV explanation of what information would be shared with Children’s Centres. One parent [an obstetrician] pointed out that this question was more complex than the others and therefore less
likely to be well understood by everyone. The newly worded statement became the new statement 10. ‘I was comfortable with the explanation the health visitor gave me as to why she would share information with other people’ [Table 6-3].

**Statement 12. I knew by the words that she used that the health visitor understood me.  [Table 6-2 ]**

This statement was removed. There was overlap between this statement and statement 8. I knew by her facial expression that the health visitor did not understand me [Table 6-2]. Both statements were intended to be a measure of HV empathy. The analysis of the response profile to statement 12 [Appendix 9] showed that no parent marked this negatively indicating that all the HVS demonstrated their empathy and understanding of parents by their verbal responses. Statement 8 [Table 6-2] had one negative response although the response to statement 12 [Table 6-2] was positive indicating that although the HVS verbal responses demonstrated understanding her facial expression did not. This was not observed during the visit so may have been an error on the part of the parent. Three parents had commented that they thought that these two separate statements could be combined. They were, therefore, amalgamated and became the new statement 8. I knew the health visitor did not understand me by the way she looked/spoke [Table 6-3].

There were comments from two fathers about the lack of reference to the HVS relationship with fathers. However, as fathers were not always present during the HV visit it was decided omit a statement regarding this to avoid incomplete questionnaire responses. Although the questionnaire was for ‘parents’ usually it was the mother who was the participant even if the father was present. The mother was the person with whom the HV most frequently related. It was mothers who were interviewed during the qualitative phase of the study and who gave their views on relationships with HVS from which the indicators were distilled. Caution may therefore be needed using the First Visit relationship indicators with fathers even where they may be the sole carers of the new infant.

The HV quality of being non-judgemental was thought fundamental by one parent. Consideration was given to the idea of adding a statement specifically about this but it was thought that if the HV was judgemental in her approach then she would not give the parent the sense of being
understood. This is covered in statement 8. 'I knew the HV did not understand me by the way she looked/spoke'. [Table 6-2, Table 6-3].

As some features of the relationship at a first meeting were possibly more important than others parents were asked about this in the interview following completion of the questionnaire. This produced a variety of answers, as different things were important to different parents. The most important statements were 1, 8 & 12, 6, 7, 10, 13 [Table 6-2]. Because of the wide variation in parents’ perceptions, it was decided that weighting of the statements during the analysis was unnecessary. Weighting is a mathematical correction procedure which may be used to arrive at a normal value when the design or sampling has been disproportionate (Polit et al. 2001). However, the important statements noted by parents here indicated a random spread.

Table 6-3. New version of First Visit Questionnaire [Parent version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The health visitor introduced herself.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>At the end of the meeting I still had questions that I had not been able to ask the health visitor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>The health visitor complimented me on my baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The health visitor did not look at me when I was talking.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>The health visitor gave me time to talk about my situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>The role of the health visitor is unclear to me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>The advice/information the health visitor gave me made sense in my situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>I knew the health visitor did not understand me by the way she looked/spoke.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>The health visitor played with/examined my baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>I was comfortable with the explanation the health visitor gave me as to why she would share information with other people.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>My future contact with the health visitor is unclear.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The first visit questionnaire was developed with a version for HVs as well as parents [Chapter 5]. The HV version was also piloted and relevant adjustments made. These are now presented.
### 6.3.2 First Visit Questionnaire [HV Version].

Table 6-4. Pilot Version of First Visit Questionnaire [HV version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The parent took no interest when I spoke to and/or played with/examined her baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>The parent’s facial expression indicated that she was unhappy to see me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>The parent indicated by nodding, repeating it back or asking further questions, that she/he was interested in what I was saying.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The parent looked through the red book when I gave it to her.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>The parent spoke in detail about her situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>The parent failed to ask questions and initiate topics for discussion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>I did not speak to/play with/examine the baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>The parent indicated by what she said that she is planning to do the best she can for her baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>The parent and I agreed a way forward for future contact.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>The parent welcomed me into her home [e.g. offered me refreshment, showed me where to sit].</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>The parent indicated by what she said that the information/advice I gave her was irrelevant to her baby/situation.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Statement 4. The parent looked through the red book when I gave it to her.** [Table 6-4]

This statement was removed. The comments from the HVs about this revealed that when a parent was having a second or subsequent child then the parent may not be as interested in the red book as with a first child. This would not necessarily indicate that the parent was uninterested. During observation of the visits it was also clear that at a first visit the HV often held the book for the parent and showed it to her explaining as she went along, so the parent did not ‘look through’ the book. Again, this did not mean that the parent was uninterested.

The analysis of the response profile [Appendix 10] indicated that HVs observed that parents frequently did not look through the red book. There were six negative responses to this statement, more than to any other statements. It was felt necessary therefore, to remove the statement to avoid response bias.

**Statement 7. I did not speak to/play with/examine the baby** [Table 6-4]. This statement was also removed; it was the only statement that asked the HV about her own actions. The questionnaire was intended for the HV to rate the parent interaction and contribution to the relationship just as the parent version was intended to rate the HVS contribution to the interaction. The statement was re-worded so that it became about what the parent did in response to the HV interaction with the baby [Statement 1. ‘The parent took no interest when I spoke to and/or
played with/examined her baby/child [Table 6-5]. This also covered the element of ‘parent interest’, which had been part of statement 4 [Table 6-4], which was also removed.

**Statement 11. The parent indicated by what she said that the information/advice I gave her was irrelevant to her baby/situation** [Table 6-4]. This statement was re-worded so that there was consistency across all the questionnaires about the various options that occur because families are visited who are in different situations. A first visit commonly occurs as a result of a new birth on or around 10 day post-natally. However, a first visit may also occur when the HV becomes aware of a family newly moved into her area or practice. It was decided therefore, to use the options of ‘baby/child/family/situation [statement 9 Table 6-5].

**Statement 10. The parent indicated that she was comfortable with my explanation of the circumstances under which I would share her information with other services.** [Table 6-5]. This statement was added to the questionnaire. After discussion with the HVs about whether or not they discuss the sharing of information with other services at the first visit it was decided to add a statement, affirming or not as the case may be, the parent’s acceptance of the way in which this was done. It was agreed that some HVs omit to do this at a first visit but it is generally considered good practice and therefore included. The statement was an indicator of the HV skill in this regard and also of her openness and honesty with the parent.

The importance of the statements to HVs was assessed at the post-visit interview. HVs thought that statements 2. ‘The parent’s facial expression indicated that she was unhappy to see me’ and 6. ‘The parent failed to ask questions and initiate topics for discussion’ [Table 6-4] were of particular importance. When the parent was happy to see them and initiated topics for discussion then it was likely that they were in control of the interaction and this was felt by HVs to be important to the quality of the relationship. Statement 8. ‘The parent indicated by what she said that she is planning to do the best she can for her baby’ [Table 6-4] was also important to the HVs but they qualified this by saying that, what was being observed was the parental ability to be involved emotionally with the baby and that she needed to demonstrate caring. It was felt however, that the wording as it stood was sufficient to measure the HVs trust in the parent’s ability to care for her baby/child.
Table 6-5. New Version of First Visit Questionnaire [HV version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The parent took no interest when I spoke to and/or played with/examined her baby/child.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>The parent's facial expression indicated that she was unhappy to see me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>The parent indicated by nodding, repeating it back or asking further questions, that she/he was interested in what I was saying.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The parent spoke in detail about her situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>The parent failed to ask questions and initiate topics for discussion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>The parent indicated by what she said that she is planning to do the best she can for her baby/child.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>The parent and I agreed a way forward for future contact.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>The parent welcomed me into her home [e.g. offered me refreshment, showed me where to sit].</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>The parent indicated by what she said that the information and/or advice I gave her was irrelevant to her baby/child/family/situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>The parent indicated that she was comfortable with my explanation of the circumstances under which I would share her information with other services.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Having described the piloting of the first visit questionnaires for both the parent and HV the questionnaire for measuring an established relationship will now be considered. The piloting of the parent version will be described initially.

6.3.3 An Established Relationship Questionnaire [Parent Version]

Table 6-6. Pilot Version of An Established Relationship Questionnaire [Parent version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The health visitor's responses indicated that she did not understand me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Decisions that I make for my baby/child/family/situation are not encouraged by my health visitor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>When I saw my health visitor, she remembered me and called me by name.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The health visitor failed to do what she said she was going to do.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>The health visitor gave me information/advice, which was not relevant to my situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>The health visitor returned my phone message.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>The health visitor’s facial expression let me know that she understood me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>When the health visitor visits me, she is often late without letting me know.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>When I spoke to the health visitor, she made eye contact that did not make me feel uncomfortable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>When I met the health visitor, she had forgotten details of my situation from the previous meeting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>When we met the health visitor gave me time to talk about my situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>When the health visitor visited me at home, she was punctual.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Statement 6. The health visitor returned my phone message [Table 6-6]. This statement was re-worded in response to parents who said that they had not left telephone messages for the HV and so could not complete the statement. However, it was still thought to be important that the
HV s accessibility and reliability be measured and so the statement was changed to be less specific; ‘I am able to make contact with the health visitor if I need to’ [statement 6, Table 6-7].

An analysis of the response profile for this statement [Appendix 0] showed that no parent marked this negatively indicating that HVs did return telephone messages. It also indicates that, although parents made the comments, as noted above, they still completed the questionnaire as if they had left telephone messages for the HV. When asked by the researcher about this they said they were sure the HV would return their messages and so did not want to indicate that the HV may not be reliable. It would seem that trust in the HV’s reliability had been well established.

**Statement 12. When the health visitor visited me at home, she was punctual.** [Table 6-6]

This statement was removed as it overlapped with statement 8 ‘When the health visitor visits me, she is often late without letting me know’ [Table 6-6]. The overlap was noted by the parents. Both of these statements measured HV punctuality and respect. An analysis of the response profile showed that one parent who had marked statement 12 negatively also marked statement 8 negatively indicating the overlap. However, another parent who marked statement 12 negatively did not mark statement 8 in the same way, which may have indicated that although the HV was not punctual she did let the parent know that she was going to be late. The important thing to the parent was that the HV let her know about her being late as this demonstrated her respect. This provided further evidence for retaining statement 8. Statement 12 [Table 6-6] was therefore excluded.

**Statement 12. I see my health visitor at clinic** [Table 6-7]. This new statement was included as the continuity of contact with the same HV was very important to parents as demonstrated in analysis of the interviews [4.2.3]. As the relationship develops, it is likely that the parent will make more contact with the HV through clinic attendances and the parents wanted this to be someone that they knew. The addition of this statement also made this questionnaire congruent with the HV version, which also refers to clinic attendance i.e. ‘The parent attends clinic to see me regularly’ [Statement 12 Table 6-8].

**Statement 9. When I spoke to the health visitor, she made eye contact that did not make me feel uncomfortable** [Table 6-6, Table 6-7]. Parents did not like the statement as the ‘yes’ or ‘no’ answer made it a double negative. However, in order to reduce response bias and increase
reliability, it was retained as it reduced the likelihood that parents would just tick ‘yes’ or ‘no’ without thinking about it carefully reducing the possibility of an unforced error.

Statements 1, 11, 7, 10, 5, 2, 4 [Table 6-6] were all of importance to the parents. The most important were statements 11. ‘When we met the health visitor gave me time to talk about my situation’ and 7 ‘The health visitor’s facial expression let me know that she understood me’ [Table 6-6]. This was followed by statements 1. ‘The health visitor’s responses indicated that she did not understand me’ and 10. ‘When I met the health visitor, she had forgotten details of my situation from the previous meeting’. Parents clearly appreciated being able to talk freely about their situation [4.6.3], being understood by the HV [4.5.2] and being remembered [4.6.2]. Because there were a large number of statements that were considered important to a variety of parents, it was considered unnecessary to use any corrective mathematical weighting of the statements, as with the first visit questionnaire, parent version [p.180.] (Polit et al. 2001).

Table 6-7. New Version of an Established Relationship Questionnaire [Parent version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The health visitor’s responses indicated that she did not understand me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Decisions that I make for my baby/child/family/situation are not encouraged by my health visitor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>When I saw my health visitor, she remembered me and called me by name.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The health visitor failed to do what she said she was going to do.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>The health visitor gave me information/advice, which was not relevant to my situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>I am able to make contact with the health visitor if I need to.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>The health visitor’s facial expression let me know that she understood me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>When the health visitor visits me, she is often late without letting me know.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>When I spoke to the health visitor, she made eye contact that did not make me feel uncomfortable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>When I met the health visitor, she had forgotten details of my situation from the previous meeting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>When we met the health visitor gave me time to talk about my situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>I see my health visitor at clinic.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The results of the piloting of the HV version of the Established Relationship Questionnaire will now be described.
6.3.4 An Established Relationship Questionnaire [HV version]

Table 6-8. Pilot Version of an Established Relationship Questionnaire [HV version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I could not remember the parent when she came to clinic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>In the last three months, the records show that the parent needs constant advice from me and does not make her own choices/decisions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>The parent is at home when I call.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The records show that the parent acts in a way that disregards the information I have given her.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>The parent regularly seeks out information in the interests of the child/baby by asking me questions when we have contact.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>In the last three months, the records show that the parent has acted positively in her child's best interests.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>The records show that the parent contacts me if she has a problem.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>The parent said little about her/his situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>In the last three months the records show that the parent has not accessed or used other services e.g. children's centre, GP, speech and language, hospital, CAMHS, social services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>The parent is often not at home when I call.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>I was able to comment to the parent on her growing confidence in the management of her situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>The parent attends clinic to see me regularly.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Statement 3. **The parent is at home when I call** [Table 6-8]. The wording of this statement was thought by HVs to be ambiguous. ‘Call’ could mean a telephone call but it was meant to indicate a home visit. The wording was therefore changed [statement 3. The parent is at home when I arrange a visit [Table 6-9] to minimise item non-response.

Statement 10. **The parent is often not at home when I call.** [Table 6-8] was removed as it overlapped with statement 3 [Table 6-8]. An analysis of the response profile showed that two HVs who marked statement 10 negatively also marked statement 3 negatively, as would be expected when there is overlap between statements. One HV marked statement 10 negatively but not statement 3 which may have been an error. The item was removed to minimise response bias.

The question about clinic attendance was raised by the HVs as a problem as some parents did not attend clinic. It was decided that clinic attendance was an important indicator of the parent/HV relationship. During the pilot phase, the questionnaires were used with parents who had met their HV on more than one occasion. Some of these home visited parents, however, were not attending clinic. A decision needed to be made about what length of time the parent needed to have been in contact with the HV for a relationship to be considered fully developed.
As a result of this it was decided that a relationship would be considered established if the parent had been in contact with the HV for at least three months and had, both attended clinic and received home visits. In future, the questionnaire would only be used with parents who fulfilled these criteria in order to minimise item non-response.

Table 6-9. New Version of an Established Relationship Questionnaire [HV version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I could not remember the parent when she came to clinic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>In the last three months, the records show that, the parent need constant advice from me and does not make her own choices/decisions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>The parent is at home when I arrange a visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>The records show that the parent acts in a way that disregards the information I have given her.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>The parent regularly seeks out information in the interests of the child/baby by asking me questions when we have contact.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>In the last three months, the records show that the parent has acted positively in her child’s best interests.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>The records show that the parent contacts me if she has a problem.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>The parent said little about her/his situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>In the last three months the records show that the parent has not accessed or used other services e.g. children’s centre, GP, speech and language, hospital, CAMHS, social services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>I was able to comment to the parent on her growing confidence in the management of her situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>The parent attends clinic to see me regularly.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The third set of questionnaires pertained to the organisational factors that might act as a barrier to the formation of the parent/HV relationship. The results of the piloting of the parent version will now be presented.

6.3.5 Organisational Questionnaire [Parent Version]

Table 6-10. Pilot Version of an Organisational Questionnaire [Parent version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I have been visited at home by different health visitors.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>The health visitor writes clearly in the red book the things we have discussed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>At clinic, the health visitor has time for me if I need it.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>When I attend clinic I usually see the same health visitor each time.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>At clinic, it is difficult to identify the health visitor amongst other team members.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>At the clinic where I see my health visitor, I am able to meet and get support from other parents.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>The health visitor I see at clinic is a stranger to me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>At clinic, I can ask the health visitor any questions that I have.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>At the clinic, the health visitor rarely smiles at people or greets them by name.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>I cannot see the health visitor in clinic without an appointment.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
These organisational questionnaires, like the ones for an established relationship, were initially used with parents where the HV was visiting for, perhaps the second or third time. This was generally in response to issues that had arisen during the first new birth visit. This meant that this questionnaire could also be irrelevant to them, as they had not yet had a chance to attend the clinic. For this reason, it was suggested that it be offered to parents whose relationship with the HV was more fully developed with the tool for measuring established relationships. It was therefore decided that this questionnaire would be given to parents who had attended clinics and had known their HV for at least three months.

**Statement 1. I have been visited at home by different health visitors** [Table 6-10].

This statement was of particular importance to parents as they felt that continuity of care from one HV was what they wanted. The response profile showed that six of the 20 parents completing the questionnaire found that they were not able to have this.

**Statement 2. The health visitor writes clearly in the red book the things we have discussed** [Table 6-10]. This statement was re-worded to simplify it following a comment from a parent regarding this. She thought it was an important statement, as she wanted to be able to read what the HV said so that she did not have to remember it. [Statement 2. The health visitor writes the things we have discussed clearly in the red book. Table 6-11]

**Statement 4. When I attend clinic I usually see the same health visitor each time** [Table 6-10].

The analysis of the response profile showed this to be the area of greatest concern to parents with 12 of the 20 parents completing this questionnaire marking this statement negatively. One mother went out of her way to ensure that she saw the same HV each time by finding out where that HV was going to be the following week so that she could attend that clinic. This information, showing the lengths to which parents may go to maintain their relationship with their HV, was obtained by interview, post questionnaire completion. This kind of data would not usually be collected by questionnaire and demonstrates the advantages of qualitative approaches to data collection.
Statement 5. At clinic, it is difficult to identify the health visitor amongst other team members [Table 6-10].

The statement was reworded following discussion with supervisors, as the difficulties in identifying the HV from amongst other staff may not be something that was always present. The addition of the word ‘sometimes’ was thought to be more appropriate. [Statement 5. It is sometimes difficult to identify the health visitor amongst other team members. Table 6-11].

Statement 6. At the clinic where I see my health visitor, I am able to meet and get support from other parents [Table 6-10].

Two parents commented that they did not expect to be able to socialise at the clinic. However, another partially sighted mother felt that this was a particularly important aspect of the clinic and appreciated her HVs efforts to ensure that this was so. Likewise, HVs in the qualitative interviews felt that parents appreciated this aspect of the clinic environment and it contributed to their relationships with parents [4.2.3]. This statement was therefore retained

Statement 10. I cannot see the health visitor in clinic without an appointment [Table 6-10].

This statement was reworded following discussions with parents about the issue of having an appointment system at the clinic or not. Initially it had been felt that the lack of an appointment system may have a negative impact on the relationship. This is supported by existing research (Bowns et al. 2000). However, when asked about this during the questionnaire, post-completion interviews, parents said that they preferred the system where there were no appointments as this allowed them flexibility to attend to their baby’s needs and arrive at clinic when it was convenient for them. The wording was then altered so that the statement reflected the ability of the parent to see the HV within the allotted clinic time. [Statement 10. I cannot see the health visitor when I want to within the clinic time. Table 6-11]
Table 6-11. New Version of an Organisational Questionnaire [Parent version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I have been visited at home by different health visitors.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>The health visitor writes the things we have discussed clearly in the red book.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>At clinic, the health visitor has time for me if I need it.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>When I attend clinic I usually see the same health visitor each time.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>It is sometimes difficult to identify the health visitor amongst other team members.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>At the clinic where I see my health visitor, I am able to meet and get support from other parents.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>The health visitor I see at clinic is a stranger to me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>At clinic, I can ask the health visitor any questions that I have.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>At the clinic, the health visitor rarely smiles at people or greets them by name.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>I cannot see the health visitor when I want to within the clinic time.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The organisational questionnaire was also piloted with HVs. The results of this pilot are now described.

6.3.6 Organisational Questionnaire [HV Version]

Table 6-12. Pilot Version of an Organisational Questionnaire [HV version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>My workload is such I cannot carry out follow-up visits to clients who are in greater need.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>I lead a team who are able to help me meet the client’s identified needs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>The HV team that I work with is small enough to get to know each other and meet together weekly.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The time spent on record keeping does not reduce routine face to face contact with clients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Attending meetings interferes with my routine face to face contact with clients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>I do not receive helpful clinical supervision regularly.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Working in a skill mix team prevents me developing relationships with clients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>The clients I visit at home I do not see in clinic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>My caseload meets CPHVA guidelines i.e. 250 children in affluent areas or 100 children in deprived areas.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>I can use my professional judgment to decide which clients to see on a continuing basis.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Statement 1. My workload is such I cannot carry out follow-up visits to clients who are in greater need [Table 6-12]. This statement was reworded so that the word ‘always’ was added to the statement. [Statement 1. My workload is such I cannot always carry out follow-up visits to clients who are in greater need. Table 6-13] This was changed as HVs said that the workload made it difficult for them to carry out the follow-up visits but that they were able to do so on
occasions. The statement on Table 6-12 was too concrete to capture practice accurately. One HV felt that this was the most important statement on the questionnaire.

**Statement 2. I lead a team who are able to help me meet the client's identified needs** [Table 6-12].

There were some comments from one HV who felt that she did not ‘lead a team’ as there was no official team leader role. However, this was about to change in the PCT where she worked and in the HV implementation plan (Department of Health 2011) HVs are expected to lead teams of skill mix practitioners. Interestingly although the HVs worked with staff nurses and nursery nurses, they did not feel that these practitioners helped them to meet parents’ identified needs as they each had their own workload; for example, they would be doing the developmental reviews. Within the PCT, the policy was that staff nurses and nursery nurses would be allocated the routine developmental reviews of children under five. This work was previously part of the HVs role and the skill mix team had been implemented to free up HV time to work with families that are more vulnerable. The statement was left unaltered.

**Statement 4. The time spent on record keeping does not reduce routine face to face contact with clients** [Table 6-12].

This statement was considered very important by the HVs as they felt that record keeping impinged on their time with parents. As the response profile indicates, all HVs in the pilot study felt that this was so.

**Statement 6. I do not receive helpful clinical supervision regularly** [Table 6-12].

This statement was reworded, as there was confusion with the HVs as to whether the statement meant child protection supervision or more general caseload supervision. The statement was changed, therefore to reflect the meaning as intended of more general clinical supervision. [Statement 6. Apart from child protection supervision, I do not receive helpful clinical supervision regularly. Table 6-13]

**Statement 7. Working in a skill mix team prevents me developing relationships with clients** [Table 6-12]

This statement was reworded as HVs felt that the skill mix team did not ‘prevent’ the formation of relationships with parents but rather limited their ability to do so. The statement was reworded to
reflect this fact. [Statement 7. Working in a skill mix team limits my ability to develop relationships with clients. Table 6-13]

Statement 9. My caseload meets CPHVA guidelines i.e. 250 children in affluent areas or 100 children in deprived areas [Table 6-12].

The wording of this statement was changed, as the way of working that entailed HVs carrying an individual caseload, for which they were responsible, was no longer being used in any of the PCTs where the research was carried out. The wording was changed to reflect this. It was more accurate to speak of the ‘ratio of children under the age of five to the number of HVs’. [Statement 9. The ratio of children under five to health visitors meets CPHVA guidelines i.e. 250 children in affluent areas or 100 children in deprived areas. Table 6-13]

Statement 11. I do not have the authority to determine my working pattern according to client need [Table 6-13].

This statement was added to the questionnaire. This was done in response to the often-observed fact that HVs did not have complete autonomy when deciding when and whom to visit. Appointments were made for them by administrative staff to cover new birth visits so that when a HV was out visiting she was unaware of engagements that were added to her diary. Although it was possible for HVs to cancel arrangements made by the administrative support staff they felt that this gave a negative impression of the service to a parent, who was newly in contact with the health visiting service. Their lack of authority to determine their own working patterns was a continual source of frustration to them.
Table 6-13. New Version of an Organisational Questionnaire [HV version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>My workload is such I cannot always carry out follow-up visits to clients who are in greater need.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>I lead a team who are able to help me meet the client's identified needs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>The HV team that I work with is small enough to get to know each other and meet together weekly.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The time spent on record keeping does not reduce routine face to face contact with clients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Attending meetings interferes with my routine face to face contact with clients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Apart from child protection supervision, I do not receive helpful clinical supervision regularly.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Working in a skill mix team limits my ability to develop relationships with clients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>The clients I visit at home I do not see in clinic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>The ratio of children under five to health visitors meets CPHVA guidelines i.e. 250 children in affluent areas or 100 children in deprived areas.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>I can use my professional judgment to decide which clients to see on a continuing basis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>I do not have the authority to determine my working pattern according to client need.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6.4 Piloting the statistical analysis

This section of the chapter will explain the pilot processes employed for the hypothesis testing to establish the construct validity of the data. These processes will be explained using the example of the first or only visit questionnaires. Each set of questionnaires were statistically examined in the same way.

A TELER workbook was used to convert the questionnaire, for each respondent into a TELER quiz style indicator and to analyse the data provided by the indicators. The first step in the process was to enter the questionnaire data into a table that gives a response profile for each respondent. Each negative response or barrier to the relationship was recorded in the profile. This produced a useful response profile table from which it was easy to see at a glance if a particular practitioner was having problems with their parent relationships [Appendix 10] or if a parent was having particular difficulties with her relationship with the HV. It was also possible to see from the response profile which of the relationship indicators was acting as a barrier to the relationship.

The next step was to convert each response profile into a TELER indicator code. This required the binomial probability distribution for the questions in the questionnaire and the standard deviation of the distribution to be calculated.
- Codes 1 and 5 on the indicator are defined as the numbers of barriers two or more standard deviations to the left and right, respectively, of the mean;

- Codes 2 and 4 are defined as the numbers of barriers one or more but less than two standard deviations to the left and right, respectively, of the mean; and

- Code 3 is defined as the number of barriers less than one standard deviation to the left or right of the mean. These definitions are shown in [Table 6-14]

<table>
<thead>
<tr>
<th>Number of barriers</th>
<th>TELER Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 or 11</td>
<td>1</td>
</tr>
<tr>
<td>8 or 9</td>
<td>2</td>
</tr>
<tr>
<td>4 to 7</td>
<td>3</td>
</tr>
<tr>
<td>2 or 3</td>
<td>4</td>
</tr>
<tr>
<td>0 or 1</td>
<td>5</td>
</tr>
</tbody>
</table>

The results of doing this were then displayed in a table to show the effect of the parental barriers on the parent/HV relationship [Appendix 11].

The next step was to explore the data further to find out if the combined parental barriers [or group effects] were a relationship problem [Appendix 12]. As the level of measurement used was ordinal this calculation was carried out using the non-parametric chi-squared test (Clegg 2001) to determine the statistical significance of the proportion of HVs who reported parent barriers and their impact on their relationships.

The aim was to explore the data to see if an observed or reported number of barriers could have occurred by chance. If the answer was, it could have occurred by chance then there would be no evidence that barriers to the relationship exist. To test this null hypothesis data were entered into cells in a contingency table [Appendix 12].

There are a number of rules that apply to the calculation of the chi-squared statistic.
1. The number of barriers reported by one HV must be independent of the number reported by another HV. One way in which this rule is breached is by HVs consulting with each other on how the questions should be answered.

2. The items in the ‘expected’ category must be at least five. This rule is designed to avoid calculation effects being mistaken for treatment effects and was not observed in this study. Other statistical methods were employed to avoid this error. For example, a method for continuing to observe the rule of five is to reduce the number of impact categories by combining adjacent categories to increase the sizes of small expected values. However, this strategy was not successful as two of the ‘expected’ values remained below five [Appendix 12]. However, this is not a problem as the C value for Code 3, which was not combined with any other code, is larger than the total of the C values which shows statistical significance. It shows that the differences between the observed and expected values were statistically significant and therefore a relationship effect not a calculation effect.

3. The tests have to be carried out on the numbers of items and not on percentages or derived proportions. (Clegg 2001)

The result of the chi-squared test was statistically significant \[p = 0.05\]. This suggests the difference between the observed 13 HVs who reported three or fewer barriers and the two HVs expected to do so is so large that it could not have occurred by chance. It also shows that the difference between the maximum of three reported barriers and the 11 that could have been reported by each HV is sufficiently large to imply, that from the perspective of the HVs, there were no relationship problems attributable to parent barriers. This statistical result further validated researcher observation of the visits and comments made by parents and HVs and indicated the construct validity of the questionnaires.

A t-test was performed on the items in the questionnaire to ensure they were sensitive indicators of parent/HV relationships. The exploration was to ascertain whether particular reported parental barriers, as captured in the individual statements, were a problem for the parent/HV relationship. This test [Appendix 13] was performed to determine the statistical significance of the proportion of HVs who reported parent barriers on the relationship. This was done by comparing the proportion of HVs who responded by identifying parent barriers with the ideal number zero. The 95% confidence interval was calculated by finding \( L \), [Appendix 13] the upper limit of the confidence interval. This limit was the largest proportion of HVs who by chance or without thinking would select the response, which showed a problem. The only statement that produced a statistically significant \[p = 0.05\] negative effect on the relationship was statement 4 ‘The parent looked through the red book when I gave it to her’ [Table 6-4]. This statement was removed because a parent having a second or subsequent child they may not be as interested in the red book as with a first child. This would not necessarily indicate that the parent was uninterested. Also during a first visit the HV often held the book for the parent and showed it to her explaining as she went
along, so the parent did not 'look through' the book. Again, this did not mean that the parent was uninterested. The other statements had no influence on the parent/HV relationship and this was also a statistically significant result \( p = 0.05 \).

The results of the t-test calculation had the potential to provide useful indications of areas of practice that needed to be tackled from an organisational perspective. This was proved to be true with the indicators in the other measures developed. In the particular example quoted above the item was removed to avoid response bias. However, the t-test on the parent data also revealed one item that required addressing [see below]

The same statistical processes that were used on the HV data were repeated on the parent data. The aim of the chi-squared test was to explore the data to see if the reported number of HV barriers to the relationship could have occurred by chance. If this were just a chance occurrence then the combined effect of the HV barriers reported by parents would not be a relationship problem. To test this null hypothesis data were entered into a contingency table [Appendix 15], as with the HV data. The result of the chi-squared test was statistically significant \( p= 0.05 \). This suggests that the difference between the observed 13 parents who reported four or fewer barriers to their relationships and the two expected to do so is so large that it could not have occurred by chance. The difference between the maximum of four reported barriers and the 13 that could have been reported by each parent was sufficiently large to imply that from the perspective of the parents there were no relationship problems attributable to HV barriers. This confirmed researcher observation and HV and parent comments

The parent data were further explored to ascertain whether particular reported HV barriers to the relationship, as captured in the individual questionnaire statements, were a problem for the parent/HV relationship. A one sample t-test calculation revealed a statistically significant result \( p = 0.05 \) for statement 2 [Appendix 16]. This referred to the HV playing with or examining the baby. As discussed previously, this was an area of practice that varied greatly between HVs and needed addressing at an organisational level. It was therefore, important to retain the statement within the questionnaire. The other statements had no influence of the parent/HV relationship and this too was statistically significant \( p = 0.05 \). The ability of the tool to detect these areas of practice requiring organisational remedies emphasises its usefulness.
The next step taken in the data analysis was to compare the analysis of the two sets of data i.e. that of the parents and that of the HVs [Appendix 17] to determine the statistical significance of the numbers of HVs and parents who reported the same impacts on their relationships with each other. As was expected the chi-squared test of independence showed that parents and HVs agreed that there were no relationship problems between them. The result was statistically significant \( p = 0.05 \).

6.5 Conclusion

Having established the content and construct validity of the questionnaires through this process of piloting the new questionnaires were ready for further testing in the community with more parents and HVs. The analysis of the data gathered using the new questionnaires is presented in the next chapter.
Chapter 7 Questionnaire Analysis

7.1 Introduction

This chapter presents the findings of the statistical analysis of the three sets of questionnaires for measuring relationships between parents and HVs. Details are given of the analysis of the first visit relationship, the established relationship and the organisational barriers data. The demography of the participants is presented. This is by the HV data analysis, the parent data analysis and the analysis of the combined data. The findings are with reference to field notes of the observations and comments made at the time of the visits. The aim of the data analysis was to validate the instruments through the process of hypothesis testing. Standard tests of statistical significance were less helpful than a consideration of the clinical significance of the results, which will be explained.

7.2 First Visit Questionnaire [New]

The new first visit questionnaires, adapted from the original pilot version [Chapter 6, Table 6-3, Table 6-5], were trialled across three PCTs in an inner city urban environment with areas of high deprivation and population diversity.

7.2.1 Demography of Participants

The questionnaire was analysed for 25 HV/parent dyads. 14 HVs and 25 parents took part. It was hypothesised that the years of experience that a HV has in working with families might influence her ability to establish relationships with parents. Figure 7-1 below shows the number of years of experience of the participating HVs in relation to those relationships.
Likewise, it was hypothesised that the age of the parent and number of children that they had may influence the parent’s relationship with the health visitor [Figure 7-2]. As with the first phase, pilot data the numbers proved to be too small to allow any meaningful statistical analysis.

None of these families presented as a cause for concern or had child protection issues. HVs may have booked a further follow-up visit to some of these families as there may have been child or parent health issues; for example, jaundice, feeding difficulties or potential post-natal depression.
7.2.2 HV First Visit Questionnaire Results [New]

The data entry and analysis followed the same methods as described in chapter six [6.4 p.196]. The results are presented below. [Table 7-1.]

Table 7-1. HV data coded and showing numbers of parent barriers

<table>
<thead>
<tr>
<th>Number of parent barriers</th>
<th>TELER Code</th>
<th>Parental impact on the relationship</th>
<th>HVs</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 or 11</td>
<td>1**</td>
<td>Severe</td>
<td>0</td>
</tr>
<tr>
<td>8 or 9</td>
<td>2*</td>
<td>Moderate</td>
<td>0</td>
</tr>
<tr>
<td>4 to 7</td>
<td>3</td>
<td>Indeterminate</td>
<td>0</td>
</tr>
<tr>
<td>2 or 3</td>
<td>4*</td>
<td>Slight</td>
<td>3</td>
</tr>
<tr>
<td>0 or 1</td>
<td>5**</td>
<td>None</td>
<td>22</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>25</td>
</tr>
</tbody>
</table>

** p ≤ 0.0108 * 0.0108 < p ≥ 0.1719

Table 7-1 shows the parent barriers and the impact on their relationship with HVs is:

- None or slight for 25 HVs indicating a good relationship
- Moderate or severe for zero HVs.
- Indeterminate for zero HVs

A chi-squared test [Appendix 18] was performed on the data to determine the statistical significance of the numbers of HVs who reported parent barriers and their impact on their relationships. The result [$\chi^2 = 120.6$] indicated that the combined impact on the relationship of the parent barriers reported by HVs was not a chance occurrence [$\chi^2 = 5.991$, df 2, p ≤ 0.05]. The conclusion was that from the perspective of the HVs there were no or only slight relationship problems attributable to parent barriers.

A t-test [Appendix 19] was performed on the data to determine the statistical significance of the proportion of HVs who reported parent barriers as shown by the statements on the questionnaire. There was one barrier that achieved a statistically significant result [$t=5.15$ df 24, $p ≤ 0.05$] suggesting that it did not occur by chance and there was sufficient evidence to conclude that this was a problem, which influenced the HVs relationships with parents.

The item on the questionnaire that proved problematic for five HVs was ‘The parent indicated by what she said that the information/advice I gave her was irrelevant to her baby/situation’.

7.2.3 Parent First Visit Questionnaire Results [New]

The data from the parents were explored in the same way as the data from the HVs. The results are displayed below in Table 7-2
Table 7-2. Parent data coded and showing number of HV barriers.

<table>
<thead>
<tr>
<th>HV Barriers</th>
<th>TELER Code</th>
<th>HV impact on the relationship</th>
<th>Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 - 12</td>
<td>1**</td>
<td>Severe</td>
<td>0</td>
</tr>
<tr>
<td>8 or 9</td>
<td>2*</td>
<td>Moderate</td>
<td>0</td>
</tr>
<tr>
<td>5, 6 or 7</td>
<td>3</td>
<td>Indeterminate</td>
<td>0</td>
</tr>
<tr>
<td>3 or 4</td>
<td>4*</td>
<td>Slight</td>
<td>5</td>
</tr>
<tr>
<td>0, 1 or 2</td>
<td>5**</td>
<td>None</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>25</td>
</tr>
</tbody>
</table>

** p ≤ 0.0059    * 0.0059 < p ≤ 0.1134

The conclusion here is that the impact on the relationship of the HV barriers was:

- None or slight for 25 parents indicating they had good relationships with HVs

A chi-squared test was performed to determine the statistical significance of the numbers of parents who reported HV barriers influencing their relationships with HVs. The TELER codes were analysed so that one and two were amalgamated, as were codes four and five, whilst code three was analysed independently [Appendix 20]. The result \( \chi^2 = 195.08 \) showed statistical significance \( \chi^2 = 5.991, df = 2, p \leq 0.05 \) for codes 4 and 5 indicating that the HV barriers had little or no impact on relationships with parents.

A t-test was performed to determine the statistical significance of the proportion of parents who reported HV barriers as shown by the statements on the questionnaire. Only one of the eleven barriers achieved a statistically significant result \( t= 5.15, df = 24, p \leq 0.05 \) suggesting that this did not occur by chance and that there is sufficient evidence to conclude that this HV barrier was a problem which influenced the parents’ relationships with HVs. The statement that was problematic for five parents was, ‘The health visitor played with/examined my baby’.

7.2.4 HV and Parent First Visit Data Analysis

The association between the HV and Parent data was tested to determine the statistical significance of the numbers of HVs and Parents who reported the same impacts on their relationships with each other. [Appendix 21]

The result \( \chi^2 = 300.16 \) was statistically significant \( \chi^2 = 5.991, df = 2, p \leq 0.05 \). The conclusion was that the combined impact of the parent barriers reported by HVs was the same as that of the HV barriers reported by parents and that the two sets of data were associated. As the majority of the TELER codes were on four and five this suggested that they agreed that there were no relationship barriers.
7.2.5 Discussion

The statistical analysis of these data for the First visit appears to confirm the observations made at the visits. HVs were able to establish a good rapport with the parents and parents and HVs appeared relaxed. For both data sets, one barrier affected the relationship that was statistically significant. For HVs, it was the parent’s lack of interest in information that they gave and for parents it was the fact HVs failed to examine or play with the baby.

If HVs experienced the parents as uninterested in the information they were giving them, this may have been because they were giving unsolicited advice of which the parent was already aware (Mitcheson & Cowley 2003). It may also be that the parent was not having her first baby so had already received the information. This was so when HV [A5] visited a mother [P1.2] who was having her third baby and refused the HV leaflet information on breast-feeding, as she was happy with how the baby was latching on and feeding. The HV did not examine the baby either for this mother. Her explanation of this omission was that in the previous PCT where she worked it was against their health and safety advice to do this.

The HVs failure to examine or ‘play’ with the baby was surprising in that the Healthy Child Programme (Department of Health 2009) refers to this review as the ‘new baby review’. However, it also suggests that the baby be monitored for growth and development at this visit only ‘if there is professional concern or if the parents wish it’. Newland (2004) included this as a component of the new birth visit when piloting a method investigating HV decisions and judgements made during the new birth home visit. However, it was apparent also in her study that a physical examination of the baby was not always carried out.

There are implications here for health visiting practice and also for the HV relationship. It would seem, from a practice point of view, important that the HV establish a base line of information from which to assess future health, growth and development. Failure to do this at this point may lead to delay in identifying difficulties. As far as the relationship is concerned, which is our focus here, the fact that the baby was not examined could lead to misunderstandings of the role of the HV. When HV [A4] failed to examine the baby, the parent [P1.2] remarked that she felt that it was not the role of the HV to examine the baby. This may have had repercussions at a later stage of the relationship when the HV was carrying out developmental reviews on her child.
There are alternative explanations for the HV not carrying out an examination of the baby. The HV may, on occasions, meet with overriding parental concerns and have to deal with these before managing more routine assessments. For example, HV [A6] who was a practice teacher managed her new birth visits over two visits. At the first visit, the mother [P 2.1] was in tears because she was struggling with breast-feeding. The whole of the visit was given over to managing this issue and the HV made an appointment to return the following week when she said that she would continue to do a complete health needs assessment with the baby and family. Her omission of a baby examination at the visit was appropriate and sensitive to the parental and infant needs.

On reflection, this item from the questionnaire may need adjustment, as there are a number of valid reasons why the HV may not examine a baby at a first visit. The baby may be sleeping for example and the parents may therefore refuse permission to examine the baby. Although best practice may dictate that HVs visit when the baby is likely to be awake this cannot always be accomplished. Alternative wording may be helpful, ‘The HV examined my baby or explained why she did not.’

The results from the questionnaire indicate that parents and HVs can establish good relationships at a first meeting. However, observation of the interactions showed that there were differences in the HV approaches within PCTs even with experienced HVs who had been trained in the same model of partnership working (Davis et al. 2002b). HV [A4] had over 20 years experience of working with families in the community, but her approach in terms of interaction with parent [1.2] left much to be desired. She asked many closed questions and did not respond to the emotional content of the mother’s story. This meant that she effectively controlled the conversation. Copious information was given by the HV but it felt as though she wanted to do the job as quickly as possible and then leave. However, the field notes reflect that her overall manner was friendly and respectful. The items that the parent marked negatively on the questionnaire were items 9 and 11. Item 9 states, as mentioned previously, that the HV did not examine the baby, and item 11, that she was unsure about when she would see the HV again. This was because the HV made it clear that she worked in a team and that the parent may meet other members of the HV team and not necessarily herself. A staff nurse was going to carry out a follow-up visit to the parent who was a single mother living with her grandmother and aunt.
HV [A4] viewed a new birth visit as ‘just giving information’ and ‘looking for targeted families’. She admitted that she did not invest ‘emotional labour’ in the interaction, as it was unlikely she would ever meet the parent again. On her organisational questionnaire, this HV had noted eight organisational barriers to her work with parents including that she could not use her professional judgement to decide which clients to see on a continuing basis.

This was the one point on which HV [A4] differed from HV [A6] who, although working for the same organisation and identifying seven organisational barriers to her work, had decided that she could use her professional judgement to decide which clients to see on a continuing basis. Although managers were keen that HVs do one new birth visit she cited her code of professional conduct and her ability to do her job as a HV as reasons why she would usually do a follow-up visit to a new birth. She also said that she could justify these visits on clinical need. Her approach to her new birth visits was relaxed. She asked open questions and responded with empathy to the emotional content of the mother’s story. She only gave information and advice that was necessary to deal with the present feeding difficulties and was happy to leave a more detailed health needs assessment to the second visit that she would make the following week. However, this meant that from the parent’s responses on the questionnaire, she was unclear about the HV role, when she would have future contact with her, or if the HV would share her information with anyone else. Future contact was agreed between the HV and the parent but the parent marked this statement negatively, possibly mistakenly, because of her emotional turmoil. The HV first visit questionnaire agreed with the parent one that the HV had not given the details about information sharing with other services.

Both the parents in the above example had similar response profiles to two very different styles of interaction. Neither parent had met a HV before, and had no idea what to expect, although both seemed satisfied with the meetings. The first visit questionnaire may not therefore be sensitive enough to detect these differences in interaction styles. However, the more therapeutic approach of HV [A6] appeared ideal whilst the approach of HV [A4] might be described in the terms of being ‘good enough’. The questionnaire may not be a substitute, therefore, for careful observation and interview as a research tool, but as a useful addition to these qualitative methods.

The statistical analysis of these questionnaires demonstrated their construct validity as the scores reflected the hypothesis that barriers to the parent/HV relationship as determined by the indicators proved to be, or not, as in this case, a relationship problem. At a first meeting, parents and HVs
were able to establish positive relationships. Once established, the health visiting service tries to maintain this relationship throughout the child’s first five years of life. A similar though different questionnaire was necessary to consider established parent/HV relationships, the analysis of which is presented in the following section.

### 7.3 An Established Relationship Questionnaire [New]

These new questionnaires, adapted from the pilot version, were trialled across the same three PCTs as the First Visit questionnaires.

#### 7.3.1 Demography of Participants

The participants in this phase of the pilot of these questionnaires were 14 health visitors and 28 parents. Figure 7-3 below shows the years of experience of the HVs in connection with the 28 relationships that they formed between them.

![HVs Years of Experience](image)

Figure 7-3. HVs Years of Experience

Families were recruited through the HVs and reflected the diversity of their caseloads. They were living in a variety of circumstances across the social strata and were of varying ethnic backgrounds, although these data were not collected systematically. There were child protection issues [CP], children in need or other significant causes for concern [CC] in seventeen of the 28 families [Figure 7-4]. These data were collected as these more difficult issues may also have an
influence on both the HV’s and parent’s abilities to establish positive, ongoing, working relationships.

![Bar chart showing number of families per age group and number of children]

**Figure 7.4.** Parent Participants in Established Relationships Questionnaire

### 7.3.2 HV Established Relationship Questionnaire Results

The data entry and analysis followed the same procedures as for the pilot data [6.4]

The coding of the data from the response profiles showed the results displaying in Table 7-3.

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Families</th>
<th>Parental impact on the relationship</th>
<th>HVs</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 - 28 yrs</td>
<td>10 or 11</td>
<td>1** Severe</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>8 or 9</td>
<td>2* Moderate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 to 7</td>
<td>3 Indeterminate</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>2 or 3</td>
<td>4* Slight</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>0 or 1</td>
<td>5** None</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>**Total</td>
<td>28</td>
<td></td>
</tr>
</tbody>
</table>

Table 7-3 shows that the effect of the parent barriers and the impact on their relationships with HVs is:

- None or slight for 21 HVs indicating a positive relationship
- Indeterminate for seven HVs indicating that the HV’s response was recorded without considering the content of the statements, or was a chance occurrence, or possibly indicative of a potential problem.

The result of the binomial probability scores at the bottom of the table shows statistical significance for codes 1 and for code 5.

A chi-squared test was performed on the data to determine the statistical significance of the numbers of HVs who reported parent barriers and their impact on their relationships. This indicated that the combined impact on the relationship of the parent barriers reported by HVs was not a random event. The result \( \chi^2 = 104.39 \) was statistically significant \( \chi^2 = 5.991, df = 2, p \leq 0.05 \). The conclusion was therefore that, from the perspective of the HVs, there were relationship problems attributable to parent barriers but as the majority of the codes were 4 or 5, these had little or no effect.

A t-test was performed on the data to determine the statistical significance of the proportion of HVs who reported parent barriers to the relationship. For HVs seven of the 11 possible parent barriers caused an impact on their long-term relationships with parents \( t = 5.45, df = 27, p \leq 0.05 \). The factors that were the problem areas for HVs are highlighted in red [Table 7-4]. The statements could be answered ‘yes I agree’ or ‘no I disagree’. The positively worded statements that were answered negatively were therefore counted as a problem.
7.3.3 Discussion

There were seven of the 11 statements on the questionnaire that were statistically significant showing that they were considered parent barriers to the relationship. Statement 2 was the first of these. This was intended to measure one of the outcomes of the relationship, which parents identified as being important, that of parenting self-confidence. This had been identified as being brought about by the HVs encouragement and confirmation of the parent’s choices. It is linked to item 10. Where a HV is not able to do this it may indicate that the parent may not be making wise choices and that the HV has given explicit advice for the parent to follow. This may have the effect of creating a dependent relationship not a partnership.
If parents disregard information that is given then this too may be an indication of a problem. This may be because the information was not personalised or relevant to the family presenting a problem or that the parents chose to disregard it in spite of it being in the best interests of their child. Lack of contact is also an indication that there may be a problem with the relationship. The parent may not need the HV but, on the other hand, may be avoidant because of child protection issues. However, lack of contact may also reflect an issue of service organisation.

These results suggest that HVs do experience parent barriers to their relationships but these barriers, statistically, have little or no impact on their relationships with parents. However, this is not the same as there being no effect. For the seven HVs who had ‘indeterminate’ responses there were observed relationship problems. This will be discussed further in the section on clinical significance.

### 7.3.4 Parent Established Relationship Questionnaire Analysis.

As with all the previous data the HV barriers to the relationship were counted and allocated TELER codes [Table 7-5].

<table>
<thead>
<tr>
<th>HV barriers</th>
<th>TELER Code</th>
<th>HV impact on the relationship</th>
<th>Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 - 12</td>
<td>1**</td>
<td>Severe</td>
<td>1</td>
</tr>
<tr>
<td>8 or 9</td>
<td>2*</td>
<td>Moderate</td>
<td>0</td>
</tr>
<tr>
<td>5, 6 or 7</td>
<td>3</td>
<td>Indeterminate</td>
<td>2</td>
</tr>
<tr>
<td>3 or 4</td>
<td>4*</td>
<td>Slight</td>
<td>2</td>
</tr>
<tr>
<td>0, 1 or 2</td>
<td>5**</td>
<td>None</td>
<td>23</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>Total</strong></td>
<td>28</td>
</tr>
<tr>
<td><strong>p ≤ 0.0161</strong></td>
<td>* 0.0161 &lt; p ≥ 0.1906</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The conclusion here indicates that the impact on the relationship of the HV barriers is:

- None or slight for 25 parents indicating that parents had positive relationships with HVs
- Moderate or severe for one parent indicating a poor or ineffective relationship with the HV
- Indeterminate for two parents indicating that the parent’s response was recorded without considering the content of the statements, or was a chance occurrence, or possibly indicative of a potential problem.

A chi-squared test was performed on the data to determine the statistical significance of the numbers of parents who reported HV barriers to their relationships. This showed that the combined impact on the relationship of the HV barriers reported by parents did not happen by
chance. The result \( \chi^2 = 89.47 \) was statistically significant \( \chi^2 = 5.991, df = 2, p \leq 0.05 \). This means that from the perspective of the parents there were relationship problems attributable to HV barriers. However, most of the codes fall into the categories 4 or 5, indicating that from the perspective of the parent there were no or only slight relationship problems that were attributable to HV barriers.

A t-test was performed to determine the statistical significance of the proportion of parents who reported HV barriers as shown by the statements on the questionnaire. There were three of the 12 barriers that achieved a statistically significant result \( t = 5.45, df = 27, p \leq 0.05 \) suggesting that these did not occur by chance and that there was sufficient evidence to conclude that they were problems that influenced the parents’ relationships with HVs. These three statements were:

- Statement 2. Decisions that I make for my baby/child/family/situation are not encouraged by the health visitor [8 parents]
- Statement 9. When I spoke to the health visitor she made eye contact that did not make me feel uncomfortable [5 parents]
- Statement 12. I see my health visitor at clinic [11 parents].

[The statement responses could be ‘yes, I agree’ or ‘no I disagree’]

7.3.5 Discussion

The statistical results show that parents in this study have positive relationships with HVs. However, for the five parents who experienced HV barriers to their relationship, these barriers were important and could not be ignored. Again, there is a question that group results should not obscure the very real problems experienced by these five parents. Parents may have felt undermined when HVs did not support their decisions. The statement about eye contact was intended as a measure of the listening behaviour of the HV so it may have been that parents did not feel listened to either. Furthermore, they were unable to see their HV at clinic. Eleven parents agreed that this was so. This may have been because of a reluctance to attend the clinic to see the HV because the relationship was not good or it may have been to do with the organisational difficulties in these localities that was common to both parents and HVs. The teams were arranged so that different people covered different clinics each week making continuity of contact very difficult for them both.
7.3.6 HV and Parent Established relationship analysis

The association between the HV and parent data was tested to determine the statistical significance of the numbers of HVs and parents who reported the same impacts on their relationships with each other.

The result of the chi-square test [$\chi^2 = 194.58$] was statistically significant [$\chi^2 = 5.991$, $df = 2$ $p \leq 0.05$] suggesting that the combined impact of the parent barriers reported by HVs was the same as that of the HV barriers reported by parents. This meant that the two sets of barriers were associated, and relationship barriers did not affect the relationships between HVs and parents. Parents and HVs had similarly statistically significant distributions over the TELER codes. However, for the majority HVs although the codes were on 4 or 5 indicating good relationships, seven HVs were coded 3 which was ‘indeterminate’ which may mean that either HVs were not paying attention when filling in the questionnaires or that they may have been experiencing problems with their relationships with parents.

7.3.7 Discussion

The construct validity of the instruments was established, as the tools were sensitive to the differences in the parent/HV relationships as demonstrated by the results above. However, the statistical evidence is interesting when compared with clinical observation of the visits and the notes made at the time. Those HVs with the statistically ‘indeterminate’ pattern [code three] to responses appeared to be finding problems in relating to parents who were often a cause for concern to the HV because of child protection or child in need issues. The seven HVs who were coded 4 [slightly affected] reported parent problems such as postnatal depression or child health problems, which also may have influenced their relationships.

It is interesting to note, that although the analysis of the HV data shows that HVs do not have trouble in their long-term relationships with parents, HVs may be struggling to maintain their relationships. This is, as shown in the analysis of the HV questionnaires, especially true where there are child protection concerns, but parents do not perceive that there are any relationship problems or difficulties. This result reflects findings in the psychotherapy literature that clients rate their relationships with therapists more positively than therapists do (Huber et al. 2005) and lends further evidence of the construct validity of these instruments.
However, these findings suggest it might be more meaningful to define TELER codes according to ‘clinical significance’ rather than statistical significance, to comprehend them more fully.

7.4 Clinical Significance

Definition: Clinical significance generally refers to the practical value of the effects of an intervention, or the extent to which an intervention makes a “real” difference in the everyday life of an individual (Kazdin 1999; Kazdin 2008). A clinically significant result, as opposed to a statistically significant result, in this study would refer to the practical importance of the changes in the relationships between HVs and parents. Each statement on the questionnaire is an important indicator of the relationship in itself, so even one barrier may have clinical significance.

The practical significance of the relationship changes is based on knowledge of the parent/HV relationship. Only knowledge of the relationship will allow accurate assessment of any changes. Clinical knowledge and the explicit use of that knowledge were an essential element for selecting the indicators initially, as prescribed in the TELER method (Le Roux 2003). Specifically for this project, knowledge was based on personal extensive experience of working with parents as a health visitor and experience in the development and training of the Family Partnership Model (Davis et al. 2002). This approach supported the development of questionnaires that were sensitive to the individual relationships under scrutiny and sought to understand why they may not be in different circumstances.

When the statistical analysis was carried out on the HV data, 14 of the 28 HVs found that the parental barriers influenced the relationship either ‘slightly’ or ‘indeterminately’. However, it was clear from observation that in practice there were some very real difficulties in the relationships for these 14 HVs. The following example shows the difficulties that HVs may encounter as part of their practice.

HV [A12], with over 20 years experience in the profession, visited a father [P2.2] with eight children. Neither he nor his partner, who had learning disabilities and was very childlike, were literate. The children’s ages ranged between 13 years and 2 years. There were difficulties about entry into the house initially. An older child opened the door saw the HV and researcher and closed it again. Eventually one of the smaller children opened the door. There were used nappies and dirty clothes all over the hallway and Mum and Dad were said to be in bed watching videos. In spite of it being late morning, all the children were running around in pyjamas and in
various stages of undress. The mother eventually came down and showed us into the living room where chaos reigned with the children shouting and swearing at the mother when she asked them to go upstairs. There was one four-seater settee and a large TV in a room with no carpet or curtains. The children’s aunt was sitting on the sofa watching TV with the children. There was nowhere for the HV or researcher to sit. The HV was able to engage the mother in limited conversation but enough to let her know that a staff nurse would be coming to do the youngest boy’s two year developmental assessment the following Monday. Eventually the father appeared wearing only his boxer shorts, as he could not find his trousers. The children were all chased away to play. The HV then engaged the father in conversation and he proved more articulate than the mother did. However, throughout the conversation the children could be heard screaming, shouting and crying with the mother shouting at them from time to time. The discussion was about housing and problems of schooling with the eldest boy who was attending the Child and Adolescent Mental Health unit and had been stealing. There was to be a ‘team around the child’ meeting at the school the following week. One of the other boys also needed to attend an audiology appointment. The family were very bad appointment keepers because they ignored letters due to their literacy problems. The aunt, who seemed to have come to live with the family, could read and write but her own children had been taken into care. Social services were investigating this. During conversation with the father, the HV was respectful at all times. Following the interaction the HV said that she despaired of there ever being any change with this family, with whom she had been involved for the last eighteen months. It was clear that she had many concerns for the well-being of the children. She found it hard to deal with the father whom she neither liked nor trusted. He was the parent with whom the HV had most interaction, as he seemed to take charge of the household.

HV [A12] marked seven barriers to her relationship with this father. He needed constant advice from her and did not make his own choices. He disregarded information given to him and failed to ask questions in the interests of his children. The HV’s records showed that the parent had not acted positively in the children’s’ best interests and he failed to contact the HV when there was a problem and he never attended clinic. Unsurprisingly, the HV felt unable to comment on the parent’s growing confidence in the management of the family.

The parent on the other hand only marked the HV as presenting two barriers to the relationship. He agreed that he never saw the HV at clinic and he indicated that when he was speaking with
the HV she failed to make eye contact. It is possible that he misunderstood this statement on the questionnaire as from observation the HV made good eye contact with the father. The researcher read the statements to the parent on this occasion.

As shown in the statistical analysis, although the HV struggled with the relationship the father was happy with his relationship with the HV. The seven barriers encountered by the HV, however, are considered statistically 'indeterminate'.

Statistical probability is increasingly relied upon in the push towards evidence-based practice in order to enhance the objectivity of findings. However, statistical tests provide the necessary information regarding whether a change has taken place and do not provide information of the clinical meaning or relevance of the change (Grundy et al. 1996). Researchers and practitioners may therefore have differing perspectives on what might be significant. In fact statistical significance has been seen as limited for use in psychotherapy outcome research as it is based on group means and does not take into account individual variability of outcome nor address clinical significance (Hansen & Lambert 1996).

In earlier work Kazdin (1977) also stated that,

‘clinically important changes should be dramatic and obvious from the data so that there is no need to resort to statistical tests.’ (p.428)

He stressed the need for techniques that assessed the clinical or practical significance of behaviour change in psychotherapy. In psychotherapy, methods have been developed to assess this clinical significance based on judgements about societal norms for evaluating psychotherapy outcomes (Hansen & Lambert 1996).

The TELER method allows for individual differences in responses to be noted before statistical tests are carried out. However, a technique for determining clinical significance that relates to changes in the parent/HV relationship needs to be found so that the relative importance of those differences can be determined and acted upon where necessary. When considering parent/HV data the judgement about clinical significance was made based on clinical knowledge of the parent/HV relationship within routine universal health visiting practice.

Clinical significance was determined by consulting the database of participants in the study with the notes made about each family and their interaction with the HV. It was readily apparent that
where there were a number of concerns for the parent or the HV, some action would need to be taken by the HV to remedy the relationship. This may for example mean that the HV would need to discuss her concerns in supervision and gain some understanding of what was happening in her relationship with the parent. As with the example of HV [A12] with parent [P2.2], when there were problems there were often child protection issues present [p.215].

Similarly, if the parent questionnaire showed difficulties in the relationship then this would signal the need for an open discussion with the parent about the problems that the parent was facing. The willingness of the HV to address the situation may enhance the relationship without further steps needing to be taken.

An example illustrating this is that of HV [C3] with parent [P1.3]. The parent questionnaire was completed in retrospect to test its sensitivity to relationships where there were HV barriers. The relationship, at this stage, had broken down completely. The parent marked all 12 statements negatively indicating 12 barriers to the relationship. However, at this stage she was still extremely angry with the HV concerned who had challenged her about her extreme over-feeding of her children. The HV only learnt of the parent’s dissatisfaction later when she rang the HV’s office and left a very angry message on the answer phone. Had she been more aware of this at the time she may have been able to address the issues and maintain her relationship. Retrospectively the HV [C3] also completed a questionnaire and this showed six barriers to the relationship. The parent was not at home when a visit was arranged and disregarded information that she was given at previous encounters. The parent was not asking relevant questions at contact with the HV nor did the HV records show that she had acted positively in the child’s best interests. The parent did not contact the HV with problems, as she did not consider that she had any. The HV was not able to comment on the parent’s confidence in managing her situation.

At an observed visit to the same parent, the HV manager [C4], who had agreed to take responsibility for the family so that there could be continuing input from the health visiting service, had replaced this HV [C3]. The parent marked no HV barriers to this relationship. However, this HV did not challenge the parent at all regarding her feeding behaviour towards her two children instead she was at pains to remind the parent about attending the adult mental health services appointments and the parent appeared happy to do this. During this visit and there was no discussion by the HV around parent/HV relationships, the obvious feeding issues and what the role of the HV might be. The reason for this may have been that it was too early in her
relationship with this parent for the HV to risk any confrontation of the feeding issues and were the cause of the previous relationship breakdown.

The analysis of the established relationship questionnaires were re-examined and re-coded to account for the clinical significance of the barriers presented. The results of this recoding and second analysis will now be presented.

7.4.1 Analysis of clinical significance of HV established relationship questionnaire

Initially the numbers of barriers present, as indicated in the response profiles, were re-coded for clinical significance rather than using the binomial probability distribution dictated by statistical methods [Table 7-6].

Table 7-6. Clinical indicators of parental barriers to HV relationships

<table>
<thead>
<tr>
<th>Parental Barriers</th>
<th>TELER Code</th>
<th>Parental impact on the relationship</th>
<th>Clinical Significance</th>
<th>No. of HVs</th>
</tr>
</thead>
<tbody>
<tr>
<td>9, 10, 11**</td>
<td>1</td>
<td>Severe</td>
<td>Barriers obstruct relationships</td>
<td>0</td>
</tr>
<tr>
<td>6 or 7 or 8*</td>
<td>2</td>
<td>Moderate</td>
<td>Barriers severely inhibit relationships</td>
<td>4</td>
</tr>
<tr>
<td>4 or 5</td>
<td>3</td>
<td>Indeterminate</td>
<td>Barriers inhibit relationships</td>
<td>3</td>
</tr>
<tr>
<td>2 or 3 ++</td>
<td>4</td>
<td>Slight</td>
<td>Barriers mildly inhibit relationships</td>
<td>7</td>
</tr>
<tr>
<td>0 or 1+</td>
<td>5</td>
<td>None</td>
<td>Barriers do not obstruct relationships</td>
<td>14</td>
</tr>
<tr>
<td>** p ≤ 0.0327</td>
<td>* 0.3207 &lt; p ≤ 0.5000</td>
<td>++ p ≤ 0.0059</td>
<td>+ 0.0059 &lt; p ≤ 0.1133</td>
<td>28</td>
</tr>
</tbody>
</table>

The clinical significance indicators require further clarification.

The term ‘barriers do not obstruct relationships’ indicates that the parent and HV have a good relationship. The HV trusts that the parents will access the health visiting service or other services in the community, such as Sure Start Children’s Centre, as and when necessary and always guided by the child’s best interests. It may indicate that a universal level of intervention is service level required (Department of Health 2011).

The term ‘barriers mildly inhibit relationships’ may indicate that the HV may need to visit the family more often. This may mean that a ‘universal plus’ level of service is needed (Department of
Health 2011) to deal with problems such as postnatal depression, feeding or sleeping difficulties or other childhood health or behaviour problems.

The clinical indicator ‘barriers inhibit relationships’ suggests that there is a relationship giving cause for concern. The HV may need to discuss this relationship with her clinical supervisor with a view to taking some remedial action.

At the level of ‘barriers severely inhibiting relationships’ HVs need to be pro-active about discussing the difficulties with the parent at the next visit. This level suggests a poor relationship. It is possible that a ‘universal partnership plus’ level of service (Department of Health 2011) may be indicated as the family is likely to have complex needs that require a range of services as well as the ongoing support of the HV.

Finally, where ‘barriers obstruct relationships’, the HV needs to consider whether it is possible for her to salvage the relationship or whether another practitioner needs to start a new one with the family. Occasionally there may be a complete relationship breakdown particularly where the HV and parent have differing expectations and goals. This may happen in child protection proceedings, for example, where the parent may lack insight into the problems that she/he has or where the HV is perceived not to have been entirely candid about her level of concern and yet referred the family to social services.

The level of coding may indicate the HV’s lack of trust in the parent and parent’s lack of trust in the HV. This could be indicative of child protection issues being present. In this sample, all those with a TELER code one to three either were a cause for concern to the HV or were on the child protection register. However, on the HV questionnaires seven of the 14 families with a code zero to one had either a child in need concern or child protection issues so clearly HVs and parents are able, in some circumstances, to maintain good relationships where these issues are present.

The clinical indicator data analysed so far show the level of barriers to the HV relationships from parents. Reflection on these relationships may indicate individual actions for practitioners, which could be of practical use to them. However, in order to interrogate the data further to inquire if a service level response was required the clinical indicator data were submitted to a chi-square test. Although some statistical artefacts arose in the course of the analysis, showing statistical significance where there was none, the result \[
\chi^2 = 1.143.28
\] when checked using traditional
methods, showed statistical significance [$\chi^2 = 9.488$, df = 4, $p \leq 0.05$] indicating, as in the previous analysis, that no response was needed at a service level [Appendix 22].

### 7.4.2 Analysis of clinical significance of parent established relationship questionnaire

Following the same procedures as for the HV data, the parent data were re-coded for clinical significance as in Table 7-7.

#### Table 7-7. Clinical indicators of HV barriers to parent relationships.

<table>
<thead>
<tr>
<th>HV barriers</th>
<th>TELER Code</th>
<th>HV impact on the relationship</th>
<th>Clinical significance</th>
<th>No. of Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>10, 11 or 12**</td>
<td>1</td>
<td>Severe</td>
<td>Barriers obstruct relationships</td>
<td>1</td>
</tr>
<tr>
<td>7, or 8 or 9*</td>
<td>2</td>
<td>Moderate</td>
<td>Barriers severely inhibit relationships</td>
<td>1</td>
</tr>
<tr>
<td>5 or 6</td>
<td>3</td>
<td>Indeterminate</td>
<td>Barriers inhibit relationships</td>
<td>1</td>
</tr>
<tr>
<td>3 or 4**</td>
<td>4</td>
<td>Slight</td>
<td>Barriers mildly inhibit relationships</td>
<td>2</td>
</tr>
<tr>
<td>0, 1 or 2†</td>
<td>5</td>
<td>None</td>
<td>Barriers do not obstruct relationships</td>
<td>23</td>
</tr>
<tr>
<td>** Total</td>
<td></td>
<td></td>
<td></td>
<td>28</td>
</tr>
<tr>
<td>** p ≤ 0.0193</td>
<td>* 0.0193 &lt; p ≤ 0.1939</td>
<td>† † p ≤ 0.0193 † † 0.0193 &lt; p ≤ 0.1939</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There is no imperative on the part of the parent to ensure a good relationship with the HV. However, it is incumbent on the HV to maintain the relationship with the parent. If the HV is aware of the way in which the parent views the relationship then she may be able to take steps to remedy the situation. It is useful and interesting to note that all three of the parents with TELER codes one to three had safeguarding issues present.

Although this would seem to indicate that there might be a link between the less good relationships and safeguarding issues, there were 13 families with safeguarding or cause for concern issues who registered good relationships with HVs. This shows that parents are able to have and to maintain good relationships with HVs even where the circumstances are difficult.

The data were analysed, using a chi-squared test, to inquire whether a service response was needed. The result [$\chi^2 = 954.53$] was, once again, statistically significant [$\chi^2 = 9.488$, df = 4, $p \leq 0.05$] indicating that there was no action needed at a service level as the majority of parents were coded 5. This meant that they only encountered no or slight barriers to their relationships with HVs [Appendix 23].
The two clinical indicator data sets from HVs and parents were tested to see if there was an association between them [Appendix 24]. The result \( \chi^2 = 1,881.95 \) was statistically significant \( \chi^2 = 9.488, df = 4, p \leq 0.05 \) showing that the HV and Parent data were associated as the majority of the codes were code 5 for both parents and HVs indication that they agreed that there were no problems in their relationships.

7.4.3 Discussion
Following the re-analysis of the established relationship questionnaire for clinical significance, the results appeared similar to the statistical analysis at a group level. However, at an individual level the data now indicate the seriousness of the relationship problems that HVs face and, if made aware of them, may be able to take remedial steps. The parent barriers for HVs and the HV barriers for parents needing to be addressed were determined in the original statistical analysis.

The seven parent barriers in the HV data were:

1. In the last three months, the records show that the parent needs constant advice from me and does not make her own choices/decisions.
2. The records show that the parent acts in a way that disregards information I have given her.
3. The parent regularly seeks out information in the interests of her child/baby by asking me questions during contact.
4. In the last three months, the records show that the parent had not acted positively in the child’s best interests.
5. The records show that the parent contacts me if she has a problem.
6. I was able to comment on the parent’s growing confidence in the management of her situation.
7. The parent attends clinic to see me regularly.

The three HV barriers in the parent data were:

1. Decisions that I make for my baby/child/family/situation are not encouraged by the health visitor.
2. When I spoke to the health visitor she made eye contact that did not make me feel uncomfortable.
3. I see my health visitor at clinic.

[A negative response was either yes, I agree’ or ‘no, I disagree’ dependent on the statement wording]
Given the importance of these findings it was decided to re-examine the First Visit questionnaires for clinical significance. Overall there was little difference in the outcome. Statistical and clinical significance were achieved showing good relationships between HVs and parents. These results will now be presented.

7.4.4 Analysis of clinical significance of HV first visit questionnaire.

Table 7-8 shows how the response profiles of the HVs were converted to a TELER code and the impact on relationship of the parent barriers reported by HVs on their individual relationships with parents. It also shows the addition of the clinical indicators so that the clinical significance of these individual results can be understood.

Table 7-8. Clinical indicators of parent barriers to HV relationships.

<table>
<thead>
<tr>
<th>Parent Barriers</th>
<th>TELER Code</th>
<th>Parental impact on the relationship</th>
<th>Clinical Significance</th>
<th>No. of HVs</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 or 10</td>
<td>1**</td>
<td>Severe</td>
<td>Barriers obstruct relationships</td>
<td>0</td>
</tr>
<tr>
<td>6,7 or 8</td>
<td>2*</td>
<td>Moderate</td>
<td>Barriers severely inhibit relationships</td>
<td>0</td>
</tr>
<tr>
<td>4 or 5</td>
<td>3</td>
<td>Indeterminate</td>
<td>Barriers inhibit relationships</td>
<td>0</td>
</tr>
<tr>
<td>2 or 3</td>
<td>4*</td>
<td>Slight</td>
<td>Barriers mildly inhibit relationships</td>
<td>3</td>
</tr>
<tr>
<td>0 or 1</td>
<td>5**</td>
<td>None</td>
<td>Barriers do not obstruct relationships</td>
<td>22</td>
</tr>
</tbody>
</table>
| ** p < 0.0107 * 0.0107 < p ≤ 0.3769 ** p < 0.0107 * 0.0107 < p ≤ 0.1718

A chi-squared test was performed on each TELER code separately. The result $[\chi^2 = 1,769.83]$ was statistically significant $[\chi^2 = 9.488, df = 4, p ≤ 0.05]$, suggesting that the combined impact of the parent barriers reported by HVs did not occur by chance. This means that from the perspective of the HVs there were relationship problems attributable to parent barriers. However, these barriers had either no or slight effect on the relationship with the HV. One interpretation of this might be that the HV perceives that there are parental issues that affect the relationship but that they are insignificant or minor in terms of their relationships. The result was the same as the analysis of the data analysed without accounting for clinical significance, indicating that the original analysis was correct.
7.4.5 Analysis of clinical significance of parent first visit questionnaire.

The analysis of clinical significance followed the same process as that for the HV first visit questionnaire.

Table 7-9 shows how the response profiles of the parents were converted to a TELER code and the impact on relationship of the HV barriers reported by parents on their individual relationships with HVs. It also shows the addition of the clinical indicators so that the clinical significance of these individual results can be understood.

Table 7-9. Clinical indicators of HV barriers to relationships with parents

<table>
<thead>
<tr>
<th>HV barriers</th>
<th>TELER Code</th>
<th>HV impact on the relationship</th>
<th>Clinical significance</th>
<th>No. of Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>9, 10 or 11</td>
<td>1**</td>
<td>Severe</td>
<td>Barriers obstruct relationships</td>
<td>0</td>
</tr>
<tr>
<td>6, 7 or 8</td>
<td>2*</td>
<td>Moderate</td>
<td>Barriers severely inhibit relationships</td>
<td>0</td>
</tr>
<tr>
<td>4 or 5</td>
<td>3</td>
<td>Indeterminate</td>
<td>Barriers inhibit relationships</td>
<td>0</td>
</tr>
<tr>
<td>2 or 3</td>
<td>4+</td>
<td>Slight</td>
<td>Barriers mildly inhibit relationships</td>
<td>5</td>
</tr>
<tr>
<td>0 or 1</td>
<td>5**</td>
<td>None</td>
<td>Barriers do not obstruct relationships</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td>25</td>
</tr>
</tbody>
</table>

A chi-squared test was performed in the same way as with the HV data. The result \( \chi^2 = 2.514.78 \) was statistically significant \( \chi^2 = 9.488, df = 4, p \leq 0.05 \), and suggested that the combined impact of the health visitor barriers reported by parents did not occur by chance. This means that from the perspective of the parents there were relationship problems attributable to HV barriers. However, these barriers had either no or slight effect on the relationship with the parent. One interpretation of this might be that the parent perceives that there are HV issues affecting the relationship but that they are insignificant or minor. As with the HV data, the same result was achieved when the data were analysed without accounting for clinical significance.

As previously, the data were analysed to test the statistical significance of the association between the HV and Parent data of the numbers of HVs and Parent who reported the same numbers of barriers on their relationships with each other. The result \( \chi^2 = 4,159.54 \) was statistically significant \( \chi^2 = 9.488, df = 4, p = 0.05 \). The conclusion was that the combined impact
of the parent barriers reported by HVs was the same as that of the HV barriers reported by parents and that the two sets of data were associated. As the majority of the TELER codes are on four and five this would suggest that they agree that there are no problems.

7.4.6 Discussion

Although the first visit data were re-coded for clinical significance, the new analysis did not reveal greater insight in the original findings. However, as with the established relationship data it is now possible to be aware of the importance of the barriers to the relationship and to take account of these in a clinical setting.

7.5 Organisational Questionnaire [New]

The questionnaire data were analysed for 27 parent/HV dyads. Fifteen HVs and 27 parents completed the questionnaires. Parents were asked to complete the organisational quiz if they had more than one child or had an ongoing relationship with their HV and had experience of attending child health clinics in addition to home visiting. This was deemed necessary as parents who were seeing HVs for a new birth visit in the early days would not have experienced the ways in which the service was organised by seeing their HV on more than one occasion and making use of clinics.

7.5.1 Demography of Participants

There were 15 HVs in the organisational questionnaire pilot forming 27 relationships with parents. Four HVs took part from PCT A, six from PCT B, and five from PCT C. These were neighbouring trusts covering a large ethnically diverse population in an inner city environment in England.

It was hypothesised that the years of experience that a HV had in working with families might influence her perception of organisational barriers that impinged upon relationships with parents. Figure 7-5 shows the years of experience of the HV in relation to those relationships.
Likewise, it was hypothesised that the age of the parent and number of children that they had may alter the perception of organisational barriers that may influence their relationships with the health visitor [Figure 7-6]. However, the numbers involved were too small to allow this exploration to be examined statistically.
Data were collected from across the parental age range and from families of varying social class and ethnicity. Eight families had problems that gave rise to the HV categorising them as families who were a cause for concern or who had a child on the child protection register. The number of children in the families ranged from one to four. All had met their HV on at least two occasions. Most families had seen their HV much more frequently over a period of up to and including six years. The parents’ experiences of the service were varied. All of them had experience of home visits and clinic attendance.

7.5.2 HV organisational Questionnaire [New]

The data entry and analysis followed the same methods as for the relationship measures. Table 7-10 shows the outcome of the analysis with application of the TELER codes.

Table 7-10. HV organisational barriers and impact on HV relationships

<table>
<thead>
<tr>
<th>Number of organisational Barriers</th>
<th>TELER Code</th>
<th>Organisational impact on the relationship</th>
<th>HVs</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 or 11</td>
<td>1**</td>
<td>Severe</td>
<td>2</td>
</tr>
<tr>
<td>8 or 9</td>
<td>2*</td>
<td>Moderate</td>
<td>10</td>
</tr>
<tr>
<td>4 to 7</td>
<td>3</td>
<td>Indeterminate</td>
<td></td>
</tr>
<tr>
<td>2 or 3</td>
<td>4*</td>
<td>Slight</td>
<td>3</td>
</tr>
<tr>
<td>0 or 1</td>
<td>5**</td>
<td>None</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>15</td>
</tr>
</tbody>
</table>

The conclusion from these data is that the impact of organisational influencing factors on the relationship of HVs with parents is:

- None or slight for three HVs.
- Moderate or severe for two HVs suggesting a poor or ineffective relationship.
- Indeterminate for 10 HVs indicating that the HV’s response was recorded without considering the content of the statements, or was a chance occurrence, or possibly indicative of a potential problem.

The chi-squared test result [$\chi^2 = 1.32$] was not statistically significant indicating that the combined impact of the organisational barriers reported by HVs did not create a problem for the relationship [$\chi^2 = 5.991$, $df = 2$, $p > 0.05$]. However, ten HVs had a TELER code 3 suggesting either an indeterminate effect or possible problems. Given that two HVs also experienced moderate problems affecting their relationships it is possible that 12 out of the 15 HVs were experiencing organisational problems affecting their relationships with parents.
A t-test was performed on the data to determine the statistical significance of the proportion of HVs who reported organisational barriers to their relationships. There were seven of the 11 possible organisational barriers that were statistically significant and were a cause of concern, affecting their relationships with parents \( [t = 4.18, df = 14, p \leq 0.05] \). For HVs the problem areas were to do with workload, record keeping, clinical supervision, skill mix, attendance at meetings and continuity of contact [Table 7-11 statements could be answered ‘yes, I agree’ or ‘no, I disagree’].

Table 7-11. HV Organisational barriers affecting their relationships with parents

<table>
<thead>
<tr>
<th>Statements</th>
<th>No. of HVs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My workload is such that I cannot always carry out follow-up visits to clients who are in greater need.</td>
<td>10</td>
</tr>
<tr>
<td>2. I have a team who are able to help me meet the client's identified needs.</td>
<td>4*</td>
</tr>
<tr>
<td>3. The HV team that I work with is small enough to get to know each other and meet together weekly.</td>
<td>1</td>
</tr>
<tr>
<td>4. The time spent on record keeping does not reduce routine face to face contact with clients.</td>
<td>11*</td>
</tr>
<tr>
<td>5. Attending meetings interferes with my routine face to face contact with clients.</td>
<td>9*</td>
</tr>
<tr>
<td>6. Apart from child protection supervision I do not receive helpful clinical supervision regularly.</td>
<td>6*</td>
</tr>
<tr>
<td>7. Working in a skill mix team limits my ability to develop relationships with clients.</td>
<td>5*</td>
</tr>
<tr>
<td>8. The clients I visit at home I do not see in clinic.</td>
<td>12*</td>
</tr>
<tr>
<td>9. The ratio of children under five to health visitors meets CPHVA guidelines i.e.250 children in affluent areas or 100 children in deprived areas.</td>
<td>15*</td>
</tr>
<tr>
<td>10. I can use my professional judgement to decide which clients to see on a continuing basis.</td>
<td>0</td>
</tr>
<tr>
<td>11. I do not have the authority to determine my working pattern according to client need.</td>
<td>2</td>
</tr>
</tbody>
</table>

* \( p = 0.05 \)

7.5.3 Parent Organisational Questionnaire [New]

The parent data were entered and analysed in the same way as the HV data. The numbers of organisational barriers experienced by parents were allocated a TELER code [Table 7-12]
Table 7-12. Organisational barriers and impact on parent relationships with HVs

<table>
<thead>
<tr>
<th>Number of organisational barriers</th>
<th>TELER Code</th>
<th>Organisational impact on the relationship</th>
<th>Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 or 10</td>
<td>1**</td>
<td>Severe</td>
<td>1</td>
</tr>
<tr>
<td>7 or 8</td>
<td>2**</td>
<td>Moderate</td>
<td>1</td>
</tr>
<tr>
<td>4,5 or 6</td>
<td>3**</td>
<td>Indeterminate</td>
<td>8</td>
</tr>
<tr>
<td>2 or 3</td>
<td>4**</td>
<td>Slight</td>
<td>6</td>
</tr>
<tr>
<td>0 or 1</td>
<td>5**</td>
<td>None</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>27</td>
</tr>
</tbody>
</table>

** p ≤ 0.0108       * 0.0108 < p ≥ 0.1719

Table 7-12 shows that the impact of organisational barriers on the parental relationships with HVs was:

- Moderate or severe for one parent suggesting a poor or ineffective relationship.
- Indeterminate for eight parents suggesting that the parents’ responses were recorded without considering the statements, or was a chance occurrence or possibly an occurrence indicating a problem.
- None or slight for 18 parents.

The result of the chi-squared test [$\chi^2 = 46.66$] showed that the combined impact of the organisational barriers reported by parents did not occur by chance and that they created a relationship problem [$\chi^2 = 5.991$, $df = 2$, $p < 0.05$]. However the problems attributable to organisational barriers may only have a no or slight effect on parental relationships with HVs as most of the parents [N = 18] were coded 4 or 5. Given that one parent was experiencing moderate to severe problems, it is also possible that the eight parents recording an indeterminate code three were experiencing problems.

The t-test showed where these organisational barriers were occurring. There were five of the possible 10 barriers that were statistically significant [$t = 5.35$, $df = 26$, $p < 0.05$]. The problem areas for parents were to do with continuity of care, HV approachability, the business of clinics, and peer support [Table 7-13 Statements could be answered ‘yes I agree’, or ‘no, I disagree’].
Table 7-13. Parent Organisational Barriers to relationships with HVs

<table>
<thead>
<tr>
<th>Parent Organisational Barriers</th>
<th>No. of Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have been visited at home by different health visitors.</td>
<td>14*</td>
</tr>
<tr>
<td>2. The health visitor writes clearly in the red book the things we have discussed.</td>
<td>2</td>
</tr>
<tr>
<td>3. At clinic the health visitor has time for me if I need it.</td>
<td>3</td>
</tr>
<tr>
<td>4. When I attend clinic I usually see the same health visitor each time.</td>
<td>13*</td>
</tr>
<tr>
<td>5. At clinic it is difficult to identify the health visitor amongst other team members.</td>
<td>4</td>
</tr>
<tr>
<td>6. At clinic where I see my health visitor, I am able to meet and get support from other parents.</td>
<td>11*</td>
</tr>
<tr>
<td>7. The health visitor I see at clinic is a stranger to me.</td>
<td>10*</td>
</tr>
<tr>
<td>8. At clinic I can ask the health visitor any questions that I have.</td>
<td>1</td>
</tr>
<tr>
<td>9. At the clinic the health visitor rarely smiles at people or greets them by name.</td>
<td>6*</td>
</tr>
<tr>
<td>10. I cannot see the health visitor when I want to within the clinic time</td>
<td>5*</td>
</tr>
</tbody>
</table>

*p = 0.05

Data were analysed to test the statistical significance of the association between the HV and parent data of the numbers of HVs and parents who reported a similar number of organisational barriers to their relationships with each other. The statistically significant result \( \chi^2 = 39.42 \), \( \chi^2 = 5.99, df = 2, p < 0.05 \) indicated that the affect of the organisational barriers reported by HVs was not the same as that of the organisational barriers reported by parents, as the majority of codes for parents were 4 and 5 but for HVs was 3. The two sets of data were therefore not associated. Parents did not or only slightly experienced barriers to their relationships but health visitors may or may not have been experiencing problems. As with the other two sets of data, this organisational set was explored further for clinical significance.

7.5.4 Analysis of clinical significance of HV organisational questionnaire

The HV organisational data showed that there might have been problems attributable to organisational factors that affected HV relationships with parents. However, most of the data fell into the statistically indeterminate category. Through observation of practice, the researcher was aware of the needs of HVs for organisational support for parent/HV relationships, noticing the level of stress that HVs encountered in trying to manage their day-to-day workloads.
For example, in PCT A where the researcher attended a staff meeting statistics were kept of the numbers of face-to-face contact with parents by HVs, staff nurses and nursery nurses. Managers were at pains to show how some teams had better statistics than others did and seemed to be achieving more. HVs were dismayed to think that perhaps league tables were about to be produced, as there was no consideration of the differences in deprivation scores. In areas of high deprivation, families often live in situations that are more complex and consequently health visiting may take more time. Those wards where deprivation was not an issue may therefore be able to achieve more face-to-face contact. This pressure to increase the numbers of visits or contacts rather than the quality of them made it difficult for HVs to invest time in their visits. This is shown with the visits of HV [A4] [7.2.5 p. 205] who did her job in a mechanical way, without investing emotional labour, acutely aware that she would never see the parent again. She felt that she did not have authority to determine her own working pattern according to client need. As a result, she lacked enthusiasm for her job.

This example was just one way of coping with the difficulty of management being unsupportive of relationship building. Another way was not to pay attention to the wishes of management. HV [A6] [7.2.5 p. 205] felt that she did have the authority to determine her own working pattern and visited according to parent need. The problem for this HV was that she was trying to manage an impossible workload caused by her more caring approach.

Record keeping was a huge issue for some HVs, particularly those with under-developed keyboard skills. One HV was being threatened with disciplinary action after revealing to her manager that she was behind with her data inputting. This severely curtailed her ability to have contact time with parents and added stress to her working day as she was staying late sometimes to 7 pm to finish writing records. Both paper and electronic records were being kept so there was double the work to be done.

These examples show that, as with the established relationship data, there seemed to be a discrepancy between observations that were of clinical significance and the statistical findings. The number of barriers were, therefore TELER coded to take into account clinical significance rather than statistical theory, so that the data might be more meaningful to practice [Table 7-14].
Table 7-14. Organisational TELER codes re-allocated for clinical significance

<table>
<thead>
<tr>
<th>No. of barriers</th>
<th>TELER code</th>
<th>Organisation impact</th>
<th>No of HVs</th>
<th>No. of barriers</th>
<th>TELER Clinical Indicator Code</th>
<th>Clinical Significance</th>
<th>No. of HVs</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 or 11</td>
<td>1</td>
<td>Severe</td>
<td>0</td>
<td>8-11</td>
<td>1**</td>
<td>Barriers obstruct relationships</td>
<td>2</td>
</tr>
<tr>
<td>8 or 9</td>
<td>2</td>
<td>Moderate</td>
<td>2</td>
<td>5-7</td>
<td>2*</td>
<td>Barriers severely inhibit relationships</td>
<td>7</td>
</tr>
<tr>
<td>4-7</td>
<td>3</td>
<td>Indeterminate</td>
<td>10</td>
<td>4</td>
<td>3</td>
<td>Barriers inhibit relationships</td>
<td>3</td>
</tr>
<tr>
<td>2 or 3</td>
<td>4</td>
<td>Slight</td>
<td>3</td>
<td>2 or 3</td>
<td>4++</td>
<td>Barriers mildly inhibit relationships</td>
<td>3</td>
</tr>
<tr>
<td>0 or 1</td>
<td>5</td>
<td>None</td>
<td>0</td>
<td>0 or 1</td>
<td>5+</td>
<td>Barriers do not obstruct relationships</td>
<td>0</td>
</tr>
</tbody>
</table>

** p < 0.1133  * 0.1133 < p ≤ 0.7256  ** p < 0.0059  * 0.0059 < p ≤ 0.1133

The definitions of clinical significance may indicate that an organisation has to take steps to address the problem areas of practice that impact on an individual HV’s ability to manage their workload. As shown by the t-test the problem areas to be addressed were to do with workload, record keeping, clinical supervision, skill mix, attendance at meetings and continuity of contact [Table 7-11 p. 228].

A chi-squared test was carried out on the revised data to explore the need for a service level response to the impact of organisational barriers on HV relationships with parents. The result [$\chi^2 = 2.00$] was not statistically significant [$\chi^2 = 9.488$, $df = 4$, $p > 0.05$] suggesting that the overall impact of the organisational barriers was in the expected mode ‘barriers severely inhibit relationships’.

7.5.5 Discussion

The lack of statistical significance here may have been due to the small sample size and the pilot nature of the data. However, the result suggests that organisational barriers severely inhibit parent/HV relationships. This is a clearer definition of the coding for the problems that HVs face. The original analysis showed that 12 of 15 HVs may be experiencing barriers in their relationships with parents but this was not clear as 10 HVs were coded as ‘indeterminate’. Now the 12 HVs
experiencing organisational barriers are coded so that the impact of the barriers to their relationships with parents can be clearly noted. An organisation whose HVs were experiencing such difficulties would need to rectify the situation regardless of statistical significance of the findings.

7.5.6 Analysis of clinical significance of parent organisational questionnaire

The data were re-coded to account for the clinical importance of the number of barriers rather than their statistical distribution Table 7-15.

Table 7-15. TELER codes re-allocated for clinical significance

<table>
<thead>
<tr>
<th>No. of Barriers</th>
<th>TELER code</th>
<th>Organisation impact</th>
<th>No. of parents</th>
<th>No. of Barriers</th>
<th>TELER Clinical Indicator Code</th>
<th>Clinical Sig.</th>
<th>No. of parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 or 10</td>
<td>1</td>
<td>Severe</td>
<td>0</td>
<td>8-10</td>
<td>1**</td>
<td>Barriers obstruct relationships</td>
<td>0</td>
</tr>
<tr>
<td>7 or 8</td>
<td>2</td>
<td>Moderate</td>
<td>1</td>
<td>5-7</td>
<td>2*</td>
<td>Barriers severely inhibit relationships</td>
<td>7</td>
</tr>
<tr>
<td>4, 5 or 6</td>
<td>3</td>
<td>Indeterminate</td>
<td>8</td>
<td>4</td>
<td>3</td>
<td>Barriers inhibit relationships</td>
<td>2</td>
</tr>
<tr>
<td>2 or 3</td>
<td>4</td>
<td>Slight</td>
<td>6</td>
<td>2 or 3</td>
<td>4**</td>
<td>Barriers mildly inhibit relationships</td>
<td>6</td>
</tr>
<tr>
<td>0 or 1</td>
<td>5</td>
<td>None</td>
<td>12</td>
<td>0 or 1</td>
<td>5*</td>
<td>Barriers do not obstruct relationships</td>
<td>12</td>
</tr>
</tbody>
</table>

** $p < 0.0547$, * $0.0547 < p \leq 0.7231$, ** $p < 0.0107$, * $0.0107 < p \leq 0.1718$

Table 7-15 shows that:

- Organisational barriers do not obstruct relationships for 12 parents.
- Organisational barriers mildly inhibit relationships for six parents.
- Organisational barriers inhibit relationships for two parents.
- Organisational barriers severely inhibit relationships for seven parents.

A chi-squared test was carried out on the revised data to explore the need for a service level response to the impact of parent organisational barriers on their relationships with HVs. The result $\chi^2 = 481.59$, suggested that there was no need for a service level response $[\chi^2 = 9.488, df = 4, p < 0.05]$
The data were further explored to see if there was an association between the HV and parent data. The result \( \chi^2 = 363.41 \) suggested that there was no association between the two sets of data \( \chi^2 = 9.488 \text{ df } 4, p \leq 0.05 \). The HV data showed that barriers severely inhibited relationships and needed a service level intervention whilst the parent data showed that the organisational barriers did not inhibit relationships with HVs so did not require a service level response.

7.5.7 Discussion

The recoding and re-analysis of the organisational data proved a fruitful exercise that produced results that were more in keeping with observations made at the time of visits. HVs were struggling with the demands of the organisation as well as trying to do the best they could for the families in their care. The families were not affected by organisational constraints to the same degree, however, nine of the 27 parents experienced organisational barriers that either inhibited or severely inhibited their relationships with HVs. The problem areas for parents were to do with continuity of care, health visitor approachability, the business of clinics, and peer support.

One parent [P2.1] who recorded six barriers to her relationship with HVs was a victim of domestic violence with a sixteen-year-old son in the care of social services with a foster family and attending psychiatric services. She had a baby of eight months and the HV [A12] was home visiting to carry out an eight-month developmental review. The mother was depressed, yet not taking her anti-depressants. She was clearly worried about her eldest son and talked a lot about him with the HV. The research field notes record an open and empathic interaction from the HV. The parent was pleased to see the HV and told her when she was leaving the house that it had been lovely to see her again. This parent would have benefitted from an ongoing relationship with a HV whom she could get to know. Her organisational questionnaire recorded that she had been seen by different HVs. Furthermore, when she attended clinic the HV did not have time for her and was someone she did not know and it was a different person each time she attended. There was insufficient time to talk with the HV and she did not feel able to get peer support from other parents in the clinic environment.

Although statistically the clinical indicators have suggested that there is no need for a service level response to the organisational barriers that parents experience, it would appear from the example that it might be beneficial for some re-consideration of how clinics are organised to enable continuity of care especially where parents are more vulnerable.
Although data collected from across three different trusts were explored and analysed together, the HVs and parents experienced barriers across three distinct organisations. With greater numbers of participants there is potential to explore these issues across various employing organisations.

Although in this study, a dichotomous variable response was chosen for the questionnaires this choice might have influenced the veracity of the results. Parents and HVs may have felt that for some of the variables they would have liked to answer ‘sometimes’ instead of ‘yes, I agree’ or ‘no, I disagree’. For example the statement, ‘I am able to make contact with the health visitor if I need to’ on the established relationship questionnaire for parents, might reasonably be answered ‘sometimes’. There may therefore, be a case that the either the wording of the statements needs to change or that the number of responses needs to include a ‘sometimes’ column.

When designing a TELER questionnaire, others have used a multi-modal response. For example in assessing the knowledge of a student on food safety a choice of three responses was given, ‘Don’t know’, ‘Agree’ and ‘Disagree’ (Le Roux 2003). Where these responses are used, the answers are weighted. In the example given here an incorrect response is equal in weight to a correct response and the ‘don’t know’ response effect is considered negligible (Le Roux 2003). Introducing such weighting into the parent/HV relationship instrument might have been problematic since there is no way of knowing whether (to follow the example), being able to contact the health visitor ‘sometimes’ would be considered neutral by the parent.

Efforts were made during the design phase of the study to eliminate the possibility of needing to use a ‘sometimes’ response by careful wording of the statements used. Because the statements sought to be as objective and observable as possible the ‘sometimes’ response was not considered necessary. During the course of the study the need for a ‘sometimes’ column was not raised HVs or parents.

7.6 Conclusion

The piloting of the measures has shown that it is possible to measure the relationships between HVs and parents and to measure the impact of organisations on those relationships. Further research using these measures would help to validate them further, and given sufficient numbers, allow conclusions to be drawn not only from the demographic data but also from across different organisations.
The data from the first visit questionnaires showed that both HVs and parents were able to establish constructive relationships at their first meetings [Table 7-16]. Although there were some barriers experienced by both HVs and parents these had little or no effect on their relationships. This result was consistent whether using the original analysis or the new re-coded analysis for clinical significance [Table 7-17].

A similar result was obtained for the established relationship data with HVs and parents agreeing that although there were barriers these made no little or no difference to the relationship [Table 7-16]. Again using the new clinical indicator codes the re-analysis of the data showed no statistical difference to this finding [Table 7-17]. However, barriers can inhibit or severely inhibit relationships for HVs.

The HV organisational data in the first analysis showed no statistically significant result indicating that the organisational barriers experienced by them occurred by chance [Table 7-16]. The parent data however, showed a statistically significant result suggesting that the organisational barriers did not occur by chance and that there were problems [Table 7-16]. However, these problems made little or no difference to parents’ relationships with HVs.

When these data were re-coded and analysed for clinical significance, once again there was no statistical significance to the HV data findings [Table 7-17]. However, the effect of a code 3 instead of being designated ‘indeterminate’ was now designated as ‘barriers severely inhibit relationships’ which has clinical significance. The statistically significant finding in the parent data was that ‘barriers did not obstruct relationships’. The re-analysed data showed a statistically significant result when the HV and parent data were compared [Table 7-17]. This indicated that there was no association between the data sets. In terms of what was observed this made clinical sense. HVs experienced the organisational barriers more than parents did, suggesting that, although they may have been struggling with difficulties, the parents experienced little effect on their relationships. However, the data were collected from parents with whom the HV had a relationship with the only exception being where the relationship had broken down completely [HV C3 and P 1.3, 7.4 p.218].
Table 7-16. Statistical results of chi-squared tests

<table>
<thead>
<tr>
<th></th>
<th>$\chi^2$</th>
<th>df</th>
<th>$\chi^2 = 5.991$</th>
<th>Sig*</th>
<th>Relationship effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Visit HV</td>
<td>120.36</td>
<td>2</td>
<td>$\chi^2$</td>
<td>$p \leq 0.05^*$</td>
<td>None or slight</td>
</tr>
<tr>
<td>First Visit Parent</td>
<td>195.08</td>
<td>2</td>
<td>$\chi^2$</td>
<td>$p \leq 0.05^*$</td>
<td>None or slight</td>
</tr>
<tr>
<td>First Visit HV &amp; Parent</td>
<td>300.16</td>
<td>2</td>
<td>$\chi^2$</td>
<td>$p \leq 0.05^*$</td>
<td>Agree none or slight</td>
</tr>
<tr>
<td>Established Relationship HV</td>
<td>104.39</td>
<td>2</td>
<td>$\chi^2$</td>
<td>$p \leq 0.05^*$</td>
<td>None or slight</td>
</tr>
<tr>
<td>Established Relationship Parent</td>
<td>89.47</td>
<td>2</td>
<td>$\chi^2$</td>
<td>$p \leq 0.05^*$</td>
<td>None or slight</td>
</tr>
<tr>
<td>Established relationship HV &amp; Parent</td>
<td>194.58</td>
<td>2</td>
<td>$\chi^2$</td>
<td>$p \leq 0.05^*$</td>
<td>Agree none or slight</td>
</tr>
<tr>
<td>Organisational HV</td>
<td>1.32</td>
<td>2</td>
<td>$\chi^2$</td>
<td>$p &gt; 0.05$</td>
<td>Indeterminate [Non-sig.]</td>
</tr>
<tr>
<td>Organisational Parent</td>
<td>46.6</td>
<td>2</td>
<td>$\chi^2$</td>
<td>$p \leq 0.05^*$</td>
<td>None or slight</td>
</tr>
<tr>
<td>Organisational HV &amp; Parent</td>
<td>39.42</td>
<td>2</td>
<td>$\chi^2$</td>
<td>$p \leq 0.05^*$</td>
<td>Do not agree</td>
</tr>
</tbody>
</table>
Table 7-17. Clinical Significance Statistical Results

<table>
<thead>
<tr>
<th></th>
<th>$\chi^2$</th>
<th>df</th>
<th>Sig*</th>
<th>Clinical Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Visit HV</td>
<td>1,769</td>
<td>4</td>
<td>$p \leq 0.05^*$</td>
<td>Barriers do not obstruct relationships</td>
</tr>
<tr>
<td>First Visit Parent</td>
<td>2,514.78</td>
<td>4</td>
<td>$p \leq 0.05^*$</td>
<td>Barriers do not obstruct relationships</td>
</tr>
<tr>
<td>First Visit HV &amp; Parent</td>
<td>4,159.54</td>
<td>4</td>
<td>$p \leq 0.05^*$</td>
<td>Agree that barriers do not obstruct relationships</td>
</tr>
<tr>
<td>Established Relationship HV</td>
<td>1,143</td>
<td>4</td>
<td>$p \leq 0.05^*$</td>
<td>Barriers do not obstruct relationships</td>
</tr>
<tr>
<td>Established Relationship Parent</td>
<td>954.53</td>
<td>4</td>
<td>$p \leq 0.05^*$</td>
<td>Barriers do not obstruct relationships</td>
</tr>
<tr>
<td>Established relationship HV &amp; Parent</td>
<td>1,881.95</td>
<td>4</td>
<td>$p \leq 0.05^*$</td>
<td>Agree that barriers do not obstruct relationships</td>
</tr>
<tr>
<td>Organisational HV</td>
<td>2.00</td>
<td>4</td>
<td>$p &gt; 0.05$</td>
<td>Barriers severely inhibit relationships [Non-sig]</td>
</tr>
<tr>
<td>Organisational Parent</td>
<td>481.75</td>
<td>4</td>
<td>$p \leq 0.05^*$</td>
<td>Barriers do not obstruct relationships</td>
</tr>
<tr>
<td>Organisational HV &amp; Parent</td>
<td>363.41</td>
<td>4</td>
<td>$p \leq 0.05^*$</td>
<td>Do not agree</td>
</tr>
</tbody>
</table>

The group level statistical data are less revealing than the individual level data, where the impact of the barriers on relationships is more clearly seen [Appendix 9 & 10]. The ability to remain in contact with the data and to explore it fully for clinical significance was instructive and helpful. The usefulness of the tools in measuring the relationship between HVs and parents needs further exploration to ascertain whether the group level data may be of service in research and in practice. At an individual level, the response profiles showing the numbers of barriers experienced by participants to their relationships may be of use not only in research but also in practice. The questionnaires demonstrated their sensitivity to different relationships and thus their construct validity.

The next chapter will critically review the work undertaken so far and make recommendations for future research.
Chapter 8 Critical Review and Conclusions

8.1 Introduction

This chapter reviews the methods and outcomes of this study. The discussion will support the conclusion that the new measures for the parent/HV relationship are underpinned by theories of measurement and of helping relationships and are appropriate for use in health visiting research and practice, following a rigorous research process. This will be achieved by a critical review of:

- The appropriateness of the study methods and philosophy and of
- The study outcomes presented in chapters four to seven.

This will be followed by:

- An assessment of the contribution of this research to health visiting knowledge
- A reflection on the limitations of the study and
- Recommendations for further research.

8.2 A critical review of the appropriateness of the study methods and philosophy

This thesis began with an exploration of the instruments that already exist for measuring helping relationships across a number of professions. These instruments were developed from a flurry of endeavour, which began in the psychotherapy profession. The stimulus to action, which occurred during the 1950s and 1960s, were studies that indicated that psychotherapy did not seem to produce any benefits that would not have occurred without the intervention of therapy (Kazdin 2008). The profession found itself in the situation of needing to justify what it did and how it achieved successful outcomes. Carl Rogers believed that if the therapist was able to be empathic, congruent and give unconditional positive regard then that was all that was necessary for the patient to improve (Horvath & Symonds 1991). However the development of the concept of the 'working alliance' started to take into account the contribution of the client to the relationship (Horvath & Symonds 1991; Horvath & Bedi 2002). There followed an avalanche of measures of relationship to be used in mental health settings; indeed Cahill et al. (2008) reviewed 83 such measures [2.3.4.4].
The need to produce an evidence-base of effectiveness however, spans multiple professions. Social work, nursing, medicine, mental health and more generic relationship measures were therefore considered in the review of measures in this study, to explore their utility in health visiting. None were found that were appropriate. This was not surprising as, although there may be some overlap between health visiting and the professions mentioned above it is the, ‘combination of health promotion, safeguarding children, education, social work, as well as their accessibility, ability to work with individuals, families and communities that gives health visiting its distinctive identity’ (Baldwin 2012, p.14)

There is evidence to suggest that others looking at health visiting, may see a similar case to that of psychotherapy 50 years ago, that is with a need to demonstrate effectiveness (Roberts *et al.* 1996; Cowley & Bidmead 2009b). This need to add to the knowledge base drives the research. As discussed in Chapter one, the temptation is to focus on outcomes of health visiting interventions rather than the process questions of how outcomes are achieved. The evidence base is therefore more likely to be established for interventions suitable for particular problems rather than an approach suitable for universal health visiting practice where promotion and prevention may be all that is required [1.1] (Department of Health 2011).

Elkan *et al.* (2000a) in their review of domiciliary health visiting remarked that there was a notable lack of research evidence that linked the processes of health visiting with health outcomes. Ongoing research at the National Nursing Research Unit, King’s College supports this view (Cowley *et al.* 2012). The intention of this study was, therefore, to create a tool that would be useful in research to link an important process in health visiting, namely the relationship with the parent, to outcomes. Without a suitable measure, it has not been possible to make the links necessary to prove or disprove that the parent/HV relationship is or is not central to outcomes.

In the new world of user involvement in nursing research, the formation of a tool for measuring parent/HV relationships required an innovative approach. Traditional approaches depend heavily on expert knowledge and the use of psychometric tests to validate instruments. However, the researcher in this study believed that the expertise about parent/HV relationships lay in not only the literature and experts in the field, but also with the parents and health visitors. It is they who observe and experience these relationships and their knowledge was therefore the basis of the formation of the questionnaires through the qualitative study. Knowledge from health visiting literature was also utilised, as was the knowledge of theories of relationship by the researcher.
This knowledge ensured minimal bias in the development of the measuring tools. As it was the parents and HVs who would be completing the questionnaires, their views were kept to the forefront during instrument development. Furthermore, it is asserted by the Royal College of Nursing that user involvement

> ‘increases the likelihood that research asks the right questions, in the right way’

(RCN 2007, p.2).

Nowhere is this more important than in the development of a new instrument especially where it is measuring something as complex and intimate as a relationship. Hence the key to the validity of the measures lies in the in-depth work of their creation with parents and health visitors and not in psychometric tests, which have been shown to have limited usefulness (Sijtsma 2009). Likewise, as this measure is the first of its kind there were no instruments with which to establish concurrent validity so a qualitative observational approach was used to identify the relational qualities and skills of parent/HV interactions alongside the use of the questionnaires.

Further steps were taken throughout the study to ensure that the instruments produced would be valid and reliable. The content validity of the instruments was established by making certain that the questionnaires provided an adequate description of the parent/HV relationship. The meaning and relevance of the items on the measures was self-evident to the users, as was confirmed by the post questionnaire interview data, and so face validity was also established (Le Roux 2003).

The hypothesis that the barriers, as measured by the items on the questionnaire would constitute an indication of a positive or negative relationship was tested with health visitors and parents in the communities from which the tools had been developed. The questionnaires were sensitive to differences within the relationships and therefore proved their construct validity.

### 8.2.1 Instrument Development

For all the reasons noted above it was the intention throughout the research to ensure that health visitors and parents remained involved contributors, to the understanding of their relationships and the ongoing development of the instruments. Their views on the developing tools proved an invaluable source of knowledge and experience enhancing the validity and reliability of the research and of the final version of the instruments.
The rich, qualitative data provided the basis of the construct validity of the measures. The initial wording of the questionnaires was based on the qualitative research interviews with the parents and HVs. Furthermore, the statements themselves were constructed so that they had unambiguous or singular meanings (Le Roux 2003). Adjustments were made in line with parent and HVs comments on the first draft of the tools along with researcher observations of the relationships that were under scrutiny. Observations followed by interviews with the participants were useful ways of ensuring that relevant questions could be asked about participant experience of questionnaire completion.

Through these processes, efforts were made to reduce the response bias and possible item non-response. The wording of the statements was simplified as necessary to ensure parent and HV understanding. A balance was achieved between the positively and negatively worded statements so that parents and HVs needed to consider carefully their answers. Furthermore, during data collection, the researcher adopted a non-judgemental stance to help participants be completely candid in their responses and participant confidentiality was protected at all times.

Some items on the questionnaires were identified as possible sources of measurement error during the first pilot phase of the study. Not only was it the comments of HVs and parents but also the piloting of the statistical methods that enabled recognition of these items during hypothesis testing [6.4].

8.2.2 The TELER method

The TELER method provided a useful way of designing a set of valid questionnaires based on a clear understanding of the parent/HV relationship. The strength of the TELER method, over and above other statistical approaches, was that it allowed the analysis of group level data but the individual data were not lost. The TELER approach allows objective examination of single cases, for example, one parent/HV relationship or perhaps one HV and all her relationships. This is something for which a standard measure would be less suitable.

Creating a TELER ordinal scale measure was not without its challenges. From the key variables identified in the qualitative phase, it was necessary to formulate statements that were as objective as possible. The best way of doing this was to make them observable so that they were not just the subjective feelings of the parents and HVs. This ensured that they were verifiable by a third party, if necessary. During the pilot phase the researcher acted as a third party observer of the
interactions. The parents and HVs, however, were the observers of each other’s interactional processes and as such produced reliable data with minimum bias. This was as it should be as the questionnaires were based on stimulated recall interview data supplied by them.

There are limitations to the measures but only those that might apply to any new measure. Validation of a new instrument is an ongoing process that is increased through its use in research (Stewart & Archbold 1997). The instruments devised in this study thus require further testing in the field with parents and HVs across different communities.

8.3 A critical review of the study outcomes presented in chapters four to seven.

The qualitative research undertaken in the first phase of this study supports Cahill et al.’s (2008) suggestion that any measure needs to be suitable for the context in which it is used. The use of the existing tools was therefore, inappropriate in the health visiting context, which was identified as a distinctively different area of practice from other helping professions [Figure 4-1, Chapter 4]. The analysis of the qualitative data identified the active constituents of the parent/HV relationship and produced a model of the process of health visiting, which went beyond what was, strictly speaking, necessary for a ‘relationship’ or ‘bond’ measure. The relational qualities and skills used by parents and HVs come together at a first meeting to create a relationship that is central to any ongoing work. How that work was completed, [the tasks], and what it set out to achieve, [the goals], was seen to be a collaborative enterprise dependent on the relational qualities and skills of the participants, a ‘working alliance’ that has been identified as the parent/HV working relationship.

Furthermore, during the collection of the qualitative data it became apparent that the practice of health visiting also took place within a specific context, that of a particular service organisation. The organisational issues, identified by practitioners and parents in the qualitative data, affected their abilities to use their relational qualities and skills effectively to make relationships [4.2]. This necessitated developing a set of organisational indicators of support for a relationship approach to health visiting and was an important addition to the relationship indicators.

The search for objective indicators of relationship entailed a transition from an interpretive analysis to a post-positive synthesis that was not easy. The in-depth analysis had produced a vast quantity of data covering HV and parent qualities and skills, and the health visiting process,
and revealed the impact of organisational issues. A further synthesis of the data and comparison with other relationship measures enabled data reduction to observable and objective indicators suitable for inclusion in the measures [5.2].

The outcome of this painstaking process [5.2] was a first draft of the questionnaires for parents and health visitors, measuring the relationship at a first meeting and for established relationships. Furthermore, an additional set of questionnaires were produced to measure the impact of service organisation on the participants' abilities to form relationships.

The first pilot highlighted a number of difficulties for parents and health visitors with some of the statements [Chapter 6]. Attention to the detail of these comments and suggestions from the participants ensured that the questionnaires had construct and content validity and avoided possible response bias and item non-response. The statistical methods that were to test the hypothesis were also piloted, ensuring that the data were treated as ordinal for the purposes of analysis, using non-parametric statistical tests as appropriate (Stevens 1946).

The experts in the field of health visiting are the parents and the HVs; it is through them that the tools have face and content and construct validity. Reliability was viewed as a precursor to validity and separate from it, however in more recent approaches to this issue, an instrument's reliability is viewed as a part of its construct validity (Goodwin 1997). Construct validity of the instrument was established using hypothesis testing. It was hypothesised that barriers experienced by the HV or parent as measured by the items on the questionnaire would or would not constitute a relationship problem. The pilot studies showed that it was possible to use the instruments to measure the parent/HV relationship and the results demonstrated that the instruments were sensitive to differences in those relationships. The items on the relationship questionnaires also demonstrated differences between parents and between HVs. The organisational questionnaires showed an impact of organisations on HV relationships but not on parents' relationships. The questionnaire was sensitive to differences between HVs perceptions of organisational support for the building of relationships with parents. Group data showed that parents and HVs establish positive relationships at a first meeting and that their ongoing relationships are unaffected by barriers. However, at an individual level the data revealed important differences in the relationships formed and demonstrated the questionnaires' sensitivity towards these differences. The clinical significance of these findings was established.
The strengths of this study undoubtedly lie in its grounding in the qualitative work carried out at its beginning. This has ensured that the instruments have content, face and thus construct validity. The central part played by parents and health visitors both during this phase and during the pilot phases cannot be underestimated. As described above, their contributions have been invaluable to the validation of the instruments.

Elkan et al. (2000b) suggest that it is important to know the theoretical underpinnings that form the framework for practice. Most HVs in this study were trained in the Family Partnership Model (Davis et al. 2002b), which meant that they strove to work in partnership with families using their relational qualities and skills. The tool may therefore show the most positive results where health visitors work within this paradigm, seeing their relationships with families as central to their work.

8.4 Assessment of the contribution this research to health visiting knowledge.

This study has demonstrated that indicators of the parent/HV relationship can be measured. In the process of achieving this there have been five major contributions to health visitor knowledge and theory development:

1. Identification of the HV micro-skills and qualities involved in forming working relationships with parents.
2. Identification of the parental contribution to the HV working relationship in terms of their qualities and skills.
3. Identification of the health visiting process.
4. The creation of valid instruments to measure these relationships.
5. The creation of a valid instrument to measure the impact of organisations on HV and parent working relationships.

This study adds considerably to the HV knowledge base and theory development of the parent/HV relationship. Not only have the HV relational qualities and skills been identified at the micro-level, but also those of the parent. This is new knowledge within UK health visiting and warrants further exploration. It appears self-evident that the quality of the HV working relationship is dependent on both participants [parents and HVs], but previous qualitative studies of UK HVs have reported the relational qualities and skills of the HV alone and little about the contribution of the parent. This is equivalent to the position in psychotherapy theory taken by Rogers (1959),
who held the opinion that all that was required for successful therapy was that the therapist establish the necessary and sufficient conditions of unconditional positive regard and empathy. It was not until the development of the theories around the ‘working alliance’ that there began to be acknowledgement of the interplay between therapist qualities and skills and the ability for the client to collaborate (Horvath & Bedi 2002).

HVs are required to work with parents even when working relationships are more difficult as highlighted in this study during the piloting of the questionnaires. Parents whose children are subject to child protection plans may also be required to co-operate with health visitors and there is pressure therefore on both parties to make their relationships with each other work. As noted in Chapter seven, this appeared to be more difficult for health visitors, who recognised the difficulties in their relationships with some of these more complex families, than it was for most of the parents concerned. However, there were individual differences, which were apparent in the data analysis [7.3.6]. The clinical significance of these findings was established through a secondary analysis [7.4].

The fact that parental qualities and skills have begun to be identified in this study is one difference between the model of the HV working relationship [4.3, 4.4] and FPM [Figure 1-2]. In the latest version of the FPM (Davis & Day 2010) the contribution of the family or parents is shown as the ‘family characteristics’. It is acknowledged that parents do have ‘interpersonal skills’ and ‘personal qualities’ (Davis & Day 2010, p. 259) however, these are not clearly defined but only mentioned as ‘likely to enhance the effectiveness of the process, if they do occur.’ However, the FPM appears to concern itself primarily with helping parents resolve problems or difficulties. HVs may not encounter any family problems or difficulties and yet need to provide a service that is promotional and preventive. The question arises therefore as to what sort of relationship is necessary to:

- Enable the identification of family risk and resilience factors.
- Encourage access by the family to the universal healthy child programme.
- Encourage contact with the HV should a difficulty arise.

When this study began, there was no HV implementation plan [1.1] (Department of Health 2011). HVs were under pressure to keep the service going at a universal level and worked at either end of a spectrum of need. They visited families where a baby had just been born and they most
often continued to visit those families in greatest need. They were working at, what now would be
designated, the universal and the universal partnership plus service levels [1.1].

This study identified two levels of different skills and qualities needed both at a first visit and
during established relationships. In Chapter four [Figure 4-1] a model of HV working relationships
was presented as a generic way of looking at parent/HV interactions. However, the service does
not require use of all of the relational skills and processes all of the time. A therapeutic
relationship where HVs work with parents to address particular difficulties may only be necessary
at the ‘universal plus’ and ‘universal partnership plus’ levels of service (Department of Health
2011). At a universal level the HV needs to be able to engage the parent and establish herself as
someone reliable and trustworthy so, that should there be a need, the parent would feel happy to
contact him or her. The qualities, skills and processes involved in this are outlined from the
qualitative data of this study in Table 8-1. Clearly the complexity of the qualities, skills and
processes that are involved in ‘building a relationship’ with parents can no longer be argued as
‘non-work’ (Elkan et al. 2000b). A valid and reliable tool now exists to measure this relationship
established at a first meeting [Appendices 28 & 29].
There are further qualities and skills that can be identified from the data that were applicable to a universal partnership or universal partnership plus level of service. These are identified in Table 8-2 and can be measured with the established relationship questionnaires [Appendices 30 & 31].

<table>
<thead>
<tr>
<th>HV qualities, skills</th>
<th>Parent qualities and skills</th>
<th>Health visiting process</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge and experience</td>
<td>Friendliness</td>
<td>Introductions</td>
<td>Enables the identification of family risk and resilience factors,</td>
</tr>
<tr>
<td>Friendliness</td>
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<td>encourages access by the family to the universal healthy child programme and</td>
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<tr>
<td>Active listening</td>
<td>Open Questions</td>
<td>Eliciting parental expectations</td>
<td></td>
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<tr>
<td>Silence</td>
<td>Encouragement</td>
<td>Ensuring clarity of roles</td>
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<td>Encouragement</td>
<td>Following parental lead</td>
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<td>Giving parent time</td>
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<tr>
<td>Observation skills</td>
<td>Interest</td>
<td>Explaining boundaries of confidentiality</td>
<td>Encourages parenting self-confidence</td>
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<td></td>
<td>Exploration of health needs</td>
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<tr>
<td>Relating to the baby/child</td>
<td></td>
<td>Clarification and understanding</td>
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<tr>
<td>Availability &amp; approachability</td>
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<tr>
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Universal Health Visiting Service

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</tbody>
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There are further qualities and skills that can be identified from the data that were applicable to a universal partnership or universal partnership plus level of service. These are identified in Table 8-2 and can be measured with the established relationship questionnaires [Appendices 30 & 31].
The organisational issues that influenced the ability of HVs and parents to establish relationships were captured during the qualitative phase of the study and were thought to be important to include as a contextual variable. HVs and parents agreed that continuity of care was crucial to the development of their relationships. For HVs there were more factors than for parents, which affected this. HVs found themselves with difficulties around record keeping, caseload size, skill mix, unsupportive management and interagency working as well as the very busy clinics. Parents on the other hand found themselves visited at home by a number of different HVs and did not know the HV in the child health clinic. They wanted a familiar face who would remember them.
These factors are captured in the measures for the organisational factors affecting parent/HV relationships [Appendix 32 & 33].

In this study the discipline of developing the indicators for the instruments meant that greater clarity about the health visiting process was required than in earlier studies. The outcome was that not only were the relational qualities and skills of parents and HVs described and a model of the health visiting process produced, but this resulted in a valid way of measuring these working relationships. The profession now has a way of answering the question, once and for all, whether health visiting is best served through a relationship or problem orientated approach to practice or if both approaches are necessary. In this study, the problem-orientated approach was observed but it was based on an existing relationship between the HV and parent. It is hoped that the instruments developed here will continue to be used within ongoing health visiting research to link the vital processes of parent/HV relationships with health visiting outcomes. This would replicate the processes within psychotherapy research, where the development of tools to assess the therapist/client relationship led to a number of research studies demonstrating the effectiveness of the relationship in positive outcomes for the client (Lambert & Barley 2002).

8.5 Limitations of the Study

8.5.1 Qualitative data
There were some difficulties in recruiting parents and health visitors to this part of the study, initially. This may have been due to the use of the stimulated recall method and some reluctance to be videotaped during the interaction. Although the quality of the data accessed through this method was very rich, the one parent who did not agree to viewing the video as part of her interview post her interaction with the HV also produced very rich and enlightening data. Were the study to be repeated, possibly a semi-structured interview approach to collecting this data would be sufficient and would incur less difficulties in recruitment of participants. It was noticeably easier to recruit both parent and HVs to the pilot studies of the questionnaires where no videotaping was involved.

8.5.2 Questionnaire Design
As already discussed (7.5.7) a multi-modal response using a ‘sometimes’ reply instead of the dichotomous responses ‘yes, I agree’ or ‘no, I disagree’ may have increased the veracity of the results of the pilot. However, the dichotomous questionnaire provided focus and clarity, and
neither parents nor HVs raised concerns about their dichotomous nature when answering the questionnaires, which they found were quick and easy to complete. This was considered crucial as questionnaire completion took place following, on average, an hour’s interaction. Small children and babies requiring attention were also present so it was important that the questionnaires were easily understood and did not take long to complete. However, creating the statements for the dichotomous questionnaire is difficult, as noted by Polit and Beck (2008) and there may be some room for and adjustment to the wording of some statements.

8.6 Recommendations for future Research

As noted previously validation of instruments is an ongoing journey. It has begun here with development within an inner city diverse, urban environment, but now these instruments need to be used in other parts of the UK, with parents and HVs working in other types of communities. It is recommended that further research be carried out in order to build the validity of the instruments as well as demonstrate the effectiveness or not in health visiting of the parent/HV working relationship. Studies may include:

- Those that are researching health visiting outcomes to demonstrate the possible impact of the parent/HV working relationship on outcomes.
- The impact of organisations on the abilities of parents and HVs to establish and maintain their relationships.
- The impact of HV professional experience or training on his/her ability to forge relationships with families.
- The impact of parental family structure, complexity of problems, maternal age, education, and social class might also be examined in connection with their ability to engage with the HV.
- Research into complex families and their ongoing relationships with HVs using the questionnaires to give a case sample of one.
- Mixed methods research studies where a quantitative exploration of the parent/HV relationship could sit alongside a qualitative examination of parent/HV relationships.
- Development of an instrument [TELER component indicator] to measure ongoing parent/HV relationships.
When some or all of these studies are completed no longer will it be true to say that the process of health visiting cannot be linked to outcomes (Elkan et al. 2000a). The means of doing so have now been created. It is for researchers of the future to take up the challenge of using the tools developed in this study to extend further the evidence-base for health visiting practice.

The TELER method allows a holistic approach to be taken to measurement. Perhaps from this study it may be best described as a qualitative approach to the scientific quantification of an abstract phenomenon. Indicators of the parent/HV relationship have been identified but it is acknowledged that they are purely ‘indicators’ of the relationship and that the relationship itself is more than these. Measurement necessarily entails a reductionist approach to the qualitative data but the focus that the parent/HV relationship was more than the sum of its constituent parts was never lost. Group data were obtained but sight of the individual differences was not obscured. This makes the measures particularly suitable for use in the health visiting context where holism is valued in research and practice.


Cornwell J. (2009) See the person in the health professional; how looking after staff benefits patients. *Nursing Times* 105(48), 10-12.


Cowley S. (1995) In health visiting, a routine visit is one that has passed. *Journal of Advanced Nursing* 22, 276-284.


Cowley S. (1995) In health visiting, a routine visit is one that has passed. *Journal of Advanced Nursing* 22, 276-284.


Unite/CPHVA. (2009) What size caseload should a health visitor have? CPHVA. London


Watson J. (1985) Nursing human science and human care Appleton-century, Norwalk, CT.


Appendices

1. Information for Participants [Parents] 17.11.06. Version 2

Title of Study: Developing and validating a tool to measure the parent helper relationship.

You are being invited by your health visitor to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

Ask your health visitor or researcher if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

In some jobs, like health visiting, the relationship between the worker and parents seems very important, and we need to look at how that works out in practice. That is why we are asking if you would take part in the study, so that we can research how your health visitor works with you. We are hoping to work with up to 60 parents in this way so should you decide to take part you will not be alone.

Do I have to take part? No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen to me if I take part? If you decide to take part a researcher will visit you with your health visitor. The researcher will video-record the meeting that you have with the health visitor. Following the visit you will either then view the recording at home and or at a later date at the clinic with the researcher and health visitor to talk about what happened during the time you were talking together. The video-tape will help you remember what happened. The researcher will record this interview on an audio-tape. This information will be used to help us find out what was important about the relationship for you and your health visitor. The researcher may visit with your health visitor on subsequent occasions and repeat the process as your relationship with her develops. The visit should take no longer than an hour but about an hour and a half should be allowed for the review of the meeting.

Will my taking part in the study be kept confidential? Video and audio recordings will be stored for two years on a password protected secure web space at King's College, London and only made available to the research team. All information, which is collected, about you will be kept strictly confidential. Your name will not be used in any research reports so that you will not be recognised.

What will happen if I don’t want to carry on with the study? Should you decide to withdraw at any time then the recordings will be destroyed and your care will not be affected in any way.

Complaints

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions [Tel. No]. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained from the [named NHS Foundation Trust].

Who is organising and funding the research? The funding for this study comes from the [Charitable NHS Trust].

Who has reviewed the study? The study has been reviewed and given approval by the Local Research Ethics Committee. The local Primary Care Trust Research and Development group have also given their permission for this research.

Thank you for taking the time to read this sheet and for considering taking part in this research. If you require further information do not hesitate to contact me [researcher name] on [tel. no.]
2. Parent Consent Form

Centre Number:
Study Number:
Participant Identification Number for this trial:

**Title of Project:** Developing and validating a tool to measure parent-helper relationships

Name of Researcher:

1. I confirm that I have read and understand the information sheet dated 17.11.06. [version 2] for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my care or legal rights being affected.

3. I understand that data collected during the study will be viewed by the research team only. I give permission for these individuals to see or hear this data.

4. I agree to the interview with my health visitor being video-recorded.

5. I agree to my interview with the researcher being audio-recorded.

6. I agree to take part in the above study.

_______________________  ______________________  ______________________
Name of Participant Date Signature

_______________________  ______________________
Name of Person taking consent Date Signature
[if different from researcher]

_______________________  ______________________
Researcher Date Signature

When completed, 1 for parent; 1 for researcher site file
3. Ethical Approval

19 December 2006

Mrs Christine Bidmead
Training Facilitator
South London & Maudsley NHS Trust
Centre for Parent and Child Support
Munro Centre
66, Snowfields
London
SE1 3SS

Dear Mrs Bidmead

Full title of study: Developing methods for investigating the processes of promoting child mental health. Research Question: How can we measure the relationship that is developed between parents and helpers?

REC reference number: 06/Q0705/45

Thank you for your letter of 22 November 2006, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information was considered at the meeting of the Committee held on 14 December 2006. A list of the members who were present at the meeting is attached.

Confirmation of ethical opinion
On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites
The Committee has designated this study as exempt from site-specific assessment [SSA]. There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval
The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents
The final list of documents reviewed and approved by the Committee is as follows:
Research governance approval
You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Statement of compliance
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees [July 2001] and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Please quote this number on all correspondence

With the Committee’s best wishes for the success of this project
Yours sincerely

Ms Carol Jones

REC Chair
4. Stimulated Recall – a protocol for interviews

- Following completion of the interaction stop the video – tape and rewind. Check if the parent or health visitor is comfortable and can see the screen OK.

- Say: ‘OK now we are going to look at what happened in the meeting. I am interested in what you thought about the relationship that you have developed with ----. I’ like to go through with you what you were thinking during the meeting.

- As we watch the tape I want you to try to remember what you were thinking then about your relationship with each other. I want to know what you were thinking then not what you think now’.

- Put the remote near to the participant and show them where the pause button is.

- Say: ‘I want you to stop the video whenever you remember what you were thinking. I’l also stop the tape from time to tame and ask you to think back and tell me what was going on in your mind’.

- Get the participant to try using the pause button.

- They can stop it as often as they want.

- You do not have to take turns.

- When the tape is paused you might ask:

  - ‘What were you thinking then?’

  - ‘Do you remember anything else about what you were thinking at that moment?’

  - ‘I see you were laughing/looked confused/saying something, what were you thinking then?’

  - ‘When she did that what did you think?’

  - ‘Can you tell me what you thought when she said that?’

  - ‘What does she do that tells you she understands you?

  - ‘What does she do that tells you she is listening to you?'
5. Health Visitor Discussion Group Plan

Date: 15th July 2009
Time: 12 -1.30pm
Place:
Number: 7

Purpose and Outcome

To present findings of health visitor interview data analysis and seek any participant disagreement/agreement
To identify gaps in data. [Possibly asking about negative experiences of contact with health visitors]
To identify possible indicators for TELER tool e.g. Health visitors identify that the parent needs to show them respect. How do you [health visitors] know that the parent respects you? [Trying to get at observable phenomena]

Methods

Room set up – Arrive an hour before group to begins. Set up table for health visitors to sit around.

Test out adequacy of recording equipment.
Ensure refreshments available.

Greeting and Welcome [10 mins.]

As health visitors arrive greet and introduce self and thank them for coming. Offer drink. Help make them feel at ease without talking about the project.

When all present and seated introduce yourself more fully and briefly introduce the project and findings of the data so far.

Explain what you want to do at this group i.e.
Listen to the findings so far and identify anything with which they agree or disagree;
identify any gaps in the data so far obtained
To find some observable features of health visitor client relationships that may contribute to the development of a tool to measure the relationship.

Explain that you will ask questions but are happy for interaction between participants not just through myself as the facilitator.

Explain that the discussion is being audio recorded and will later be transcribed and analysed. All data will be anonymised. Ask them to complete consent forms for this.

Switch on audio recorder.

Introductions [10 mins.]

Ask each health visitor to introduce themselves and to say how long they have been qualified as a health visitor and how long they have held their particular caseload.

As each health visitor introduces themselves, researcher will note down the name and place at the table on a plan of the room drawn up before the meeting begins. [This will help to identify participants when transcribing the recording]

Question 1. Organisational Issues [10mins.]

From the interview data that I have gathered so far I have heard from parents and health visitors how important continuity of care is to the development of working relationships. How does the way in which health visiting services are organised impact on your relationships with clients?

Question 2. Client Qualities and Skills [10 mins.]
The easiest and most comfortable relationships that health visitors have are with clients who themselves have a certain level of qualities and skills. Tell me about relationships that are not so easy. What are the clients like?

**Question 3. Health visitor qualities [15 mins.]**

When client relationships are more problematic what particular qualities do you have to show?

How do you build trust with these clients?

How do you show them respect?

**Question 4. Health visitor skills [5 mins.]**

Exploring a clients needs is an important part of the process of health visiting. How do you do this sensitively?

**Question 5. Health visitor client relationship [10 mins.]**

Is the health visitor client relationship different from other relationships that parents have with other health professionals and if so how is it different?

**Question 6. Helping Process [10 mins.]**

Building a good relationship with parents is key to helping to resolve any problems that might arise. The data showed that the ability of health visitors to put parents at ease was a very important part of this.

What do you do to put parents at ease?

Do parents try to put you at ease? If so what do they do?

**Question 7. Outcomes [10 mins]**

What do you hope will be the outcome of your relationships with parents? What do you want for them?

How do you know when you have achieved this?

Thank everyone for coming and for their valuable contributions.
6. Parent Discussion Group Plan

Proposed Dated: 10.07.09
Place:.
Time: 11 am – 12.30 pm

Number: 8 participants recruited. 3 attended.

Purpose and Outcome

- To present findings of parent interview data analysis and seek agreement/disagreement.
- To identify gaps in data. [Possibly asking about negative experiences of contact with health visitors]
- To identify possible indicators for TELER tool e.g. Parents identify the health visitor needs to show them respect. How do you [parents] know that the health visitor respects you? [Trying to get at observable phenomena]

Methods

Room set up – Arrive an hour before group to begin so at 10.00 am. Set up table for parents to sit around. [I don't like tables in group as it tends to create barriers but it seems the easiest way as there may be babies or young children present and tables are an easy place to put microphones.]

Test out adequacy of recording equipment.
Ensure refreshments available.

Greeting and Welcome [10 mins.] 11.00 – 11.10

As parents arrive greet and introduce self and thank them for coming. Offer drink. Help make them feel at ease without talking about the project.

When all present and seated introduce yourself more fully and briefly introduce the project and findings of the data so far.

- Explain what you want to do at this group i.e. identify any gaps in the data so far obtained and to find some observable features of health visitor client relationships that may contribute to the development of a tool to measure the relationship.
- Explain that you will ask questions but are happy for interaction between participants not just through myself as the facilitator.
- Explain that the discussion is being audio recorded and will later be transcribed and analysed. All data will be anonymised. Ask them to complete consent forms for this.

- Switch on audio recorder.

Introductions [10 mins.] 11.10 – 11.20

- Ask each parent to introduce themselves and to say how long they have known their health visitor.

As each parent introduces themselves, researcher will note down the name and place at the table on a plan of the room drawn up before the meeting begins. [This will help to identify participants when transcribing the recording]

Question 1. Organisational Issues [10 mins.] 11.20 – 11.30

[a] Home Visiting was identified by parents as important in building the relationship with health visitors. What is it about home visiting that makes this so? Why is it different from a clinic contact for example?
Continuity of Care was also identified by parents as being important to the building of a relationship with a health visitor. It seems that seeing the same person on different occasions benefits the relationship. What is happening in the community at present?

Question 2. Client Qualities and Skills [10 mins.] 11.30 – 11.45

[a] You bring certain qualities and skills to your relationship with your health visitor. What is it about how you are that helps to make the relationship work? What do you do?

[b] Are there times when you felt you could not be yourself? Can you give an example?

Question 3. Health visitor qualities [15 mins.] 11.45 – 11.50

Health visitors bring their personal qualities to the relationship such as their respect for you, their knowledge and experience and understanding.

[a] How do you know when a health visitor respects you? What do they do that demonstrates that respect? [It may help to think of a situation in which you did not feel respected]

[b] How do you know when a health visitor understands your situation? [It may help to think of a situation when you did not feel understood]

[c] How do health visitors build trust into their relationships with you? What they do so that you trust/mistrust them?

Question 4. Health visitor skills [5 mins.] 11.50 – 12.00

Parents said that the ability of the health visitor to listen was very important.

[a] How do you know the health visitor is listening to you? What do they do that demonstrates that they are listening?

Question 5. Health visitor client relationship [10 mins.] 12.00 – 12.10pm

[a] How is the parent/health visitor relationship different from other relationships that you have for example with your friends, family, other health professionals e.g. GP.?


Building a good relationship with parents is key to helping you with any problems that might arise. The data showed that the ability of health visitors to put parents at ease was a very important part of this.

[a] How do health visitors put parents at ease and make them feel comfortable? What do they do?

Question 7. Outcomes [10 mins.] 12.20- 12.30pm

[a] What do you hope will be the outcome of your relationships with health visitors? What do you expect to gain?

Thank everyone for coming and for their valuable contributions.
### 7. Participants in Qualitative Study

<table>
<thead>
<tr>
<th>Participant</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>HV1</td>
<td>HV with over 20 years experience. HV family partnership trained. Eventually retired but returned part-time.</td>
<td>HV took care of baby whilst interview took place.</td>
</tr>
<tr>
<td>P1</td>
<td>First time mother with 3 week old breast feeding baby who wants to feed constantly.</td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Breast Feeding Cafe</td>
<td></td>
</tr>
<tr>
<td>Researcher notes</td>
<td>Articulate, professional woman very able to speak about her relationship with HV. Challenging to video and audio record in a situation where other mothers and babies were present. Used remote microphone between participants.</td>
<td></td>
</tr>
<tr>
<td>HV2</td>
<td>HV with 15 years experience. Family partnership trained. Left a few months later and joined the Family Nurse Partnership team.</td>
<td></td>
</tr>
<tr>
<td>P2</td>
<td>Breast feeding first time older mother. Has had mastitis. Baby present during interview.</td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Home visit</td>
<td></td>
</tr>
<tr>
<td>Researcher notes</td>
<td>Articulate mother, former TV producer. Easier to video in home than clinic. No sound problems.</td>
<td>Mother recruited HV to study. I met mother at breast feeding café and explained research to her and she gave me details of her HV with whom she felt she had a good relationship.</td>
</tr>
<tr>
<td>HV3</td>
<td>HV with over 20 years experience. Family partnership trained. Practice teacher soon to retire.</td>
<td></td>
</tr>
<tr>
<td>P3</td>
<td>First time Irish mother married to an older man attending appointment with HV for 8 month developmental review. Baby has history of eczema. Baby present at interview.</td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Clinic room</td>
<td></td>
</tr>
<tr>
<td>Researcher notes</td>
<td>Interaction took place in clinic room but no other people were present so no problems.</td>
<td></td>
</tr>
<tr>
<td>HV4</td>
<td>HV qualified 6 months. Not family partnership trained. Experienced former paediatric nurse.</td>
<td></td>
</tr>
<tr>
<td>P4</td>
<td>Second time mother living in council block flat. Baby 6 weeks old [mixed race]. Follow up visit from new birth. Mother has previous history of post-natal depression. HV does Edinburgh post natal depression score. Feeding and weaning advice sought and given. Baby present at interview.</td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Home visit</td>
<td></td>
</tr>
<tr>
<td>Researcher notes</td>
<td>Needed to keep interview short as mother needed to collect her older son [9 years] from primary school. HV was able to talk about relationship but more in terms of her knowledge base than the relational qualities and skills</td>
<td></td>
</tr>
<tr>
<td>HV5</td>
<td>HV with over 20 years experience</td>
<td>Family Partnership trained. Due to retire</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>P5</td>
<td>27 year old Lithuanian, first time, mother with 13 month old baby boy. Mother has post-natal depression and some difficulties with her partner relationship. HV does listening visit.</td>
<td>Baby present at interview. Interested in equipment.</td>
</tr>
<tr>
<td>Location</td>
<td>Home visit</td>
<td></td>
</tr>
<tr>
<td>Researcher notes</td>
<td>Mother shy at first and not sure that she wanted to be videoed. However, she agreed when reassured about confidentiality. When interviewed did not want to see herself on the video. She was happy to be interviewed without the reminder of the video. English was not her first language but managed to express herself well with regard to her relationship with HV.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HV6</th>
<th>HV 2 years trained</th>
<th>Not Family Partnership trained. An experienced paediatric nurse who had, prior to HV training, worked on local neonatal intensive care unit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>P6</td>
<td>Mixed race mother [European/Caribbean] attending the clinic her daughter’s 2.5 year developmental review with HV. Pre-term birth with respiratory problems. Mother also has health problems</td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Clinic room</td>
<td></td>
</tr>
<tr>
<td>Researcher notes</td>
<td>Very articulate mother happy to talk about her relationship with HV. Mother an artist who had decorated her local Sure Start walls with murals. HV not confident about how involved she becomes in relationships with parents.</td>
<td>Child present at interview but played quietly.</td>
</tr>
</tbody>
</table>
Health Visitor/Parent Relationship Quiz

First Visit

[Parent version]

In health visiting, the relationship between the health visitor and the parent seems very important, and we need to look at how that works out in practice. Completing the questionnaire below will help us understand more about that relationship. Thank you for your time.

Name: .................................................................

Address: ....................................................................

..............................................................................

..............................................................................

Tel. No. .................................................................

Age:  Under 20 yrs □
       21- 28 yrs □
       29- 35 yrs □
       36- 45 yrs □
       Over 45 yrs □

Area Number [   ]
Parent Research Number [   ]
HV Research Number [   ]
9. Response Profile from Parents indicating HV barriers to relationship

<table>
<thead>
<tr>
<th>Code</th>
<th>Number of HV Barriers to the relationship with parent</th>
<th>Number of parents</th>
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<td>0 4 0 1 0 0 1 1 0 1 2 0 0</td>
</tr>
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<td>A 2.1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>A 1.2.1</td>
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<tr>
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</tr>
<tr>
<td>A 1.6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>A 2.6</td>
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<td>1</td>
</tr>
<tr>
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<td>0</td>
</tr>
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<td>1 1</td>
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</tr>
<tr>
<td>A 1.3.7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>A 2.3.7</td>
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<td>0</td>
</tr>
<tr>
<td>A 2.9</td>
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<td>1</td>
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<tr>
<td>B 1.1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>B 2.2</td>
<td>1 1</td>
<td>2</td>
</tr>
<tr>
<td>Number of Parents</td>
<td>0 4 0 1 0 0 1 1 0 1 2 0 0</td>
<td>1 1 0 1 0 1 2 0 0</td>
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</table>
10. Response profile from HV data indicating parent relationship barriers

<table>
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<tr>
<th>Code</th>
<th>Number of Parent Relationship Barriers</th>
<th>Number of barriers</th>
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<td>2</td>
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<td>A 1.2.1</td>
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<td></td>
</tr>
<tr>
<td>A 1.4</td>
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<td>A 2.9</td>
<td></td>
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<td>B 1.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B 2.2</td>
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Number of HVs: 0 1 2 6 0 0 1 0 2 0 1
11. Allocation of TELER codes showing parental relationship barriers [HV data]

<table>
<thead>
<tr>
<th>HV number</th>
<th>Number of effects</th>
<th>Code</th>
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<tbody>
<tr>
<td>1</td>
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</tr>
<tr>
<td>13</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
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</tr>
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</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Parent barriers</th>
<th>HVs</th>
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<tbody>
<tr>
<td>1**</td>
<td>Severe</td>
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</tr>
<tr>
<td>2*</td>
<td>Moderate</td>
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</tr>
<tr>
<td>3</td>
<td>Indeterminate</td>
<td>0</td>
</tr>
<tr>
<td>4*</td>
<td>Slight</td>
<td>4</td>
</tr>
<tr>
<td>5**</td>
<td>None</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td></td>
</tr>
</tbody>
</table>

** p = 0.0059  * 0.0059 < p = 0.1134
12. \( \chi^2 \) test for HV data - First Visit Pilot Questionnaire

<table>
<thead>
<tr>
<th>Code</th>
<th>HVs</th>
<th>O</th>
<th>p</th>
<th>( E = p \times T )</th>
<th>( C = (O - E)^2 \div E )</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0.1134</td>
<td>1.47</td>
<td>1.47</td>
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<tr>
<td>2</td>
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<td>0.7732</td>
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<tr>
<td>3</td>
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<td>4</td>
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<td>5</td>
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<td></td>
<td></td>
<td></td>
<td>101.96</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>13</td>
<td>1.0000</td>
<td>12.99</td>
<td>101.96</td>
</tr>
</tbody>
</table>

**Null hypothesis:** The combined affect of the parent barriers reported by HVs is not a relationship problem.

**Alternate hypothesis:** The combined affect of the parent barriers reported by HVs is a relationship problem.

Result: \( \sum C > 5.991 \) Reject null hypothesis and accept alternate hypothesis. The result is statistically significant \([p = 0.05]\). Parent barriers have *no or a slight* affect on HV’s relationships with parents when the code with the largest number of parents is Codes 4 or 5.
13. t-test for items on HV First Visit Pilot Questionnaire

Table 1.5

<table>
<thead>
<tr>
<th>Table of t-values</th>
</tr>
</thead>
<tbody>
<tr>
<td>HVS</td>
</tr>
<tr>
<td>t</td>
</tr>
<tr>
<td>HVS</td>
</tr>
<tr>
<td>t</td>
</tr>
</tbody>
</table>

T = 13  \sqrt{T} = 3.60  t = 2.18  0.5 \times t = 1.09  L = (0.5 \times t) \times \sqrt{T} = 3.92

Statistical significance of the number of HVSs who reported an item as a parent barrier to the relationship

<table>
<thead>
<tr>
<th>Parent barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>HVS</td>
</tr>
<tr>
<td>Problem</td>
</tr>
</tbody>
</table>

Null hypothesis: N = The parent effect is not a problem at the 0.05 level of significance.

Alternate hypothesis: Y = The parent effect is a problem at the 0.05 level of significance.

14. Allocation of TELER codes to Parent data – First Visit Questionnaire

<table>
<thead>
<tr>
<th>HV barriers to relationship with parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>1**</td>
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<td>2*</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4*</td>
</tr>
<tr>
<td>5**</td>
</tr>
</tbody>
</table>

Total 13

**p = 0.0112  *0.0112 < p 0.1333
15. $\chi^2$ test for Parent data – First Visit Pilot Questionnaire

<table>
<thead>
<tr>
<th>Code</th>
<th>Parents</th>
<th>O</th>
<th>P</th>
<th>E = p x T</th>
<th>C = (O - E)^2 ÷ E</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1.73</td>
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<td>0.1333</td>
<td>1.73</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>12</td>
<td>13</td>
<td>1.0000</td>
<td>12.99</td>
<td>84.68</td>
</tr>
</tbody>
</table>

$\sum C > 5.991$ therefore the combined effect of the HV barriers reported by parents is a relationship problem. (p=0.05) However these are either no or slight effects [see table 0.6.7 above].

16. t-test for items on Parent First Visit Questionnaire

<table>
<thead>
<tr>
<th>Table of t-values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents</td>
</tr>
<tr>
<td>T</td>
</tr>
<tr>
<td>Parents</td>
</tr>
<tr>
<td>T</td>
</tr>
</tbody>
</table>

$T=13 \sqrt{T}=3.60$ $t=2.18$ $0.5 \times t = 1.09$ $L= [0.5 \times t] \times \sqrt{T} = 3.92$

Statistical significance of the number of parents who reported an item as a HV barrier to the relationship

<table>
<thead>
<tr>
<th>HV Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>Parents</td>
</tr>
<tr>
<td>Problem</td>
</tr>
</tbody>
</table>

Result: N = the barrier is not a relationship problem at the 0.05 level of significance

Y = The barrier is a relationship problem at the 0.05 level of significance
17. $\chi^2$ test of association between HV & Parent data – First Visit Pilot Questionnaire.

<table>
<thead>
<tr>
<th>Code</th>
<th>OH</th>
<th>pH</th>
<th>$EH = pH \times \Sigma OH$</th>
<th>OP</th>
<th>$pP$</th>
<th>$EP = pP \times \Sigma OP$</th>
<th>O</th>
<th>E</th>
<th>$C = \frac{(O - E)^2}{E}$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.1134</td>
<td>1.47</td>
<td>0</td>
<td>0.1333</td>
<td>1.73</td>
<td>0</td>
<td>3.20</td>
<td>3.20</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>0.7732</td>
<td>10.05</td>
<td>0</td>
<td>0.7334</td>
<td>9.53</td>
<td>0</td>
<td>19.58</td>
<td>19.58</td>
</tr>
<tr>
<td>3</td>
<td>13</td>
<td>0.1134</td>
<td>1.47</td>
<td>13</td>
<td>0.1333</td>
<td>1.73</td>
<td>26</td>
<td>3.20</td>
<td>162.45</td>
</tr>
<tr>
<td>5</td>
<td>13</td>
<td>1.0000</td>
<td>12.99</td>
<td>13</td>
<td>1.0000</td>
<td>12.99</td>
<td>26</td>
<td>25.98</td>
<td>185.23</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>1.0000</td>
<td>12.99</td>
<td>13</td>
<td>1.0000</td>
<td>12.99</td>
<td>26</td>
<td>25.98</td>
<td>185.23</td>
</tr>
</tbody>
</table>

Null hypothesis: the combined effect of the HV and parent barriers reported by HVs and parents is not statistically significant at the 0.05 level of significance and are therefore not associated.

Alternate hypothesis: the combined effect of the HV and parent barriers reported by HVs and parents is statistically significant at the 0.05 level of significance and are therefore associated.

Result: $\sum C > 5.991$ this confirms the alternate hypothesis but HV and Parent codes are on codes 4 and 5 which suggests that they agree that there are no problems.
18. $\chi^2$ test on HV data indicating Parent relationship barriers [First Visit Questionnaire]

<table>
<thead>
<tr>
<th>Code</th>
<th>HVs</th>
<th>O</th>
<th>P</th>
<th>E = p x T</th>
<th>C = $[O - E]^2 \div E$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0.1719</td>
<td>4.30</td>
<td>4.30</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0.6562</td>
<td>16.41</td>
<td>16.41</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0.1719</td>
<td>4.30</td>
<td>99.65</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>25</td>
<td>0.6562</td>
<td>16.41</td>
<td>16.41</td>
</tr>
<tr>
<td>5</td>
<td>22</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>25</td>
<td>1.0000</td>
<td>25.01</td>
<td>120.36</td>
</tr>
</tbody>
</table>

$\chi^2 = 5.991, \ 2 \ \text{df}, \ p \leq 0.05$

19. $t$-test on items in HV First Visit Questionnaire

$T = 25 \ \sqrt{T} = 5 \ \ t = 2.06 \ [df = 24] \ 0.5 \times t = 1.03 \ \ L = [0.5 \times t] \times \sqrt{T} = 5.15$

Statistical significance of the number of HVs who reported a parent barrier [N = no, Y = yes]

<table>
<thead>
<tr>
<th>Parent Barrier</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>HVs</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Significant</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>
20. $\chi^2$ test for parent data indicating relationship barriers [First Visit Questionnaire]

<table>
<thead>
<tr>
<th>Code</th>
<th>Parents</th>
<th>O</th>
<th>P</th>
<th>E = p x T</th>
<th>C = $[O - E]^2 / E$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0.1134</td>
<td>2.84</td>
<td>2.84</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0.7732</td>
<td>19.33</td>
<td>19.33</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>25</td>
<td>0.1134</td>
<td>2.84</td>
<td>172.91</td>
</tr>
<tr>
<td>5</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>25</td>
<td>1.0000</td>
<td>25.01</td>
<td>195.08</td>
</tr>
</tbody>
</table>

$\chi^2 = 5.991, 2 df, p \leq 0.05$

21. $\chi^2$ test of association between HV & Parent data [First Visit Questionnaire]

<table>
<thead>
<tr>
<th>Code</th>
<th>OH</th>
<th>pH</th>
<th>EH = pH x $\Sigma$OH</th>
<th>O</th>
<th>P</th>
<th>EP = pP x $\Sigma$OP</th>
<th>O</th>
<th>E</th>
<th>C = $[O - E]^2 / E$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.1719</td>
<td>4.30</td>
<td>0</td>
<td>0.1134</td>
<td>2.84</td>
<td>0</td>
<td>7.14</td>
<td>7.14</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>0.6562</td>
<td>16.41</td>
<td>0</td>
<td>0.7732</td>
<td>19.33</td>
<td>0</td>
<td>35.74</td>
<td>35.74</td>
</tr>
<tr>
<td>4</td>
<td>25</td>
<td>0.1719</td>
<td>4.30</td>
<td>25</td>
<td>0.1134</td>
<td>2.84</td>
<td>50</td>
<td>7.14</td>
<td>257.28</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>1.0000</td>
<td>25.01</td>
<td>25</td>
<td>1.0000</td>
<td>25.01</td>
<td>50</td>
<td>50.02</td>
<td>300.16</td>
</tr>
</tbody>
</table>

$\chi^2 = 5.991, 2 df, p \leq 0.05$
22. Clinical Indicator $\chi^2$ analysis of HV Established Relationship Questionnaire.

<table>
<thead>
<tr>
<th>Code</th>
<th>HVs</th>
<th>O</th>
<th>P</th>
<th>$E = p \times T$</th>
<th>$C = [O - E]^2 \div E$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0.0327</td>
<td>0.92</td>
<td>0.92</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>4</td>
<td>0.4673</td>
<td>13.08</td>
<td>6.30</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>3</td>
<td>0.3867</td>
<td>10.83</td>
<td>5.66</td>
</tr>
<tr>
<td>4</td>
<td>7</td>
<td>7</td>
<td>0.1074</td>
<td>3.01</td>
<td>5.29</td>
</tr>
<tr>
<td>5</td>
<td>14</td>
<td>14</td>
<td>0.0059</td>
<td>0.17</td>
<td>1,125.11</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>28</td>
<td>1.0000</td>
<td>28.01</td>
<td>1,143.28</td>
</tr>
</tbody>
</table>

$\chi^2 = 9.488, 4 df, p \leq 0.05$. $\sum C$ has one component larger than the value showing statistical significance. This implies it is a statistical artefact produced by an $E$ value less than 5, and shows statistical significance where it does not exist. However, the value of the component results from the high concentration of HVs on Code 5, and is not a statistical artefact. This can be checked by using the traditional method to calculate $C$ values. Now the $C$ value for code 5 is $[14 - 5.6]^2 \div 5.6 = 12.6$, and on its own shows statistical significance.

23. Clinical Indicator $\chi^2$ analysis of Parent Established Relationship Questionnaire

<table>
<thead>
<tr>
<th>Code</th>
<th>Parents</th>
<th>O</th>
<th>P</th>
<th>$E = p \times T$</th>
<th>$C = [O - E]^2 \div E$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0.0193</td>
<td>0.54</td>
<td>0.39</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0.3679</td>
<td>10.30</td>
<td>8.40</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>1</td>
<td>0.4190</td>
<td>11.73</td>
<td>9.82</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>2</td>
<td>0.1745</td>
<td>4.89</td>
<td>1.71</td>
</tr>
<tr>
<td>5</td>
<td>23</td>
<td>23</td>
<td>0.0193</td>
<td>0.54</td>
<td>934.17</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>28</td>
<td>0.9998</td>
<td>28.00</td>
<td>954.49</td>
</tr>
</tbody>
</table>

$\chi^2 = 9.488, 4 df, p \leq 0.05$. $\sum C$ has two components each larger than the value showing statistical significance. This implies they are statistical artefacts produced by an $O$ or $E$ values less than 5, and shows statistical significance where it does not exist. However, the values of the components result from the high concentration of parents on Code 5, and are not statistical artefacts. This can be checked by using the traditional method to calculate $C$ values. Now the $C$ value for code 5 is $[23 - 5.6]^2 \div 5.6 = 54.06$, and on its own shows statistical significance.
24. Clinical Indicator $\chi^2$ test of association HV & Parent [Established Relationship Questionnaire]

<table>
<thead>
<tr>
<th>Code</th>
<th>OH</th>
<th>pH</th>
<th>EH = pH x $\sum$OH</th>
<th>OP</th>
<th>pP</th>
<th>EP = pP x $\sum$OP</th>
<th>O</th>
<th>E</th>
<th>C = $[O - E]^2$ $\div$ E</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>0.0327</td>
<td>0.92</td>
<td>1</td>
<td>0.0193</td>
<td>0.54</td>
<td>1</td>
<td>1.46</td>
<td>0.14</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>0.4673</td>
<td>13.08</td>
<td>2</td>
<td>0.1746</td>
<td>4.89</td>
<td>6</td>
<td>17.97</td>
<td>7.97</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>0.3867</td>
<td>10.83</td>
<td>2</td>
<td>0.6123</td>
<td>17.14</td>
<td>5</td>
<td>27.97</td>
<td>18.86</td>
</tr>
<tr>
<td>4</td>
<td>7</td>
<td>0.1074</td>
<td>3.01</td>
<td>0</td>
<td>0.1746</td>
<td>4.89</td>
<td>7</td>
<td>7.90</td>
<td>0.10</td>
</tr>
<tr>
<td>5</td>
<td>14</td>
<td>0.0059</td>
<td>0.17</td>
<td>23</td>
<td>0.0193</td>
<td>0.54</td>
<td>37</td>
<td>0.71</td>
<td>1,854.88</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>1.0000</td>
<td>28.01</td>
<td>28</td>
<td>1.0001</td>
<td>28.00</td>
<td>56</td>
<td>56.01</td>
<td>1,881.95</td>
</tr>
</tbody>
</table>

$X^2 = 9.488$, 4 df, $p \leq 0.05$
25. Guidelines for the use of the First Visit Questionnaire.

- These questionnaires are designed to be used following a new birth or a removal into an area by a family.
- The questionnaires, one for the HV and one for the parent, are designed to be used together.
- At the end of the visit the parent should be asked to complete the questionnaire and put it into an envelope that the parent can seal. The HV similarly completes a questionnaire and this is put into an envelope and sealed. Each envelope and questionnaire should be marked so that they can be identified as belonging to the same relationship.
- The questionnaire can be used to explore the relationships of one HV with all the parents that are visited at a new birth or removal in using both HV and Parent questionnaire.
- Visits may benefit from observation of the interaction to ascertain contextual information about the relationship.
- The front sheet of the questionnaire should capture parental age and number of children. Other demographic information may be relevant such as parental education and employment.
- The TELER method should be adopted for analysis of the data.
- Anyone may use the questionnaires for the purpose for which they were intended but a TELER licence must be obtained for the TELER analysis of these questionnaires. Available from Rebecca Germaine at R.germaine@Longhanddata.com

26. Guidelines for the use of the Established Relationship Questionnaire

- These questionnaires are designed to be used with parents and HVs who have known each other for at least three months having had at least three contacts within that time. The parent should have had the opportunity to attend clinic during this time.
- Similar points to those mentioned above apply to the established relationship questionnaire.
27. Guidelines for the use of the Organisational Support for Parent/HV Relationships Questionnaire

- These questionnaires are designed to be used with parents and HVs who have known each other at least three months. The parent should have had the opportunity to attend clinic during this time.
- PCTs may wish to use the instruments to monitor their progress in respect of their support for the parent/HV relationship and use them with HVs and with parents on a regular basis.
- Researchers may use them to collect data to compare organisations’ support for parent/HV relationships.
- Again similar points should be observed to those mentioned for the first visit questionnaires.
## 28. First Visit Questionnaire [Parent Version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The health visitor introduced herself.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>At the end of the meeting I still had questions that I had not been able to ask the health visitor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>The health visitor complimented me on my baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The health visitor did not look at me when I was talking.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>The health visitor gave me time to talk about my situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>The role of the health visitor is unclear to me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>The advice/information the health visitor gave me made sense in my situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>I knew the health visitor did not understand me by the way she looked/spoke.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>The health visitor played with/examined my baby or explained why she did not.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>I was comfortable with the explanation the health visitor gave me as to why she would share my information with other people.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>My future contact with the health visitor is unclear.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### First Visit Questionnaire [HV Version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The parent took no interest when I spoke to and/or played with/examined her baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>The parent’s facial expression indicated that she was unhappy to see me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>The parent indicated by nodding, repeating it back or asking further questions, that she/he was interested in what I was saying.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The parent spoke in detail about her situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>The parent failed to ask questions and initiate topics for discussion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>The parent indicated by what she said that she is planning to do the best she can for her baby.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>The parent and I agreed a way forward for future contact.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>The parent welcomed me into her home (e.g. offered me refreshment, showed me where to sit).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>The parent indicated by what she said that the information/advice I gave her was irrelevant to her baby/situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>The parent indicated that she was comfortable with my explanation of the circumstances under which I would share her information with other services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Statement</td>
<td>Yes, I agree</td>
<td>No, I disagree</td>
</tr>
<tr>
<td>-----</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>---------------</td>
</tr>
<tr>
<td>1.</td>
<td>The health visitor’s responses indicated that she did not understand me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Decisions that I make for my baby/child/family/situation are not encouraged by the health visitor.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>When I saw the health visitor she remembered me and called me by my name.</td>
<td></td>
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</tr>
<tr>
<td>4.</td>
<td>The health visitor failed to do what she said she was going to do.</td>
<td></td>
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</tr>
<tr>
<td>5.</td>
<td>The health visitor gave me information/advice which was not relevant to my situation.</td>
<td></td>
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<tr>
<td>6.</td>
<td>I am able to make contact with the health visitor if I need to.</td>
<td></td>
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<tr>
<td>7.</td>
<td>The health visitor’s facial expression let me know that she understood me.</td>
<td></td>
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<tr>
<td>8.</td>
<td>When the health visitor visits me she is often late without letting me know.</td>
<td></td>
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<tr>
<td>9.</td>
<td>When I spoke to the health visitor she made eye contact that did not make me feel uncomfortable.</td>
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<tr>
<td>10.</td>
<td>When I met the health visitor she had forgotten details of my situation from the previous meeting.</td>
<td></td>
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<tr>
<td>11.</td>
<td>When we met, the health visitor gave me time to talk about my situation.</td>
<td></td>
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</tr>
<tr>
<td>12.</td>
<td>I see my health visitor at clinic.</td>
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<td></td>
</tr>
</tbody>
</table>
## 31. Established Relationship [HV Version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I could not remember the parent when she came to clinic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>In the last three months the records show that the parent needs constant advice from me and does not make her own choices/decisions.</td>
<td></td>
<td></td>
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<tr>
<td>3.</td>
<td>The parent is at home when I arrange a visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>The records show that the parent acts in a way that disregards information I have given her.</td>
<td></td>
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<tr>
<td>5.</td>
<td>The parent regularly seeks out information in the interests of her child/baby by asking me questions when we have contact.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>In the last three months the records show that the parent has acted positively in her child’s best interests.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>The records show that the parent contacts me if she has a problem.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>The parent said little about her/his situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>In the last three months the records show that the parent has not accessed or used other services e.g. children’s centre, GP, speech and language, hospital, CAMHS, social services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>I was able to comment to the parent on her growing confidence in the management of her situation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>The parent attends the clinic to see me regularly.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 32. Organisational Questionnaire [Parent Version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I have been visited at home by different health visitors.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>The health visitor writes the things we have discussed clearly in the red book.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>At clinic the health visitor has time for me if I need it.</td>
<td></td>
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<tr>
<td>4.</td>
<td>When I attend clinic I usually see the same health visitor each time.</td>
<td></td>
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<tr>
<td>5.</td>
<td>It is sometimes difficult to identify the health visitor amongst other team members.</td>
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</tr>
<tr>
<td>6.</td>
<td>At the clinic where I see my health visitor, I am able to meet and get support from other parents.</td>
<td></td>
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</tr>
<tr>
<td>7.</td>
<td>The health visitor I see at clinic is a stranger to me.</td>
<td></td>
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<tr>
<td>8.</td>
<td>At clinic I can ask the health visitor any questions that I have.</td>
<td></td>
<td></td>
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<tr>
<td>9.</td>
<td>At the clinic the health visitor rarely smiles at people or greets them by name.</td>
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</tr>
<tr>
<td>10.</td>
<td>I cannot see the health visitor when I want to within the clinic time.</td>
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</tr>
</tbody>
</table>
### 33. Organisational Questionnaire [HV Version]

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Yes, I agree</th>
<th>No, I disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>My workload is such that I cannot always carry out follow-up visits to clients who are in greater need.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>I lead a team who are able to help me meet the client’s identified needs.</td>
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<tr>
<td>3.</td>
<td>The HV team that I work with is small enough to get to know each other and meet together weekly.</td>
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<tr>
<td>4.</td>
<td>The time spent on record keeping does not reduce routine face-to-face contact with clients.</td>
<td></td>
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<tr>
<td>5.</td>
<td>Attending meetings interferes with my routine face-to-face contact with clients.</td>
<td></td>
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<tr>
<td>6.</td>
<td>Apart from child protection supervision, I do not receive helpful clinical supervision regularly.</td>
<td></td>
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</tr>
<tr>
<td>7.</td>
<td>Working in a skill mix team limits my ability to develop relationships with clients.</td>
<td></td>
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<tr>
<td>8.</td>
<td>The clients I visit at home I do not see in clinic.</td>
<td></td>
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<tr>
<td>9.</td>
<td>The ratio of children under five to health visitors meets CPHVA guidelines i.e.250 children in affluent areas or 100 children in deprived areas.</td>
<td></td>
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<tr>
<td>10.</td>
<td>I can use my professional judgement to decide which clients to see on a continuing basis.</td>
<td></td>
<td></td>
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<tr>
<td>11.</td>
<td>I do not have the authority to determine my working pattern according to client need.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>