Health visitor feedback on a structured, behavioural training for working with families of children with behaviour problems

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Abstract

Childhood behaviour problems are a growing concern and can be particularly challenging for parents and health visitors are ideally placed to provide support. The Enhancing Parenting Skills (EPaS) programme is a structured, home-based, behavioural intervention designed for parents of children reporting significant levels of behaviour problems. This study reports on health visitor feedback following training and implementation of the EPaS programme with families. Thirty-seven health visitors enrolled on the training and 29 delivered the intervention with a family. Health visitors reported varying levels of current use of behavioural techniques, such as parent-child observations and designing record sheets for parents, and confidence in using the techniques. Following training, significantly more health visitors reported feeling confident that behavioural techniques are useful for working with families. Feedback was very positive with all reporting that they would continue to use the techniques in their day-to-day work. Some suggested that additional support/ supervision from clinical psychologists would have been helpful. The EPaS programme is a potentially useful course for teaching core behavioural techniques that are known to be effective in working with families of children with behaviour problems.

Keywords: health visitor; child behaviour; families; training; early intervention

Introduction

Childhood behavioural problems, such as sleeping and eating disturbances, non-compliance, and regulatory problems, are increasing in the UK (British Medical Association [BMA], 2013) and children's early environments affect the development of these problems. Furthermore, once established, they predict long-term, lifelong, difficulties (Shonkoff et al. 2012). Several risk factors have been identified including socio-economic disadvantage, however poor parenting is the key risk factor for these problems (Farrington and Welsh, 2007). Early intervention, specifically parenting support has repeatedly demonstrated effective ways of addressing these problems (National Collaborating Centre for Mental Health [NCCMH], 2013).

Health visitors are UK public health practitioners who provide a universal service to families with children under five years of age and targeted services for more vulnerable families (Cowley et al., 2015). The three core practices of health visitors are home visiting, relationship formation, and health needs assessments (Whittaker, 2014; Malone et al. 2016). Home visiting is essential for being able to tailor intervention for families' needs (Doi et al. 2017). A strong, trusting relationship is of utmost importance when working with families (Myors et al. 2014; Whittaker, 2014), especially when introducing targeted services (Marshall et al. 2014).

Health visitors have always provided advice for parents (Doi et al. 2017; Hogg et al. 2013a) and are ideally placed to deliver interventions for children with behaviour problems (Myors et al. 2014; Cowley et al. 2013). Parents report positively on the health visiting services and especially value their knowledgeable advice on parenting, child behaviour and development (Brook and Salmon, 2017). It is of concern, therefore, that many parents report reducing service levels over recent years with less visits from health visitors, less time to support families, and high rates of staff turnover (Brook and Salmon, 2017; Glasper, 2017; Whittaker et al. 2015). This appears to be due to increasing caseloads, more complex cases, and public health funding cuts (Appleton and Sidebotham, 2018; Glasper, 2017). Parental concerns about their child's behaviour is a strong predictor for increased service use putting increasing pressure on the health visiting service (Wilson et al. 2013). Health visitors are reporting large and growing caseloads of children with behaviour difficulties. Wilson et al. (2008a) found that 34% of health visitors had 10 or more child psychological, emotional and behavioural cases in their current caseloads, the most common problems being externalising behaviour problems. They also report spending a lot of time dealing with these cases, with 20% spending more than four hours a week with families of children with behaviour problems (Wilson et al. 2008a). Working with children aged 3-5 years is more time-consuming and complex than infants (Myors et al. 2014). Many report feeling ill-equipped in assessing the parent-child relationship and want more training (Kristensen et al. 2017; McAtamney, 2011; Wilson et al. 2008b).

The most effective evidence-based interventions to address child problem behaviour incorporate behaviour management strategies based on social learning theory, which

suggests that people learn through observing others (Furlong et al. 2012; NCCMH, 2013). A number of health visitor-led interventions for parents of children with behaviour problems (e.g. conduct problems, hyperactivity, sleeping and eating problems) have been reported, however evaluations have tended to have small samples and are frequently conducted within one service setting (e.g. see reviews by Public Health England, 2015; Whittaker, 2014; Cowley et al. 2013).

The Enhancing Parenting Skills Programme

In 2002, Lane and Hutchings examined the effectiveness of training for health visitors in a behaviour management programme for parents of children with challenging behaviour. This was named the Enhancing Parenting Skills (EPaS) programme. EPaS has three core components: assessment tools and skills; case analysis strategies; and intervention components incorporating core parenting skills. Following the training, health visitors reported increased knowledge of behavioural terminology and use of specific behavioural techniques. The content and usefulness of EPaS training was rated positively for their work with families (Lane and Hutchings, 2002). However, EPaS was an intensive course with health visitors attending 12 weekly half-day sessions. Attendance was high however it became clear that it is no longer considered feasible due to increasing demands on health visitors (Cowley et al. 2015).

In 2012, EPaS was revised for wide-scale dissemination. The training was restructured and delivered in two full days with a greatly expanded manual. The new format was trialled across Wales with early intervention staff, from a variety of backgrounds and found to be feasible. A small number of staff (n = 10) delivered the programme to a family and collected pre- and post-intervention measures, which showed promising results (Hutchings and Williams, 2013). Feedback from attendees was that two days was insufficient to cover the whole programme and some staff lacked essential knowledge in child development. In 2014 the training was extended to three days, one for each programme component (assessment, case analysis, and intervention) and the material and resources expanded to include videotaped recordings of parent-child interactions. In addition, the programme returned to its initial focus on health visitors because their knowledge of child development enables them to deliver the programme effectively.

Aim of Current Study

The aim of this study is to report participant feedback regarding the usefulness of the training, and various course components, of the revised EPaS training with health visitors in north Wales and Shropshire. A separate paper reports on the benefits to families in terms of significant reductions in child behaviour problems (Williams, 2017).

Methods

Design

This study used a pre-post questionnaire design to evaluate the usefulness of the revised EPaS training programme. Health visitors were asked to complete a number of questionnaires (see measures section) before commencing the EPaS training course and following the conclusion of their work with a family.

Ethical approval

Informed consent was obtained from each participating health visitor. Ethical approval was granted by the North Wales Research Ethics Committee (application number 14/WA/0187).

Participants

Thirty-seven health visitors undertook the EPaS training. The inclusion criterion was that they had a Specialist Community Public Health Nursing qualification. There were no exclusion criteria. Health visitors were asked to identify two families from their caseloads to take part in the study. Families were eligible if they had a child aged between 30 and 60 months who scored above the clinical cut-off on the Eyberg Child Behaviour Inventory (ECBI; Eyberg, 1980). This is a well-established child behaviour assessment which is recommended for use to identify children with established patterns of behaviour problems (Public Health England, 2015). Of the 37 health visitors who attended the training, only 29 (78.4%) worked with one randomly allocated family to whom they delivered the intervention in the first instance. A variety of reasons were given by those who did not recruit two families including lack of time, job change, and personal issues.

Materials

Two questionnaires were used to collect pre and post data: The EPaS baseline questionnaire was developed as part of the EPaS programme and was used to assess the health visitors' use of behavioural techniques before commencing the training. The questionnaire consisted of two sections: 1) current frequency of use of nine specific behavioural intervention techniques and strategies in their work with children and families. Some of the techniques included parent-child observations, designing record sheets for parents, and discussing specific factors in the home environment that may be affecting the parent-child relationship; 2) their confidence in their knowledge and ability to apply this approach. The questionnaire was completed during the first session of the EPaS training (before commencement of the training).

The EPaS feedback questionnaire (also developed as part of the EPaS programme) was used to gather health visitors' feedback on the training after completing the EPaS programme with a family. The questionnaire consists of three sections: 1) views on how helpful the course teaching was on various components; 2) confidence in their knowledge and ability to apply the EPaS approach; 3) general feedback on the course. There was also an option to give any further feedback. The questionnaire was completed by health visitors after they finished delivering the programme with a family and returned to the research team through the post or email.

Procedures

Health visitors completed three days of training, each approximately one month apart. An experienced clinician (second author) who developed the EPaS programme conducted the training. Each day of training corresponded to the three phases of the programme:

1) assessment phase – introduces a standard assessment procedure that includes a range of tools including questionnaires, interview schedules, and observation skills. These were used to collect information about the family, their current circumstances, specific child problem behaviours, child's skills and strengths, and parents' goals;

2) case analysis phase – teaches how to produce a case analysis based on the information collected in the assessment sessions. A case analysis is an aid to understanding the problem, its history and current function, the assets available in the situation that will support change, and potential short and longer-term goals for

parents.

3) intervention phase – introduces effective intervention strategies that parents could use to achieve their short and longer-term goals. These include core parenting skills, such as praise and rewards for behaviours parents want to see more of, ignoring unwanted behaviours, setting limits for the child, and time-out. Parents are asked to keep simple records about their efforts to achieve weekly goals that clarify whether the intervention strategies are effective.

All intervention resources were provided including a detailed training manual, assessment tools for information-gathering sessions, and packs of carbonated paper for drawing up record sheets and writing weekly targets for families. When delivered with a parent, the programme takes approximately 12 sessions to complete, depending on the complexity of the problem(s) being targeted (3 assessment sessions, 1 case analysis feedback, and 6-8 intervention sessions). These would normally be conducted weekly but it was up to the health visitors to arrange appropriate times to conduct home visits with families.

Results

Demographic Data

Participating health visitors had a mean age of 42 years and all were female. The number of years working as a health visitor was varied with a median of four years but ranging from a few months to 30 years. Eleven (29.7%) were newly qualified and had been working as a health visitor for no more than one year.

Current Use of Behavioural Techniques

Health visitors were asked about their current use of behavioural techniques. Table 1 reports numbers and percentages for health visitors that used the techniques always or often. Table 1 also provides a comparison with data from Lane & Hutchings (2002). Health visitors reported varying rates of the different techniques in their work with families. Most often used were teaching parents to reinforce alternative behaviours (75.7%) and discussing specific factors in the home environment (83.8%). Compared to Lane and Hutchings (2002) the least used technique was providing written

summaries of homework tasks (10.8%) however overall, health visitors in the current trial reported similar levels of use for the other techniques.

Table 1

Baseline questionnaire results

Use of behavioural techniques[1]	**Lane & Hutchings (2002) (*N* = 11) *n (%)***	**All (*N* = 37) *n (%)***
Record what is happening during observation	3 (27)	19 (51.3)
Design record sheets and ask to keep records	6 (55)	12 (32.4)
Provide written summary homework tasks	5 (45)	4 (10.8)
Provide written agreements for specific goals	2 (18)	5 (13.5)
Provide star charts and record sheets	5 (45)	15 (40.5)
Use observation/records to determine what works best as best reinforcement and punishment	4 (36)	11 (29.7)
Provide specific feedback based on observations/records	7 (64)	21 (56.7)
Teach to reinforce alternative behaviour	6 (55)	28 (75.7)
Discuss specific factors in home environment	7 (64)	31 (83.8)
Mean use of techniques	5.0 (45)	16.2 (44)

[1] Represent those who answered 'always' and 'often'

Confidence in Using Techniques

Health visitors were asked, before and after attending the course, how confident they were that behavioural approaches were helpful to families; that they had sufficient

knowledge to use behavioural techniques with families; and in implementing behavioural programmes (see Table 2). Prior to training, over half (59.5%) felt confident that behavioural approaches were helpful to families with 37.8% giving a neutral response and one feeling unconfident. Responses to the other two questions were mixed with 40.5% feeling confident that they had sufficient knowledge and in implementing behavioural programmes. Many health visitors use their own experiences to inform their professional practices (McAtamney, 2011), therefore the mixed responses may be due to the range of experience of the health visitors in the sample where 29.7% were newly qualified.

Eighteen (62.1%) health visitors had both baseline and follow-up data (see Table 3) and all had delivered EPaS programme with a family. There was a significant change in confidence with 100% reporting that behavioural approaches were useful to families ($p < .001$). For the two other questions, there were mean increases in knowledge and confidence but these did not reach clinical significance.

Health Visitor Feedback on EPaS Course

After completing the course, health visitors were asked for feedback regarding several aspects of the course, including the teaching of behavioural techniques and general feedback. Eighteen health visitors (62.1%) who had identified and worked with families returned the feedback questionnaire (see Table 4).

Feedback was very positive with 90.5% rating the teaching of all behavioural techniques as 'very helpful' or 'a little helpful'. The general course feedback was positive with all respondents reporting that they would continue to use the course methods. The majority (88.9%) were satisfied with the written material. For the overall course, 72.2% were satisfied and two-thirds (66.7%) would recommend it to a colleague. Some health visitor added comments put these percentages into perspective.

Table 2

Baseline levels of confidence

Confidence	**All (*N* = 37)**
Behavioural approach useful to families	***n (%)***
Confident	22 (59.5)
Neutral	14 (37.8)
Unconfident	1 (2.0)
Sufficient knowledge to use techniques	***n (%)***
Confident	15 (40.5)
Neutral	13 (35.1)
Unconfident	9 (24.3)
Implementing behavioural progs	***n (%)***
Confident	15 (40.5)
Neutral	12 (32.4)
Unconfident	10 (27.0)

Table 3

Change in confidence

Confidence	**Baseline (*N* = 18)**	**Follow-up (*N* = 18)**	***p***
Behavioural approach useful to families	***n (%)***	***n (%)***	
Confident	11 (61.1)	18 (100)	< .001*
Neutral	7 (38.9)	0	
Unconfident	0	0	
Sufficient knowledge to use techniques	***n (%)***	***n (%)***	
Confident	6 (33.3)	12 (66.7)	.082
Neutral	8 (44.4)	5 (27.8)	
Unconfident	4 (22.2)	1 (5.5)	
Implementing behavioural programmes	***n (%)***	***n (%)***	
Confident	7 (38.9)	12 (66.7)	.259
Neutral	8 (44.4)	6 (33.3)	
Unconfident	3 (16.7)	0	

Note: * significant at $p < .001$

Table 4

Feedback on course (N = 18)

Teaching of behavioural techniques on course	**Helpful**[1] ***n (%)***
Record what is happening during observation	18 (100)
Design record sheets and ask to keep records	18 (100)
Provide written summary homework tasks	15 (83.3)
Set homework tasks in reading	14 (77.8)
Provide written agreements for specific goals	17 (94.4)
Provide star charts and record sheets	14 (77.8)
Use observation/records to determine what works best as best reinforcement and punishment	17 (94.4)
Provide specific feedback based on observations/records	16 (88.9)
Teach to reinforce alternative behaviour	17 (94.4)
Discuss specific factors in home environment	17 (94.4)
Course feedback	***n (%)***
Overall course	
Satisfied	13 (72.2)
Neutral	4 (22.2)
Dissatisfied	1 (5.6)
Written material provided	
Satisfied	16 (88.9)
Neutral	2 (11.1)
Continue to use methods	
Likely	18 (100)
Recommend to colleague	
Likely	12 (66.7)
Neutral	4 (22.2)
Unlikely	2 (11.1)

[1] Represent those who answered ‘very helpful’ and ‘a little helpful’

Eleven (61.1%) of the 18 health visitors wrote additional comments at the end of the questionnaire. Six (54.5%) were positive comments about the course. One health visitor described the course as excellent and that it *"[gave] me and the parents a framework to tackle behavioural problems"*. Another referred to the course as *"Powerful stuff"* and liked the fact that *"The tools provided ... [were] flexible and can be tailored to each individual child and family."*. These health visitors were satisfied with the overall course and were likely to recommend to a colleague. One health visitor (9%) gave negative feedback and were dissatisfied with the course. She *"felt that 99% of the time we saw [the trainer] we discussed cases in detail but hardly ever looking at how to actually manage behaviour."*. The course was run in a group setting and even though every effort was given to discuss individual cases, it was not always possible to discuss all the cases in a session. This suggests that additional support from clinical psychologists working within the health service would be helpful when implementing the EPaS programme with a family. The need for additional support was highlighted by three (27.3%) health visitors. Two health visitors (18.2%) suggested that their ability to implement the programme effectively depended on characteristics of their families, highlighting that it was *"Difficult to engage high need families consistently to follow EPaS"*. Another suggested that the course may be more suited to experienced health visitors since *"... you needed some experience in behaviour management to work out what methods to use with a family, as most of the forms were for collecting information."*.

Discussion

Health visitors have reported the need for more training in assessing the parent-child relationship (Kristensen et al., 2017). The current study supports this with some health visitors reporting feeling unconfident in using behavioural techniques with families, including using observation assessments. The first phase of the EPaS programme teaches participants how to use assessment tools to collect information about a family. After the course, health visitors reported increased confidence in using the techniques and generally rated them as helpful. All health visitors reported that they would continue to use the methods suggesting that the programme increased health visitor knowledge and use of core behavioural skills that are important in addressing child behaviour problems (NCCMH, 2013).

The need for clinical supervision from clinical psychologists was highlighted in the post-course feedback. Clinical supervision is an important part of effective programme implementation and is recommended by the Royal College Nursing (2014). For the current study, clinical supervision from local clinical psychologists was planned but, due to scheduling difficulties, this did not happen. Future research should explore the feasibility of adding clinical supervision.

Limitations

The main limitation of this study is the small sample size. Thirty-seven health visitors enrolled onto the training, of whom only 29 identified two families. Another limitation is the lack of follow-up evidence for actual use of behavioural skills. It would be interesting to see whether the rate of use of techniques changed following course attendance. It would have also been more informative to conduct qualitative interviews with the health visitors.

Conclusion

Health visitors were not using many of the known evidence-based effective behavioural techniques at baseline and felt ill-equipped to use them suggesting a potential gap in training. The EPaS programme is a potentially useful course for health visitors that teaches core behavioural techniques that have been shown to be essential in working with parents to reduce child behaviour problems (Public Health England, 2015; NCCMH, 2013). Providing health visitors with a structured evidence-based programme, tailored to individual family needs, could decrease the time spent on these cases but more works needs to be conducted to explore its feasibility and effectiveness within the health visiting service.

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