

Defining 'hard to reach': the work of Health Visitors with Vulnerable Families

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Abstract and Key Words

The term 'hard to reach' first appeared in the Health Visiting Review (Lowe 2007). This review claimed that the health visiting service was able and experienced in reaching the 'hard to reach'. Yet there was a dearth of health visiting literature on what this concept meant and how it was interpreted in practice. A wide literature review was undertaken which examined government child health policies on reducing health inequalities and how the targeting of services to meet the needs of 'vulnerable', 'disadvantaged' or 'hard to reach' families had developed. The literature review identified how the concept of risk in relation to child health promotion had been defined and redefined since the 1970s. The latest shift involved the identification of 'new social risks' and the promotion of early intervention to prevent social exclusion and health inequalities. At the time of the study's inception, health visiting was a service both in decline and under threat. In contrast, the development of new early intervention programmes such as Sure Start (National Evaluation of Sure Start 2005), On Track (Doherty et al. 2003) and intensive home visiting (Barlow et al. 2005) also led to the critical examination of the concept of 'hard to reach'.

In response to the lack of information on the concept of 'hard to reach' in health visiting, I set out to examine critically how Health Visitors (HVs) working in a disadvantaged area conceptualised and operationalised the concept of 'hard to reach'. This qualitative ethnographic case study (Yin 2003), by using research methods of focus groups, participant observation of a Well-Baby Clinic and interviews, gathered perceptions and experiences of HVs and service users. Thematic analysis was guided by Gee's (2005) method of critical discourse analysis and revealed how the term was contested by HV practitioners. It was considered a broad term that in practice could be applied widely and negatively as a label for non-engaging service users; yet themes emerged which also demonstrated how HVs related to and constructed the concept in their day-to-day practices of client engagement. The findings were categorised and a typology was developed in relation to the reach of health visiting within a predominantly deficit model of health.

The typology consists of four types, all of which relate to the 'reach' of the health visiting service at the interpersonal level. The first type, the 'easy to reach' client, highlights the diversity of clients: not all clients living within a disadvantaged area were 'hard to reach'. This category also identifies how some clients living within this disadvantaged area developed relationships with HVs. Including the type 'easy to reach' within the typology acknowledges the diversity of clients living within an area of disadvantage, and also the facilitators in HV/Client relationships. The second type identified was the 'emotionally hard to reach' client, and identifies characteristics of clients who had a tentative relationship with the health

visiting service. Working with 'emotionally hard to reach' clients involved negotiation and the building of trust at each encounter. The third type, 'physically hard to reach', developed following the identification of a range of barriers that reduced access to vulnerable clients. The fourth type, 'hard to reach services', arose from the findings - and this type relates to barriers created by the organisation of the health visiting service in a disadvantaged area.

The typology highlights the importance of both clients' and HVs' engagement in the development of working relationships. It recognises the organisational structures and discourses that act as barriers and facilitators to client engagement. It recommends that health visiting should take the opportunity offered in the Health Visitor Implementation Plan (DH 2011) to develop a health visiting service underpinned with a strengths-based model of public health.

Key words: 'hard to reach', 'health visiting', 'case study', 'user perspectives', 'typology of reach', 'Strengths Model'.

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Table of Contents

Abstract and Key Words	i
Acknowledgements.....	iii
Table of Contents.....	iv
Table of Content - Tables.....	vii
Table of Contents - Figures.....	viii
Glossary of Terms.....	1
1. Introduction.....	2
1.1 Rationale for choosing the topic.....	2
1.2 Organisation of the Study	6
2. Families and the ‘new social risk’ policy agenda – the construction of parents as a social problem.....	9
2.1 Introduction.....	9
2.2 Continuities in family policies – constructing problem families.....	10
2.3 New Labour and family policy	16
2.4 Health inequalities, social exclusion and parenting	21
2.5 Conclusion.....	27
3. ‘Hard to reach’ new social risk and the health visiting response	29
3.1 Introduction.....	29
3.2 Health visiting and the NHS	29
3.3 Utilisation of maternal and child health services.....	32
3.4 Threats to health visiting	37
3.5 Influence of Primary Care	41
3.6 New Labour Policies and Public Health.....	44
3.7 Health visiting and ‘new social risks’	50
3.8 Hard to reach’	58
3.9 Conclusion.....	58
4. Literature review on ‘hard to reach’ in health visiting and early intervention programmes.....	60
4.1 Introduction.....	60
4.2 Professional judgement in health needs assessment and the identification of vulnerable families	60
4.3 Early intervention: research into ‘hard to reach’	70
4.4 Conclusion.....	72

5.	Methodology	74
5.1	Introduction.....	74
5.2	Research questions and case study research.....	74
5.3	Yin's (2003) case study research design.....	77
5.4	Case study and qualitative nursing research.....	79
5.5	Single case study design	89
5.6	Conclusion.....	91
6.	Case Design, Data Collection and Analysis	93
6.1	Introduction.....	93
6.2	Ethics.....	94
6.3	Research Methods.....	96
6.4	Selection of the single case study site	103
6.5	In-depth Interviews	117
6.6	Data analysis	122
6.7	The process of analysis	127
6.8	Triangulation.....	137
6.9	Conclusion.....	139
7.	Findings.....	141
7.1	Introduction.....	141
7.2	Findings from the focus groups.....	141
7.3	HV perceptions of the barriers to client engagement.....	143
7.4	Barriers to engagement – the HV service.....	147
7.5	Easy to help facilitators to service delivery.....	151
7.6	Findings from the field site	154
7.7	Organisational barriers to client engagement.....	165
7.8	Co-encounters in the clinic.....	170
7.9	Facilitators and barriers to relationship and engagement	171
7.10	Interviews with clients	188
7.11	Emergence of a typology of the reach of the health visiting service	196
7.12	Conclusion.....	202
8.	Discussion	204
8.1	Introduction.....	204
8.2	Health Visitor's perception of 'hard to reach'	205
8.3	Development of the Typology	209
8.4	Successful approaches to client engagement	210
8.5	Qualities in the client that enhanced participation	213

8.6	Emotionally ‘hard to reach’	219
8.7	Physically ‘hard to reach’	224
8.8	Services are ‘hard to reach’	230
8.9	Conclusion.....	233
9.	Conclusion.....	237
9.1	Introduction.....	237
9.2	Implications of the Typology.....	239
9.3	Implications and recommendations for health visiting practice	243
9.4	Implications and recommendations for health visiting education	246
9.5	Implications and recommendations for research	248
	References	250
	Appendix 1: Search Criteria	274
	Appendix 2: Ethics Approval from NMSWCJC Ethics Committee.....	276
	Minor Modification to an existing Protocol Approval (Audio Recording of the clinic)	277
	Minor Modification to an Existing Protocol Approval.....	278
	Appendix 3: Time line of research study.....	279
	Appendix 4: Information and Consent form for Focus Groups	280
	Appendix 5: Demographics of Focus Groups	283
	Appendix 6: Topic Guide for Focus Groups.....	285
	Appendix 7: Poster Information displayed during participant observation	286
	Appendix 8: Poster to advertise and recruit interview participants	287
	Appendix 9: Information for Interview participants	288
	Appendix 10: Example of a Consent Form for In-Depth Interviews.....	290
	Appendix 11: Topic guides for Interviews	291
	Appendix 12: Information/consent Audio recording of Baby Clinic.....	294
	Appendix 13: Audio recording poster displayed in the Children’s Centre.....	297
	Appendix 14: Tools of Inquiry from Gee 2005 (pp.110-111)	298

Table of Content - Tables

<i>Table 1: Research question and objectives</i>	6
<i>Table 2: Multifactorial causes of health inequalities (Black Report 1980)</i>	39
<i>Table 3: The three components of the Child Health Promotion Programme (DH 1996, p.31)</i>	42
<i>Table 4: Aims of Every Child Matters</i>	48
<i>Table 5: Risk factors in relation to child health promotion 2003-2009</i>	55
<i>Table 6: Protective Factors: The Healthy Child Programme (DH 2009a)</i>	57
<i>Table 7: Definitions of vulnerability factors in health visiting</i>	62
<i>Table 8: Evidence of barriers and facilitators to client engagement</i>	65
<i>Table 9: Typology of Resistance to Therapeutic Services (Bloor and McIntosh 1990)</i>	69
<i>Table 10: Definitions of ‘hard to reach’</i>	71
<i>Table 11: Inductive, Deductive and Abductive Paradigms (based on Blaikie 2007 Morgan 2007)</i>	82
<i>Table 12: Approaches to Qualitative Case Study Design</i>	86
<i>Table 13: Research Methods</i>	97
<i>Table 14: Attendance at the Children’s Centre</i>	106
<i>Table 15: Demographic information of interview participants</i>	120
<i>Table 16: Gee’s (2005) Seven Building Tasks</i>	128
<i>Table 17: 1st Coded Clinic Encounter</i>	129
<i>Table 18: 2nd Coded Clinic Encounter</i>	130
<i>Table 19: Experienced mothers’ dissonance and synergy in relationships</i>	133
<i>Table 20: Reasons for attending clinic (audio-recordings)</i>	163
<i>Table 21: Typology of the reach of health visiting</i>	202

Table of Contents - Figures

<i>Figure 1 Yin's (2009) Technical Definition of Case Study</i>	78
<i>Figure 2 Embedded Units of Analysis within a Children's Centre: the case of 'hard to reach'</i>	90
<i>Figure 3 Diagram demonstrating areas of participant observation</i>	108
<i>Figure 4 Funnel approach used in the study</i>	109
<i>Figure 5 Schematic diagram of 'discourse, Discourses and Conversations influences on the Client /HV encounters. From Gee (2005) and applied to the Well-Baby Clinic</i>	127
<i>Figure 6 Early model of a theme</i>	136
<i>Figure 7 Barriers to client engagement</i>	143
<i>Figure 8 HV perceptions of the service barriers to client engagement</i>	148
<i>Figure 9 Facilitators to Client/HV engagement</i>	151
<i>Figure 10 Spatial Map of the entrance and reception area of the Children's Centre.</i>	155
<i>Figure 11 Spatial Map of Staff Office</i>	156
<i>Figure 12 HV service provision within the reach of a Children's Centre</i>	158
<i>Figure 13 Spatial Map of the Health Room</i>	160
<i>Figure 14 Clinic Attendance during participant observation</i>	162
<i>Figure 15 Facilitators to relationship and engagement</i>	170
<i>Figure 16 Barriers to relationships</i>	178
<i>Figure 17 Clients' views of themselves and the HV service</i>	188
<i>Figure 18 Easy to reach</i>	197
<i>Figure 19 Barriers to client engagement: 'emotionally hard to reach'</i>	198
<i>Figure 20 Barriers to partnership work: 'physically hard to reach'</i>	200
<i>Figure 21 Barriers to service delivery: 'hard to reach' services</i>	201
<i>Figure 22 Emotionally 'hard to reach'</i>	222
<i>Figure 23 Physically 'hard to reach'</i>	226

Glossary of Terms

CAF	Common Assessment Framework
CC	Children's Centre
CETHV	Council for the Education and Training of Health Visitors
CSN	Community Staff Nurse
CPAG	Child Poverty Action Group
FNP	Family Nurse Partnership
HCP	Healthy Child Programme
HV	Health Visitor
HVIP	Health Visiting Implementation Plan
LA	Local Authority
NESS	National Evaluation of Sure Start
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NN	Nursery Nurse
PCHR	Personal Child Health Record
PCT	Primary Care Trust
SETF	Social Exclusion Task Force
SEU	Social Exclusion Unit
SSLP	Sure Start Local Programmes

1. Introduction

This thesis was concerned with undertaking a critical exploration of the concept of 'hard to reach' and its meaning for health visiting practice, in relation to HVs and clients who lived or worked in disadvantaged areas within the reach of Children's Centres (CC). CCs were developed in neighbourhoods described as the most disadvantaged in the country. In order to understand the concept, the study has problematised the notion of 'hard to reach' in the context of health visiting; it has examined the taken for granted, tacit understanding of the concept. In doing so it has been able to render the facilitators and barriers to service delivery at the HV/client interface. This introductory chapter aims to explain the rationale behind the choice of the topic and the approach taken to address the research questions

1.1 Rationale for choosing the topic

My interest in understanding the term 'hard to reach' developed whilst working as a HV with homeless families. This public health HV post aimed to improve access to health visiting for families who were experiencing homelessness. At this time, the health visiting service was being commissioned to lead and carry out 'the core work' of the Healthy Child Programme (HCP) and the service was being redesigned into a progressive, universal service (Lowe 2007). Health visiting is a universal health-promoting service offered to families with children aged from 0-5 years. The majority of HVs are generalist HVs, i.e. their caseloads are derived either from a geographical, locality area or from a General Practitioner registered practice list. HVs are based in the community and are at present employed by National Health Service (NHS) Trusts. In 2015 the HV service will be commissioned by Local Authorities to provide the HCP to all families with children aged from 0-5 years of age (NHS 2014).

In 2009, the HCP was revised and re-launched, acknowledging that health visiting and HVs had a leadership role in the delivery of the programme. The document also formally placed the health visiting service as part of the wider, early years, multidisciplinary approach to social inclusion and early intervention (DH 2009a). As a practitioner with an interest in health promotion and addressing health inequalities, this change appeared to me to have resulted in a tension in health visiting practice. Resources in health visiting were being provided to areas of disadvantage, but mainly in relation to safeguarding or child protection work, and this approach was supported by research which identified HVs' competence to work with families who were considered 'vulnerable' in relation to the risks associated with child protection (Appleton 1994, Hall and Elliman 2003, 2006). Subsequently, a clearly defined structure and strategic policy for safeguarding and child protection developed in

commissioned child health services. For example, in complex cases, the common assessment framework (CAF) has been introduced as a tool to enhance holistic assessment and as an integrated approach for a family when there is more than one professional involved.

In contrast, the work of HVs in reducing health inequalities and promoting health to families living in disadvantaged areas appeared to be underdeveloped and based on individual HVs' tacit knowledge. The initial literature review revealed a dearth of evidence about generalist/universal HVs' understanding or approach to the concept of 'hard to reach' and health inequalities or social exclusion. Instead, there was a taken for granted or tacit professional understanding concerning the concept. For example, the HV review championed health visiting as a service that was able to reach the 'hard to reach' (Lowe 2007). A discourse analysis of the review by Greenway et al. (2008) was critical of the rhetoric in the document, considering that it related only to the modernising agenda; i.e. changing the service to meet 'targeted health needs' within increasingly limited resources. There was little information on how either HVs or health visiting defined and worked with 'hard to reach' families to achieve this approach.

The initial literature review undertaken for this study into the concept of 'hard to reach' also revealed little empirical evidence to support the rhetoric in the health visiting review. What did surface were conflicting opinions about how successful the health visiting service was in working with 'vulnerable' families. Some reports (Audit Commission 1994, Lowe 2007) highlighted the need for change from universal provision to the specific targeting of disadvantaged children within a universal service. In contrast, robust health visiting research (Appleton 1994, Mitcheson and Cowley 2003) into professional decision-making and assessment of health needs clearly demonstrated how HVs assessed and accessed complex health needs in 'vulnerable' families, and how this approach resulted in families being offered both universal and targeted health visiting (Appleton 1994). Furthermore, research into health promotion and families who, in policy terms, would fit the description of 'hard to reach' - i.e. ethnic minority families, young mothers and women experiencing domestic violence - indicated that some families remained 'under the radar' of the universal health visiting service (Peckover 2003, Barlow et al. 2005a, Kirkpatrick et al. 2007).

Moreover, HVs' tacit understanding of the term 'hard to reach' appeared to be 'taken for granted' - described and accepted in health visiting literature as simply 'families who didn't engage with the services provided for them' (Broadhurst 2008). Additionally, policy and research papers (see below) revealed a range of differing definitions of the term 'hard to reach', which reinforced my developing critique of the term as underdeveloped and

unsophisticated. 'Hard to reach' was being applied differently in different contexts; in the policy documents produced by the Social Exclusion Task Force (SETF), the term described the characteristics of groups of people who were considered to be 'at risk' of social exclusion (SETF 2007), or was used to define geographical areas which were under-served with little or no service provision, and people who would benefit from additional universal services (Belsky, Meluish et al. 2006). In delivering parenting programmes, terms such as 'difficult to engage' or 'non-engagers' were being used to describe or label families who seemed to be resistant to services that were specifically designed for 'the hard to reach' (Doherty et al. 2003).

Academics (Lewis 2003, Gillies 2005a) recognised how government policy to include early intervention strategies began with the introduction of New Labour's Green Paper *Supporting Families* (Home Office 1998). This shift resulted in many new initiatives for families with children under the age of four. One major example was the Sure Start Local Programmes (SSLP); Sure Start was part of a national programme set up to provide multi-agency services in disadvantaged areas. One aim of this new service was to reach the 'hard to reach' (Cabinet Office 1998). However, evaluations which examined both service delivery and the uptake of services (Doherty et al. 2003, Barlow et al. 2005a, Belsky, Melhuish et al. 2007) also indicated that working with families living in poverty was challenging and complex work and many 'hard to reach' families were still not accessing these services.

The initial literature review revealed three important findings: firstly, how there appeared to be investment in the development and evaluation of new programmes in relation to 'hard to reach'; secondly, there was little evidence of government funding for the evaluation of established services, such as health visiting, on the subject of 'hard to reach'; thirdly, the literature review revealed the concept of 'hard to reach' as a contested concept and demonstrated how there was very little known about how the concept had developed. Yet working with the 'hard to reach' appeared to be a key concept in developing a robust approach to targeted health visiting practice.

1.1.1 Influences on health visiting

The approach taken in this study has been to include an understanding on the wider political, economic and health influences on health visiting since the 1970s. The 1970s appeared an appropriate choice for three reasons: firstly, in the 1970s the growing numbers of families living in poverty were causing anxiety for the government of the day (Welshman 2006); secondly, it was also a time when NHS maternity and child services were being criticised for not reaching families living in poverty (Robinson 1982); thirdly, national health services were

under threat and changing in response to the economic downturn that occurred in the 1970s. Exploring the historical and political contexts around health visiting has led to my greater understanding of how health visiting has been shaped by government policy, advances in medical technology and a medical 'model of health' that views health as the absence of disease and reflects a deficit, narrow, biomedical interpretation of health. This is despite the fact that a broad, social model of health is espoused in health visiting literature (Cowley and Frost 2006). In a social model of health (Whitehead and Dahlgren 1991), health and participation in health promotion is viewed from the individual's socio-economic and cultural background. Health visiting aims to promote health by encouraging a salutogenic approach which includes encouraging client participation in a health dialogue to promote health and well-being (Cowley et al. 2013). This approach is considered especially important to achieve with groups who are known to be marginalised or excluded from services (Chalmers 1993, 1994). Health visiting literature has strongly acknowledged the importance of relationship building and partnership work with clients living in poverty (Robinson 1982, Blackburn 1991, Elkin et al. 2000, Hall and Elliman 2006). The partnership nature of health visiting has been described as a facilitator in relationships with clients (Chalmers and Luker 1991, Bidmead and Cowley 2005a).

A recent influence on health visiting has been the focus in social exclusion policy documents (SETF 2007) to tackle social exclusion and health inequalities through the 'new social risks' of social exclusion. Tackling social determinants of health has been demonstrated to reduce health inequalities (Whitehead and Dahlgren 2006). The UK's approach has been based on improving and developing area-based services such as Sure Start Children's Centres. In addition, a growing body of documents has defined 'hard to reach' parents and the need for early intervention to prevent the next generation from becoming 'hard to reach' or at risk of social exclusion and health inequalities (SETF 2007, DH 2009a, Allan 2011, Field 2010). These reports have all clearly identified parenting as a social determinant of child health. Using evidence in this way can be explained in policy terms as a way to target resources effectively to those most in need. It can also be defined in terms of a deficit model of health concerned with the identification of problems to be solved by professionals, and this position places the client as a passive recipient of services who can only be reached through the actions of the HV. This model appears in contrast to the empowering approach advocated through partnership and health promotion. Whitehead and Dahlgren (2006) explain how tackling social determinants of health requires an understanding of the processes that generate and maintain social inequalities. Understanding 'hard to reach' may lead to greater understanding of how HVs promote health with disadvantaged families.

1.1.2 Investigating the concept of 'hard to reach' in health visiting

Whilst the initial literature review revealed the concept of 'hard to reach' as a contested concept, it also demonstrated how, in relation to health visiting, there was very little known about the concept. I embarked on this qualitative ethnographic case study to develop an understanding of the concept of 'hard to reach' within the context of health visiting and health promotion at the individual/family level. It appeared important to investigate the concept in the field in order to understand the processes within the health visiting service involved in access, engagement and participation of 'hard to reach' families .

An overarching research question, and four objectives within that question, was developed to gain an understanding of the concept of 'hard to reach' in relation to the work of HVs in a disadvantaged area (Table 1, p.6).

Table 1: Research question and objectives

<p>Research Question</p> <p>How is the term 'hard to reach' conceptualised and operationalised in health visiting practice?</p> <p>Research Objectives:</p> <ul style="list-style-type: none">• To develop a definition of the term 'hard to reach' in relation to families and the child health promotion programme• To examine critically health visitors' perceptions of working with families and service provision• To explore with 'hard to reach' parents their health needs and requirements from child health services during early parenthood• To develop an understanding of the barriers and facilitators for 'hard to reach' families.
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1.2 Organisation of the Study

To understand the concept of 'hard to reach' in relation to health visiting it appeared important to examine how recent government child health policies, related to reducing health inequalities and social exclusion, have influenced the health visiting service.

Chapter 2 critiques the continuities and discontinuities in government family policies since the 1970s.

Chapter 3 evaluates how the health visiting service responded and adapted to the differing political ideological approaches and medical influences in addressing health inequalities with 'vulnerable' families. Chapter 3 also examines the notion of risk in relation to health visiting

and sets out to discover how the 'new social risks' of social exclusion are being debated in the health visiting literature.

Chapter 4 critiques the health visiting literature on vulnerability and the role of the HV in the assessment of vulnerability factors. It also includes literature on client engagement and partnership work, especially in relation to the barriers and facilitators to client engagement and participation. It is worth mentioning that there was very little recent literature on these topics; consequently, seminal health visiting papers on client engagement have been included. Also, non-health visiting literature exploring the concept of 'hard to reach' in other contexts was included. This extensive review of the literature leads to the identification of the research question and objectives (Table 1 p.6)

Chapters 5 and 6 outline the overall design and methods utilised in this qualitative case study. It includes the justification for being guided by Yin's (2003, 2009) approach to case study research design and the rationale for the research methods of focus groups, participant observation of the Well-Baby Clinic and interviews with clients. It also gives a reflexive account of the process involved in developing an 'ethnographic self' (Coffey 1999) which incorporated both my position as a HV 'insider' and researcher 'outsider' within the study. Each data set was analysed separately. The focus group data set was initially analysed to understand the question, 'What does the term "hard to reach" mean to you?'. Initial themes were identified but, as there was very little literature on the topic of 'hard to reach' in health visiting, it was not possible to build a basic conceptual framework to aid analysis. Instead, Gee's (2005) method of critical discourse analysis guided the iterative process of thematic analysis across the three data sets. Themes were identified or discarded with regard to understanding the concept and also with regard to the facilitators or barriers to client engagement in HV/client encounters. Chapter 6 also includes the study's limitations in relation to the design and analytical process.

Chapter 7 is organised sequentially with the findings from the different data sets - the focus groups, ethnographic study and interviews - presented separately. This presentation enables the themes to build across the data sets. Themes tentatively discovered in one data set were developed and substantiated across the data sets. For example, there was no clear understanding of the term 'hard to reach' in the focus group analysis: in contrast, the theme of 'partnership working' was clearly understood and articulated. The participant observation captured the barriers and facilitators of HV/client engagement in relational work and the interviews included the views of clients who perceived the health visiting service as potentially 'hard to reach'. The converging data led to the emergence of a typology of 'hard to reach' in relation to both families and the health visiting service.

Chapter 8 discusses the findings within the wider health visiting and non-health visiting literature on client engagement and partnership. The typology captures the multidimensional nature of the concept in relation to the health visiting service. It also illuminates the variation in the reach of the current health visiting service in a disadvantaged area, and is able to support and extend the findings in relation to developing a different way of practising.

Chapter 9 draws the thesis to a close. It aims to demonstrate clearly how the development of the typology contributes to health visiting knowledge. Critically analysing the concept of 'hard to reach' has identified how engagement work with clients undertaken in a sensitive and flexible way was paramount to building effective relationships. The study also discovered that health visiting was carried out within a culture or framework of a largely deficit model of health where clients were expected to ask for help with their 'problems'. Importantly, the study has found that clients often wanted to engage with the health visiting service but were not always able to do so. For example, some clients were not used to articulating their health needs in public. This Chapter also discusses the implications for practice and education and identifies areas for further research.

2. Families and the ‘new social risk’ policy agenda – the construction of parents as a social problem

2.1 Introduction

This chapter sets out to explore the term ‘hard to reach’ in relation to health visiting practice and child health policy. An extensive literature search (Appendix 1) revealed that there was very little health visiting literature specifically on the topic of ‘hard to reach’. In contrast, there was a growing body of literature arising from the National Evaluation of Sure Start (NESS 2006, 2007) and academic papers from a variety of backgrounds, i.e. from education (Doherty et al. 2003, 2004, Evangelou et al. 2009); from local government (Brackertz 2007); and from voluntary organisations working with the family (Barrett 2008). All were examining ‘hard to reach’ in relation to service development and improving the reach of their services. Policy commentators (Denham and Garnett 2001, Deacon 2002, Welshman 2006, 2007, and Gilles 2005) connected New Labour policies with Sir Keith Joseph, a Conservative minister, who coined the phrase ‘*cycle of deprivation*’ in a speech delivered in 1972. This wider literature has been included as it appears to explain how the concept of ‘hard to reach’ has developed in policy from the term ‘problem family’.

Children’s Centres developed from SSLPs which had been originally set up to:

“break the intergenerational transmission of poverty, school failure and social exclusion by enhancing the life chances for children less than four years of age growing up in disadvantaged neighbourhoods” (Belsky and Meluish 2007, p.133).

SSLPs had been designed to reach disadvantaged families through the provision of high quality, joined-up local services (Meluish and Hall 2007) and there was some evidence of health visiting teams being co-located within Children’s Centres but there was little research on their effectiveness within the SSLPs (NESS 2007). At the inception of this current study, families who did not attend local Sure Start services were described as ‘hard to reach’ (Belsky, Meluish et al. 2007). It appeared that ‘hard to reach’ was an umbrella term that could be applied in many different situations: to services, individual parents or their circumstances. SSLPs were viewed as essential to the UK government’s campaign to reduce child poverty and social exclusion (Meluish and Hall 2007). Subsequently, ‘hard to reach’ seemed linked to the themes of ‘breaking the cycle of disadvantage’ and parenting. To understand the concept of ‘hard to reach’, it appeared important to examine the continuities in government family policies from the 1970s, beginning with Sir Keith Joseph’s

'cycle of deprivation' speech and ending with the Coalition government's approach to 'troubled families'. This chapter will also analyse the discontinuities of government policy, and approaches towards families and children during the same time period.

Barrett (2008), in her study on 'hard to reach' families and the voluntary sector, thought the term had come into use in the 1970s or 80s. She suggested 'hard to reach' had developed as it was more positive than previous labels such as 'problem families', 'chaotic families' or 'vulnerable families'. In relation to health visiting, families with the 'greatest health risk' were described negatively as being 'outside the system' (Hall and Elliman 2006). In the fourth edition of the Hall Reports, families 'outside the system' consisted of groups similar to those described as 'hard to reach' in social exclusion policy documents such as "*Reaching Out: Think Families*" (SETF 2007).

"alcohol and drug abusers, victims of domestic violence, many homeless families, refugees and some with unorthodox lifestyles. They do not seek help; they cannot handle the bureaucracy and perceived middle class orientation of the health care system; they find that public health services are largely irrelevant to their lives. Understandably, such families are often suspicious of professionals and may see them as inspectors, or as representatives of the police or social services" (Hall and Elliman 2006, p.36).

From 1996, there was some recognition in the Hall Reports that child health services had difficulty in accessing and reaching all client groups but, as the quote above suggests, this was because these client groups did not seek help for a variety of reasons. The series of Hall Reports (1989-2006) aimed to identify a national evidence base for a national screening programme for children and, whilst it recommended a wider health promotion approach to reach and engage with all families, there was little evidence of this service being additionally funded. One reason given for this lack of funding was the growing government support that individuals, rather than the State, should take responsibility for their own health. In her critique of the Health of the Nation (DH 1992), Pearson (1998) suggested how the notions of individual responsibility or irresponsibility appeared to stem from the government policy rhetoric of the 1970s.

2.2 Continuities in family policies – constructing problem families

In 1970, the Conservative government appointed Sir Keith Joseph as Secretary of State for Social Services, responsible for the Department of Health and Social Services (DHSS). Following his appointment, Sir Keith Joseph began to discuss his approach to the cycle of

deprivation theory (Parton 2008). Welshman (2007) described Sir Keith Joseph as a traditionalist who held traditional views on the role of parents, with the father as the main breadwinner and the mother caring for their children. Welshman (2007) highlighted how Sir Keith Joseph believed that children would suffer deprivation unless they were brought up by a married couple within a stable, loving relationship.

He claimed that his main motivation on entering the House of Commons was to eliminate poverty, demonstrated through his charitable works on both a personal and professional level (Denham and Garnett 2001, Welshman 2007). However, his concern with low-income families was reported to be focused on families who were not in work, and single mothers or parents who had been involved in benefit fraud (Denham and Garnett 2001). Welshman (2007) explained how, in the 1970s, it was believed that parenting in poverty was a cause of 'problem families', because parents from poor households failed to provide their children with the skills needed to succeed in school. This approach appears similar to both the New Labour and the Coalition governments' focus on parenting and the promotion of parenting advice as a way to address social exclusion.

2.2.1 Cycle of deprivation speech

Sir Keith Joseph's 'cycle of deprivation' speech was delivered at a Pre-school Playgroups Association conference on 29th June 1972. Welshman (2007) explains how he believed that early childhood provision was an important focus area for voluntary organisations, and playgroups were an essential service to promote the emotional and social wellbeing of children. In a sense, this part of his speech appears to be a forerunner of the early intervention programmes introduced by New Labour after they were elected to power in 1997. In the second half of his speech, Sir Keith Joseph developed his 'cycle of deprivation' idea. He saw the increasing number of single parent families as a threat to 'normal' family life; he acknowledged that the existence of families living in poverty was a complex product of economic, environmental and personal factors, yet he focused on the character of parents, presenting neglectful, unloving parenting as the main cause of social problems:

“There are economic factors - persistent unemployment and low income: living conditions play a part - bad housing and overcrowding and few opportunities for recreation. There are personal factors arising from illness or accident or genetic endowment. And there are many factors which affect patterns of child rearing. When a child is deprived of constant love and guidance he is deprived of that background most likely to lead to stability and maturity. All these factors are interactive and a combination of them produces the greatest hazards. In

short, deprivation embraces many disadvantages, which can occur singly or through society, and which we see persisting despite all our advances”.

He then developed his idea of a cycle of deprivation, and begins to discuss the need to intervene in the lives of families living in poverty:

“Perhaps there is at work here a process, apparent in many situations but imperfectly understood, by which problems reproduce themselves from generation to generation. If I refer to this as a cycle of deprivation I do not want to be misunderstood”. (Reprinted from Butterworth and Holman (1975 pp.388-389). Part of Sir Keith Joseph’s speech given at a conference organised by the Pre-school Playgroups Association on 29th June 1972).

2.2.2 Problem families and poverty

Sir Keith Joseph discussed how the majority of the population had experienced a rise in general living standards, and this had highlighted a group of families who had not achieved this improved standard of living. He suggested that the resistance to change was due to individual families’ lifestyles and a perceived growing culture of deprivation, described as ‘transmitted deprivation’. His approach appeared to be based on a deficit approach: families living in poverty, with multiple disadvantages, were blamed for the wider social problems of the time. He also implied that professionals supported his notion of cyclical processes:

“In my view we need to study the phenomenon of transmitted deprivation – what I have called the cycle of deprivation. It is not something new: it has become apparent for the very reason that developments over the last 20-30 years have had the effect of raising standards and revealed more clearly situations where standards have failed to rise. The cycle is not a process that we fully understand, but a number of objective studies do tend to bear out the subjective belief of many practitioners that cyclical processes are at work.” (Reprinted from Butterworth and Holman (1975 pp.388-389)).

Welshman (2007) described the immediate reaction to the speech as ‘muted’, and an early legacy of the speech was the establishment in 1972 of the Social Science Research Council (SSRC) and DHSS Joint Working Party Into Transmitted Deprivation.

At Edgbaston on 20th October 1974, Sir Keith Joseph made his second speech on the cycle of deprivation. Deacon (2002) and Welshman (2007) have remarked on how he was here much more explicit about an underclass, predominantly made up of teenage mothers, a

trend he perceived as a threat to British family life. Deacon (2002) explained how Sir Keith Joseph used an article on family planning, published in *Poverty*, a magazine produced by the Child Poverty Action Group (CPAG), to promote his support for compulsory birth control for young women in Social Classes 4 and 5. Welshman (2007) and Deacon (2002) explain how he had misinterpreted the article and how, consequently, his speech was badly received and how this was credited with his losing support from the Conservative Party:

“They are born to mothers who were first pregnant in adolescence in social classes 4 and 5. Many of these girls are unmarried, many are deserted or divorced or soon will be. Some are of low intelligence, most of low educational attainment. They are unlikely to be able to give children the stable emotional background, the consistent combination of love and firmness which are more important than riches. They are producing problem children, the future unmarried mothers, delinquents, denizens of our borstals, sub-normal educational establishments, prisons, hostels for drifters. Yet these mothers, the under-twenties in many cases, single parents, from classes 4 and 5, are now producing a third of all births. A high proportion of these births are a tragedy for the mother, the child and for us”.

<http://www.margarethatcher.org/document/101830> downloaded 20.09.2010

2.2.3 Legacy of the ‘cycle’ speech

A legacy of his second speech was the setting up of the Social Science Research Council and a research programme into transmitted deprivation. Sir Keith Joseph apparently tried to disband the project when it failed to produce the results he wished for (Welshman 2007, Deacon 2002). From the outset, the complexity of undertaking a wide ranging research programme was acknowledged. Psychologists involved in the research programme called for disadvantage to be examined at the individual level: this was to discover how to prevent or stop the cycle of disadvantage experienced by children (Rutter and Madge 1976). Their review emphasized Sir Michael Rutter’s focus on resilience, risk and protective factors in children. Sociologists (Brown and Madge 1982) were concerned with both the family and wider sociological explanations, and the focus of their collection of research examined individual and structural causes of disadvantage:

“it is an attempt to understand the effect of deprivation and disadvantage upon families in the light of a multiplicity of factors from the personal to the structural” (Brown and Madge 1982, p.5).

The research programme resulted in the publication of 'Despite the Welfare State' (Brown and Madge 1982) and a greater understanding of families living in poverty was gained. For example, Blaxter, Paterson and Bethel (1982) traced the influence of grandmothers on young mothers' attitudes to health and illness. They concluded that transmission of attitudes did not occur; instead, young people formed their own opinions. Subsequently, the transmission theory fell out of favour as other studies began to highlight multiple structural factors that affected living standards and parenting (Black et al. 1980, Deacon 2002, Gillies 2008).

2.2.4 Conservative policy on the family

A further legacy of the cycle speech was that Sir Keith Joseph had begun to articulate the future Conservative policy on the family (Deacon 2002, Welshman 2006). For example, he had made clear his support for the traditional nuclear family with a breadwinning father and a caring, stay at home mother. The family was and still is described as an institution, within the private domain (Coote, Harman and Hewitt 1990), and is given a great deal of autonomy and privacy. The family was also viewed as an important site of social control, particularly paternal control, and families without fathers were seen as the main cause of social problems (Coote, Harman and Hewitt 1990). Sir Keith Joseph, whilst at the DHSS, was the first post-war politician publically to link the breakdown of society with individual types of families, and he is reported to have become a leading influence in Margaret Thatcher's Conservative Party policy on the state/family/individual responsibility within the welfare state (Denham and Garnett 2001, Welshman 2007).

2.2.5 Culture of poverty theory

Sir Keith Joseph's speeches supported his belief that there remained a small percentage of people/families who were in an intergenerational cycle of disadvantage. This belief bears a strong resemblance to the culture of poverty theory, an American theory (Murray 1994) where culture refers to the intergenerational aspect of families living in a poverty perpetuated by poor parenting. The culture of poverty theory appears to have been interpreted by Sir Keith Joseph as involving unemployed and single parent families, groups who, in the 1970s, often were living in poverty (Blackburn 1991). This theory holds that the lower health status and educational attainment of children living in poverty could be explained by a parenting culture lacking in appropriate attitudes to health, childcare or family responsibilities (Blackburn 1991, Deacon 2002, Gillies 2008). Both the theory of transmission and the culture of poverty theory argue that the problem lies within the family because attitudes are

passed from one generation to the next, and this behaviour prevents some families from breaking free from poverty. The provision of benefits by the welfare state was alone unable to shift the attitudes of these problem families (Deacon 2002).

2.2.6 Continuity between Sir Keith Joseph and New Labour family policy

A striking similarity between Sir Keith Joseph and New Labour family policy is that both supported the provision of pre-school services in areas of multiple deprivation as a way of breaking the cycle of disadvantage (Welshman 2006). In his first speech, Sir Keith Joseph announced the implementation of grants to support playgroups, and influenced the setting up of Home Start, a voluntary befriending agency (Welshman 2007). His speech discussed family values and linked it to the ideology of the Conservative Party: the role of the family as an institution, and the role and responsibilities of parents in relation to the socialisation of children. He presented a traditional view of the nuclear family as one which recognises its responsibilities to the wider society. He also presented a view of single parent families being deficient in the social values of society and therefore being the cause of social problems.

The early 1970s was a period of austerity, and individuals were experiencing huge social change including high divorce rates, unemployment, economic shortages and increasing industrial action. Sir Keith Joseph's first speech appeared to attempt to address the limitations of the welfare state, as seen by a Conservative government. He also wished to prove his theory of transmission and therefore commissioned an extensive programme of research (Brown and Madge 1982). Although his theory of transmission of deprivation was never proved, his commission did produce findings on resilience, behaviour and structural factors of disadvantage. Those findings also appear to have been highly influential on New Labour's social exclusion policy (Welshman 2007, Meluish and Hall 2007).

2.2.7 Later legacy of the 'cycle' speech

The controversy and criticism of Sir Keith Joseph's second speech, at Edgbaston, resulted in subsequent governments approaching the subject of families with great caution (Deacon 2002). For example, the Labour government produced 'The Court Report' (1976), which was concerned with the welfare of children rather than families. From 1979, Conservative Party ideology supported traditional married family life over other types of families, and their policies stressed the importance of both parents who were responsible for raising children within the norms of British society (Lewis 2001):

“It all really starts with the family, because not only is the family the most important means through which we show our care for others... it is the place where each generation learns its responsibilities towards the rest of society. Statutory services can only play their part successfully if we don't expect them to do things for us that we could do for ourselves.” (Margaret Thatcher 1981 WRVS Conference, cited by M Maclean 2002).

On a policy level, this evolved into freedom from the ‘nanny state’, in which HVs were viewed as a representation of that nanny state (Maclean 2002). Ferdinand Mount was Thatcher’s policy advisor in the early 1980s and apparently robustly defended the autonomy of the family. For example, Mount is credited as referring to HVs as having ‘*Stalinist powers*’, a very negative term which clearly demonstrated the lack of support for health visiting and intervention in the family (Maclean 2002). State intervention was sanctioned only if a family was in need of outside help through statutory services in relation to child protection (Maclean 2002).

Under the Conservative government, family policy appeared to focus on reducing social security entitlements and on developing new systems, such as the Child Support Allowance for absent fathers (Lewis 2006, Gillies 2008). As a consequence, single parents or lone parent families - headed by women, dependent on state benefits - experienced increased poverty and health inequalities (Commission on Families and the Wellbeing of Children 2005). One well known consequence of Conservative ideology was the ignoring of the recommendations of the Black Report (1980). Deacon (2002) suggested this was because the report focused on the structural causes of poverty and poor health. This approach did not match the Conservative view of health as an individual responsibility. The Black Report (1980) offered a different approach: a shift away from individual responsibility towards structural causes of ill health, and the increasing health inequalities between social classes. In 1985, the Conservative government finally acknowledged these wider structural causes of ill health when they signed up to the World Health Organisation’s ‘Health for All’ charter (Ham 1994).

2.3 New Labour and family policy

Bradshaw (2001) describes four influential factors on the New Labour government’s strategy. Firstly, it had pledged in its 1997 manifesto to stay within the previous Conservative government’s spending policies for their first two years in office. In effect, this meant reducing benefits to lone parents and it was met with a rebellion by Labour backbenchers.

The effect of the revolt may have been a contributing factor to a shift in policy: in 1999, Tony Blair announced that tackling child poverty was to be central to the government's policies on social inclusion.

Secondly, in 1993 when Jamie Bulger was murdered by two young children, Tony Blair was the Shadow Home Secretary, and this event is thought to have contributed to his strong stance on crime (Deacon 2002) and parenting (Gillies 2005). As Shadow Home Secretary, Blair famously coined the phrase, '*tough on crime, tough on the causes of crime*' (Blair 1993). On becoming Leader of the Opposition, he also linked the notion of social exclusion to crime, antisocial behaviour and family instability. Welshman (2007) noted how the focus on reducing the causes of crime was an important part of New Labour's manifesto and how the recurrent mention of an underclass in Blair's (1996) speeches (Levitas 1998) appeared to reflect Sir Keith Joseph's (1972) comments on 'a culture of an underclass'. Welshman (2007) has argued convincingly how New Labour returned to the cycle of deprivation as a way of linking antisocial or criminal behaviour with poor parenting. The political discourse on responsible parenting, started by the Conservative government, was continued with New Labour and more recently with the Coalition government.

Thirdly, another explanation for the continuation of Conservative policies and ideas under New Labour has been related to the influence of the Third Way philosophy. This has been acknowledged as the leading influence on New Labour; an economic reason for this approach was that the 'Third Way' was viewed as an answer to Conservative criticism of Old Labour policies of providing too much welfare and encouraging dependency on the welfare state (Deacon 2002).

"The Third Way stands for a modernized social democracy, passionate in its commitment to social justice and the goals of the Centre Left...But it is a third way because it moves decisively beyond an Old Left preoccupied by state control, high taxation and producer interests; and a New Right treating public investment, and often the very notions of 'society' and collective endeavour, as evils to be undone" (Blair 1998, p.1).

New Labour's Third Way approach has been strongly criticised for stressing moralistic ideals of obligation, duty and family values whilst not redistributing wealth or tackling wider determinants of health (Gillies 2005). Gillies highlighted the contradictory nature of Third Way politics in relation to parents and parenting. For example, she argues that this approach attempts to support the traditional family whilst making only some allowances for other family forms.

Fourthly, following the publication of 'Despite the Welfare State' (Brown and Madge 1982), a growing body of research indicated how growing up in poverty was a determinant of poor health, wellbeing and educational status (Acheson Report 1998). New Labour's first 'annual report' on poverty stated that poverty needed to be stopped and was "*being transmitted through generations*" (DSS 1999, p.5) - an approach that, as both Welshman (2007) and Deacon (2002) noted, appeared similar to Sir Keith Joseph's beliefs. Deacon (2002) argues that Sir Keith Joseph's approach was primarily focused on individual behaviour, whereas New Labour's policies for reducing poverty or social exclusion were wide-ranging responses to a multi-dimensional issue, achieved through policies providing structural change and policies tackling parenting in poverty; for example, the introduction of early intervention programmes, such as SSLPs (Deacon 2002, Clarke 2006).

2.3.1 Discontinuities in Family policy – crossing the threshold into family life

Deacon (2002) explains how, when New Labour came to power in 1997, their approach was not only different from that of the previous Conservative government, but had also moved on from ideas about redistribution of wealth to policies influenced by a social investment model (Jensen 2006). The term 'social investment state' was introduced by philosopher Anthony Giddens as an alternative to the traditional welfare state (Lister 2006). Rather than provide the insurance of Unemployment Benefit, New Labour began to link benefits with paid work and investment in the lives of disadvantaged children.

To understand the changes brought about by New Labour's introduction of a 'social investment state', welfare state analysts (Dobrowolsky and Jensen 2005, Jensen 2006, Clarke 2006) describe how New Labour's family policy concerned pre-school children. Lister (2006) explains how children were viewed as central to the social investment state. Investment in wellbeing and education have been described as a 'spend to save approach'; investment was to be achieved through anti-poverty measures and improved education for pre-school children living in disadvantaged areas and was aimed to avoid the costs of social exclusion in the future (Williams 2004).

Clarke (2006) described the introduction of SSLPs as epitomizing a social investment approach. New Labour appeared to demonstrate how 'breaking the cycle of deprivation' required targeted interventions at both the structural and behavioural levels of society (Deacon 2002). As well as increased early intervention provision, parenting support to disadvantaged families was championed in policy (Harker and Kendall 2003) as a way that government could invest in the parent-child relationship. This movement was supported by a

growing body of evidence which suggested that children could be protected from the stress of social disadvantage by authoritative parenting approaches (Harker and Kendall 2003).

With growing knowledge of the importance of early family support to poor families, policy-makers were also lobbying for family policy to:

“gently cross the threshold into the private realm of the family” (Harker and Kendall 2003, p.i).

The centre staging in policy of children under five has been recognised as a shift in British public policy (Williams 2004, Clarke 2006) to a more interventionist approach to parenting. With their election to power, New Labour published the Green Paper *“Supporting Families”* (1998) and followed this with the development of SSLPs, which became Children’s Centres with new services for families. More recent social investment programmes have been the establishment of the Family Nurse Partnership Programme, a home visiting service provided to teenage mothers. These early intervention programmes have, at the time of writing, been continued and supported by the Coalition government as effective early intervention programmes.

Whilst HVs were acknowledged as family workers who were already working in the family home at the time of this study’s inception, there was little evidence of the strategic involvement of the health visiting service in the development of SSLPs. Instead, integration with Sure Start was often at the individual level (Anning and Ball 2007). Furthermore, health policies such as the Hall Reports (2003, 2006) continued to discuss health in relation to ‘vulnerable’ groups, ‘disadvantaged families’ and ‘health inequalities’ or health risks that affected families living in poverty. Social exclusion and ‘new social risks’ were not discussed in great detail (see chapter 2.3.2 below for further discussion).

2.3.2 New ‘social risks’ – a shift from families in poverty to social exclusion

In the late 1990s there was renewed focus on the family, and the idea of an underclass that was caught up in a cycle of deprivation or disadvantage was viewed by Blair and Mandelson as being the major cause in the breakdown of law and order in society:

“social exclusion is one of the scourges of modern times, driving communities apart and leaving broken lives in its path” (Mandelson 1997, p.5 Speech at the Fabian Society Summer Lecture).

Welshman (2006) explained how politicians used the rhetoric of social exclusion and ‘broken lives’ to reassure the public that New Labour would continue to protect working families. The

focus on the breakdown in society was part of New Labour's approach and the mention of social exclusion by New Labour again appeared to reflect Sir Keith Joseph's belief in a culture of an underclass. Welshman (2006) also identified how New Labour's policies were returning to early intervention and parenting as a way to address social exclusion.

Welshman (2007) credits New Labour with introducing the concept of social exclusion to the UK. Originally a French term, it was adopted by the European Commission and then the UK because it encompassed more than just a definition of poverty:

“Social exclusion happens when people or places suffer from a series of problems such as unemployment, discrimination, poor skill, low incomes, poor housing, high crime, ill health and family breakdown. When such problems combine they can create a vicious cycle. Social exclusion can happen as a result of problems that face one person in their life. But it can also start from birth. Being born into poverty or to parents with low skills has a major influence on future life chances” (http://archive.cabinet_office.gov.uk)

Morris et al. (2009) described this definition as descriptive: it recognises multiple factors and includes the cyclical nature of disadvantage or deprivation. Levitas' (1998) concept analysis discussed how social exclusion had been applied by New Labour in different ways at different times. She also identified three different discourses: RED, a redistribution discourse; MUD, a moral underclass discourse; and SID, a social integrationist discourse. Levitas (1998) described the MUD discourse as focusing on differences from mainstream norms and behaviours:

“focus on the poor and their presentation as culturally and morally distinct from the ‘mainstream’, with its assumptions about state benefit and dependency and about ‘idle criminal young men and single mothers’ (Levitas 1998, pp.9-21).

In her analysis, Levitas (1998) explained how the three different discourses could be traced in New Labour policies. She viewed this as unusual because, historically, the three different discourses represent different political positions and assumptions about how problems are to be addressed (Levitas 1998, Clarke 2006). Levitas (1998) explained how the redistributionist discourse (RED) was concerned with the redistribution of wealth, previously a key component of Labour policy. Levitas (1998) also found that New Labour's social policy had been greatly influenced by the social integrationist discourse (SID), which emphasised the importance of work as a key to social inclusion.

2.4 Health inequalities, social exclusion and parenting

In “*Tackling Health Inequalities: Consultation on a plan for delivery*” (DH 2001) and the more recent Marmot Review (2010), groups of people at greatest risk of health inequalities were people who experienced one or more structural or individual reasons for living in poverty:

“People who experience one or more of material disadvantage, lower educational attainment and/or insecure employment are likely to experience worse health than the rest of the population” (DH 2001, p.7).

These groups included teenage parents, families from ethnic minorities, homeless families, single parent families, or families where a parent has a mental health problem or a disability.

The government report, *Tackling Health Inequalities* (DH 2003), and the Marmot Review (2010) have proposed focusing on those most in need. Their intention is to improve the health of the most disadvantaged groups at a faster rate than the rest of the population. The health visiting service was advised to target families in greatest health need (Hall 2003, 2006, Marmot Review 2010, Audit Commission 2010, Allen Report 2011), yet there was very little discussion within health visiting on the similarities between health inequalities and social exclusion .

2.4.1 Children and social exclusion

In relation to SSLPs and Children’s Centres, parenting in poverty was associated with increased risks to the child’s development and future life plans (Cabinet Office 2007b, Meluish and Hall 2007, Allen Report 2011), and this was supported by a growing body of evidence which began to demonstrate the relationship between the number of ‘parent-based disadvantages’ and a range of adverse outcomes for children (SETF 2007, Meluish and Hall 2007, HCP 2009a, Allen Report 2011). More recently, both health inequalities and social exclusion policy documents identified parents living in poverty as a ‘new social risk’ or a health determinant in relation to the future health and wellbeing of their children. Here, the idea of social exclusion as a trans-generational experience was viewed as a way of offering practical help that aimed to intervene and change parenting practice in poor families (Clarke 2006). Historically, early examples include HVs working with families in response to concerns about high infant mortality and the poor health of working families (Davin 1978, Robinson 1982): Sir Keith Joseph was keen to develop parenting tuition for poor parents (Welshman 2006). New Labour introduced the idea of help and support from the developing SSLPs with parenting as normal (Supporting Families 1998).

From 1998, New Labour began to tackle both structural and behavioural causes of poverty. When services were not utilised, those parents who chose not to use them were described as 'hard to reach' (NESS 2005), because they were perceived as unwilling or reluctant to attend services that were intended for their use. By 2007, the focus was again on behaviour change in parents (Belsky and Meluish 2007). At the same time, HVs continued to work with individual families within disadvantaged areas. Health visiting literature (Appleton 1994, 1996) suggests that HVs viewed the 'socially excluded' as 'vulnerable' and disadvantaged and at risk of health inequalities and they worked with individual families with identified health needs. The term 'social exclusion' was introduced by the Social Exclusion Unit (SEU) in 1999, and 'hard to reach' in relation to families was mentioned in the HV Review (Lowe 2007) and in the HCP (DH 2009a), and was broadly associated with families who were recognised as being difficult to engage with or who did not access mainstream services. At the same time, families who live in areas of deprivation have continued to be linked with increased risk of health inequalities (Tackling Health Inequalities 2003, Choosing Health 2004, HCP 2009a, Marmot 2010). The HCP (DH 2009a) promotes the social and emotional development of pre-school children as an early intervention programme. HVs together with Children's Centres have been given a key role in policy documents in addressing the new social risks of social exclusion and parenting by the Coalition Government (DH 2009, 2011).

2.4.2 Parenting and new social risks

Whilst SSLPs were later promoted as universal services relevant to all families, the underlying goal was to provide services for those parents defined as socially excluded and who lived in disadvantaged areas, in order to allow their children to develop and reach their full potential (Meluish and Hall 2007). The next section will describe how parenting is viewed in health and social policy and as a result continues to reinforce traditional gender roles.

2.4.3 Parents and gender

The term 'parenting' has been described (Gillies 2005, Clarke 2006) as an example of gender neutral language, which hides the fact that women as mothers are still the main carers of children. Gillies (2005), in her analysis of family policy, critiqued the term as being too broad and which as a result may have obscured the different issues which affect women or men as parents. Furthermore, Clarke (2006) found that, when specific issues were mentioned, they were only in relation to the mother. This approach to parenting was also found in the HCP policy document (DH 2009a). Whilst it issued advice relating to the woman's role in breastfeeding and the reduction in maternal smoking, there was no

corresponding information about the man's role in breastfeeding support or in relation to stopping smoking. Clarke (2006) believes that an effect of this gendered approach within a discourse on parenting results in the reinforcement of the moral obligation of women to be responsible for family health.

2.4.4 Parenting and caring

Social exclusion policy from the SEU (2004) appeared to take a broad approach; it considered that all parents living in disadvantaged areas were a risk to the future health and wellbeing of their children. This view has been challenged by feminist academics (Gillies 2005, Edwards and Gillies 2004) and a growing body of knowledge of resilience and the assets families have to help them live and flourish in adversity (Orthner et al. 2004, Davidson 2008, Carvin et al. 2009, Bartley et al. 2010, Marmot 2010). This body of work has challenged the assumption that parents living in poverty are always a risk to their children. Edwards and Gillies (2004) explain how their research has identified how the culture of parenting in poverty has developed out of caring and necessity. They do not believe that the answer to poverty and disadvantage lies solely in a change in parenting style, especially one shaped by middle class values around a child's personal development. Their research has highlighted the positive aspects of parenting in adversity, such as the caring aspect of parenting within the context of the parents' socio-economic background and lives (Edwards and Gillies 2004). The changing context of women's lives is an aspect also examined by Bartley et al. (2005) who believe that since women entered the workplace, valuable skills that were carried out as unpaid labour have been lost. They argue that, previously, women's caring role included skills which were asset building. Whilst parenting is seen as one such skill, Edwards and Gillies (2005) argue that a model based only on improving parenting will not address the wider causes and issues of poverty and social exclusion. This approach appears important for HVs because they work with individuals in partnership (Cowley and Bidmead 2005) within a social model of health that takes into account the individuals' and communities' wider social context.

However, the main focus in policy documents such as the HCP (DH 2009a) is on developing parenting support and is based on evidence from randomised controlled trials (DH 2009a). Whilst evidence-based medicine is viewed as value-free and a scientific approach, in practice it can be much more problematic. For example, 'On Track' was a New Labour initiative set up to prevent crime. It was a system of evidence-based parenting classes, set up through government funding, led by professionals and held in disadvantaged areas. This type of programme can be understood as an example of a moral underclass discourse

(MUD). Government policy had identified a need for a parenting programme to address poor parenting within a deprived area. When parents did not attend the classes, they were described as ‘hard to reach’ (SEU 2004, Doherty et al. 2003, NESS 2005). Doherty et al. (2003) produced a typology of ‘hard to reach’ parents that highlighted how service providers needed a more sensitive approach to recruiting participants as there were many reasons why people did not attend the services provided for them (this is discussed in greater detail in Chapter Four below). His research highlighted how social exclusion and the labelling of an area as consisting of disadvantaged ‘hard to reach’ people may be too broad, and may result in parents being blamed and labelled as ‘hard to reach’.

2.4.5 The Coalition government’s approach to family policy

Since the last General Election in 2010, the Coalition government has pursued a general welfare austerity approach. At the same time, the Coalition government’s family policy documents reveal evidence of continued government anxiety on certain types of families:

“families who both have problems and often cause problems” (DCLG 2014 p.7)

This has resulted in the continued support for intervention programmes that have been targeted towards ‘troubled families’ or teenage mothers. The original research, which has influenced the Coalition government, was carried out for the SETF and published in 2007 (SETF 2007). The research provided evidence that 2% of families, that is, approximately 120,000 families in the UK, were multiply disadvantaged. These families were originally described as the ‘hard to reach’ or socially excluded. Whilst the term ‘hard to reach’ has disappeared from policy documents, the risk factors in relation to families living in adversity and poverty remained central to early intervention policy (Levitas 2012). The SETF (2007) influenced the Coalition government’s ‘Troubled Families Programme’ (TFP), which was set up as part of the government’s social justice strategy (2012) and aimed to turn 120,000 troubled families’ lives around by 2015.

“Troubled families are families who both have problems and often cause problems - where children are truanting or excluded, where there is youth crime or anti-social behaviour and where parents are not working. They also tend to have other problems including domestic violence or drug or alcohol abuse. In addition to the obvious human costs of this, families also costs local services, and the taxpayer, a lot of time and money – which was adding up to a burden on the public purse of an estimated £9 billion a year.” Excerpt from **Understanding Troubled Families** (DCLG 2014, p.7)

The TFP was originally aimed at families with school-aged children and a recent government report (DCLG 2014) highlighted it as a successful programme and believes its holistic and joined-up approach has been beneficial for families previously described as disadvantaged (DCLG 2014).

Since coming to power, the Coalition government have also continued to fund and support targeted early intervention programmes such as the Family Nurse Partnership (FNP) (Barnes 2010, DH 2010). The FNP - a targeted secondary prevention service - is offered to expectant teenage mothers, who meet the criteria of the programme and have agreed to take part (Allen 2011). The FNP aims to work with pregnant teenage women until their child reaches its second birthday. The FNP is a proactive or 'upstream' programme, i.e. it aims to prevent problems before they occur. Both the FNP and TFP are intensive home visiting parenting programmes: concerned with building relationships with vulnerable families, they aim to break the cycle of disadvantage. Both the TFP and the FNP have identified new ways of working with families (DCGL 2014, APPC 2015) for whom conventional or traditional approaches often meant that vulnerable families were 'slipping through the net'.

2.4.6 Health Visiting and the Coalition government

The Coalition government has also supported government reports (Allen Report 2011, Field 2010) that have explicitly highlighted the importance of early intervention services for pre-school children. The Allen Report (2011) identified the importance of parents providing sensitive parenting and loving interactions with their baby in the first two years of life. This work has been developed further with the recent publication of Building Great Britons (APPC 2015), and the development of the 1001 Critical Days Manifesto (Best Beginnings 2015 <http://www.1001criticaldays.co.uk/>). All documents support early intervention to enable families to break the cycle of disadvantage for the next generation. This manifesto is within a time frame of the child's first 1001 days, which is the period from conception to two years of age, and a key period for a child's brain development: there is a growing recognition that their experiences during the pre-school years can have positive benefits on both the present and long-term health of the individual (Marmot 2010).

The Marmot Report (2010) into health inequalities also provided evidence for early intervention. In this report, addressing health inequality is to be achieved through proportionate universalism. This approach can be described as a redistribution approach; services are offered universally but then targeted to meet the needs of those most at risk of health inequality. The Healthy Child Programme (2009) developed this approach into progressive universalism. HVs aim to build relationships with individuals and community

services in order to deliver an individual tailored service according to the child's acknowledged health need.

HVs are described as the leaders of the Healthy Child Programme (DH 2009): they provide a universal service for improving the health and wellbeing of all children. Yet in 2010, the health visiting service was experiencing a fall in numbers (DH 2011a).

The Coalition government responded to these reports and developed and delivered new policy on the universal health visiting service. In 2011 the Health Visiting Implementation Plan (HVIP) (DH 2011a) was announced. It aimed to transform health visiting by increasing the number of HVs by over 4,000 and by becoming a service embedded in evidence-based practice. The revised HCP (DH 2009), and subsequently the HVIP (DH 2011a), set out to achieve a transformed service that aimed to improve health and wellbeing outcomes for children under five; reduce health inequalities; improve access to services; and improve the experience of children and families. It aimed to achieve this through an increased number of HVs, the provision of a new model of health visiting and using evidence-based practice, resulting in improved service coverage to reach all families.

The HV service now offers four levels of service, plus five evidence-based health assessment reviews that begin in the antenatal period and are completed with the Two Year review; and improving health and wellbeing outcomes in six high impact areas: transition to parenthood; maternal mental health; breastfeeding; healthy weight; managing minor illnesses; healthy two year olds and school readiness (DH 2013). The prime purpose of the increased workforce and transformed service is to improve the reach of its service in order to provide services to all families (DH 2013). Consequently, families who require more support will be identified and connected to sources of additional support (Cowley et al. 2015). These positive steps have been welcomed and embraced by the health visiting profession.

In order to recruit 4,000 new HVs and to transform the service by 2015, new guidance for Higher Education Institutions (DH 2011b) was issued, which incorporated the importance of relationship work with vulnerable families. The HVIP (DH 2011a) has also provided funding for extra training for qualified HVs to further develop evidence-based practice and to learn from successful evidence-based interventions.

Whilst, this programme has been successful, a possible future threat to the continued development of the transformed health visiting service lies within the changes that will occur in the commissioning of the service. The Health and Social Care Act (2012) gave Local Authorities the responsibility for local population health improvement. In October 2015, the

health visiting service will be commissioned by LAs who are mandated to provide the existing universal healthy child programme until 2017 (NHS England 2014). This is an interesting change as, following the inception of the NHS and up until 1974, the health visiting service was provided by LAs. A further threat to the development of a transformed health visiting service is that there remains very little research into health visiting and vulnerable families who do not meet the criteria for intensive health visiting or complementary initiatives such as the FNP (Cowley et al. 2013). Cowley et al.'s (2013) scoping review found little research into the concept of 'hard to reach' in health visiting and recommended that further research into the HV service will be required to build on the developing knowledge base. Therefore, understanding the concept of 'hard to reach' in relation to health visiting and addressing health inequalities appears to remain a pertinent topic for a transformed service concerned with improving its reach.

2.5 Conclusion

This chapter has argued that, throughout the cycle of deprivation rhetoric, there has been a continuing and renewed interest within government policy and critical attitudes towards families who are described as living in deprived, disadvantaged areas. Conservative policies in the 1980s and 1990s upheld the values of the traditional family as a private institution that was outside of government intervention. Furthermore, the Conservative government in the 1980s remained critical of other family forms and blamed single parent families for causing the breakdown of society, a belief that continues to be raised by the present Prime Minister, David Cameron, as the reason behind 'Broken Britain' (Amelia Gentleman, Guardian Newspaper 2013).

When elected to power, New Labour continued the rhetoric of being 'tough on crime and the causes of crime'. As a consequence, families living in poverty were no longer viewed as private but in need of state intervention. At first, interventions through the Children Act (1989) were devised to protect children from experiencing abuse. In the 1980s and 1990s, following Sir Keith Joseph's fall from grace, interventions were put in place to maintain the obligation of fathers to support their offspring after divorce or parental separation. In 1998, New Labour's Third Way approach recognised the diversity in family forms whilst supporting marriage as the preferred choice in which to raise children. New Labour and, since the 2010 election, the Coalition government, have continually highlighted how they believe that in some families there has been a decline in the traditional values of duty and responsibility towards children, and this has contributed to the continuity of intergenerational poverty and dysfunctional or troubled families.

This chapter has demonstrated how some of the different ideological approaches to family policy have developed and changed the pre-school provision of services and the role of parents in relation to their children. Since before the onset of the National Health Service, HVs have been providers of universal health services to families with children aged 0-5 years; they have also signposted families to wider services within the community (Anning and Ball 2007).

The next chapter will examine the role of the HV in relation to the 'new social risks' of social exclusion to young children, and will critically examine how changes in government policies since the 1970s together with developments in the resurgence of public health in relation to children, have affected and influenced the health visiting service.

3. 'Hard to reach' new social risk and the health visiting response

3.1 Introduction

The previous chapter demonstrated how different political ideological approaches influenced family policy. From 1997, as a consequence of New Labour's 'Third Way' ideological position, the newly-elected government championed an early intervention approach and invested heavily in the development of SSLPs and, more recently, in Children's Centres. This investment resulted in a new, universal pre-school provision of services for families with children under five, and included the offer of parenting support for disadvantaged families. This provision of parenting support to families living in disadvantaged areas has been described as a discontinuity in government policy (Dodds 2009). Previously, parenting of children had been viewed as the responsibility of parents within the private domain of the family. The rationale by New Labour for this discontinuity was based on the growing body of research into child development, the rising gap in both social and health inequalities, and the perceived risk of social exclusion to children growing up in poverty (Meluish and Hall 2007). The concept of risk in this context appears related to social exclusion. This is relevant to this study because the 'new social risks' of social exclusion have also been used to describe the risks associated with 'hard to reach' (SETF 2007).

This chapter will critically examine child health policy literature, research and seminal papers from the 1970s about health inequalities that recognised the public health role of HVs with 'at risk clients'. It will also examine how the notion of 'risk' has been interpreted in government policies and the HCP that have shaped and influenced health visiting. Finally, it will critically examine the health visiting service in the light of the 'new social risks' of social exclusion and how this is reflected in the updated HCP (DH 2009a). Consequently, it does not aim to provide a comprehensive history of health visiting since 1974.

3.2 Health visiting and the NHS

Health visiting began as a voluntary service and was gradually encompassed by the welfare state (Cowley 1996). The health visiting service was included in the 1946 NHS Act (Ministry of Health 1946). Oakley and Williams (1994) described the creation of the NHS in 1948 as a watershed moment in the history of the welfare state. Before this date, free health care could only be accessed by men who were in paid work but in 1948, free health care was

established as the right of all UK citizens (Oakley and Williams 1994). The health visiting service was included in the NHS and the specific activity of health education was assigned to them as:

“giving advice as to the care of persons suffering from illness... to expectant mothers and nursing mothers, and to mothers and others with the care of young children” (NHS Act 1946, p.24)

Consequently, important aspects of the HV role included the delivery of health education to new mothers, and health promotion. At this time, the role of the HV appeared to resonate with the idea of the welfare state as a national insurance policy to prevent ill health (Dodds 2009, Lister 2006). In reality, the practice within the welfare state in the UK was acknowledged as being much narrower (Lister 2006). Governments held the view that the main purpose of welfare was to act as a safety net, for short periods, when people were ill or unemployed (Lister 2006). Subsequently, the central focus of the NHS was concerned with treating ill health rather than promoting good health (Robinson 1982, Cowley 1996). This may explain why, after the creation of the NHS, health visiting continued to be situated within Local Authorities and why, after the NHS reorganisation in 1974, tension was experienced between health visiting and acute hospital care managers (Robinson 1982, Cowley 1996). Robinson (1982) argued that the legitimacy of health visiting had been supported by social policy only when the government perceived that there was a threat to the nation. For example, the lack of sufficiently healthy young people during the First World War resulted in social policy that promoted child and maternal health. Robinson (1982) believed that there had been little *“investment”* in the health of women and children except at these times.

As discussed in Chapter 2 above, a reason for the lack of investment in health services in the 1970s was that it was a time of change, with high levels of unemployment and severe economic disruption. The government also began to legislate for the spiralling costs of the NHS (Lewis 1992). Following the reorganisation of the NHS in 1974, there was a period of time described as the demise of child public health medicine, and three reasons were given for this (Blair et al. 2010).

Firstly, medical advancements resulted in improved child health. There was a new childhood immunisation programme, improvements in the treatment rates for children with life-threatening illnesses, and earlier detection of disability (Blair et al. 2010). Secondly, governments in the 70s, 80s and early 90s believed that parents were responsible for their own children’s health and wellbeing and, as explained in Chapter 2 above, both the

Conservative and Labour governments supported the belief that the family was an institution outside of the public sphere.

Thirdly, the old system of community child health run by the Medical Officers of Health had received much criticism for being overly bureaucratic, and was virtually dismantled by the 1974 reorganisation (Baggott 2004). The Court Report (1976) recommended the reinstatement of community child health services. At the time, this report had little initial impact and, instead of child health services being reinstated as a separate service, they became part of General Practitioner Services (Baggott 2000, Robinson 1982).

The 1970s were a time of great change: advancements in medical knowledge and treatments resulted in a growing demand for health services during an economic recession. The 1974 NHS reorganisation was an attempt to improve the efficiency of the NHS. The next section will explore the effects of these changes on health visiting.

3.2.1 Structural influences on health visiting in the 1970s

Health visiting in the 1970s was also undergoing great organisational change (CETHV 1977, Robinson 1982, Cowley 1996). Some of this was due to structural change. The 1974 NHS reorganisation saw the management of HVs move away from Medical Officers of Health within the Local Authorities to hospital managers within the District Hospital Authorities. These changes reportedly resulted in HVs being compared unfavourably with nurses (Robinson 1982). Furthermore, it was argued that the employment of practice nurses and the development of the social work profession had seriously undermined the role of the HV (Robinson 1982).

HVs also had to compete with nurses for the scarce resources in acute care (Robinson 1982). Robinson's seminal work was an evaluation of health visiting: her research aimed to improve the effectiveness of the service by providing evidence to support the need for more resources. The catalyst for this study was her experience as a HV manager. Within the new management structure, she experienced problems in obtaining resources to develop health visiting. She believed this was because HV caseloads were historically organised and based on the size of the population in an area (Robinson 1982).

3.2.2 The reach of maternal and child health services

Robinson (1982) recognised that research into Maternal and Child health services was highlighting the limitations of existing services in reaching certain families who were living in

poverty. It was also beginning to be recognised that other factors outside of the remit of medicine, such as the social determinates of health, affected the health of families (Court Report 1976). Also, Members of Parliament and the pressure group, CPAG, (DHSS/CPAG 1978) held a conference on the under-utilisation of services by the poorest of families, to discuss how those in greatest need made least use of preventative maternal and child health services. Whilst the focus of the conference was on maternity services, it was an example of the inverse care law (Tudor Hart 1971), and clearly demonstrated the inequity of NHS service provision for people living in disadvantaged areas:

“the availability of good medical care tends to vary inversely with the need for it in the population served” (Tudor Hart 1971, p.1).

The frustration of not being able to gain more resources to address the findings of such ground-breaking research was part of the impetus for the study (Robinson 1982).

3.3 Utilisation of maternal and child health services

In the 1970s there was a growing body of sociological research into the utilisation of health services (Zola 1973, McKinley 1973, Rosenstock 1975). This body of research provided evidence demonstrating how the ‘lower social classes’ were most at risk of ill health but were least likely to use preventative maternal child health services and were resistant to health education. This research was highly influential on policies and reports on services provided by the NHS. For example, in relation to child health services, ‘under-utilisers’ were described as poorer and less well educated (McKinlay 1973), while services were perceived as being either too middle class or geographically distanced (Court Report 1976). Therefore it was argued that child health services were seen to be ineffective because they were unable to reach an at risk population (Court Report 1976).

Robinson’s (1982) report incorporated a literature review with a section on ‘risk factors’ associated with infant mortality and morbidity. For example, it discussed factors relating to the mother, her age and pregnancy history, and factors related to the child’s birth circumstances, all of which had been shown to increase the risk of infant mortality (Carpenter and Emery 1974). Characteristics of the ‘lower social classes’ that were found to increase the risk of under-utilisation were also described (McKinlay 1973). Much of Robinson’s review concentrated on studies which highlighted the barriers experienced by working class families in accessing or engaging with the health service. It also included recommendations to address these barriers. The Court Report recommended structural changes through more enlightened provider services, i.e. clinics held at different times, in the

evenings or at weekends; or attitudinal changes where parents should be encouraged to develop a sense of responsibility for the health and wellbeing of their new baby (Robinson 1982).

However, Robinson appeared to be critical of this approach. These reservations may have been based on her experience of having had little success in making the case for increased HV resources, especially when competing against the ever-increasing demands of acute care. Furthermore, she appeared wary of using 'risk factors' to develop the reach of health visiting into the early detection of illness, disability and mortality (Robinson 1982). This approach had been tried before: under the Medical Officers of Health, HVs had been responsible for the maintenance of 'at risk' registers (Dingwall 1977) and research had criticised them for a lack of robustness (Oppe 1967). Instead, Robinson argued for a different approach, one linked with the development of the health visiting profession and building relationships with clients.

3.3.1 Health visiting and 'at risk' registers

In the 1970s, research into 'at risk' populations related to infant mortality and morbidity (Court Report 1976). The risk of death in the under-five age group was higher than at any other time in childhood (Wadsworth and Morris 1978). At this time, early intervention and the role of the HV appeared concerned with early detection of illness and disability:

"A child born into the family of a semi-skilled worker is twice as likely to die between the end of the first month and the first year of his life... as a child born to parents in social class I and II" (Court Report 1976, p.6).

The Court Report also gave a definition of disadvantage:

"Disadvantage is not determined by class alone. Disadvantaged children are more likely to be born to young mothers who are less likely to have used antenatal services and are more likely to have smoked heavily during pregnancy. They are more likely to be born prematurely and have a low birthweight. In the early days and weeks of life they are more exposed to the risk of infection and death. Evidence to this committee suggests that it is largely possible for this group to be identified" (Court Report 1976, pp.6-7).

Blaxter (1981) explained that in the 1970s new born babies did not routinely receive health screening. The Court Report (1976) envisaged HVs having a key role in the identification of children most at risk of illness, and recommended that HVs carry out universal screening of

all new born babies. This recommendation was never developed as it would have enabled HVs to develop their own body of knowledge on infant development, which at the time was part of the paediatrician's role. Also Oppe's (1967) influential research indicated that the existing role of the HV in determining and identifying ill health was seriously flawed and in need of review. Oppe's investigation into 'at risk registers' maintained by HVs discovered that there was great variation in the numbers on the registers. For example, between 15-60% of all births could be registered (Oppe 1967). Younghusband and Birchell (1970) had also reported that only a small number of children with disabilities were identified after birth through these registers. Furthermore, Wadsworth and Morris (1978) concluded that a child wrongly identified as 'at risk' and placed on a register would cause the family a great deal of distress. This research did not fault the HVs' skills in assessment but criticised the risk assessment tool, which was described as a "crude measure" in predicting childhood illness (Wadsworth and Morris 1978). It was also recognised that to improve the effective use of HV assessments in detecting children 'at risk' of illness would require extra expenditure. Wadsworth and Morris (1978) supported the recommendation in the Court Report (1976) that the role of the HV should become focused on sensitive surveillance and observation of children in the home, and develop ways to involve parents in promoting the health of their children.

3.3.2 Reaching the unreachable

Wadsworth and Morris's (1978) study also supported the findings of Carpenter and Emery's (1974) study into preventing sudden death syndrome. These studies provided evidence of the effectiveness of intensive health visiting input resulting in improved infant mortality rates. Carpenter and Emery's (1974) study identified eight variables or risk factors in relation to infant mortality. Interestingly, these factors included age of mother, intention to breastfeed and medical problems during pregnancy, and these findings resonate with the more recent FNP, an early intervention programme for teenage mothers. Furthermore, in a subsequent study into infant deaths, not attending for follow-up hospital appointments was discovered to be the single most important criterion for identifying high risk infants (Protestos et al. 1973). It was surmised that intensive health visiting at home to 'at risk' families might reduce the incidence of infant mortality, because health visiting was able to 'reach the unreachable' (Robinson 1982). This term shares similarities with 'hard to reach' because the attributes of parents with children 'at risk' of infant mortality were in relation to the mothers' individual behaviours and lifestyles and related to families on low incomes.

Robinson (1982) developed her inclusion criteria for interviewing families from the study by Protestos et al. (1973) and intended to interview families who had had a premature baby but who did not attend the HV clinic. During the study she realised that, although important, basing interventions on such a narrow definition of risk was limiting. Non-attendance related to a very small percentage of women and it excluded other women who might benefit from an intensive service:

“the family of a low birth weight baby in the control group appeared more like the non-attender group inasmuch that the mother was extremely elusive; four wasted visits and finally not interviewed. From the health visitor assessment it appeared that the mother was aged 18, pregnant, father unemployed, and 9 months PDE (developmental review) was overdue. The health visitor reported many social problems and a local extended family with similar difficulties. She stated that she had easy access to the home but there was little response to her interventions” (Robinson 1982 p.72).

Importantly, Robinson appeared critical of the HV role recommended by these studies, describing it as a palliative role - treating the symptoms and not the causes of poverty. She implied that these interventions only encompassed part of the health visiting role, the part identified through medically-related risk factors. She gave an example of the difference in the role: if the HV role only involved mediating between the mother and the GP then, she argued, the public health role would be lost. Robinson (1982) appeared to disagree strongly with this narrow view of health visiting, arguing that it would change health visiting from a separate autonomous profession to a form of nursing for the family that ignored the structural and material causes of ill health.

Robinson believed that the use of individual risk factors to direct HVs' work presented a reductionist approach to 'reaching the unreachable'. Instead, Robinson argued that HVs were autonomous practitioners who worked from a universal primary prevention approach. Furthermore, a model of health visiting based on identified risk factors alone would provide a very different approach, and it would not be the same as using one's professional judgement in identifying needs within a community. Importantly, she identified HVs' work as being based on a health needs assessment of a population, and argued that a health visiting service based solely on identified individual risk factors would be a very different service. She also identified the broad nature of health visiting practice based on professional judgement within a universal health promoting service.

Robinson's study involved qualitative interviews with both 'utilisers' and 'non-utilisers' of the health visiting service. Her main findings related to the role of the HV. She identified a major barrier to service utilisation as the perceived 'ambiguity and conflict'¹ within the role of the HV, and this was influenced by the beliefs and attitudes of families, HVs and other practitioners (Robinson 1982).

Robinson's (1982) study also identified that the quality of the relationship between the family and HV acted as a facilitator in the utilisation of services. Furthermore, success from the client's point of view was measured by the development of a warm relationship. This led to her proposal for health visiting to be based on relationships. Her literature review and small-scale study supported her major finding, which related to the quality of the relationship between the HV and client as paramount and which should be allowed time to develop.

The study recommended two ways in which to achieve an improvement in the reach of the service. Firstly, the universal service would benefit from adequate staffing levels, as had been proposed by two previous reports (Jameson 1956, Court Report 1976). Secondly, Robinson argued that the health visiting profession needed to respond to research findings that were developing new knowledge in the 'social dimensions' of disease and health inequalities. She believed health visiting could not afford to ignore the growing body of research, which clearly demonstrated how families living in poverty made least use of preventative health care services for mothers and children:

"The most important failing of our present child health services is that the children who need them most use them least" (Right Honourable David Ennals 1978, cited by Robinson 1982, p.2).

Several themes were identified in Robinson's study in relation to 'reaching the unreachable'. Robinson strongly advocated for an improved and sensitive universal service: she believed that a model of health visiting based solely on risk factors would be a reductionist approach. She argued that HVs' practice had to be socially acceptable to consumers, which could be achieved through a universal "*relational model of health visiting*" (Robinson 1982, p.85), in conjunction with an individual health needs assessment. This study was published after the publication of 'The Principles of Health Visiting' by the Council for the Education and Training of HVs (CETHV 1977), and both publications supported the philosophy and practice of a universal health visiting service based on health needs rather than on health risks.

¹ Ambiguity and conflict relates to the supportive/authoritarian role of the health visitor in relation to reporting families to social services for child neglect

3.4 Threats to health visiting

In the 1970s there was growing interest in researching professional groups of women such as HVs (Dingwall 1977). Baggot (2000) and Cowley and Frost (2006) also discussed how health visiting experienced discrimination and loss of authority under the control of the Medical Officers of Health. Dingwall (1977) and Robinson (1982) both discussed the wider implications of the influence of gender on professions. In the case of health visiting, it was viewed as women's work, public work carried out within the private sphere of the home or the 'clinic'. As a result, health visiting shifted from a broader public health approach to an individual approach, focused on changing individual behaviours and the 'ignorance' of the poorer classes (Dingwall 1977). Rolls (1992) explains how health visiting appeared to employ women who demonstrated sufficient 'feminine qualities' to enable them to gain entry to the home. Rolls (1992) argued that this type of paid labour was a recognised extension of the stereotypical female carer role. Robinson (1982) also noted that a further benefit of using health visiting was financial, as it was a relatively low cost female profession. After the 1974 reorganisation of the NHS, practice nursing and social workers were perceived as a threat to health visiting as they competed with aspects of the HV role.

3.4.1 Health visiting's response to the threats

In 1977, in response to the changes and threats against health visiting (Robinson 1982, Cowley and Frost 2006), the CETHV convened a series of workshop meetings to examine the principles that guide health visiting. In doing this, the CETHV also appeared to be examining the 'reach' of health visiting. Their report acknowledged the limits of a deficit model of health and 'traditional' health education approaches. Rather than viewing health as the absence of disease, the report concluded that HV work was to be underpinned by a positive belief in the value of health; four guiding principles encompassing the philosophy of health as a value were developed (CETHV 1977, Cowley 1997) The four principles are:

1. The search for health needs
2. The stimulation of an awareness of health needs
3. The influence on policies affecting health
4. The facilitation of health enhancing activities (CETHV 1977)

This approach to health prevention was considered to be in contrast to the prevailing UK policies at the time, and appeared to be influenced by the New Public Health movement, which recognised a wider understanding of health that included both individual behaviours and social determinants of health (Cowley and Frost 2007). The principles were considered

to be forward-looking because they questioned the mainstream support for health education within an individual deficit model of health, and drew attention to the different and wider contexts of people's lives (Cowley 1996).

3.4.2 Influences on the Principles of Health Visiting

The Principles of Health Visiting (CETHV 1977) recognised the significance of both the wider determinants of health and personal behaviour to health promotion. The late 1970s saw the development of an international public health movement whose approach aimed to improve health by reducing health inequalities (Ashton and Seymour 1988). Beginning in the 1970s, the New Public Health movement began to challenge the increasingly costly hospital-based therapeutic era and, in 1974, the Canadian Minister of Health, Marc Lalonde, published a government document which called for a reorientation of health services away from a hospital-based curative model and towards a community-based health prevention model (Lalonde 1974). 'New Public Health' was committed to reducing health inequalities and had an emphasis on community participation and on developing health goals to improve health (Ashton and Seymour 1988).

Whilst this model was based in Primary Care, its emphasis was on a multidisciplinary approach to health improvement (Moran and Simpkin 2009). Ashton and Seymour (1988) describe how the WHO (1981) concept of primary health was a social concept concerned with improving the health of populations as well as of individuals. This approach advocated for an increase in public participation in the planning and implementation of local health care. Tackling health and social inequalities was a key principal of the New Public Health model and it aimed to improve access to resources that were considered health-promoting for communities.

Community development work is a recognised approach in health visiting and developed from the model of new public health (Cowley and Frost 2006). In the '80s and '90s, many HVs became involved in community development projects in providing specialist services and health visiting networks to support work with travellers and homeless people or to provide services in disadvantaged areas. For example, Strelley was a successful community project set up by the community and HVs to promote health in a deprived area of Nottingham (Boyd et al. 1994). However, since the late 1990s the focus of health visiting has been mainly on work with individuals (Lowe 2007, DH 2011). Dalziel (2008) has described community development work as difficult to achieve when the dominant model of health is concerned with individual health and, as a result of the reduction in health visiting numbers, this public health strand of health visiting has not been supported financially (Pearson 2008).

3.4.3 Government policy individual lifestyle approach

The Labour government, when in power in the 1970s, attempted to shift health care from an emphasis on cure to one of prevention (Kelly and Symonds 2003). The publication of the consultative document, *Prevention and Health: Everybody's Business* (DHSS 1976) is one such example, yet it was unable to shift the balance away from the growing approach to health as an individual responsibility (Baggott 2000).

The Conservative government elected in 1979 aimed to reduce the costs of the National Health Service and encouraged freedom of choice for the consumer whilst aiming for a reduction in state provision (Joseph and Sumption 1979, Kelly and Symonds 2003, Ham 2009). This political ideology resulted in a health policy that persuaded people to take personal responsibility for their health, whilst GPs remained focused on providing medical care rather than primary health care (Ashton and Seymour 1988). As a result, health prevention from 1979 was increasingly defined as an individual responsibility, and individuals were urged to reduce their risks to health by developing and maintaining a healthy lifestyle (Ham 2009). In 1980, the Black Report - commissioned by the Labour government in 1977 - was published and provided a very different approach to improving the nation's health. It clearly documented how health inequalities between social classes had continued since the inception of the NHS (Ham 2009), and it offered a structural explanation for these health inequalities (Table 2, p.39) that was in addition to the behavioural/lifestyle approach being taken by the Conservative government elected in 1979.

Table 2: Multifactorial causes of health inequalities (Black Report 1980)

Multifactorial causes of health inequalities	Recommended policy response to health inequalities
Poor Housing	Broad ranging Multi-sectorial responses
Low Income	Health, Housing
Poor Education	Transport, Environment Education
Unsafe Working Environments	Working Conditions and Benefits

Ham (2009) explained how the Black Report was side-lined by a Conservative government concerned with improving the efficiency of the NHS. As a result, their policies promoted effective management of public services, encouraged individual responsibility and strengthened the role of GPs and providers of primary care.

In 1985, under John Major's leadership, the UK Government signed up to 'Health for All' (WHO 1981), a strategy for improving the health of all by the year 2000. This was followed by the development of the health strategy White Paper, *The Health of the Nation* (DH 1992). On the one hand, this paper marked the recognition by the Conservatives of the need to discuss urban regeneration and health 'variations', the term used by the Conservative government to describe health inequalities (Carpenter 2007). On the other hand, its failure to recognise poverty and socio-economic factors as significant in shaping people's health experience was also demonstrated. The UK Government's policy response supported a shift to a medical model of public health, concerned with improving the population's health by the identification and reduction of individual risk factors (Baggott 2000, Pearson 2008, Moran and Simpkin 2009).

3.4.4 Health visiting response to the lifestyle approach to health promotion

Academics with a health visiting background (Cowley 2008, Pearson 2008) were highly critical of the Government's approach to improving the health of the nation and continued to promote a health visiting service underpinned by the philosophy and principles of health visiting and the process of promoting health (Cowley and Frost 2006).

Whilst understanding the complex and contested nature of the concept of health promotion, the definition of health promotion in this thesis is guided by the theoretical principles of health visiting, and the practical application of health promotion to young families. It is concerned with reducing known health risks, such as by promoting immunisation, but it is equally influenced by the notion of health as a process - building and promoting health, helping families to be healthy whatever their social, economic or cultural context, with either individuals (Cowley 1995a) or wider community services (McIntosh & Shute, 2007, Stewart-Brown et al. 2004).

Thus, health is viewed as a positive concept and relates to a salutogenic orientation, which identifies health promoting factors to build and maintain health (Antonovsky 1996). Antonovsky's (1996) philosophy and research concentrated on understanding how salutary² factors promoted health. He was interested in the positive ways of responding and adapting to life situations, but he also recognised how negative experiences may affect people's responses to and participation in supportive services.

This approach to positive health has been linked to the principle of health visiting related to the facilitation of health-enhancing activities. Cowley and Frost (2006), suggest that the term

² Salutary factors: Sense of Coherence (SOC) and factors that promote health

'health-enhancement' reclaims the positive focus of health as a resource for living as promoted by WHO (1986). However, this literature review found little empirical evidence of a salutogenic model of health visiting being implemented successfully in practice. In contrast there was evidence (Hall Reports 1989, 2006, HCP 2009) that points to the influence of 'risk' factors and the deficit model of health being incorporated into health visiting.

3.5 Influence of Primary Care

Following the 1974 reforms, the majority of HVs became attached to primary health care teams and were based in a health centre, a medical centre or within a GP surgery, alongside practice nurses. Ashton and Seymour (1988) have described how primary health care in the UK is organised around primary medical care. They explain how this type of medical care is built on access to both preventative and treatment services provided by a community-based team of health care professionals. In contrast, primary health care is explained as a social concept that takes a wider population approach to health and which seeks to involve local lay people as well as trained professionals. The aim is to encourage public participation to develop community services that are responsive to the needs of both individuals and communities and to facilitate closer co-operation with other agencies (Ashton and Seymour 1988). This broad concept of primary health care fits with public health principles which emphasised the positive definition of health, inter-sectorial strategies and community participation (WHO 1981).

However, primary care in the UK is dominated by GPs who have tended to adopt a much narrower perspective, focused on care and treatment of patients with disease processes rather than health promotion and the prevention of illness (Baggott 2000). This approach has been supported by government policy, and GPs have maintained their positions of power within the primary health care team. Recently, there has been a move away from HVs being based in primary care teams, as several difficulties and restrictions were identified with the delivery of a locality-based health visiting service (Smith 2004, Hoskins 2009). These studies also illustrated how GP contracts and commissioning resulted in GPs acquiring more control over the development of primary nursing care than the nurses themselves (McIntosh 2003). For example, health promotion within primary care has been based on a deficit model of health, shaped by GP contracts to reduce the risk of ill health (McIntosh 2003). Since the onset of GP fund-holding, health visiting services have been purchased in line with this model (Table 3, p.42 below). At this time the practice reality of a universal selective service was also influenced by the evidence-based Hall Reports (1989-2006) and the Audit Commission Report on "*Seen but not heard*" (1994). As a consequence, an evidence-based

model of child health promotion, based on a number of recommended core health contacts and the targeting of child health services to those with the greatest health needs, has been commissioned and is highly influential on health visiting practice.

3.5.1 Influence of the Hall Reports (1989-2006)

In 1989, a national standard programme of Child Health Surveillance was established by the British Paediatric Association. A total of four reports were published by Sir David Hall, a Sheffield-based paediatrician. The Hall Reports (1989, 1991, 1996 and 2003) identified the requirements for a National Child Health Promotion Programme (Blair et al. 2010). The core universal programme described in the fourth edition was also implemented as the core programme for the National Service Framework for Children, Young People and Maternity Services (DH 2004). Following the onset of GP fund holding, GPs purchased the health visiting service, in conjunction with the primary health care team, to provide the Child Health Promotion Programme to families who were registered with their practices.

The Hall Reports also provided guidance to purchasers of child health services on how the services should be purchased. For example, in 1996 (Table 3, p.42 below) health service commissioners were advised to commission a narrowly focused health visiting service based within a deficit model of health, reducing ill-health and child abuse through immunisations and screening of risks:

“the activities of health visitors should be targeted towards families most in need” (DH 1996 p.40).

Table 3: The three components of the Child Health Promotion Programme (DH, 1996, p.31)

<p>Primary prevention concerned with reducing the incidence of a disease, disorder or condition in a population, e.g. through immunisation, prevention of accidents and child abuse, and help to families to bring up their children.</p>
<p>Secondary prevention aimed at reducing the prevalence of disease and other departures from good health by shortening their duration or diminishing their impact through early detection, and prompt and efficient intervention, e.g. screening programmes currently included in the child health surveillance.</p>
<p>Tertiary promotion aimed at reducing disabilities and promoting the child’s and parents’ adjustment to diseases which cannot be ameliorated” (DH, 1996).</p>

As Table 3 (p.42) demonstrates, HVs working from a practice population were commissioned to concentrate on the delivery of the core service to individuals rather than to

communities. In this model, primary and secondary prevention involved assessment and screening of individuals for the purpose of identifying a health problem. This approach was critiqued as causing a tension for a wider community public health practice concentrating on individual behaviours and away from the underlying social and contextual causes of ill health (Cowley 2008). The focus on individual screening for risk in the core work and child protection resulted in less time being spent by generic HVs on wider community-based health promotion activities within localities. Cowley and Frost (2006) suggest that this was because community work was not recognised by commissioners as legitimate. Subsequently, the narrow individual focus has been described as a major barrier to wider community service delivery as it has reduced the time available to HVs to tackle the wider determinants of poor health, both in practice and at a more strategic level (Smith 2004, Hoskins 2009).

3.5.2 Health visiting and targeting services to those “most in need”

Since the early 1990s the health visiting service has experienced a reduction in the number of HVs, leading to HVs having larger caseloads and having to prioritise their work (Elkan et al. 2000). There has also been pressure to change from a universal health promotion service to targeting “families in need” within a universal caseload (Audit Commission 1994). More recently, the HV Implementation Plan (DH 2011) has again reconfigured the service. Health visiting is now described as a progressive universal service with four levels (which will be further discussed later in the chapter):

- Community
- Universal
- Universal Plus and
- Universal Partnership Plus.

Elkan et al. (2000) suggested that the introduction of a universal selective approach resulted in a reduced service being offered, as the service would be shaped in relation to targets, i.e. improving breastfeeding, or in relation to ‘at risk’ families (Elkan et al. 2000). Using breastfeeding as an example, Elkan et al. (2000) explained how a purely top down, targeted public health approach would lead to an increase in support services for breastfeeding women. However, the cost of this service development would be a reduction in the help and advice offered to women who were using formula to feed their babies. This, they predicted, would eventually lead to a more stigmatised, less flexible and acceptable service (Elkan et al. 2000).

Another objection to the targeting of selected services to 'at risk' groups is based on the epidemiological argument that disease and risk factors form a continuum of health across a population. Therefore, the most morbidity arises in people who are not considered at high risk rather than in the few who are. The argument for developing services for those 'most at risk' of ill health is therefore based on what has been described as the limits of epidemiological knowledge (Elkan et al. 2000). This criticism of epidemiology has many supporters, including eminent epidemiologists (Rose et al. 2008, Marmot 2010) who believe that the population cannot easily be divided into 'healthy' and 'unhealthy'. Instead, effective health promotion requires that many people must take precautions (Rose et al. 2008, Marmot 2010). Rather than viewing ill health and 'risk' of ill health as deviancy from the norm, Rose et al. (2008) advocated that health should be seen as a continuum with population-wide programmes of intervention to address health inequality and achieve maximum gains in public health. Marmot et al. (2010) describe this as proportionate universalism, because the resources, in this case health visiting, are directed to address known health inequalities. Elkan et al. (2000) support this approach, because a selective health visiting service purchased within narrow provider targets of a core service may become a service out of the reach of the most disadvantaged, and less accessible to the most vulnerable in society.

The final section of this chapter aims to examine critically the health visiting service in the light of 'new social risks' of social exclusion, and to demonstrate how HVs are now part of the 'early intervention' paradigm.

3.6 New Labour Policies and Public Health

This chapter has demonstrated how, over the last thirty years, the concept of risk has been applied to health visiting. This has been in relation to infant mortality and, more recently, to child protection and the key role of HVs '*to identify children with high risk and low protective factors*' (DH 2009a p.14). The concept of risk therefore appears to be an ambiguous concept whose meaning can be constructed and reconstructed through government policy, commissioned services and in practice. Since 1997, there has been a discontinuity in family policy (Lister 2006, Dodds 2009), resulting in more services for families living in disadvantaged areas with pre-school children.

In 1997, New Labour policies - underpinned by 'Third Way politics' - promoted a 'social investment state' in which citizens actively participated in both their rights and responsibilities as members of society. In relation to the NHS, the rights of an individual

would equate to access to free health care, whilst their responsibility would be to maintain a healthy lifestyle for themselves and their children.

The development of this 'social investment state' is accredited to have been influenced by Beck's theory of the 'risk society' (Beck 1992). This theory emphasises how individuals can actively engage with particular risks. This is in contrast to individuals assuming a passive attitude, which leads to dependency on the state (Dodds 2009). New Labour 'Third Way politics' argued that this notion of passivity and dependence on state benefits needed to be addressed (Giddens 1994). Rather than believe that someone would take care of the problem, Giddens instead argued that the role of the state was to invest in services that would help people to help themselves, to provide opportunities for people to participate in society. Giddens argued that, in a modern society, individuals can confront the risk of poverty either through employment or by participating in local services. Subsequently, by not engaging with the services provided to help them to gain employment, these individuals were viewed as socially excluded, hard to reach and 'at risk' to themselves and their children (Dodds 2009).

As discussed in Chapter 2, government investment in children was not new. What was new was New Labour's approach of putting children at the centre of government policy and thereby marking a discontinuity in the social policy relating to children (Glass 1999, Lister 2006). More recently, the inclusion of the statement: "*children who are at risk of social exclusion*" in the HCP (DH 2009a p.8) is a reflection of New Labour's social investment policy and clearly links health and parenting with social exclusion policies. While parents have primary responsibility for the outcomes of their children, there is a growing acknowledgement that they have a right to support from government to help them to meet their responsibilities (DfES 2004).

With the election of the Labour government in 1997, it was recognised that the individualistic model of public health as presented by previous governments was limited, and new strategies were required to begin to address health inequalities (Ham 2009). The New Labour government set in place many initiatives concerned with both reducing health inequalities and promoting the health of individuals and families (Earwicker 2007, Ham 2009), and the recommendations of the Acheson Report (1998) giving high priority to the health of families with children were also taken on board (Earwicker 2007).

3.6.1 Universal Early Years Services – Early Intervention

Shortly after the New Labour government was elected, the Green Paper ‘*Supporting Families*’ consultation document (Cabinet Office 1998) was published and, in 1999, SSLPs were introduced. This rapid development in early years’ services demonstrated the importance that New Labour gave to recent early childhood research (Glass 2006). In particular, the work from the research group commissioned by Sir Keith Joseph was highly influential, as was the positive evidence from randomised controlled trials of early years’ interventions carried out in the USA (Meluish and Hall 2007). The Government appeared to view early intervention programmes as a means of preventing problems from developing in later life. In the beginning, these problems related to social exclusion, criminal behaviour, health inequality and well-being. In relation to health, the government appeared to be influenced by life course epidemiology. ‘Life course epidemiology’ is defined as:

“the study of long term effects on later health or disease risk of physical or social exposures during gestation, childhood, adolescence, young adulthood and later adult life” (Kuh et al. 2003 p.778).

The life course approach amalgamates material, structural and psychosocial explanations of ill health and health inequalities. It also reveals how a child’s health may be affected by socioeconomic status *in utero*, in childhood and also in later adult life. Anning and Ball (2007) explain how this also represented the adaption by policy makers of an ecological approach to understanding child, parent, family and community. Bronfenbrenner’s (1979) model of child development, which was and is highly influential in the USA, has been influential in England in recent years. It shares similarities with Whitehead and Dahlgren’s (1991) social model of health. Both models place the individual or child at the centre and both models emphasise the layers that can influence personal behaviours and lifestyles. Bronfenbrenner’s model emphasises the cultural influences on a child and the psychological and structural factors that may have influenced their parents’ experience of, for example, authority figures such as teachers or health professionals. Bronfenbrenner’s model has been adapted for use in practice in the UK. For example, the Framework for the Assessment of Children in Need and Their Families (DH 2000) is underpinned by Bronfenbrenner’s (1979) ecological model. The intention of the Framework is to enable an assessment which allows for both the risk factors and the strengths of a parent to be acknowledged. This is a shift in practice as, historically, HVs have been concerned with the identification of parental risk factors or vulnerabilities (Robinson 1982, Appleton 1996, Lowe 2007). A strengths-based model is now being promoted in health visiting with the most at risk families. For example, the Bronfenbrenner (1979) model of child development is incorporated into the Family

Nurse Partnership (Barnes 2010) and, within that, programmes such as the Ages and Stages Developmental Screening Tool also incorporate an ecological strengths-based approach and aim to encourage parental involvement and participation in their child's developmental assessment.

SSLPs were originally part of a national programme designed to provide joined-up services of health, childcare, play, early education and parental support to families with a child under the age of four. Anning and Ball (2007) have described the introduction of pre-school programmes influenced by Bronfenbrenner's (1979) ecological model as reflecting a shift in conceptual models that underpin child policy in the UK. The SSLPs have also been described as the glue that would bind together services for families: as 'one stop shops' providing local services to disadvantaged areas which often had few services (Barnes 2007).

Subsequently, SSLPs were expected to provide outreach and home visiting, support for families, good quality play and day care, advice about child health and development, and family health. In 2006, the SSLPs were amalgamated into Children's Centres. They were described as being at the heart of the 'Every Child Matters: change for children' agenda (DfES 2003). The outgoing Labour government's policy stipulated that all children under the age of three would have access to a Children's Centre which would provide some of the integrated services described above. Since 1997, there has been huge growth in the provision of early years' services and there is continued support from the Coalition government elected in 2010 for the provision of high quality, early years' services as a way to reduce health inequalities (Marmot Review 2010, Allen Report 2011).

3.6.2 Every Child Matters

The Children Act (2004) and the associated consultation document, Every Child Matters (DfES 2004), have been described as the documents which placed children 'at risk' from social exclusion at the centre of New Labour's developing childcare policy (Morris 2005, Parton 2008). This section aims to examine briefly the changing policy understandings that arose from the shift from 'children in need' to 'children at risk' (Morris 2005) in relation to the provision of universal health visiting services.

Table 4: Aims of Every Child Matters

<p>The aim of the Every Child Matters programme was to give all children the support they need to:</p> <ul style="list-style-type: none">• be healthy• stay safe• enjoy and achieve• make a positive contribution• achieve economic well-being. <p><i>Department for Children, Schools and Families (From the DCSF website 2010)</i></p>
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The five broad outcomes of Every Child Matters (DfES 2004) (Table 4, p.48) shifted the focus from children at risk of abuse onto a wider definition of child health and wellbeing. The Department for Children, Schools and Families (DCSF) was a government department that existed from 2007 until 2010. At the time, its website portrayed the idea that the changes to the Children Act were a result of Lord Laming's inquiry (DH/HO 2003) into the death of Victoria Climbié, and were always intended to be for all children. Williams (2004), Clarke (2006) and Parton (2008) have each argued that the five outcomes were also a culmination of much research into the lives of children at risk of social exclusion, especially Looked After Children in Local Authority Care and have also described the ACT as a major reform in the delivery of universal children's services.

3.6.3 The Children Act 2004 and its relationship to 'new social risks'

In the 1990s, government-funded research (DH 1995) suggested that children's health and wellbeing could be improved, and one suggestion was to refocus services to include 'children in need' as well as child protection (DH 1995). The remit of the 1989 Children Act had legitimized local authorities to shift their focus from purely child protection work to include 'children in need'. However, government research (DH 1995) indicated that this had not happened and recognised there was a need to support families, mainly when there were concerns about parenting style

"in families which were low in warmth and high in criticism" (DH 1995 p.54).

Another reason for this change was that the definition of 'children in need' needed to be broader, as delayed speech and learning difficulties were often missed in the early years, especially amongst children from lower social class backgrounds (Barnes 2007, Meluish and Hall 2007). Furthermore, early developmental difficulties and harsh, inconsistent parenting,

unemployment, and parental mental health problems had been described as precursors to anti-social behaviour and crime (Rutter et al. 1976).

The Green Paper, 'Every Child Matters' (2003), was recognised as important in shaping the reformed children's services (Meluish and Hall 2007, Parton 2008). It achieved this in several ways. Firstly, the Children Act (2004) defined children and childhood as being from aged 0-19 years and this change in definition is accredited to the research on 'looked after children'. Its aim was to ensure that older children in the looked after system would have the opportunity for better outcomes because, at the time, there were large numbers of Looked After Children who were experiencing poor educational outcomes, engaging in anti-social behaviour, experiencing poor health or who were very likely to become teenage parents (Parton 2008).

The reforms, it was anticipated, would also result in better outcomes for children living in disadvantaged areas, and this would be achieved by offering a range of targeted services through a universal context that included Health, Sure Start Centres, Education, Social Services and Primary Child Adolescent Mental Health Services (ECM Green Paper 2003). A second aim of the Children Act (2004) was to encourage partnership working between agencies (Meluish and Hall 2007). The Act placed a duty on health agencies to work with local authorities and improve child health, welfare and well-being. It also promoted information-sharing between organisations, and the broader term 'safeguarding' replaced the term 'child protection' (Barnes 2007). The Government at that time viewed SSLPs as the approach which would achieve the five outcomes of the Children Act (DfES 2004) (Table 4, p.48)

However, the National Evaluation of Sure Start (NESS 2005) into the impact of SSLPs on children and families concluded that this highly visible Government project had not been successful in its aim of reaching all families or in being able to break the intergenerational cycle of poverty, school failure and social exclusion,

"there was very little evidence that SSLPs achieved their goals of increasing service use or of enhancing families' impressions of their communities" (NESS 2005 p.7).

NESS (2005) suggested that this might be because the programme had been running for only three years and so was still developing. They also described how 'standard' approaches such as using the Centre as a meeting place was not enough for some 'hard to reach' families. They gave examples of 'hard to reach' as groups with language difficulties, fathers,

or asylum seekers. They suggested that these groups required a strategic approach because some areas had successfully employed workers with specialist knowledge of a client group, or who were bilingual. They also spoke of clients with whom a more sensitive approach was needed, as research (Anning and Ball 2007, Meluish and Hall 2007) had indicated how the provision of new services might be overwhelming for some families, or that clients were 'turned off' because the support offered was related to finding work, stopping smoking or increasing breastfeeding and therefore might be viewed as judgemental (Belsky and Meluish 2007). Moreover, it was recognised that amongst families living in deprived areas, those families with more resources were better able to access the services. In contrast, families with fewer resources (teenage parents, unemployed families, lone parents) were least likely to be using the services (Belsky and Meluish 2007). The report discovered that 'hard to reach' groups were not using the very services that had been designed with them in mind.

NESS (2005) reached the conclusion that health-led SSLPs achieved better results in engaging with disadvantaged and 'hard to reach' families. The main reason for this was, the researchers felt, that health-led programmes were better positioned to identify 'at risk' families because of access to birth records and had a system in place for visiting young families prior to the introduction of Sure Start (Meluish et al. 2007). However, this research did not link into how that might have happened, or how the HV's approach might have helped in working with families living within the reach of Children's Centres. It appeared that having access to birth records held the implicit assumption that health visiting was able to reach the 'hard to reach'. In contrast, Robinson's (1982) study began as an investigation into improving the health visiting service for families who did not use the services provided, and concluded that relationships with disadvantaged clients were most important in reaching clients.

3.7 Health visiting and 'new social risks'

The Health Visiting Review (Lowe 2007 p.22) promoted health visiting as a service able to "*reach the hard to reach*". It also recommended that HVs in practice should be "*engaging hard to reach groups and individuals*". Furthermore, the purpose of the Review was to modernise the role of the HV.

The Review linked with the updated National Service Framework (NSF) standard on the Child Health Promotion Programme (CHPP) in two ways. Firstly, it made the recommendation that HVs should be the lead professionals in the delivery of the CHPP. Secondly, many members who worked on the Health Visiting Review were also involved in

the development of the NSF. Therefore, it would appear that the Health Visiting Review and the NSF were both influenced by the evidence available on promoting child health. Identified as Health for All Children (Hall and Elliman 2006), guidance on behaviour change from the National Institute for Health and Clinical Excellence (NICE) (2006) and postnatal care (NICE 2006), and a systematic review of health-led parenting programmes by the University of Warwick (Barlow et al. 2008). The Review and updated HCP (DH 2009a) both acknowledged parenting as a social determinant of a child's future health. The major recommendations in the Health Visiting Review represented a shift in the focus of health visiting:

“The focus of health visitors should be early intervention, prevention and health promotion for young children and families, as this is where their nursing and public health skills and knowledge can have the greatest impact” (Lowe 2007 p.6).

The Review specifically linked health visiting practice with the early intervention programmes of the Labour government. Furthermore, it proposed a shift away from a universal core service to ‘progressive universalism’, and the Review defined ‘progressive universalism’ as a universal service:

“systematically planned and delivered to give a continuum of support according to need at neighbourhood and individual level in order to achieve greater equity of outcomes for all children. Those with greatest risks and needs receive more intensive support” (Lowe 2007 p.25).

How this was to be achieved was not specified in the Review, but a definition of ‘new social risks’ was given in the revised HCP (DH 2009a)

3.7.1 ‘Hard to reach’ and Progressive Universalism

In a chapter entitled Child Health Promotion – Focus on Parents (Hall and Elliman 2006), the topic of “*hard to reach*” is discussed. The authors acknowledge the challenge of engaging all parents and believe that the recent findings into SSLPs (NESS 2006) reflect and support previous research findings into traditional child health surveillance programmes, which had demonstrated a steady decline in service uptake, in disadvantaged areas, as children grew older (Hall and Elliman 2006). Belsky and Meluish (2007) found that reducing health inequalities was very complex and sometimes unintended consequences resulted. Hall and Elliman (2006) presented a strong case against health visiting becoming a wholly targeted

service as they also recognised how shifting from a universal to a 'targeted' or 'selective' service may lead to some 'at risk' families becoming beyond the reach of the service (Hall and Elliman 2006).

They too recommended progressive universalism as a means of addressing health inequalities. Progressive universalism and the provision of a flexible targeted service has received overwhelming support as a way effectively to improve the health of the whole population (Rose et al. 2008, Acheson 1998, Marmot 2010, Allen 2011, Field 2011). Progressive universalism appears to be a public health approach to health promotion which requires partnership work with parents and other agencies to promote children's wellbeing and physical health.

Whilst only briefly referred to in the HV Review, progressive universalism has been described as having two levels: top down and bottom up (Cowley 2007). The top down approach shapes the service in response to the production of epidemiological data provided by local Public Health teams. The bottom up approach is where the HV carries out a health needs assessment in partnership with the parent at the individual family level. The combination of the two levels is described as a way of providing an effective model of health promotion. This approach to progressive universalism assumes the provision of a flexible service tailored to meet individuals' health needs, based on services being streamlined and developed both strategically and individually in accordance with health needs in that area (Baum 2007, Cowley 2007). However, there is little information on how the work of HVs is captured and given credence to by commissioners of the health visiting service.

The Coalition government continues to support the provision of effective early intervention programmes, and to recognise the effectiveness of agencies working together to promote good quality services that offer joined-up support to families (Field 2011, Allen 2011). They also continue to support and strengthen the health visiting service as the lead professionals in the delivery of an effective HCP (DH 2011).

3.7.2 The Healthy Child Programme and new social risks

In 2009, the Child Health Promotion Programme was renamed the Healthy Child Programme (DH 2008, 2009a). The Programme included risk factors previously associated with 'hard to reach' (SEU 2007) and it suggested that the term 'hard to reach' was synonymous with 'vulnerability:

“children with a number of parental risk factors and few protective factors are the most vulnerable in society and therefore, to be more effective, services will require a more targeted approach. It is estimated that around two per cent of families in Britain experience five or more of the following disadvantages:

- *Neither parent in the family is in work*
- *The family lives in poor quality or overcrowded housing*
- *Neither parent has any educational qualifications*
- *Either parent has mental health problems*
- *At least one parent has a longstanding limiting illness, disability or infirmity*
- *The family has a low income*
- *The family cannot afford a number of food and clothing items”*

(HCP 2008, 2009 p.14-15).

There had been a shift away from health promotion based purely on ill health risks to a broader approach based on both material/structural context and ‘parental risk factors’. Consequently, HV assessment focussed on assessing families’ health needs in relation to their ‘risk’ and ‘protective’ parenting factors.

3.7.3 Social exclusion - a medical definition

One aim of the HCP was to improve services in order to provide more support for families living in disadvantaged areas (DH 2009b Healthy Lives); yet there was little guidance for HVs in how to interpret the ‘new social risks’ in a positive and health enhancing way:

“One way to improve the lives of children is to make it easier to be a good parent. Being a good parent is more straightforward for those who have an adequate income and a home in a supportive community. Poverty, unemployment, disorganised services in run-down housing estates with high unemployment, shifting population, poor schools, inadequate public transport, vandalism, burglary, violent crime, etc. all affect children both directly and indirectly and through the negative impact on their parents. The term social exclusion is used to describe the situation of people living in such circumstances. It can be defined as the inability of our society to keep all groups and individuals within reach of what we expect as a society and the tendency to push vulnerable and difficult individuals into the least popular places” (Hall, Williams and Elliman 2009 p.15).

This medical definition of social exclusion appears to include references to both the moral underclass discourse (MUD) and a redistribution discourse (RED). Whilst recognising the complexity and difficulties of parenting in poverty, this definition also includes the idea of poverty *disabling* parents, preventing them from reaching the norms of society. Parton (2008) has criticised this approach because it labels parents living in poverty as being dangerous to their children, legitimising the need for the greater surveillance of some families. There is a danger that services offered to 'at risk' parents may then be resisted by families as it is based on predetermined risk factors, an approach that has been found to be a barrier to service utilisation (Appleton 1996).

In relation to safeguarding, or child protection issues, much has been written about the limitations of using 'risk frameworks' to define health visiting practice (Appleton 1996, Cowley 2008). The complexities of assessing vulnerable families incorporate a combination of risk factors, professional judgement and family involvement in order to carry out a family needs assessment (Appleton 1996, Mitcheson and Cowley 2003, Hall and Elliman 2006). However, with regard to the 'new social risks', it is recommended that a combination of any five risks would indicate that a family was 'at risk' of social exclusion, the most disadvantaged, and often the 'hardest to reach' (Social Exclusion Unit 2007). Such families were to be offered an early intervention programme that aimed to reduce health inequalities and social exclusion; in the case of teenage mothers, this would be the offer of the Family Nurse Programme (DH 2007). Consequently, the main aim of the revised HCP is to promote a paradigm shift in service delivery. It aims to prevent problems by focusing on babyhood or early child development. It also aims to reshape the universal health visiting service by supporting an increase in service provision to those families experiencing health inequalities and identified at risk of social exclusion.

The social exclusion policy document 'Reaching Out: Think Family' (SETF 2007) identifies generic risk factors in relation to families 'at risk of' social exclusion, and these risk factors have been transplanted into the most recent HCP document (DH 2009a). These 'at risk' factors appear similar to the 'risk' factors identified in relation to child abuse in previous Hall Reports (Browne 2003, cited in Hall and Elliman 2003).

Table 5: Risk factors in relation to child health promotion 2003-2009

Risk factors in relation to child abuse (Health for all Children, Hall and Elliman 2003)	'Social risk factors' in relation to children at risk of poor educational and social outcomes. (HCP 2009 pp.14-15)
	Stress in pregnancy
Parent indifferent, intolerant or over-anxious towards the child	Ambivalence about becoming a parent
History of family violence	Unstable relationships; intimate partner abuse. Parent/s with a history of antisocial or offending behaviour
Socio-economic problems such as unemployment	Families: living in poverty Families: mother's main language is not English Parents: not in education, employment or training Educational: parents with few or no qualifications, non-attendance or learning difficulties Families: social housing, especially unsatisfactory accommodation
Infant premature, low birthweight, separated from mother for more than 24 hours post-delivery	
Parent abused or neglected as a child	Families in which one or both parents grew up in care
Step parent or co-habitee parent	
Single or separated parent	Families in which the parents are not co-resident
Mother under 21 years old at the time of childbirth	Families with a young mother or father
History of mental illness, drug or alcohol addiction	Parents with mental health problems A history of abuse, mental illness or alcoholism in the mother's own family
	Families with low social capital Low self-esteem
Infant mentally or physically handicapped	
Less than 18 months between birth of children	
Infant never breastfed	
Difficult child behaviour	

On closer inspection (Table 5, p.55), the risk factors appear to have changed in 2009 and incorporate the broader risk factors related to the 'new social risks' of an individual's lifestyle, and 'risky' behaviours such as smoking or formula feeding. The newer definition has no risk factors directly associated with the child's behaviour; however, pregnancy is now recognised as a critical period across the life course of an individual (Marmot Review 2010).

Instead, the focus of the 'new social risks' is on the broader context of parents-to-be. These 'social risks' relate to the risk of social exclusion and include socio-economic factors, as well as alcohol and drug issues of the parent. Moreover, the parents' mental health, their experiences of being parented and their current health and wellbeing are all considered as risk factors which may require early intervention. The 'social risks' in Table 5 (p.55) also include the social determinants of health that may prevent family involvement or participation in services. In relation to life course epidemiology, these factors have been described as "the causes of the causes" - the social determinants of health inequalities:

"the social conditions that give rise to high risk of non-communicable disease whether acting through unhealthy behaviours or through the effects of impossibly stressful lives" (Marmot 2005 p.1102)

It would appear that within a deficit model of health, 'hard to reach' parents are being constructed as a health determinant or a health risk to their children. This new paradigm also shifts the focus onto parenting and early intervention through parenting support. Furthermore, the Health Visiting Review (Lowe 2007) places the responsibility for engaging 'hard to reach' families on HVs in partnership with the parents to build and develop on positive protective factors.

3.7.4 The Healthy Child Programme and Protective Factors

The revised HCP (DH 2009a) briefly mentions protective factors (Table 6, p.57) which relate specifically to parenting and recommended health behaviours

Table 6: Protective Factors: The Healthy Child Programme (DH, 2009a)

Protective Factors
Authoritative parenting combined with warmth, affectionate bond of attachment being built between the child and the parent from infancy
Parental involvement in learning
Protective health behaviours, smoking cessation in pregnancy
Breastfeeding
Psychological resources such as self-esteem

This marks a subtle change in direction for the HCP, especially in the child's first year. In previous programmes the focus was on more tangible health elements - the physical aspects of child promotion such as immunisation, accident prevention and safety or screening for developmental delay - as markers for HV interventions. The revised programme appears concerned with promoting the above mentioned individual protective factors in relation to parenting and evidenced-based health behaviours.

The recognition of protective behaviours in the HCP (DH 2009a) is the result of wider, evidence-based research into parenting. This approach represents a subtle change, and one influenced by the development of an international and national public health approach concerned with promoting 'assets' and 'protective factors' in families and communities. This approach offers an alternative to the mainstream deficit model of health as its focus is on adaptive behaviours that may build health and wellbeing (Schoon 2006, Morgan and Ziglio 2007).

Unfortunately, the main focus in the HCP (DH 2009a) remains on the early detection of risk factors associated with disability, child protection, and physical or behavioural problems. The families most 'at risk' are now families at risk of social exclusion or vulnerability, risk factors that have in the past also been associated with infant mortality and child abuse. There remains a danger that 'new social risks' may appear familiar to HVs and the shift to a broader health promoting approach may be lost. One reason for this is the ambiguity in how 'risk' in relation to health visiting has been defined and redefined. There was little clear guidance in either the Health Visiting Review (2007) or the Health Visiting Implementation Plan (DH 2011) in relation to practitioners working with 'hard to reach' families in order to carry out health promotion work. Consequently, there was little clear guidance on how HVs should approach early intervention work, not only to reach but to engage with disadvantaged families.

3.8 Hard to reach'

Whilst there was a dearth of literature into the concept of 'hard to reach' in health visiting literature, research into the concept has been undertaken in other community-based settings. Doherty et al. (2003, 2004) was one of the first to recognise and investigate the complexity of the term 'hard to reach'. 'On Track' was a preventative service for children aged between four and twelve years, who were at risk of involvement in crime. It was devised by the Home Office in 1999 as part of its crime reduction programme. The research for it was commissioned in 2002, and a qualitative study, incorporating focus groups with service providers, was undertaken; the study related to the delivery of 'On Track' and engagement with partners and service users and developed a broad typology of 'hard to reach', consisting of three types:

- Type A: the traditionally under-represented - those who access fewer services.
- Type B: the invisible - who do not access the services provided for them.
- Type C: the service resistant - those who are unwilling to engage with services (Doherty et al. 2004).

The providers and informants came from a variety of backgrounds: health, social work, youth offending and the police. The findings and development of a typology highlighted the complexity of the term, but replacing the concept with three further negatively named groups also identified the potentially stigmatising nature of the term (Brackertz 2007, Barrett 2008, Evangelou et al. 2011). However, understanding the term from the point of view of the different providers was an important step in appreciating how the term was understood by the different providers. Doherty et al. (2003, 2004) also highlighted 'the diversity, the variety and the multiple, complex nature of the needs of different client groups within the concept of 'hard to reach'.

In the light of these findings, 'On Track' providers re-examined their attitudes and approaches and began to tailor the service to develop different strategies in order to meet the differing needs of the various client groups within the broad description of 'hard to reach' (Doherty et al. 2004).

3.9 Conclusion

This chapter has explored how the changing nature of the term 'risk' has influenced and shaped health visiting since the 1970s. The terms 'risk' or 'risk factors' have been used to describe children 'at risk of ill health' and also children 'at risk of child abuse' (Hall and Elliman 2006). The updated HCP (DH 2009a) appeared to be discussing risk in relation to

the 'new social risk', the risk of social exclusion (see previous chapter for discussion on social exclusion) and parenting in poverty. Socially excluded families are viewed by successive policy documents as 'hard to reach', and at greater risk of health inequalities (Marmot et al. 2010) and requiring targeted services to reduce this risk. Table 5 (p.55) demonstrated the similarities between 'risk' factors in relation to child abuse and risk factors in relation to 'new social risks'. These similarities reveal how ambiguous the concept of 'risk' is and how, unless a clear definition of 'hard to reach' is provided, HVs and commissioners may not be able to recognise that a broader approach to child health and well-being is being taken.

This chapter has also demonstrated how the health visiting service has adapted to meet the changing policy landscape from 1974 onwards. It has revealed how the ability of HVs to 'reach the unreachable' has a long history and, notably, how 'reaching the hard to reach' was often in response to the growing evidence base on health inequalities (Robinson 1982). The successive Hall Reports have been influential in shaping the health visiting service towards the delivery of an evidence-based, lean core service. This has resulted in a targeted or selective health visiting service which is associated with assessment and 'risk factors' of individual families. The concept of 'hard to reach' described in the HCP shares many similarities with the notion of 'children at risk' of infant mortality, safeguarding and child protection; yet this literature review has revealed a dearth of material on how today's mainstream HVs reach and engage with families who are considered at risk of social exclusion or who are labelled as potentially 'hard to reach'. Therefore, it appeared important to find out how HVs assess, perceive and respond to 'hard to reach' clients. The next chapter will critically examine the literature on 'hard to reach' in relation to health visiting and early intervention programmes.

4. Literature review on 'hard to reach' in health visiting and early intervention programmes

4.1 Introduction

The previous chapter explored how 'risk factors' had been used to define children at risk of infant mortality, and child protection and how it was now being used to define children living in families who were members of 'hard to reach' groups. The literature search revealed that there was little empirical research on the concept of 'hard to reach' in relation to health visiting. When mentioned, it was discussed interchangeably with the synonyms 'vulnerable', 'disadvantaged', 'at risk' families, 'under-represented' or 'non-engagers' (Brackertz 2007, Hall and Elliman 2006). These terms were utilised in the literature search to identify documents for the literature review. As with many other reviews into health visiting (Elkan et al. 2000, Cowley et al. 2013) there were very few randomised-controlled trials on this subject in health visiting; instead the search revealed mainly qualitative papers as a result of PhD studies, professional interest papers and commissioned research into other services for children living in 'hard to reach' families. The search revealed papers on HVs' work with vulnerable families and these professional papers have been included in this review because they discuss how HVs engage with vulnerable 'at risk' families. This chapter aims to discuss the themes which emerged from the research literature in relation to the engagement and non-engagement of vulnerable families in both health visiting and early intervention programmes. The five themes are:

- Professional judgement in health needs assessment and the identification of vulnerable families
- Partnership work
- Client views of the health visiting service
- Settings
- Early intervention: research into 'hard to reach'

4.2 Professional judgement in health needs assessment and the identification of vulnerable families

This section will critically examine the health visiting literature on identifying families through professional judgement and health needs assessment. Chapter 2 above described how the political climate and the focus on the provision of an effective health service affected the universal nature of health visiting. Following the Audit Commission Report, '*Seen but not*

Heard' (1994), which strongly argued the need for health visiting to target their work at vulnerable families with identified health needs, this resulted in many Community Trusts implementing screening tools to identify vulnerable families in relation to child protection (Appleton 1994). In response to this top down approach, Appleton (1994) questioned the use of such tools. Appleton (1994, 1996) and Williams (1997) are examples of published papers identifying the skill involved in defining and identifying vulnerability. Both papers described the role of HVs carrying out health needs assessments based on professional judgement. Appleton (1994, 1996) and Houston and Cowley (2002) also demonstrated how the use of screening tools for health needs assessments with vulnerable families were unreliable, simplistic and difficult to use in practice. More importantly, they all highlighted how the assessment of vulnerability in relation to individual need was a complex multi-factorial process, which HVs were able to carry out successfully in a professional manner. Appleton (1996) discussed how the concept of vulnerability was difficult for HVs to articulate succinctly. Instead, HVs explained that it was an 'ambiguous' term and, rather than being a simple one-off exercise, the assessment involved a longer process of assessing and identifying vulnerability in a family; this process was defined as:

"a complex interaction of factors rather than the simple sum of factors"
(Appleton 1996, p.916)

Appleton (1994, 1996) developed a model of vulnerability at the individual/family level to describe the complex interplay of "internal and external stress factors". Internal stress factors in Appleton's study related to parental health problems, such as emotional psychological difficulties, relationship difficulties/role conflict, isolation. External stress problems were identified as social factors, including poverty, homelessness, cultural factors and factors beyond one's control, such as a lack of support networks. Characteristics or factors of vulnerability were also identified by Williams (1997). She discussed the issue of vulnerability and how vulnerable families were identified in two focus groups with HVs. One was held with HVs from an inner city area and one with HVs based in a suburban area. This small scale study only involved two focus groups consisting of seven HVs, yet they identified more than 50 factors, which were grouped into nine broad categories (Table 7, p.62). The identified categories demonstrated how vulnerability related to an assessment by the HVs of an individual's risk factors, such as poor coping skills or poor parenting skills, as well as external factors which related to the individual's social circumstances.

Table 7: Definitions of vulnerability factors in health visiting

Appleton (1994)	Williams (1997)
Vulnerability factors in relation to child protection	Vulnerability factors in relation to maternal mental health
Ambiguous and complex concept A non-permanent state Broad definition relating to individual circumstances	Diversity of factors which could give rise to vulnerability Notion of vulnerability could apply to anyone Individual assessments of client by HV
Internal stress factors Parental health problems Emotional psychological difficulties Relationship difficulties/role conflict Isolation Social problems	Personal vulnerability factors Lack of social/family support Factors relating to the mother, e.g. self-esteem, coping skills, maternal age, previous history Parental skill, e.g. parenting skills, cooking, budgeting Factors relating to the child Maternal health, including mental health
External stress problems Social factors including poverty, homelessness, cultural factors Economic factors and factors beyond one's control (e.g. lack of support networks)	External factors Socio-economic factors, e.g. poverty, unemployment, race, homelessness Access to services, e.g. availability of services, confidence in using services Issues relating to a male partner, e.g. domestic violence, role contribution to child care Child protection issues, e.g. evidence of physical abuse
Attitudes of HVs Assessment on 'maternal coping ability' 'vulnerable families not being able to function normally'	Attitudes of HVs Suburban area partnership work In deprived areas judgemental language used

These two papers had a professional focus, concerned with explaining how HVs within a universal service carried out health needs assessment and targeted their work to meet HV-identified health need. In explaining the concept of vulnerability in relation to health need or being 'at risk of child protection' (Appleton 1994, 1996, Williams 1997), both authors highlighted the skill and professional judgement required by the HVs in identifying 'vulnerable' families. This research into the concept of vulnerability identified how a HV's knowledge of a family developed over time and demonstrated how HVs were able to engage with some individual vulnerable families to identify health needs.

Whilst the client is mentioned in these papers, the perspective of the HV in assessing and detecting health needs is the priority. How the HVs developed these relationships with 'vulnerable' clients appeared to be taken for granted and was underdeveloped in both papers. Furthermore, both Appleton (1994, 1996) and Williams (1997) describe the client as having problems which required resolution with the help of the HV. The HV terminology in categorising vulnerability appears associated with a deficit model of public health. Appleton's (1994) model of vulnerability also described how clients 'deviate from the norm' and both authors mention how a mother's 'failure to cope' was considered to be a clear indicator of vulnerability. Whilst material factors such as poor housing or living in poverty were mentioned, the HVs in both studies refer mainly to parental factors. This defining of vulnerability within a deficit model of health highlights the possible stigmatising nature of the process of health needs assessment because it appears to imply that the problem lay with service users rather than their circumstances.

In these papers, the professional role of observation and assessment through a relationship appeared to be placing the professional as the 'expert' - a top down approach which is dominated by the HV's agenda. This 'problem orientated' approach (Elkan et al. 2000), in which the HV searches for problems, is based on the deficit model of health and emphasises individual treatment and care.: the HV takes a traditional role as the definer of problems.

Academics with a health visiting background (Appleton 1996, Cowley 1996) recognised that to achieve effective needs assessment the approach had to shift from an 'expert' model of health visiting to a relational or partnership model. Yet both Appleton (1994) and Williams (1997) appear to provide evidence that with vulnerable families 'at risk' of child protection, this 'expert' approach was successful in engaging vulnerable families.

4.2.1 Professional papers on partnership working and effective practice

Table 8 (p.65) demonstrates the barriers and facilitators to client engagement identified from health visiting/home visiting literature. With regard to the professional literature, a relational model of health visiting had been advocated from the early 1980s (Orr 1980, Robinson 1982) as a way to reach clients. The relation-centred model appears similar to the partnership approach, "*as one that puts the continuing relationship with the parents first, a more psycho/social model of health*" (Robinson 1982). Robinson noted that social work research into effective ways of working with families had identified how a warm, supportive and friendly approach was effective in relationship building. However, the focus is on the HV as an expert who can shift between styles as and when necessary:

“Here the health visitor concentrates on developing her relational skills. She retains the implicit objective of utilising the clinical element in her observational skills, but these may recede if the family continues to resist” (Robinson 1982, p.29).

Earlier chapters above have revealed how health visiting was being developed in the 1970s with the goal of *“reaching the unreachable”*. The continuation of a universal rather than a targeted service was promoted as the best way to achieve this (Robinson 1982, Elkan et al. 2000), with professional judgement and assessment (Robinson 1982, Appleton 1996) delivered through a partnership approach (Robinson 1982, Kendall 1993, Barlow et al. 2005, Bidmead and Cowley 2005b)). However, as the earlier chapters have demonstrated, government ideology, economic constraints, societal changes, powerful professions, deficit models of care and changing construction of risks has dominated health policy development. These factors all resulted in implications for health visiting in practice, and the service is now focused on individuals with the main emphasis in the HCP on the detection of health and social risks to prevent ill health, both now and in the future (DH 2009a).

Robinson's (1982) research aimed to identify clients whose premature babies were considered to be 'at risk' of infant mortality. Her findings stressed the importance of a universal service and recommended that effective health visiting was best achieved through relationships. Partnership working with parents is the espoused model of practice in nursing and health visiting (NMC 2002). It has been suggested that active listening and prioritising their health needs with clients is important in partnership work (Bidmead and Cowley 2005b). Partnership has been defined as:

“Partnership with clients in health visiting may be defined as a respectful, negotiated way of working together 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 tenet. 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 and Cowley 2005b, p.283).

The move to a partnership approach appeared to be theoretically sound but was much more difficult to accomplish in practice (Kendall 1993, Bidmead and Cowley 2005a, 2005b). In developing their definition of partnership, Bidmead and Cowley (2005b) examined the growing body of work on the partnership model of health visiting. More recently, these

models have been criticised as being conceptual models, theories that need development through empirical research before they can be utilised in practice (Almond and Cowley 2008). Research into achieving effective partnership in practice has been undertaken and involved HVs undergoing further training in partnership working (Barlow et al. 2005, Bidmead 2013). Vulnerable families who had initially been wary of accepting the home visiting service appreciated the partnership approach of the home visiting study (Barlow et al. 2005a). Yet when the study finished, the service with built-in clinical supervision was not purchased (Barlow et al. 2005). The literature review for the current study found a number of papers on the work of generic HVs who successfully accessed and engaged with parents in health need assessments (Luker and Chalmers 1990, Jack et al. 2005). These papers have been included as they discussed the facilitators and barriers to partnership work.

Table 8: Evidence of barriers and facilitators to client engagement

Barriers to client engagement	Facilitators to client engagement
<p>HV research</p> <p>Expert approach (Robinson 1982, Kendall 1993, Mitcheson and Cowley 2003)</p> <p>Client does not value the service (Luker and Chalmers 1990, Pearson 1991, Bloor and McIntosh 1990)</p>	<p>HV Research</p> <p>Partnership approach</p> <p>Interpersonal attributes of health professionals empathy, respectfulness, genuineness (Bidmead and Cowley 2005)</p> <p>Strategies developed that involve working alongside the client (De la Cuesta 1994, Luker and Chalmers 1994, Jack et al. 2005)</p>
<p>Client views</p> <p>Perceived stigma, 'feeling different' (Knott and Latter 1999)</p> <p>Lack of trust (Barlow et al. 2005, Jack et al. 2005, Kirkpatrick et al. 2007)</p> <p>Service seen as 'risky' is judgemental (Bloor and McIntosh 1990, Peckover 2002)</p>	<p>Client views</p> <p>Time and non-judgemental approach (Kirkpatrick et al. 2007)</p> <p>Being listened to (Jack et al. 2005)</p>
<p>Settings</p> <p>Large caseload (Mitcheson and Cowley 2003)</p> <p>Culture of the organisation (Appleton 1994, Mitcheson and Cowley 2003)</p> <p>Technical language (Mitcheson and Cowley 2003)</p>	<p>Home visits</p> <p>Promotional interviewing (Home visiting study (Barlow et al. 2005)</p> <p>Tailored services with more home visiting (Family Nurse Partnership Olds 2006)</p>

4.2.2 Facilitators in partnership work with clients

One reason for the importance of the client-practitioner relationship in health visiting is that it is considered as a health promoting approach. A partnership approach is considered important to health promotion as it enables clients to participate in health promoting activities to improve their own health. As mentioned in the definition of partnership, a key feature in this process is the recognition of the need for the development of high-level interpersonal skills and attributes in the practitioner (Bidmead and Cowley 2005). In their seminal paper on working with the client, Luker and Chalmers (1990) demonstrated the importance of the presentation of the HV as 'guests in the home' in gaining access on a home visit, and called this 'entry work'. This entry work was the first step in achieving client engagement and partnership. The HV's friendly, personable approach and listening skills (Luker and Chalmers 1990) would then lead to 'client engagement' and, as a result, the client would identify a health need. Mitcheson and Cowley (2005) recognized that respect, empathy and genuineness were important criteria in the process of partnership. Kendall (1993) found how, when the conversation with the client was managed by the HV, this professional agenda focused approach affected client participation. Kendall (1993) also found that an open agenda and listening was highly significant in encouraging client participation. Luker and Chalmers (1990) discussed how engagement of clients was on a continuum from easy to difficult and they implied that the positive attributes and presentation of the HV would result in successful access and engagement. Luker and Chalmers' (1990) paper is now 23 years old and is one of the few health visiting papers that discusses the limits of the reach of health visiting when working with families; yet this theme has remained under-researched within health visiting.

Instead of examining how clients are participating in encounters, the focus in health visiting research has remained on the HV's perspective. This has consequently created a tension or dilemma for health visiting practice. For example, working with vulnerability has identified only negative characteristics in clients. In contrast, the focus on the role of the professional HV has identified positive, warm characteristics within a framework of needs assessment and partnership. Furthermore, the concept of vulnerability in health visiting appears to be solely constructed by practitioner perspectives and does not take into account the client's perspectives of the service or how some vulnerable clients are able to work in partnership.

4.2.3 Clients' views of the health visiting service

As mentioned in Chapter 3 above, the last twenty years had seen the support for early intervention programmes such as Sure Start and the Family Nurse Partnership, and yet the

same interest in generic health visiting was not seen. The recent literature review into key HV interventions, processes and outcomes for children and families, undertaken by the National Nursing Research Unit (Cowley et al. 2013), supports this finding. Their literature review recognised that there had been a lack of funded research into health visiting over the last two decades. Their study had been commissioned by the Department of Health to support *the HV Implementation Plan 2011-2015: A Call to Action* (DH 2011). They had found limited research on the specific impact of health visiting practice and called for this to be addressed. My literature review also found a lack of research on successful generic HV interventions or on the process of client engagement, which included the voice of the client.

In contrast to health visiting, there has been a growing number of early interventions aimed at 'at risk' families in the UK and abroad, mainly with the health or home visitor acting as the intervention; for example, the Home Visiting Study in the UK (Barlow et al. 2005) and the Healthy Babies, Healthy Children early intervention programme in Canada (Jack et al. 2005). Both investigated why vulnerable women who were eligible for their studies did not engage with the programmes, and both found that the lack of trust by clients was a barrier to partnership work (Table 8, p.65).

Jack et al. (2005) described how their intervention was aimed at a group of parents who were difficult to access and engage in health promotion. Rather than discussing vulnerability factors, this study identified 'parental risk factors' for poor parenting or developmental delay. They identified risk factors which related to a parent's young age, low income and/or education levels and were similar to those previously described by HVs in relation to vulnerable families. These risk factors have also been used to identify participants for studies in the UK which offer additional postnatal support to women at high risk for postpartum depression (Murray 2003), for improved maternal and child health outcomes (Wiggins 2006, Barnes et al. 2006) and, for first time young teenage mothers at risk of social exclusion, the Family Nurse Programme (FNP) (HM Government 2006).

Jack et al. (2005) described the process of engagement with health professionals from the client perspective. They found engagement to be a dynamic process that also involved negotiation and renegotiation at each visit. They discovered that the development of a therapeutic relationship with home visitors involved three interrelated parts:

- Stage One: Overcome their fear of the service provider
- Stage Two: Building trust
- Stage Three: Seeking mutuality in the relationship.

Overcoming fear and building trust was a theme identified in several other studies when 'vulnerable clients' were asked to give their perceptions of health visiting. Vulnerable clients were described in a variety of studies as being 'at risk', i.e. being a single, unsupported parent (Knott and Latter 1999), meeting the criteria of vulnerability for a home visiting intervention (Barlow et al. 2005), experiencing domestic violence (Peckover 2002), living in poverty (Bloor and McIntosh 1990, Canvin et al. 2007), or misusing drugs (Neale, Tomkins and Shard 2007). All of these studies interviewed women retrospectively. Barlow et al. (2005) were concerned to find out why some women chose not to engage with the home visiting research programme. The women who agreed to be interviewed were a small subgroup from a mainly quantitative Randomised Controlled Trial of the Home Visiting Study and, as such, were recruited across a large area of two counties. Bloor and McIntosh's study (1990) was concerned with understanding the effect of the therapeutic gaze and it is unclear which study the participants were recruited to; like the Barlow et al. 2005 study, the findings emerged from a study not immediately related to health visiting. Research should therefore have been commissioned further to understand the findings. However, their findings are still invaluable because they highlight why some 'at risk' women were reluctant to engage with health professionals and demonstrate clearly the importance of including in the voice of clients. As a consequence, it appeared important to design a study that did include the voices of current clients.

A common theme throughout all of the client accounts was the fear of unknown risks and the consequences that might result if they began to participate in services. For example, Peckover (2002) interviewed a small group of women recruited after they had left the family home and moved to a Refuge. She found that this group of women, who had experienced domestic violence, had not engaged with the health visiting service because they feared being judged and monitored, or felt they were at risk of losing their children, rather than being offered information and support. This fear related to the perceived or experienced social control role of HVs (Peckover 2002, Barlow et al. 2005, Kirkpatrick et al. 2007) in 'policing the family' (Dingwall and Robinson 1993) and has long been identified as a barrier to client engagement.

As a barrier to the development of partnership working, the social control role of the HV has been well documented. Bloor and McIntosh's (1990) study into the complex nature of therapeutic encounters in health visiting and four therapeutic communities included the perspective of health visiting clients, and produced a typology of client resistance to power in therapeutic relationships. Their typology consisted of five types (Table 9, p.69) and they

highlighted how two types - individual ideological dissent and non-co-operation - were barriers to the development of health visiting relationships.

Table 9: Typology of Resistance to Therapeutic Services (Bloor and McIntosh 1990)

Type	Definition
Collective Ideological Dissent	An articulated counter culture opposed in principle and practice to the aims of the Institution. For example, dissent against the MMR immunisation (not observed in this current study).
Individual Ideological Dissent	Described as covert ideological dissent – parents held a different parenting approach
Non-Co-operation	This type carried out covert non-compliance. The aim was to appease the HV.
Escape or Avoidance	Non-attendance was described as a common form of escape or avoidance.
Concealment	Concealing practices or giving inaccurate accounts, similar to non-cooperation.

Bloor and McIntosh's (1990) study revealed how a solely health education approach by HVs was often resisted by clients. The focus of their paper was to describe the resistance techniques used by clients. Informants in Bloor and McIntosh's (1990) study described the HV's role as a form of social control concerned with the policing of child abuse, monitoring of maternal competence, support for the inexperienced and assessment of the home environment. This element of social control was met with resentment and, as a result, the legitimacy of the HV was challenged. For example, some HVs were considered to be young, and too inexperienced in mothering.

This resistance was identified as 'individual ideological dissent' and resulted in clients carrying out covert non-co-operation or concealment of child care practices. Bloor and McIntosh's (1990) research explained how working class women's resistance to the advice of HVs was due to holding different parenting views. On these occasions, ideological dissent occurred when participants considered mothering to be a practical, common sense skill developed through day-to-day experience, under the guidance of family members. Bloor and McIntosh's (1990) focus was on resistance to expert advice and how different child care practices resulted in barriers to the development of the therapeutic connected relationship. Research by HV's (Luker and Chalmers 1990, Pearson 1991) has also identified how clients' negative perceptions of HVs' work can affect partnership development. In a critique of engaging 'hard to reach' families and children literature, Cortis, Katz and Patulny (2009),

highlight how a focus on individual clients' resistance or non-engagement attributes detracts from addressing barriers which arise from the way services are delivered. Whilst agreeing with this sentiment, I would argue that understanding why people may not use services would help to develop more effective services for groups of clients who may be wary of current service provision.

4.2.4 Settings

Influential health visiting research (Luker and Chalmers 1990, Pearson 1991, Kendall 1993, and Appleton 1994, 1996) discusses health visiting and the process of working in partnership with clients as taking place in the home; yet there has been little recent research into improving the reach of the generic health visiting service. Recent literature has involved new interventions separate from the generic health visiting service (Barlow et al. 2005, Barnes 2012). Knott and Latter's (1999) small exploratory study into the use of Well-Baby Clinics by lone parents found that this group of clients felt judged and different from the other clients who used the clinics and, again, there was no further research into improving client engagement in Well-Baby Clinics.

There is a growing body of professional literature which describes the barriers and facilitators to partnership work at one level of the organisation. Recent research into health visiting has identified that HVs with large caseloads (Mitcheson and Cowley 2003), using technical language of a health needs assessment tool (Mitcheson and Cowley 2003) or else having limited time to home visit, assess and build relationships with families, is a barrier to effective practice (Cowley, Caan, Dowling and Weir 2007). This wider research literature on the organisation of health visiting has been included as it demonstrated that, at the time of the study's inception, there had been little strategic investment in the health visiting service either through research or in practice.

4.3 Early intervention: research into 'hard to reach'

Whilst there was a dearth of literature into the concept of 'hard to reach' in health visiting, the concept had been researched in other community-based programmes such as 'On Track' - an early intervention and prevention programme (Doherty et al. 2003) and the National Evaluation of Sure Start (NESS 2005, 2007).

4.3.1 On Track

The study by Doherty et al. (2003) was one of the first to recognise and investigate the complexity of the term 'hard to reach'. 'On Track' was a preventative service for those children aged between 4 and 12 years who were at risk of involvement in crime. It was

devised by the Home Office in 1999 as part of its crime reduction programme. The research was commissioned in 2002 and a qualitative study was undertaken relating to the delivery of 'On Track' and engagement with partners and service users. The study developed a broad typology of 'hard to reach', consisting of three types (Table 10, p.71).

Doherty et al. (2003) only included the perceptions of providers of the 'On Track' programme; however, these providers came from a variety of backgrounds, such as health, social work, youth offending and the Police. The findings and development of a typology highlighted the complexity of the term, and how different providers understood the term in relation to their previous practice. However, by replacing the concept with three further negatively named groups, it can also be critiqued as identifying the potentially stigmatising nature of the term (Brackertz 2007, Barrett 2008, Evangelou et al. 2011).

Importantly, in developing their typology they highlighted the diversity and complex nature of the needs of different client groups within the concept of 'hard to reach'. In the light of these findings, 'On Track' providers re-examined their attitudes and approaches and began to tailor the service to develop different strategies to meet the differing needs of the various client groups within the broad description of 'hard to reach' (Doherty et al. 2003)

Table 10: Definitions of 'hard to reach'

Doherty, Hall and Kinder (2003)	National Evaluation of Sure Start (NESS 2005)
<p>Type A The 'Under represented' Marginalised Economically disadvantaged Socially excluded</p> <p>Type B The Invisible Slipping through the net Unable to articulate their needs</p> <p>Type C The Service Resistant, Unwilling to engage, Suspicious Over-targeted, Blind to problem Disengaged from opportunities</p>	<p>Fathers. Bilingual families or asylum-seeking families. Parents with drug and alcohol problems. Problems with domestic violence. Having special medical needs. For example, disabled child, or mother with post-natal depression. Isolated families. Suspicious of professionals and fearful of children being removed.</p>

4.3.2 National Evaluation of Sure Start

The National Evaluation of Sure Start (NESS 2005) evaluated the impact of SSLPs on children and families living in disadvantaged areas. In contrast to Doherty et al. (2003),

NESS (2005) defined 'hard to reach' as groups of people and was similar to the social exclusion definition of the term (SETF 2003). Both Doherty et al. (2003) and NESS (2007) described how 'standard' approaches, such as improving access by providing services locally, was not enough for some 'hard to reach' families. They both gave examples of 'hard to reach' as groups with language difficulties, fathers or asylum seekers and suggested that these groups required a strategic approach to access and engagement. NESS (2005) acknowledged how some areas had successfully employed workers with specialist knowledge of a particular client group, or who were bilingual. NESS also identified that the way services were being delivered may have been a barrier to client engagement. For example, services which focused on specific public health goals, such as improving breastfeeding rates, finding work or stopping smoking, may be viewed as judgemental and required a more sensitive approach to encourage and promote behaviour change (Belsky and Meluish 2007). Moreover, it was recognised that amongst families living in deprived areas, those families with more material resources were better able to access the services. In contrast, families with fewer resources (teenage parents, unemployed families, lone parents) were least likely to be using the services (Belsky and Meluish 2007). NESS (2005) discovered that, at that time, 'hard to reach' groups were not using the services that had been designed with them in mind and this report was influential in changing how services were delivered in Children's Centres.

4.4 Conclusion

The literature review has revealed how the health visiting service has demonstrated the reach of its service by the development of professionally guided, individual health needs assessment in order to identify vulnerable families within a caseload. Much of this research took place in the 1990s. Partnership work was viewed as a facilitator to client engagement within a universal service. Yet there was a growing body of research which highlighted how some vulnerable families continued to consider health visiting to be a 'risky', 'hard to reach' service that was concerned with social control and judgement rather than with giving help and support. As a result, some families continued to avoid the service.

Wider research into the concept of 'hard to reach' illuminated how other services for 'vulnerable', 'at risk', 'hard to reach' families with children have developed a clear definition of the term in relation to the context of the service. Subsequently, services were then being delivered in relation to developing a more sensitive, informed approach (Doherty et al. 2003, 2004; NESS 2005, 2007). The review also revealed that little was known about how the term was understood in health visiting practice. Whilst much of the literature in this review alluded

to the difficulties of accessing and engaging with all clients, the main focus was on the successful reach of the universal service. This seminal health visiting research is now twenty years old, and was carried out at a time of universal home visiting. With the health visiting service now delivering a progressive universal service, it appears timely to understand how the concept of 'hard to reach' affected the working relationships between HVs and clients living in a disadvantaged area. This has led to the development of an overarching research question.

The next chapter will describe and justify the research methodology undertaken to study the concept of 'hard to reach' in relation to health visiting and the research questions.

5. Methodology

5.1 Introduction

This chapter aims to describe the choices made in the research design, and the influences which have guided those choices. These influences relate to the literature review, my background knowledge of the subject and - importantly - the qualitative approach developed during the study. Firstly, this chapter will give an overview of the research questions and how these questions influenced the choice of case study research (Yin 2003). Secondly, the process of developing Yin's approach to the research design will be explained. Case study research is recognised as an acceptable, creative research approach in nursing (Appleton 2002, Zucker 2001). However, discovering how other nursing researchers had developed a qualitative research design was more elusive. The literature revealed Yin's (2002) research approach was often viewed as positivistic and therefore not suitable for a qualitative approach (Appleton 2002). Subsequently, nursing case study research appeared to be developing as part of wider quantitative studies, utilised when qualitative research methods were required to answer some of the research aims (Luck et al. 2006). Also, whilst the flexibility of case study approach was regarded positively (Zucker 2001, Anthony and Jacks 2009), these papers also spoke of continuing confusion caused by the two very different approaches of Yin (2003) and Stake (1995). However, sociological literature (Wells et al. 1995) and a more recent nursing methodological paper (Sandelowski 2011) have successfully demonstrated the use of Yin's (2003) strategy in qualitative research. This chapter aims to demonstrate the suitability of Yin's design with regard to the research questions in this current study.

5.2 Research questions and case study research

Chapter 2 above demonstrated how some families were being discussed in terms of entrenched problems. Both Sir Keith Joseph and the New Labour government discussed certain types of families as being within a 'cycle of deprivation'. Families living in areas of multiple deprivation were identified as the 'hardest to reach' (SETF 2003) and were also described as families who were 'at risk' of experiencing health inequalities and who required a service that would deliver 'proportionate universalism' to those most in need (Marmot Review 2010). In 2007, Lowe described the health visiting service as being able to reach the 'hard to reach' through progressive universalism. However, there was little discussion or research in her review on how this was being achieved in practice. Research into work with

vulnerable families tended to be professional papers with the focus on the skills required by HVs to carry out health needs assessments in order to identify vulnerable clients., or papers which discussed how 'good' health visiting was based on the HVs' ability to develop the HV/client relationship. Whilst barriers to service delivery were also identified, it was only in relation to the 'expert approach' of the HVs. Furthermore, a great deal of this research was carried out in the 1980s and 90s when health visiting in the home was the norm. There was very little research on the role of the HV providing services from the newer setting of the Children's Centres, which are based in areas of multiple deprivation. This lack of literature on the concept of 'hard to reach' led to the development of the overarching research question: *'How is the term 'hard to reach' conceptualised and operationalised in health visiting practice?'*

Within this research question four research objectives were identified:

- To develop a definition of the term 'hard to reach' in relation to families and the HCP.
- To examine critically health visitors' perceptions of working with 'hard to reach' families and service provision.
- To explore with 'hard to reach' parents their health needs and requirements from child health services during early parenthood.
- To develop an understanding of the barriers and facilitators for 'hard to reach' families

5.2.1 Case study research design

Case study research is an approach well suited to investigate a concept of which little is known (Yin 2003). It has been recognised as a valuable strategy in health care research (Appleton 2002, Anthony and Jack 2009), and acknowledged as an ideal approach for a holistic, in-depth investigation into a complex contemporary issue. For example, the inclusion of the objectives within the research question allowed for a multi-perspective approach and included the views of both service users and service providers (Feagin, Orum and Sjoberg 1991). The aim of this chapter is to justify the approach taken in this study. Chapter 6 below will discuss in greater detail the methods utilised.

5.2.2 Case Study Approach

This chapter considers two advocates of case study research, Yin (2003) and Stake (1995, 2000), and will discuss the rationale behind the rejection of Stake's approach for this particular study. Stake (2000) states that his method was designed to lead to greater

understanding of a particular case, and how his naturalistic approach results in understanding of the case through close study (Sandelowski 1996).

In his book, *The Art of Case Study Research*, Stake (1995) described three types of cases: intrinsic, instrumental and collective. The intrinsic case study design was developed as an in-depth investigation, to seek clarity about a particular case. Stake explains how an intrinsic case is a focused approach to produce better understandings and learn more about a particular case. He explains how an intrinsic case might examine a child's educational needs within a classroom and how closer examination would produce better understanding.

The instrumental case study is where there is an interest in a particular case that enables a greater understanding of an issue relating to the case, and may provide insight or produce new explanations (Stake 1995). The case is of secondary importance as its role is to enable an understanding of something else (Stake 2000).

The collective case is the study of a number of cases in order to investigate a phenomenon, rather than the intrinsic interest of a particular case. Collective instrumental case studies have been used successfully to develop an understanding of the issues and complexities surrounding professional judgements in health visiting (Appleton 2002). However, Stake's definitions of case study was proving problematic to my research design, as the case of 'hard to reach' did not appear to fit with Stake's definition of a case. Understanding the phenomenon or concept of 'hard to reach', in relation to health visiting within the context of a Children's Centre, appeared to lack what Stake had described as specificity. By using his approach, it subsequently appeared difficult to investigate the concept within a single case study.

It could be argued here that the phenomenon of 'hard to reach' could be investigated by using other methods. For example, a survey of HVs' opinions and attitudes could be carried out. Surveys are often developed from what is known about a given topic. This was not possible here as very little was known about how the concept was understood and operationalised by HVs. However, in this research, case study appeared to be a suitable approach because, initially, the case was bounded by the reach of a Children's Centre based in an area of disadvantage, and the research questions were related to capturing an in-depth understanding of the perspectives and views of both users and providers of services. Yin's design offered an approach based on designing a case study on the concept of 'hard to reach'.

5.3 Yin's (2003) case study research design

Yin's case study design offered a research strategy that appeared appropriate, unlike an experiment, the planned study had elements within it which were beyond the control of the researcher and was investigating a contemporary event (Yin 2003). With these criteria in mind, the research questions were developed to analyse critically the concept of 'hard to reach' in relation to health visiting, multi-agency working and the Healthy Child Programme (HCP) (DH 2009a). It aimed to gain a greater understanding of the meaning, given by health professionals, to the term 'hard to reach' and to discover the consequences this has for health visiting practice and the clients using the service. Secondly, the case was concerned with understanding the phenomenon of 'hard to reach', within the context of an area designated as disadvantaged (Multiple Indices of Deprivation) and based in a Children's Centre. Thirdly, the investigation was evaluating a real life event, i.e. how HVs and Children's Centre staff reached and engaged with families living in a disadvantaged area. Unlike an experiment carried out in a laboratory, many elements in the study were beyond the control of the researcher.

Importantly, the flexibility of his approach meant that, at the beginning of a case study, the case may not be fully defined (explored further in Chapter 6 below). This approach appeared to contrast with Stake's naturalistic background which argued that, because understandings should emerge from the case, the case had to be very specific from the outset. "*A teacher may be a case but her teaching lacks the specificity, the boundedness, to be called a case*" (Stake 1995 p.2). In contrast, Yins' approach allowed for the study of a phenomenon such as 'hard to reach', rather than a specific case. This was because he argued how the complexity of studying real life events may be complex:

"phenomenon and context are not always distinguishable in real life situations"
(Yin 2003 p.13).

My understanding was that neither author had specified a particular methodology; instead, they both define their case study research to enable a focused and intensive study of a 'case'. Both strongly described case study research design as a flexible and robust research method; however, their approaches were different.

Yin's method included a second part to his 'technical definition', which related to data collection and the prior development of theoretical propositions, which would then guide the data collection. Importantly, he was explicit in describing how a case would benefit from the inclusion of a theoretical framework to help with data collection and analysis. He believed it

would introduce theoretical boundaries to a case study. The inclusion of a theoretical framework appeared important to the development of Yin's case study approach.

However, this approach was also problematic: developing a proposition felt at odds with a qualitative approach, and there was little apparent guidance on adapting Yin's design to qualitative nursing research. Whilst his approach was described as an appropriate method for nursing research (Appleton 2002), and had been used successfully in health and social sciences research (Anthony and Jack 2009), reviewing the nursing literature to discover how qualitative research had incorporated theory revealed a paucity of papers. Some nursing methodological papers were beginning to describe their pragmatic approach to case study (Luck et al. 2006) and in doing so also demonstrated how Yin's design fitted with a qualitative approach. Yin has advocated his case study approach to be utilised in complex real life situations. He has argued that a rigorous approach guided by his technical definition allows for the collection of multiple sources of data (Figure 1, p.78)

Figure 1: Yin's (2009) Technical Definition of Case Study

The case study inquiry:

- Copes with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result
- Relies on multiple sources of evidence, with data needed to converge in a triangulating fashion, and as another result
- Benefit from the prior development of theoretical propositions to guide data collection and analysis (Yin 2009 p.18)
- The most important use of a case study is to explain the presumed causal links in real life interventions that are too complex for surveys or experimental strategies.
- To describe an intervention and the real life context in which it occurred
- To Illustrate a topic within an evaluation
- To enlighten those situations in which the intervention being evaluated has no clear, single set of outcomes (Yin 2009 p.19-20)

Critics of Yin's approach (Stake 1995) have suggested that the language used is more suited to quantitative research (Figure 1, p.78). Importantly, Platt (1992) explains how Yins' approach included a defence for the use of both quantitative or qualitative case studies and how they could provide an alternative approach to more accepted quantitative research methods. As a consequence of this and his quantitative background, Yins' texts describe case study research in a quantitative manner. However, Yin appears to be a supporter of

case study over quantitative research methods. For example, case study as a method had been compared unfavourably with experiments (David 2006, Flyvbjerg 2006). Yin contests this: he argues that a strength of a case study is its flexibility (Figure 1, p.78), one that can be exploratory, descriptive or explanatory to describe, illustrate or enlighten (Yin 2003, 2009). This focus on description and explanation suggested that Yins' approach could accommodate a qualitative approach.

5.3.1 Qualitative case study approach

To gain an understanding of the concept of 'hard to reach', it was considered crucial to undertake a multiple perspective approach. Utilising both qualitative methods and a case study approach was deemed eminently suitable to investigate the case of 'hard to reach' and understand how and why HVs and clients interacted with each other and how they made sense of pre-school universal health promoting services. To answer the research questions, a broadly social constructionist approach was taken, and this approach aided the collection of multiple perspectives and achieved a holistic understanding of the term 'hard to reach' in relation to health visiting within an area of disadvantage. Furthermore, this qualitative, multi-method approach facilitated the inclusion of both users and non-users of the early years' and health services on offer and the wider influences that informed their activities.

"social constructionism can effectively marry the 'micro attention to interaction... and more macro elements (taking into account the social, economic, political and policy context) in which data is being generated and with regard to which it should be analysed" (Barbour 2008 p.27).

Originally, the choice of Yin's case study research design appeared to be straightforward. However, the process of adapting Yin's strategy to the research topic was much more challenging. This was because Yin (2009) strongly promotes the inclusion of theory to develop the case.

5.4 Case study and qualitative nursing research

The provision of clear guidelines and the renowned reputation of Yin's rigorous case study approach (Tellis 1997) were considered helpful during the planning of the research design. Trying to discover how Yin's research approach had been adapted to qualitative nursing research was more difficult. Very few articles specifically described their adaption of Yin's approach, with both a qualitative approach and the use of a theoretical framework. Articles that discussed case study research as a qualitative approach tended to focus on the

methods used to collect data (Anthony and Jack 2009). Also, some nursing research literature (Anthony and Jack 2009, Appleton 2002) were critical of Yin's approach.

This criticism was ascribed to Yin's positivistic perspective and background (Appleton 2002); for example, how the adaption of Yin's approach to qualitative research had not been fully explained. Appleton (2002) identified this as a gap in the nursing literature and argued how, from a constructionist viewpoint, she believed that to adopt Yin's approach would be problematic because of his presumed positivistic approach. Furthermore, Antony and Jack (2009) believed that Yin (2003) and Stake (1995) appeared to approach case study research from different metaphysical paradigms - positivism and constructivism - and they described this difference as leading to '*methodological confusion*' (Anthony and Jack 2009). Their review of case studies in nursing identified that the two different approaches had resulted in confusion about the name, nature and use of case studies in nursing. Consequently, they described case study research as an '*under-utilised research strategy*' in nursing (Anthony and Jack 2009, Appleton 2002).

This criticism appeared at odds with Yin's approach (Yin 2003, 2009), which clearly advocated for case study research to be designed to answer the research questions. Therefore, this next section will examine how Yin's approach had been adopted in nursing research and how this affected the design of the case study in nursing.

5.4.1 Paradigmatic Orientation

In nursing research, justification for a particular case study approach has often been described as a choice between quantitative or qualitative approaches (Appleton 2002, Luck et al. 2006, McDonnell et al. 2000). However, both nursing and non-nursing research requiring an in-depth multi-perspective approach have found Yin's approach suitable for qualitative research (Yin 2003, Platt 1992, Cowley and Billings 1999, Tellis 2003, Bergen and While 2000, Johnson and Onwuegbuzie 2004). Luck et al. (2006) explained how they aimed to gain an in-depth understanding of a case and so, for them, the case study was defined by wanting to investigate a particular case rather than using only one quantitative or qualitative approach.

This pragmatic style seemed to be recognising the limits of a purely quantitative or qualitative approach. However, nursing researchers did not appear to address how the inclusion of theory was resolved within their pragmatic approach (Luck et al. 2006). When there was a brief mention of a theoretical framework, the main focus of the paper remained

on the qualitative methods used to collect data (McDonnell et al. 2000). This appeared to be because of the naturalistic approach in Stake's (1995) method.

5.4.2 Emic or etic approach

Stake's approach to case study research in his early texts advocated for an 'emic' standpoint and he challenged Yin's approach and the use of theory, claiming it had an 'etic' perspective (Stake 1995). This challenged the suitability of adopting Yin's design to this current case study. This next section will clarify the position taken and how the inclusion of a theoretical framework was an important step in this process.

One reason for this ongoing quantitative/qualitative divide in case study research is that the two main advocates appear to write from very different perspectives. As has already been discussed, Yin offers a defence to positivistic critics of the case study approach (Yin 2003, 2009, Platt 1992) and because he had a positivistic background, he wrote in a positivistic style (Platt 1992). The rejection of Yin's approach by Appleton (2002) was because it was deemed unsuitable for a constructionist framework, and (Stake 1995, Appleton 2002, Luck et al. 2006) suggested that Yin's approach had 'an etic' or outsider stance. This approach is aligned with the positivistic or realist paradigm: here ontological assumptions regard reality as objective and predictable, separate from human meaning-making. The positivistic researcher believes the case exists in the external world, and variables to be examined and measured can be identified before the start of the study (Blaikie 2007). The differences between deductive positivism and inductive qualitative research are described in Table 11 (p.82). This 'etic' approach implied that Yin's design, and the inclusion of a theoretical framework, would try to test preconceived ideas, developed prior to entering the field, rather than allowing themes to emerge and develop from the field site. Yin's method was interpreted by Appleton (2002) as following in this positivist tradition, and defining vulnerability would be carried out in a quantitative manner of measuring variables associated with vulnerability, demographics and indices of deprivation.

Table 11: Inductive, Deductive and Abductive Paradigms (based on Blaikie 2007, Morgan 2007)

Inductive approach to the connection of theory and data Naturalistic	Deductive approach to the connection of theory and data Realist/Scientific/quantitative	Abduction approach to theory and data
Accumulation of observations or data through subjectivity	Identify a regularity to be explained through objectivity	Relationship to the research process is inter-subjectivity. Acknowledges theoretical influences prior to entering the field
Produce understandings that relate to the context	Construct a theory and hypothesis. Test the hypothesis by matching with data. Generalisations develop from the findings	Inference from data is transferability through explication. The process is iterative and unfolding

Appleton’s approach was constructivist and naturalistic; she was interested in understanding what the concept of vulnerability meant to HVs. This ‘emic’ approach aimed to gain an insider view, one that focused on understanding and explaining the culture of health visiting. Consequently, Yins’ case study method was rejected as methodologically impossible:

“The inquirer undertaking a study using a constructionist framework may feel uncomfortable with Yin’s (1993, 1994) approach to case study for a number of reasons. Firstly, there does not appear to be any recognition in Yin’s work of the importance of tacit knowledge and intuitive processes in data collection and analysis. A further feature of Yin’s approach to case study, which stems from its positivistic roots, is the fact that he recommends researchers use traditional quantitative criteria such as construct validity, internal validity, external validity and reliability to evaluate the quality of a case study. These terms certainly do not fit well with the constructivist paradigm, where Guba and Lincoln (1981) and others (Sandelowski 1996 and Marshall & Rossman, 1995) have recommended that researchers address issues of trustworthiness and rigor through the use of “truth value”, “applicability”, “consistency”, and “neutrality” (Appleton 2002 p.89-90).

This quote highlights the perceived objectivity, or outsider ‘etic’ stance, of a positivistic, deductive approach, and how quantitative criteria were considered inappropriate to evaluate the quality of qualitative research. In support of Appleton’s stance, Luck et al. (2006) have

also described how the two research paradigms produce different types of cases and the findings would be influenced by the researcher's philosophical viewpoint. These authors appear to imply that case studies are developed from one of two paradigms; qualitative or quantitative. Qualitative research has been described as an inductive research strategy (Blaikie 2007). For example, to develop knowledge about the complex and evolving nature of health visiting, a constructivist approach was adopted by Appleton (2002). Her focus was on gaining an 'emic' perspective where the findings emerge from the data (Stake 1995). This approach is aligned with the ontological assumption that reality is subjective, with findings emerging from within the boundaries of the case (Stake 1995). Stake (1995) appears to favour an approach that emphasises the 'emic', the insider's behaviour and beliefs, thus demonstrating his philosophical approach which he acknowledges is influenced by a naturalistic epistemology, which believes that explanation emerges during the course of the case study rather than it being stated at the beginning (Blaikie 2007).

Stake contrasts his approach favourably with the 'etic' or outsider approach because he suggests that the 'etic' perspective is decided by the researcher, prior to the research. From his viewpoint, the core strength of the naturalistic, case study approach is that it doesn't require theory at the beginning of a study. Stake, in advocating the 'emic' approach, is highlighting the importance to case study of gaining the 'insider' perspective. He is also suggesting that immersion in the case by the researcher is important, and he demonstrated his support of ethnographic methods in his use of case reports, produced by ethnographers, such as Geertz (1994). This is to gain 'thick description', and Stake (2000) calls his process of research and report writing, '*naturalistic generalization*'. He argues that case reports written in this way will assist researchers and readers in gaining and developing new knowledge. This view is supported by nurse researchers who believe that qualitative research methods:

"allows the case to emerge inductively through an interpretative research process" (Luck et al. 2006 p.105).

However, this view of theory developing purely inductively appeared outdated. For example, Appleton's (2002) review of the two approaches to case study is based on the constructivism view as defined by Lincoln and Guba (1985), who are recognised as strong advocates for qualitative research (Morgan 2007), and who reportedly developed their definition of qualitative research as a reaction against quantitative research (Morgan 2007). At the time, these researchers felt a need to distinguish clearly between the two approaches. Their 1980s definition of qualitative research disallowed the inclusion of theory; instead qualitative research was concerned with findings emerging from the field. Following this definition, it

would be viewed as impossible to include a theoretical framework prior to studying a complex case study in the real world (Appleton 2002).

As a result, Yin's approach was rejected by several nurse researchers because his use of theory was not considered suitable for a constructionist approach (Appleton 2002, Luck et al. 2006, McDonnell et al. 2000).

“Constructionists would argue vehemently that it is impossible to adopt a theoretical framework at the beginning of the study as not enough can be known about the constructed realities which may exist in the context under investigation” (Appleton 2002 p.93).

This quote is an example of the ‘incompatibility argument’ (Morgan 2007) which argument proposes that the inclusion of theory is epistemologically and ontologically unsuited to qualitative research, and supports the belief that quantitative and qualitative methods cannot be mixed (Morgan 2007). However, it is now recognised that such a polarised view of research is not always helpful (Wells et al.1995, Mason 2002, Denzin and Lincoln 2005, Blaikie 2007). It is also considered to be outdated and has been largely discredited (Morgan 2007). Nevertheless, the continued use of this incompatible approach allows researchers to focus on the methodological differences of the authors rather than on which method is interpreted as the most suited to answer the research question.

Consequently, a consistent criticism of case study as a research approach is that it requires clarification (Bergen and While 2000, Anthony and Jack 2009). The two main exponents of case study research, Yin (2003, 2009) and Stake (2000), have attempted to address this and several other criticisms of case study research through their informative texts, outlining their approaches (Yin 2003, Stake 1995). Yet, according to nurse researchers, there still remains *“lingering ambiguity about the nature and the use of case study”* (Anthony and Jack 2009 p.1172) and they attribute this to their (Yin and Stake) differing methodological perspectives (Anthony and Jack 2009).

5.4.3 Mixed methods in case study nursing research

As previously mentioned, there was evidence of nursing researchers taking a pragmatic approach when implementing case study research (Luck et al. 2006, McDonnell et al. 2000). Here, mixed methods were used to gain a qualitative understanding of a case through the inclusion of qualitative research methods to answer part of the research questions. This was often as an addition to a wider quantitative study (Anthony and Jack 2009). The rise in the

use of mixed methods in case studies fits with the pragmatic approach which aims to use the best methods to answer the research questions. Within case studies, this approach has been described as “*a bridge that spans the research paradigms*” (Luck et al. 2006 p.107) provided evidence of how Yin’s approach could be adapted to qualitative methods.

“like a bridge, the existing structures on either side of the bridge remain distinct, The existing paradigms, and their assumptions, equally remain distinct.” (Luck et al. 2006 p.107).

Whilst Luck et al. (2006) demonstrated how their choice of methods enhanced the collection of data consistent with the different paradigms, it was disappointing to discover that mixed methods in nursing case studies often involved a two phase design (Cresswell 1994), where the study’s phenomenon is investigated at different and separate stages, using techniques traditionally associated with each paradigm (Johnson and Onwuegbuzie 2004, Anthony and Jack 2009). Most of the literature in Anthony and Jack’s (2009) review into nursing case studies failed to demonstrate how case study approach accommodated aspects of quantitative and qualitative research together.

Table 12: Approaches to Qualitative Case Study Design

	Qualitative Nursing Research and Case Study	Paradigmatic Approaches to Nursing Research
Qualitative approach	<p>Single Paradigm</p> <p>Adaption of Stake's qualitative approach</p>	<p>Naturalistic/constructionist approach (Appleton 2002).</p> <p>Rejection of Yin's approach due to positivistic language and style.</p> <p>Focus on a purely emic/inductive approach to develop an understanding from the case.</p> <p>Used for thick description or exploratory case studies.</p>
Mixed approach	<p>Adaption of a mixture of Yin's /Stake's approach utilising qualitative research methods</p>	<p>Pragmatic approach – case study approach adopting a mix of Yin's/Stake's framework and qualitative research methods. Qualitative criteria for measuring rigour (Luck et al.. 2006, McDonnell et al. 2000 Anthony and Jack 2009). Focus on reporting the qualitative research methods and a mainly emic/inductive approach.</p> <p>Use for exploratory case studies as an adjunct to wider studies</p>
Qualitative approach	<p>Adaption of Yin's/Stake's approach utilising qualitative/ ethnographic research methods and theory</p>	<p>Pragmatic approach – adaption of Yin's approach to a constructionist approach which includes a theoretical framework (Cowley and Billings 1999, Bergen and While 2000, Johnson 2004). Aim to produce thick description and explanation. Focus on an abduction strategy with an inductive/ deductive process and unfolding of the research.</p> <p>Use for exploratory/descriptive/explanation case studies</p>

Instead, many nursing research papers in Anthony and Jack's review of nursing case studies described their approach as 'mainly qualitative' and referred only to the qualitative research findings (Anthony and Jack 2009, McDonnell et al. 2000). A limitation of the bridge metaphor appeared to be that the focus remained on the differences between the quantitative and qualitative paradigms rather than '*transcending this divide*' (Sandelowski 2011). Consequently, it would appear that in nursing, the use of mixed methods is still being developed (Table 12, p.86) and literature in nursing research reflected this use of qualitative research as an adjunct to exploring aspects of a phenomenon in larger mainly quantitative studies (Anthony and Jack 2009).

5.4.4 Case study and the continuum approach

There were a few examples of case study research in the nursing field that specifically utilised Yin's approach and included theory into the research design (Bergen and While 2000, Johnstone 2004, Sandelowski 2011). These methodological papers highlighted the choices that had been made in the research design, how the research design had been guided by Yin's approach (Bergen and While 2000, Johnson 2004) but, more importantly, how the design incorporated a theoretical framework which helped to define the case (Sandelowski 2011).

Outside of the nursing literature, I discovered one approach that was fundamental in my understanding of how theory could enhance qualitative research. This was to view qualitative and quantitative paradigms as being at opposing ends of a continuum. Rather than having polarised views, Wells et al. (1995) described how their approach to research was along a continuum, between the two research paradigms. Their approach appeared to fit the description of a pragmatic approach which Morgan (2007) had developed for two reasons. Firstly, criticism of how the two paradigms were defined had resulted in the identification of limitations and restrictions, these definitions placed on research practice. Secondly, the value of combining quantitative and qualitative approaches to answer research questions were being recognised (Morgan 2007).

Viewing the approach taken within this current study as being along a continuum was a helpful step in understanding how Yin's approach could be combined with qualitative research. This pragmatic approach linked in with a logic of enquiry, described as abductive reasoning (Blaikie 2007). Abductive reasoning enables the research process to move back and forth, in an iterative process between induction and deduction (Morgan 2007). Morgan discussed this in relation to qualitative and quantitative research and described his goal as searching for "*useful points of connection*" (2007 p.71).

Morgan (2007) described this as a pragmatic approach,

"A pragmatic approach would treat issues related to the research itself as the principle line of action" (Morgan 2007 p.68).

Thus a pragmatic process appeared to shift or transcend the incompatible paradigm debate (Sandelowski 2011). It enables research to be designed to answer research questions using the most suitable method (Yin 2003). In this instance, it indicates that including theory into a constructivist approach is possible and that acknowledging this will enhance the research process (Yin 2003, Morgan 2007). A pragmatic approach connects theory and data through

abduction, which is now recognised as abductive research strategy (Blaikie 2007) (Table 11, p.82).

5.4.5 Abductive research strategy

Abductive research has been described as a research strategy concerned with constructing theory developed from everyday life (Blaikie 2007). This begins with understanding people's views and shared understandings of institutions such as health visiting, or contested concepts such as the phenomenon of 'hard to reach'. Therefore, adapting Yin's case study research method to a qualitative approach appeared wholly appropriate. Abductive research strategy has been defined as "*an idealist ontology with a constructionist epistemology*" (Blaikie 2007 p.90). 'Idealist ontology' can be broadly understood as a social reality which has been and is created through a process of meanings and interpretation.

This ontology fits with a social constructionist epistemology which rejects the notion of one true representation of an external world discovered by an objective researcher. Instead, the view is that all knowledge is subjective, that it is based not only on the participants' knowledge and understanding, but it also incorporates the researcher's background, knowledge and beliefs. Research is developed from the researcher's standpoint; consequently, there can be no theory-free observation or true representation of the social world.

Blaikie (2007) explained how abductive research strategy is interested in the meanings and interpretations that people use in their everyday lives. Knowledge is gained from observing and interviewing those involved in the phenomenon or case. The aim is to explain the tacit, largely taken-for-granted assumptions, and mutual understandings or misunderstandings, which make up interactions between people. Most importantly, an abductive approach is concerned with understanding the complexities of interactions and explaining them.

Blaikie (2007) described three connecting stages, from data collection to thick description to explanation. The research methods used to answer the research questions should allow for iteration between data collection and the theoretical framework. These three stages appear similar to Yin's (2003) exploratory – descriptive – explanatory case study. Therefore, Yin's approach appears eminently suitable to adapt to a qualitative research strategy.

5.4.6 Theory and case study design

Yin's (2003) approach acknowledges that research is never 'theory free' but will be influenced by the views and beliefs of the researcher. His idea of theory appears very broad, but importantly it should be acknowledged that it should be part of the process of building new knowledge, theory testing or building on findings produced through other similar research in the area (Tellis 1996).

"the term 'theory' covers more than causal theories. Rather, theory means the design of research steps according to some relationship to the literature, policy issues, or other substantive source" (Yin 2003b p.5).

This quote makes explicit how case studies can develop the understanding of a topic that will enhance, refine and develop previous findings. Even choosing one case over another has been described as making a theoretical choice (Sandelowski 2011). Other researchers have used a descriptive theory to guide the research process (Tellis 1996, Wells et al. 1995). Yin (2009 p.35-40) set out this theoretical relationship throughout his research design and he gives five reasons, or five areas, for using theory in the research design:

- Selecting the cases to be studied, whether following a single-case or multiple-case design
- Specifying what is being explored when using exploratory case studies
- Defining a complete and appropriate description when you are using descriptive case studies
- Stipulating rival theories when you are using explanatory case studies
- Generalising the results to other cases.

5.5 Single case study design

The single case study was an appropriate design for this study as it was concerned with gaining an in depth insight into a complex phenomenon of which there was little known (Yin 2003). The design of the single case study was guided by Yin's tests of quality, construct validity, internal validity, external validity and reliability. These terms have been generally associated with quantitative research methods (Appleton 2002); however, in this study they were interpreted in relation to the overall design of the study. The initial design was aided by Yin's approach to two tests: external validity and construct validity.

The single case study design was devised to gain multiple perspectives on the concept, and the study included both service providers and user's perceptions. Yin's approach also

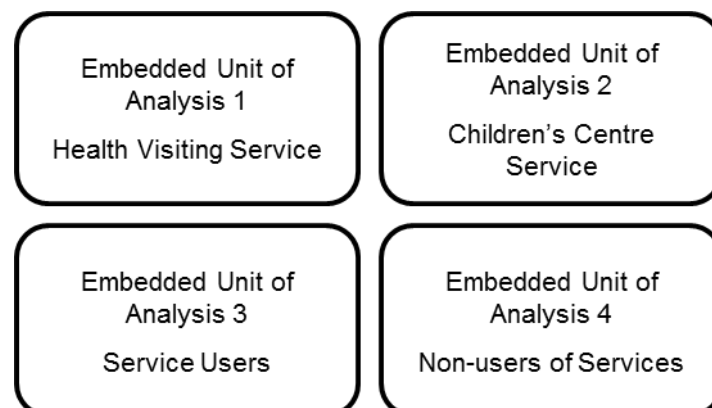
provided guidance on how to develop an analytical approach to case study. An analytical approach is interpreted in this study as relating to the relationship between the boundary of the case, the units of analysis and the focus of the research problem (Silverman 2005).

According to Yin, the first test of quality is giving a clear account of how the case study has been constructed and whether the case study allows for a variety of data to be generated through the chosen research methods: he calls this 'construct validity' (Yin 2003). Yin used terminology associated with positivism to explain how case studies can demonstrate the researcher's approach in building the case study. Qualitative researchers call this 'trustworthiness': it is where the researcher makes their practices visible and auditable (Sandelowski 1996).

5.5.1 Embedded units of analysis

The case of 'hard to reach' was physically bounded by a Children's Centre, and within four embedded units of analysis. There had been discussion within the nursing literature concerning Yin's use of the term 'embedded unit' and the confusion between 'unit of analysis', 'case' and 'embedded unit' (Bergen and While 2000). To answer this criticism, the unit of analysis is the case of 'hard to reach'. This project also takes Yin's definition of an 'embedded unit' as '*separate projects within a public programme*' (Yin 2009). At the outset, four embedded units were incorporated into the study. The unit of analysis 'hard to reach' was bounded by the reach of a Children's Centre. The four embedded units were defined simply by the different service employers: health, Children's Centre staff, and clients - both service users and non-users of the services (Figure 2, p.90).

Figure 2: Embedded Units of Analysis within a Children's Centre: the case of 'hard to reach'



The inclusion of the embedded units resulted in data being collected in a systematic way from multiple sources of evidence. This systematic approach ensured that different perspectives were considered and included into the original research design. The making of the case - investigating the phenomenon of 'hard to reach' - incorporated several different influences: Doherty's et al. (2003, 2004) research into 'hard to reach'; how the subject had been defined in nursing literature; and policy documents in relation to Public Health. This was important for these reasons:

- The concept of 'hard to reach' appeared to be a contested and shifting concept
- The majority of health policy documents which informed the case study were influenced by a public health epidemiological or deficit model of health. This top down approach had identified groups of people who were considered 'at risk' of not engaging with services
- Little was known about how HVs conceptualised and operationalised the term or how the service was perceived by clients
- There was a small amount of health visiting literature on client engagement.

Acknowledging the influences on the study helped with the initial design, and it also helped the research project to 'unfold'. This unfolding of the research project has also been noted by other researchers (Wells et al. 1995, Johnson 2004) who have combined theory with a constructionist approach. Because of this, they believed that their research led to an enhanced understanding of their topic. Yin also appeared to support this unfolding of the case study,

"Your choice of the unit of analysis, as with other facets of your research design, can be revisited as a result of discoveries arising from your data collection" (Yin 2003 p.24)

Instead of 'the case' being fixed and defined by an outsider or 'etic' view, Yin's approach appears to be promoting a flexible approach, originally guided by the research questions, but this may be further influenced as data is gathered.

5.6 Conclusion

This chapter has described the rationale behind using Yin's (2003) case study approach. Included in this chapter is the critique in nursing literature of Yin's approach, which has clearly traced how qualitative case study research has developed in nursing research. Subsequently, it has also explained how Yin's approach has been adapted by nursing

researchers to answer research questions. Importantly, in this study the acknowledgement of the theoretical influences on the formulation of the research questions was crucial in clarifying the boundaries of the case . Finally, the pragmatic approach of combining theory with a constructionist approach has enabled this study to be grounded in an abductive research strategy. The next chapter will describe in greater detail the design of the case study in relation to the methods and analysis used to answer the research questions.

6. Case Design, Data Collection and Analysis

6.1 Introduction

The previous chapter demonstrated the rationale for choosing Yin's (2003) case study research method and how a pragmatic qualitative approach was necessary to answer the research questions. This chapter 6 has two aims: firstly, it will describe the methodology underpinning the research design before describing and giving the rationale behind the choice of research methods and a narrative account of their application in the field; secondly, it will describe the process of thematic analysis which, informed by discourse analysis (Gee 2004, Gee 2005), enabled an understanding of the concept of 'hard to reach' to emerge from the data.

As discussed in the previous chapter, Yin's approach to case study had been criticized for being too positivistic and therefore being incompatible with qualitative research methods (Appleton 2002). An alternative view (Platt 1992), which I agreed with, suggested that Yin's approach developed as a theoretical exercise concerned with identifying the building blocks to case study design. Importantly, to achieve this he had to detach his case study method from traditional qualitative ethnographic approaches associated with case study (Platt 1992). Consequently, rather than dismissing ethnographic methods or qualitative methods, Yin's approach recommended using appropriate methods to answer the research question. This appeared to be similar to an argument supported by many other qualitative researchers (Mason 2002, Silverman 2005, Seale 1999). My research question was concerned with how the term 'hard to reach' was conceptualised and operationalised in health visiting practice. My interest in the topic developed whilst working as a practitioner; the literature reviews had highlighted the skills of HVs to engage and carry out health needs assessments with 'vulnerable' clients, but this had been mostly based on retrospective accounts and how this was achieved in their day-to-day practice was unclear. Ethnographic methods of participant observation, i.e. observing the everyday social interactions between staff and clients, appeared to be an appropriate research methodology.

Ethnography has been described as an approach grounded in the study of culture (Mason 2002). Ethnography has explained the culture of consultations between doctors and parents in Children's Outpatient Departments (Strong 2001, Silverman 1987) and has also been used successfully by nursing researchers. For example, understanding the culture of nursing routines (James 1992), and the social meaning of midwifery (Hunt and Symonds 1995).

Hammersley and Atkinson (2007), two experienced ethnographers, describe how ethnography originally developed from nineteenth century anthropology, where an ethnography was a descriptive account explaining the culture of a community. The main method of achieving this was through participant observation. Ethnography has been described as a method and a methodology (Hammersley and Atkinson 2007). This case study included ethnographic methods of participant observation; interviews and focus groups were also utilised. In ethnography, the stance taken by the researcher towards the research process is considered to be of extreme importance as it will be reflected in the data generated and the research findings. In early ethnography, a realist stance was based on the belief that social phenomena should be studied in their natural state “*undisturbed by the researcher*” (Hammersley and Atkinson 2007 p.7). However, the ability of a researcher to be objective and to produce reports that were theory neutral was questioned and challenged (Blaikie 2007, Hammersley and Atkinson 2007). Hammersley (1992) described how, as a result of these criticisms, ethnographers now favour different types of methodological approaches. For example, Hammersley’s (1992) approach is influenced by subtle realism: a methodology based on the ontological assumption that reality exists independently of the social actors and observers but also takes into account the politics and values of the researcher and the researched.

Ethnography has also been successfully informed by the post-modern approach of social construction (Mason 2002), where the nature of social reality is concerned with discovering the meanings and interpretations created and maintained by the participants. This present case study was designed to discover the interpretations produced and reproduced by different groups within the case study, and to enable a variety of voices to be heard. Importantly, this approach involves reflexivity which requires researchers to acknowledge their own personal and emotional responses during the field work. Coffey (1999) explains how this will lead to enhanced fieldwork notes and analysis as she believes it will add a critical perspective. Here the researcher’s role is viewed as a data generator who is also a participant and part of the social world being studied; this will be discussed further in the section below on participant observer.

6.2 Ethics

The case study was dependant on gaining ethical approval from the relevant research and clinical governance committees and then on gaining access to a suitable study site, a process which took six months. Research that aims to recruit NHS users or staff must be developed in line with the Research Governance Framework of the NHS. This Framework

was developed in 2001 to provide a consistent, nationwide approach to research ethics procedures in the NHS (Barbour 2008). The National Research Ethics Service (NRES) was set up to develop more standardised, accountable procedures for research within the NHS. At the time of the study, requirements for ethics approval of research, audit and service evaluation were separated, with audit and service evaluation within the NHS no longer requiring ethics committee approval (National Patient Service Agency (NRES) 2007).

I began the process of applying for ethics approval with an email to the Query Desk at the National Research Ethics Service. On 8th November 2008, I received a reply clarifying that, within the Research Governance Framework of the NHS, the study was classified as an evaluation study and it therefore did not require ethics approval from the Integrated Research Application System (IRAS).

The National Research Ethics Service guidance "*Defining research*" (NRES 2007) defines research as "*the attempt to derive generalisable new knowledge, including studies that aim to generate hypotheses as well as studies that aim to test them*" (p.2) This definition appears predominantly concerned with quantitative research with representative sampling strategies aimed at making generalizations for whole population groups. This is often experimental research that may involve randomised-control trials. The NRES (2007) definition of qualitative research appeared narrow in relation to the delivery of a new service or, if it included a sampling allocation, to either an intervention or control group. If qualitative methods are to be used with healthcare professionals or service users already involved in a service, it was classified as a service evaluation (NPSA 2007). However, I would argue that, because this study was towards a PhD and would involve collecting primary data from individuals through the use of qualitative research methods, it could be defined as social research and as such required the approval of a research ethics committee.

The research ethics guidance for nurses (RCN 2007) describes how all research has the potential to be harmful to participants and researchers, and the requirement is to conduct safe and ethical research. Research ethics approval was sought and received from the School of Health and Human Sciences Research Ethics Committee based at the University of Hertfordshire (NMSCC/12/08/6/A Appendix 2). The ethics application form followed the guidance in "*Research ethics*" (RCN 2007) and the principles set out in the World Medical Associations' Declaration of Helsinki (WMA 2002).

6.3 Research Methods

This next section will discuss the rationale behind the choice of research methods, beginning with why the case study method was supplemented with focus groups. It will then discuss the research methods utilised in this case study. I have included a time line, in the form of a Gantt Chart (Appendix 3), explaining when each part of the study took place.

6.3.1 Focus Groups

The focus group method was chosen because the literature review had found very little literature on HVs' understanding of the concept of 'hard to reach'. Conducting focus groups with health visitors appeared to be a suitable research method to help gain an understanding of 'hard to reach' at an operational level. Focus groups are widely regarded as an appropriate research method: to provide insights on a specific topic (Morgan 1997, Barbour and Kitzenger 1999) or as part of a multi-method study where focus groups contribute to the researcher's understanding in combination with other research methods (Morgan 1997). It was initially planned that this understanding would inform the ethnographic study, which was concerned with not only what HVs said but also to find out about the culture of health visiting, and how HVs acted and interacted with a variety of clients.

Each stage of the research had been planned to happen sequentially, it had been intended to conduct the focus groups prior to entering the field. In reality, three focus groups were held and took place between 1st June 2009 and 24th August 2009.

The delay in starting the focus groups was due to two factors; firstly, I had to wait until all the necessary approvals had been granted. I had begun to organize the focus groups by emailing the operational manager in the PCT in December 2008. The clinical governance approval, applied for on 20th February 2009 was received on 31st March 2009. Secondly, recruitment to the focus groups also took longer than expected and gaining access to HVs was also time-consuming. After receiving the necessary approvals I was able to reconnect with the operational manager and, on her advice, I emailed my request for participants to locality managers and HVs in the two areas that corresponded with the Children's Centres which had been agreed upon. Subsequently, in May 2009 I presented my study at two HV locality meetings, and put out a request for volunteers to take part in the study. At the meetings I also distributed written information and asked potential volunteers to contact me by 'phone or email.

Table 13: Research Methods used in the Study

Research Method	Definition	Rationale	Activity
Focus Groups	Data is collected through group interaction on a topic determined by the researcher (Morgan 1997)	Focus groups will provide access to forms of data that are not obtained easily (Morgan 1997). Here HVs' understandings of the term 'hard-to-reach' will be collected to inform the study and to develop a criteria for recruiting interview participants.	Three Focus Groups with HVs and HV teams.
Case Study			
Participant Observation	Participation allows 'first hand' understanding of the world (Silverman 2005).	To gain an understanding of the context and culture/cultures within the Children's Centre.	Participant Observation of activities in the Children's Centre. Field notes kept of activities and 'interviews'/discussions with staff providing services. Field notes of 'Interviews' with clients waiting to be seen in Well Baby Clinic/ attending Children's Centre activities. Audio recording of clinic encounters.
Documents/Artefacts	Artefacts that are utilised in practice.	To understand the HV/client/Children's Centre discourses.	Use of weighing scales; PCHR book; leaflets in clinic encounters.
In-depth structured interviews	One to one respondent in-depth interviews (audio-recorded).	To gain an understanding of an individual's 'experience' or story.	Seven HV's clients who did not attend Well-Baby Clinic/Children's Centre activities. One HV client who did attend local services.

The aim of this section is to explain my approach to using focus groups, which are a well-recognized method of data collection (Barbour and Kitzinger 1999, Morgan 1997). Focus groups originally developed from the field of market research (Morgan 1997) and the application of focus groups has been diverse. Because of this diversity, it is recommended that the approach taken is described to demonstrate the application taken by the researcher (Barbour and Kitzinger 1999).

Morgan (1997) and Barbour (2008) offer similar definitions of focus groups, and both highlight the importance of group interaction:

“the hallmark of focus groups is their explicit use of group interaction to produce data and insight that would be less accessible without the interaction found in a group” (Morgan 1997 p.2.).

“group discussions exploring a specific set of issues that are focused because the process involves some kind of collective activity” (Barbour and Kitzinger 1999 p.4).

It would appear that both definitions describe the importance of *focused* group interaction, on a topic introduced and actively encouraged by a facilitator (Barbour and Kitzinger 1999, Morgan 1997). Furthermore, the use of focus groups in multi-method research has been described as a developing method. Morgan (1997) has suggested that focus groups can enhance traditional approaches to ethnography because the data collected will be an additional source of information. In support of Morgan, the focus group method enabled data to be generated on understandings of ‘hard to reach’ that did not fully emerge through participant observation or interviews.

The original purpose of the focus groups in this study was supplementary, serving as a source of preliminary data to inform the rest of the case study. However, on analysing the data, two further strengths of the focus group method were recognized. Firstly, carrying out the focus groups helped to familiarise the researcher to the context and issues in the study area (Morgan 1997); for example, the first focus group demonstrated the variation in HVs’ knowledge and experience of working with Children’s Centres. Some HVs worked across many Centres whilst others had minimal contact with a Centre. Secondly, a recognized strength of focus groups is they can reveal the collective response and are accepted as a way of studying group norms (Bloor et al. 2001, Morgan 1997). This was surprisingly true in its application to HVs, as the theme of partnership working with ‘hard to reach’ families was a recurrent finding across all three focus groups.

6.3.2 Topic guides

Topic guides are viewed as an essential tool for the focus group, and are designed to encourage focused discussion amongst group members and insight into the topic (Barbour 2008, Morgan 1997, McLafferty 2004). The preparation of the topic guide also allowed for comparison between groups, as participants discussed the same issues (Barbour 2008). The topic guide was developed through reading the wider literature on ‘hard to reach’ and was based on the topic guide produced by Doherty et al. (2003) who had successfully used focus groups with a range of providers involved in ‘On Track’. His work has been recognised

as highly successful in understanding this concept. The topic guide included core areas related to HVs' understanding of the term 'hard to reach' and how it was applied in practice (Appendix 6).

The topic guide was a useful tool in promoting discussions on the topic of 'hard to reach'; each focus group lasted approximately an hour. The interactions were audio recorded and transcribed verbatim by the researcher.

6.3.3 Purposive sampling and focus groups

Recruiting participants to take part in qualitative research involved a great deal of planning and reflection throughout the recruitment process. Sampling was purposive, and volunteers to the focus group were recruited because of their knowledge of the subject (Mason 2002). Purposive sampling allows a detailed exploration and understanding of the phenomenon of interest (Ritchie and Lewis 2003, Mason 2002). The focus groups were designed to recruit HVs with a range of characteristics including age, length of experience and experience of working in an area of multiple deprivations with 'hard to reach' families. The first focus group invitation recruited three HVs (see Appendix 5): their experience ranged from working in affluent, rural areas to more urban caseloads. I intended to recruit HVs across a wide range of experience and the time they had spent in health visiting. However, recruitment to the first focus group only included three very experienced HVs.

The original aim of the purposive sampling for the focus groups was to produce a homogenous sample of HVs (Barbour 2005). It was with this aim that I originally set about setting up the focus groups in order to gain a detailed picture of HVs' views on the subject of 'hard to reach'. However, following the first focus group I realized that there was a need to reflect the diversity of HVs' experience of working with this client group, which would allow for different perspectives on the phenomenon to be included. Whilst the most important characteristic was participant's experience of working with 'hard to reach' families, I was also interested in the views of a range of HVs, including those who were more recently qualified. The second focus group followed a meeting with the HVs who had replied to an email and had received information on the study. Again, I presented my study and this time they took the information to their locality meeting where it was agreed to participate in the study.

I was invited to conduct the second focus group after the HVs' monthly meeting. Prior to my attending, information about the study had been sent to all prospective participants. At the meeting, after introducing myself and the co-facilitator, I was quite surprised when everyone agreed to participate. Participants were then given the opportunity to ask questions about

the study and to give their written consent. They also provided demographic background details relating to their work (see Appendix 5). This was a much larger focus group with nine members. It consisted of two locality managers who had recently been practicing in community health teams, five HVs, a Community Staff Nurse (CSN) and a Nursery Nurse (NN). The majority of attendees were employed in two health visiting teams; participants in this focus group demonstrated the wide variety and breadth of experience within teams.

This approach fits with qualitative research where the goal is not to produce a representative sample but to provide diversity of experience (Barbour 2008). Authors (Morgan 1997, Barbour 2004) explained how focus groups should be homogenous in terms of background and status as their experience of including participants from different professions had stifled the interaction in their focus groups (Morgan 1997, Barbour 2004). This was attributed to the power relations between the working relationships of the doctor and nurse participants, which were felt to be recreated within the focus group (Barbour 2008). In this current study, this limitation was weighed against the diversity and richness of opinions that could be gained. Including different nursing professional backgrounds in the study offered the opportunity to observe the interaction of a less homogenous group in terms of professions, but was homogenous in terms of the salient characteristics of the study (Khan and Manderson 1992, Mason 2002). The second focus group demonstrated the interaction between team members in health visiting teams and enhanced the research findings because the resources within the team meant that clients could be reached through a variety of personnel who were experienced in working with 'hard to reach' families.

The third focus group came about in response to an email sent to HVs working in the study area. On replying to the email, I followed up with a visit with information about the study. As with the previous two groups, the third focus group took place two weeks after the initial information had been provided and was arranged following the start of the participant observation. The HVs were based in a GP Centre in the town centre approximately 0.5 miles away from the study site. The participants had worked together for two and a half years (see Appendix 5).

The three focus groups were different in both size and composition. Collecting demographic details enabled details about their experience of working with disadvantaged families to be collated and allowed for recruitment of HVs and team members with a range of experience. The participants were all white, except for one member, thus reflecting the ethnic background of the community health professionals working in the county at that time. The participants had a range of experience from two to thirty years in health visiting and other disciplines, i.e. Nursery Nurses, Community Staff Nurses and School Health Nurses. All

health professionals had experience of working with at least one Children's Centre, and some worked across geographical areas where there were several.

6.3.4 Focus group setting

The initial focus group was arranged to take place in a central location and, whilst several HVs appeared willing and agreed to the location, only three HVs attended. It proved much easier to recruit people when the focus groups were conducted in the HVs' workplaces and the ease of access to a venue for participants appeared to be of importance. Carrying out focus group research within a quiet workplace setting greatly increased the attendance rate.

6.3.5 Focus group facilitation

Group interaction has been described as the most important feature of focus groups, and a key factor in promoting interaction was to try to provide a relaxed environment where people felt able to discuss their feelings on a topic in an open and natural way (Barbour 2007, Khan and Manderson 1992). In order to promote a trusting relationship between the facilitator and the participants, the setting of ground rules is recommended (Barbour 2008). Confidentiality has been recognized as an important area to discuss prior to on the onset of the focus group (Barbour 2008). Information about the study was explained both face to face and in writing and once again prior to the start of the focus group. Permission to audio-record each session was gained, both verbally and in writing on the day. Assurances of confidentiality and anonymity were given and participants were informed that, if they so wished, the tape recorder could be stopped at any time. The purpose of the focus group and the role of the facilitator and co-facilitator were also explained prior to the first question.

All three focus groups produced lively discussions and, although it was only slightly larger than the recommended number of between six to eight participants (Morgan 1997), the larger group was much more challenging to facilitate, especially for the role of the moderator in encouraging everyone to talk and in probing for clarification. On the one hand, it was the most 'formal' group because it was held at the end of a locality meeting, where HVs meet to exchange information, to receive service updates and plan services. On the other hand, it was a group that met every month and so the participants knew and worked across an area with each other and this may also have contributed to the different opinions being expressed. Each focus group lasted approximately one hour and, as two of the groups took place during a break time, food was provided by the facilitator. The audio recordings were transcribed verbatim by the researcher.

6.3.6 Reflexivity on the process

I facilitated three focus groups; this was following experience gained as a co-facilitator for a focus group at the University of Hertfordshire and in attending an ESRC course on Focus Group Method as a Craft Skill. I was able to recruit a colleague to co-facilitate the first two focus groups. The role of the co-facilitator was extremely helpful in the practical aspects: ensuring consent forms were signed, and collecting the individual demographic information sheet. I also directed the co-facilitator to produce a seating plan and this was included in the field notes made by the researcher directly after each focus group (Barbour 2008). These field notes focused on the interactions during the focus group and contained contextual information, for example, how people spoke between each other, the body language demonstrated and notes on the discussion within each focus group. The role of the co-facilitator also helped me in my role as facilitator because I was able to concentrate on facilitating a group of HVs, some of whom I knew as colleagues.

Nurse researchers (McLafferty 2004) with experience of the topic being discussed have also noted that it can be difficult to remain objective as a moderator. The need to remain objective is a way to ensure that participants have the opportunity to voice their opinions (Barbour 2008). In this instance, objectivity in facilitating related to my being actively aware of how my HV background might influence participant's replies. The co-facilitator presence enabled me to remain focused on the task of facilitating, ensuring that all participants had the opportunity to contribute. The three focus groups enabled the collection of data on HVs' perceptions of how they understood and operationalised the topic under investigation. However, two of the focus groups had only three participants; a limitation of this method was the wide variation in answers given and these variations appeared to be a consequence of three factors.

Firstly, there were a small number of focus groups, and within that number, two of the focus groups had three participants. Whilst the text books advise a maximum number of members, they do not stipulate either a minimum or how many focus groups are required in order to produce robust evidence. Initially, the focus groups were utilised to produce supplementary information and that may have reduced the full effectiveness of this method. Secondly, individual participant's experience of the concept of 'hard to reach' was dependant on the demographic makeup of their caseloads, and their understanding of the term appeared to be quite diverse. Thirdly, it became apparent that this was the first time the HVs had evaluated their practice and the reach of the service. As a result, several HVs and team members discussed clients who were 'hard to help' as well as being 'hard to reach' (for example see Appendix 5, the comments column). It would have been interesting to redesign the topic guide and continue to investigate emergent themes by further sampling (Barbour 2008) but

this was not possible given the research question and the already wide scope of the research design.

6.4 Selection of the single case study site

On receiving ethics approval, research governance approval from both the relevant Primary Care Trust (PCT) and the Local Authority (LA) was also granted. As mentioned earlier in this chapter, gaining research governance approval from the PCT and the LA took approximately four months. As an amendment to the university ethics application, a letter of support from the LA had been requested. In December 2008, I discussed the study with senior managers in both the PCT and LA, the letter of support was provided and two suitable sites were identified and approached.

The criterion for the site was that the research would be set in a Children's Centre which offered a full range of services and had a health visiting service based in the Centre. Two Children's Centres in the county were suggested. One site had originally been a part of the first wave of SSLPs and had been set up within one of the most deprived areas of the county. This was my preferred site because, as well as meeting my criterion, it was also an area that I was professionally unfamiliar with. In preparing the research study, I was aware that I would be carrying out research within my own area of professional practice. The choice of this site meant that I would not be researching an area where I had practised as a HV. A noted dilemma for nurse researchers is role conflict (Jack 2008). For example, would I be viewed as a nurse or as a researcher by participants in the study? In order to understand how my researcher role and health visiting background affected data collection and participation, it appeared important to reflect personally upon the challenges that occurred during the research process.

Carrying out an ethnographic single case study is considered an acceptable research approach (Yin 2014). The study was concerned with gaining an in-depth insight into a complex phenomenon of which little was known. Whilst suggesting that either single- or multiple-cases are acceptable, Yin (2014) also suggests an advantage of a multiple-case design over a single-case study, as the multiple-case study allows direct comparison between two or more sites and can enhance the research findings. This comparative approach was not possible in this study as the health visiting teams linked to the two Children's Centres also provided services from different settings. For example, one site provided health visiting services in the Children's Centre, whilst the other team was based and provided services from a nearby local Health Centre.

Gaining access to a research site has been described as being notoriously difficult (Hammersley and Atkinson 2005), and this was true in this study. The process of gaining approval had taken much longer than anticipated; also, the number of Children's Centres that I could approach was very small. However, as with other researchers in nursing (Lathlean 1996 and James 1992) or conducting research in medical clinics (Silverman 1987), access to the field site was helped by a chance encounter with a HV colleague. When I explained that I required access to a health visiting team within a Children's Centre, I was invited me to meet the Children's Centre manager where my colleague worked. Fortunately, the site I was invited to was the preferred site already suggested by the Local Authority Children's Centre managers. The initial fieldwork began on 17th April 2009.

Ethnography requires an involved, prolonged immersion in a social setting (Bryman 2012); I intended to carry out at least weekly visits over a period of six months. In reality, this extended to a twelve month period, from 17th April 2009 to 25th May 2010, during which time I was able to carry out participant observation across a variety of activities held at the setting. Participant observation in this study involved a variety of activities including observing, listening to, and engaging in conversations with a wide variety of staff and service users who worked or attended the Centre. Field notes and spatial maps of observations and interactions were initially used to record interactions occurring in the Centre. I was able to audio record short interviews with staff working in the Centre. I also audio recorded 'naturally occurring data' that occurred between the HV and clients in the Well-Baby Clinics.

6.4.1 Participant observation of the setting

Children's Centres cover a designated area and developed from SSLPs: they are described as area-based initiatives in disadvantaged neighbourhoods. The neighbourhoods have to be amongst the 'most disadvantaged' in the country with high numbers of families with young children (Barnes 2007).

The Children's Centre where the study took place was founded in 1998, and was a first wave Sure Start Local Programme. It began with National Lottery funding and covered an area which included the third most deprived ward in the county and also fell within the top 20% of wards of poverty and deprivation nationally (AGM Report 2010). It became a designated Sure Start Children's Centre in 2006, a statutory provision within a charitable company and a number of funding partners. It is described as a full-core offer Children's Centre, which means that it offers:

1. Integrated Early Years Childcare and Education

2. Family support and Outreach Work
3. Child Health and Family Health services
4. Training and links to Job Centre Plus.

The Centre provided services that included integrated childcare and early learning, family support and outreach, a childminder network, HV and midwifery services on site, links to Job Centre Plus and financial advice. It was a universal point of access to the above services for children and families. This case study was concerned with the health services provided to families through the Children's Centre and excluded any day-care or nursery provision.

6.4.2 Reach of the Centre

The Children's Centre was situated in an affluent county but was described as being within a pocket of severe social and economic deprivation (Children's Centre Self Evaluation Form 08). The centre's geographical reach was described as being collected from across several super output areas³. Data collected about the total population of the area was derived from the Indices of Multiple Deprivation (IMD) 2000. Further information was gathered from the Department for Work and Pensions (DWP) and related to the number of children under four and was matched to lists of postcodes within each area. The figures collated in this way demonstrated that 30.3% of 0-4 year olds within the reach of this Centre lived in households dependent on workless benefits. The overall claimant level was almost double the county value: 61% of employed people were in routine or semi-routine occupations; 39.1% of 16-64 year olds had no qualifications; and 45% of 4-7 year olds were eligible for free school meals. In 2004, eight countries, known as the A8 Countries: Czech Republic; Estonia; Hungary; Latvia; Lithuania; Poland; Slovakia; and Slovenia joined the European Union and a new wave of migration from these countries to the UK began. The Children's Centre was reliant on data published by the 2001 Census and was not able to demonstrate the number of A8 nationals who had moved into the area since 2004.

At the time of the study, the Centre had a total of 934 children who lived within the reach of the Centre (Ofsted Report 2009), of which 755 were categorised into four groups: lone parents; teenage mothers; children living in workless households and BME families. The information available through the Centre's reports, such as Ofsted (2009), only appeared to concentrate on these four groups. These groups also meet the criteria or risks of 'hard to reach' as defined in government policy guidelines in relation to parenting and child development (SETF 2007).

³ SSLP areas were decided by each Partnership Board through local consensus. This has been described as a non-traditional approach, i.e. not electoral wards. Each Children's Centre had to collect information (Table 14) based on a variety of socio-demographic indicators of deprivation and disorder (Barnes 2007).

The total percentage of children who had been reached through Centre activity was 230, or 24% of the 0-4 population within the four groups. In comparison to other Children’s Centres in the county, the number of families being reached was considered to be very successful. Table 14 (p.106), demonstrates how the services from the Centre were able to reach 50% of families who lived in ‘workless families’. The data captured clearly situated the reach of the Centre within an area of multiple deprivation and offered a snapshot of the use of services at the time of the report (Ofsted 2009). However, the data appeared limited: it only reported on the use of the Centre and not the total use of services in the area. For example, children who lived in the area but attended different day-care facilities were not included. Also, the snapshot nature of the data meant it was not able to capture the transient character of the community. For example, all of the participants interviewed in this study discussed how they had moved into or out of the area since becoming pregnant with their most recent child. Two participants explained how this had resulted in a move to a different area of the town, away from the Children’s Centre they had attended whilst pregnant.

Table 14: Attendance at the Children’s Centre in 2009

Lone parents	Teenage mothers	Children under 5 in Workless households	Children under 5 in BME groups
Total no. 285 41 reached =14%	Total no. 12 12 =100% reached through attending a midwife but no further outcomes measured and overall attendance down. This group did not regularly attend the Children’s Centre after the birth of their baby (Ofsted Report 2009).	Total no. 313 158 reached =50%	Total no. 145 32 reached =22% (but figures from 2001 census will not take into account A8 nationals).

6.4.3 Field relationships

After gaining access to the fieldwork setting, I was involved in gaining the approval and trust of the Health and Children’s Centres’ workers and clients being studied. Initially this proved quite challenging because, whilst the overall shape of the research was clear, the direction and sampling strategy relating to the case of ‘hard to reach’ developed and was refined during the course of the study. Many researchers with experience of ethnographic methods (Silverman 2005, Hamersley and Atkinson 2007) describe this as a normal part of the research process, where a study gains shape and substance as the study progresses. They, too, acknowledged how it is difficult to describe the essence of the research at the onset of a

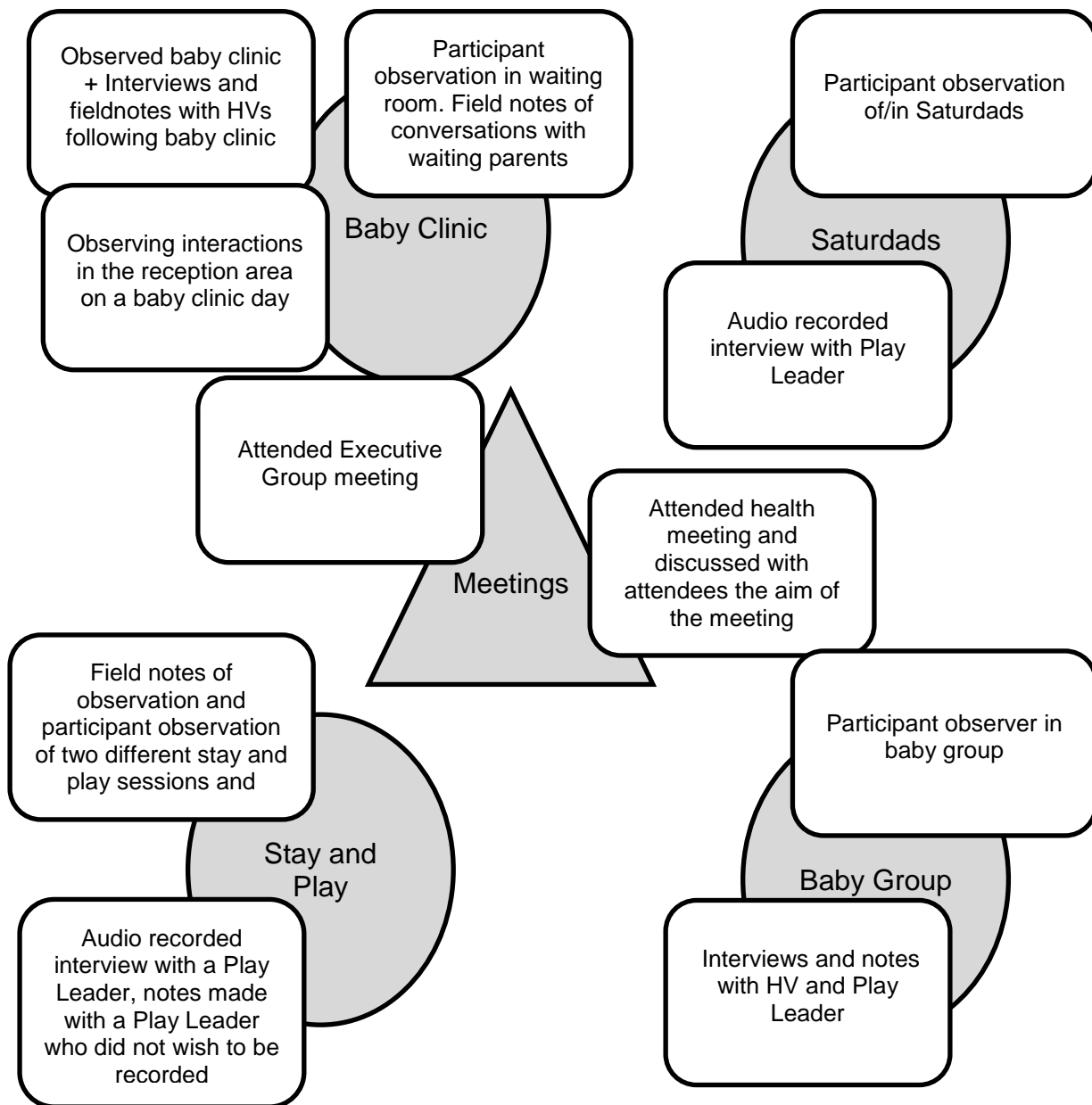
study. This was very true in this current research project; fortunately, an advantage of being in the field for a lengthy period of time was that I was able to be as transparent as possible with participants, and changes to the methods, such as the inclusion of audio recordings, were discussed with the HVs in the Children's Centre prior to applying for a modification to the original ethics application (Appendix 2).

6.4.4 Field notes 1: Shaping the focus of the research topic

During the first four months (April 2009 - October 2009) I observed many different activities for children aged 0-4 held within the Centre (Figure 3, p.108) and made field notes with and interviewed staff members to determine their understanding on the concept of 'hard to reach'. The keeping of field notes and a fieldwork diary enabled a strategy which identified the focus of the research onto the Well-Baby Clinic. Whilst I was familiar with the role of the HV, I was unfamiliar with the role within the Children's Centre. Initially, an aim of the study was to understand how the concept of 'hard to reach' was understood in the Children's Centre and I began by observing many activities within the Children's Centre (Figure 3, p.108).

Initially, my field notes recorded the broad approach taken; this was to gain an understanding of and familiarity with the setting, and it was also an example of the exploratory nature of ethnographic research. At the beginning, it was not clear which participants needed to be included, how health and the work of the HV/Children's Centre staff with 'hard to reach' families was perceived within a setting described as part of the universal provision of services (DH 2009, DH 2011). I began by interviewing service providers to discover whether 'hard to reach' was a label applied inside the setting or only given to clients who did not attend

Figure 3: Diagram demonstrating areas of participant observation

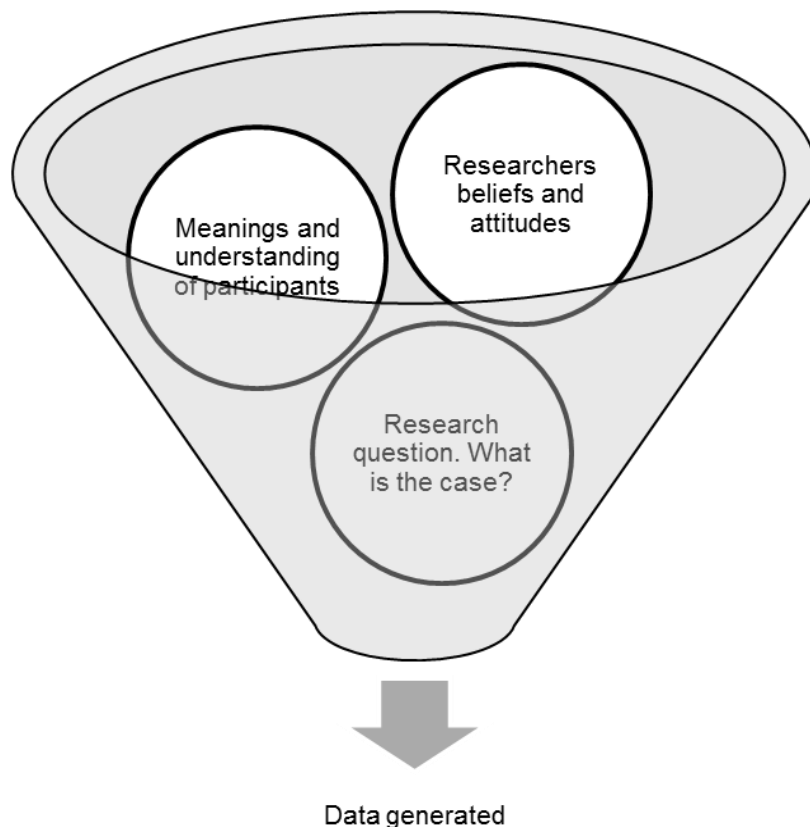


This narrowing down of a topic within a field site has been called a funnel approach (Lofland et al. 2004, Hammersley and Atkinson 2007) and as the fieldwork progressed, I focused on observing the Well-Baby Clinic encounters

Firstly, critically examining the concept of 'hard to reach' across a Children's Centre was a much larger task than I had originally perceived. As Figure 3 demonstrates, there were many different organisations working within the Children's Centre and many activities, and as a consequence I observed many different approaches to working with clients. This resulted in heavy demands on my time during the early stages of the fieldwork. Secondly, due to the

number of activities in the Centre, the protocol developed in order to gain verbal consent was very time consuming. For every activity I observed I had to plan and negotiate with the Health Visitor/Children's Centre worker a suitable time to attend, and this was then often renegotiated. Following this negotiation and prior to carrying out participant observation, at least one week was allowed, during which time a poster was displayed (Appendix 7).

Figure 4: Funnel approach used in the study



When participant observation was being undertaken, the HV/Children's Centre worker agreed to explain to clients that, with their consent, a researcher would be present to observe the activity sessions. Consequently, if consent was not given, it was agreed that I would leave the area. Gaining consent to attend activities and observe and participate was a process that was entered into every time I entered the Children's Centre and will be discussed further in section 6.4.6 below.

Secondly, as the study progressed I realised that a wide range of clients were attending the Well-Baby Clinic, some of whom were described by the HVs as 'hard to reach'. Atkinson and Pugsley (2005) describe purposive sampling in ethnography as being dependent on the key features of the research site: the Well-Baby Clinic appeared to be such a site. After the initial

period - and following discussion with my supervisors - I elected to observe the Well-Baby Clinic encounters. Between April and November 2009, I observed 10 Well-Baby Clinics held within the Children's Centre. Following verbal consent being gained, when clients entered the room I would introduce myself and ask permission again and answer any questions the participant might have. I explained my interest was in finding out what happened in the Clinic/activity session, that I would not collect any demographic details about themselves or their baby. I also tried to adopt a flexible and sensitive approach, e.g. when a personal subject was being discussed in the Well-Baby Clinic, I would offer to leave the room. Although this offer was usually refused, it did give further insight into wider issues of confidentiality/powerlessness felt by some clients attending the Centre. For example, one client who was involved with several agencies said I could stay as "*everyone knew my business*". This remark made me re-consider my presence as a researcher/observer who was able to capture this expression of powerlessness, but it also made me reconsider how my presence was perceived as yet another person who would know her "*business*", and I believe that this then influenced what was discussed and the data generated during the encounter. Gaining verbal and written consent was an ongoing process and meant that I had to negotiate and renegotiate with the HVs and clients with each clinic attendance and encounter during the time spent in the field.

6.4.5 Field Notes 2 – Spatial maps

As recommended by texts on participant observation (Lofland et al. 2004), field notes were recorded in brief note form during sessions and written up contemporaneously. Field notes, including spatial maps, were used to record how people interacted with each other and also how the artefacts in the room were used. In this study, the artefacts related to the Personal Child Held Record Book (PCHR), the weighing scales and Baby Changing Mat. Spatial maps recorded how HVs 'did health visiting'. This related to the interaction between the HV and client and also to paying attention to how the clinic room and artefacts within in it were used by the client, their partners, children and by the HV. Spatial maps gave form to the initial collection of data. The room allocated as the 'health room' was quite a small room, and making notes using spatial maps was a relatively unobtrusive and quick method that could be shared with participants if requested. The maps also demonstrated how the room and artefacts were utilized within the practice of health visiting:

1. To describe how the rooms were set out with equipment
2. To record how people moved around the clinic room: did all participants approach and enter in the same way? How were the (PCHR) Red Book and scales used in the encounters?
3. Finally, the spatial maps acted as an aide memoir to recall how the interaction had proceeded.

This micro-analysis of social interactions appeared to be a valuable way of understanding the concept under investigation. The aim was to understand the culture of health visiting within the Well-Baby Clinic and to try and elicit the barriers and facilitators to the interactions between the HV and client. The keeping of spatial maps enabled the collection of field notes that captured details of the mundane practices happening in the clinic. Atkinson and Pugsley (2005) describe how recording mundane events are important as they can help to make sense of the phenomena under investigation and the context that influenced these encounters. I was able to record the length of time taken, the number of people attending each encounter and the questions they wanted to ask, and the interruptions and demands on HV time during clinic.

Recording the interactions through participant observation built up a picture - or a 'thick description' - of how people got to the clinic, how they found out about it, what had made them attend and how they intended to use the service provided., who else they would turn to for health advice and what barriers they faced in reaching the clinic.

There were several limitations to this approach. Firstly, I did not collect demographic details about participants during the observation. So, whilst being sensitive to not interrupt the encounter and being mindful of issues of confidentiality, this approach resulted in participants' employment details only being obtained if they were mentioned during the encounter, which was not a systematic approach. The second limitation related to the recording of field notes; it proved impossible to record notes and catch all the nuances in the encounters between the HV and clients. The clinic was held in a very small room, and I would sit behind the client to try to be unobtrusive, which was difficult in such a small room. I tried to make a note of everything, and may have initially been focusing on unusual events rather than the everyday, mundane activities within the clinic. For example, I focused on an incident where the HV used a letter to introduce the non-attendance by the client of an appointment, a situation that offered potential conflict in the HV/client relationship. Nurse researchers (Rankin and Campbell 2006) and discourse analysts (Gee 2005) have found these areas of conflict or dissonance important areas to follow up or to use as an entry point to explore how 'HVs did health visiting'. However, the keeping of field notes did not capture

the essence of this challenging encounter, as both parties continued to be polite to each other and obviously knew each other well.

As I observed the clinic encounters, I was also aware of the HV trying to break down the power relationships by using her friendly approach and presentation (Discussed in Chapter 7 below). My professional background as a HV made me attuned or socialized to recognize the activities of the professional person over the client. After discussing this with my supervisor, who again felt that being an 'insider' was making it more difficult for me to observe the 'familiar as strange', she suggested audio recording in the clinic. I then discussed with the HV at the Children's Centre the possibility of making audio recordings of the clinic encounters. Following the HV's agreement, a modification was made to the original ethics proposal to include audio recordings of clinic encounters and to gain written consent from the participants (see Appendices 12 and 13). This enabled the collection of better quality, naturally occurring, data (Hammersley and Atkinson 2007). Between February 2010 and May 2010, nine sessions of the 'Well-Baby Clinic' were recorded, and consisted of 35 individual HV/client encounters. Field notes of the clinic encounters were also made and added richness to the audio tapes in relation to the interactions. During the study period, three clients did not consent to being recorded or having the researcher present.

6.4.6 Naturally occurring data

The audio recordings provided a reliable record of the 'naturally occurring' interaction between HV and parent and offered a trustworthy record for analysis (Silverman 1993). Rather than being limited by the researcher's ability to record all the events that occurred within a clinic encounter, the audio recordings were able to capture a wide range and variety of the consultations. The audio recording of the clinic demonstrated a richness of data not captured by field notes. Recording naturally occurring data also collects the data as it happens. It records how all participants are involved in the clinic encounters, which in turn would depend on their situation and circumstances and my presence in the clinic. Rather than believe that the data was being collected objectively and 'free from human hand' (Silverman 2005), the wider reading I had undertaken on reflexivity (Coffey 1999) and research as a social construction (Gubrium and Holstein 1990) meant that my presence as a researcher would influence the data being generated. My aim was to try and capture the diversity in how all of the participants represented themselves during the period of observation and audio recording when accessing the Well-Baby Clinic.

Whilst I was attentive to how my presence may affect the encounter I was observing, I was also conscious that my health visiting background would affect how I was viewing the encounters.

6.4.7 Role of participant observer

The challenges of gaining physical access to a research site are well recorded (Hammersley and Atkinson 2007). Importantly, in nursing research the researcher often has a background in nursing, and this was true in my case. Coffey (1999) presents the researcher as part of the research process, and it is important to be aware of how the researcher's cultural beliefs, attitudes and understandings shape the research findings and will influence what is being observed and recorded (James 1992, Lathlean 1996, Mulhall 2002).

The fieldwork aspect of the case study was carried out over a period of twelve months and formed the most substantive part of the study. It produced rich data but also led to many challenges, which will be discussed in relation to the researcher's background as a HV researching a familiar culture and context. These relate to the researcher role in data generation and the advantages and disadvantages of researching a known topic. There is much discussion on how participant observation is achieved in the field (Hammersley and Atkinson 2007, Silverman 2005, Barbour 2008) and many authors refer to Gold's (1958) classic typology of research roles. Prior to the fieldwork I familiarised myself with Gold's typology, which describes the role of participant observation on a continuum from complete participant to complete observer. The complete observer is described as someone who observes and records a given situation, sometimes covertly and without the knowledge or consent of those involved (Hammersley and Atkinson 2007). At the opposite end of the spectrum is the complete participant; in ethnographic terms, this is someone who conceals their researcher identity yet joins a group as a member with the purpose of researching as an 'insider'. These covert researcher roles are no longer recommended for ethical reasons of informed consent, and also because there have been safety issues for the researcher when their researcher identity has been discovered (Hammersley and Atkinson 2007). Gold's typology was helpful as it drew attention to the variety of roles that can be utilised during a study and much has been written about the nuanced and different roles researchers undertake during their time in the field (Barbour 2008, Hammersley and Atkinson 1995).

At the beginning of the fieldwork I also observed several different roles among the HV and Children's Centre staff and it was arranged that I would be able to observe and participate in many different activities within the Centre (Figure 3 p.108). For example, I volunteered as a helper in the activity days and sessions held in the Children's Centre; I also sat as an

observer in a corridor by reception and carried out observations of all who came into the building. When observing the Well-Baby Clinic, I tried to sit quietly and observe the encounters whilst making notes. During the first session of observation of the Well-Baby Clinic, I became aware that the HV based in the Children's Centre was introducing me to possible participants as a colleague rather than a researcher. Also, at times the HV would invite me to offer my opinion on a subject being discussed, which I would then give. Initially I felt uncomfortable with this shift in role as I was not currently working in the area I was researching in. I discussed this dilemma with my supervisor, who was outside of the immediate research process (Pugh, Mitchell and Brooks 1999). As a result, a field strategy was developed to promote the research and my researcher role. On my next visit, I again explained that I was observing as a research student and how I was differentiating my role by wearing my University Identification badge. I also arrived with more poster information about the study (Appendix 7) which, with agreement, I displayed in the community room prior to the commencement of each clinic. Gold's typology appeared to discuss the physical aspects of the researcher role yet it did not fully convey the intellectual shift that I was also experiencing.

6.4.8 Reflexivity and participant observation

Coffey's (1999) approach to ethnography included a reflexive stance as she believed this would strengthen the research process. Her approach appeared similar to feminist researchers (Ribbens and Edwards 1998) who have also argued that who you are and where you are situated in the research process affects not only how you approach the research but also how you collect data and produce new knowledge on a subject.

Many of the decisions and choices made in this current study were influenced by my HV background, and observing in a health setting felt very familiar. What did not feel so familiar was how I presented myself as a neophyte researcher to HV colleagues and clients. Ribbens and Edwards (1998) have attributed these feelings to being part of a process of transition: moving from a known situation to the unknown. In my case, moving from a familiar HV role as an 'insider', to a new role as a researcher and an 'outsider' was not as straightforward as I had initially thought.

Coffey (1999) pointed out how engagement in the field involved both intellectual and physical presence and she advocated that these dynamics be included in the research process. She explained that this can be achieved by researchers acknowledging the effect

that the study has on “*our ethnographic selves*”⁴. She believed this approach would aid the researcher in tackling issues of objectivity and reactivity during the research process:

“one of the strengths of ethnographic enquiry is the real involvement of the fieldworker in the setting under study. A weakness is not the possibility of total immersion, but a failure to acknowledge and critically (though not necessarily negatively) engage with the range of possibilities of position, place and identity” (Coffey 1999 p.36).

Coffey’s approach addresses issues of reactivity to the researcher presence. As I discussed with my supervisor how the HV informants were responding to my presence, it helped to devise strategies that would acknowledge how the informants were reacting to my presence. Coffey suggests that reflexive accounts should acknowledge how participants are responding to the researcher and include these in the findings. The term reflexivity is derived from ethnomethodology⁵ and has been defined as:

‘the self-organising character so that any action provides for its own context’
(Silverman 2005 p.379)

Therefore, a reflexive account would recognize that the researcher was an active participant in any situated activity within the case study and acknowledge how the researcher presence was influencing responses and data generation.

Reflexivity, then, involves understanding how a researcher is viewing or ‘framing’ the study. James (1992) and Lathlean (1996) have written about their experiences as researchers with a nursing background undertaking research into nursing. Both have discussed the advantages and disadvantages of this role. As with their experiences, I too found that there were advantages to being an ‘insider’. Recognizing that I was investigating a research topic which had developed whilst working as a HV meant that I was very close to the subject. This has been viewed as a strength in devising analytical case studies (Silverman 2005). In my experience, this related to the planning and accessing of the research site. Having a HV background gave me credibility, I was known to the HV managers and they were supportive of the research study and introduced me to the Children’s Centre managers to gain access to a fieldwork site.

⁴ An Ethnographic self - researcher is aware of their position, approach and identity, intellectually, emotionally and bodily.

⁵ Ethnomethodology is the study of folk - or members – methods persons use in doing social life. (Silverman 2007)

However, my HV background was also a disadvantage because the notion of the ethnographer as a 'stranger' appeared an important aspect of the role (Hammersley and Atkinson 2007). The advantage of taking a stranger or an 'outsider' stance is that it is a technique for creating a distance between the researcher and the participants. Seeking advice from the literature (Barbour 2008) into carrying out research in a familiar culture, I found that "*rendering the familiar strange*" (Barbour 2008 p.93) was recommended in order to find a way to question previous knowledge and assumptions. It was also recommended that, to actively generate data, researchers should shift from carrying out a purely observer role to a more active participatory role (Silverman 2005) in order to enable an understanding of real life situations from the inside (Pope 2005). Silverman's approach appeared rather broad and, whilst it gives the researcher scope to interpret the role for themselves, it was found to lead those familiar with the research area to become more of a participant and offered less time to observe as a researcher (Pope 2005). Another interpretation of the 'participant observation' role is where the researcher interacts with members of the study site whilst they work (Barbour 2008). The researcher takes an active part in the group being studied in order to enable an understanding of real life situations from the inside (Pope 2005), and this role is negotiated during each visit. A key supposition of ethnography is that, by entering into close and long-lasting interaction with the day-to-day activities, an understanding of the beliefs, attitudes and behaviours of participants is gained at first hand. However, I was an 'insider' - a HV studying health visiting. Following the advice of nurse researchers (James 1992, Lathlean 1996), the strategy I undertook during the study was to act as a data generator.

I became an 'observer as participant': at times I was able to sit and observe whilst at other times I had a more participatory role; for example, acting as a volunteer helper by collecting the names of attendees at the start of the play activities, or by replying to a question addressed to me by the HV. I also participated in the research process by asking questions and feeding back my understandings to the HVs involved in the Well-Baby Clinic, and I acknowledge that this approach may have influenced the findings.

Lathlean (1996) believes that it is important for the validity of the research to describe how the researcher can act as a 'stranger' within a familiar situation. She believes this approach allows the researcher to understand the situation, rather than impose their preconceived ideas onto the situation. In this way, new information will hopefully be discovered (Silverman 2005). In this study, I adopted a variation on the approach of 'socially acceptable incompetent' (Atkinson and Pugsley 2005) to that of 'curious researcher' (Lathlean 1996): instead of assuming that I understood how the HVs viewed the concept of 'hard to reach', I

relied on trying to elicit from the HVs their understanding of the term. This was achieved by asking each HV at the end of the clinic if anyone had attended whom they considered 'hard to reach' and discussing with them their understanding of the concept. It also involved the keeping of field notes, spatial maps, interviewing and discussing my findings with the research supervisors and the HVs working from the Centre. This strategy generated data on the practitioners' understandings and was extremely helpful in gaining an understanding of the variety of encounters and practitioners' perceptions on the concept under investigation.

6.4.9 Summary of participant observation

The participant observation was completed after twelve months of visiting the research site for at least once a week. The initial part of the fieldwork involved observation of many different activities. The narrowing down the focus to the observation of the Well-Baby Clinic followed on in a fairly textbook fashion. I found ethnographic research was an appropriate method for studying the micro-interactions within the Well-Baby Clinics in particular for understanding the complex phenomenon under investigation. Yet there were some limitations: I was only able to observe people who consented to be observed and who were choosing to attend the universal Well-Baby Clinic. Therefore it was also necessary to conduct in-depth interviews with clients who did not attend formal universal child health services.

6.5 In-depth Interviews

The initial aim of the study was to explore with 'hard to reach' parents their health needs and requirements from child health services during early parenthood. In the ethics application, I had acknowledged that recruitment of 'hard to reach' subjects was by definition a problematic area (Faugier and Sargent 1997). To help to make the information about the study accessible, a reference group was consulted with regard to producing information that was clear and understandable (Appendix 9). Following advice on involving the public in research (INVOLVE 2004), I contacted a voluntary organisation which offered community support to clients with complex needs, and which coordinated a client involvement user group commissioned by the local PCT. The user group agreed to offer me advice on the wording/formatting information sheet I was producing for participants. The advice the participants offered was useful for the design of the information sheet as was the feedback on using envelopes that wouldn't be associated with bills or official letters. However, the process to engage and meet with the group took twelve weeks. The difficulties of recruiting 'hard to reach' participants for research has been well documented (Faugier and Sargent

1997). My main reason for collaborating with the user group was to try and produce an information sheet that would be acceptable to clients who did not access mainstream services. Unfortunately, because of the required information in the participation sheet, this meant that their role was quite restricted and felt like lip service rather than true involvement. However, involving the user group did result in changes being made to the information sheet and gave insights into the benefits of involving lay researchers in making research more accessible to all client groups.

6.5.1 Recruitment to interviews

With reference to Faugier and Sergeant (1997), I devised a recruitment process that had several routes for accessing participants. The first route involved potential participants being identified and contacted by a gatekeeper. In this case study, the HVs or Children's Centre workers were asked to identify potential participants and to send them information, inviting them to take part (Appendix 9). If they wished to participate, they were asked to contact the researcher by returning the consent form/contacting by text. This method failed to recruit any participants.

The second method was much more successful and here potential participants were contacted face-to-face by the gatekeeper/staff member who gave out the information sheet and who also gained permission for the researcher to contact the participant by phone or text to explain the study. In addition, posters (Appendix 8) were displayed throughout the study area enabling parents to contact the researcher. Following initial contact by phone, I would send out the information sheet and consent forms and arrange the interview at a mutually convenient time and place, which was always at the participant's home: this approach resulted in six interviews.

The HVs working in the locality were also asked to recruit participants to the study; however, as the research progressed it transpired that the staff working from the Children's Centre acted as the main gatekeepers to participants who agreed to be interviewed. Emmel and Clark (2009) utilised HVs to act as gatekeepers in their study of a community. They described how HVs and other health workers were ideal gatekeepers to participants in community studies as they were accepted by socially excluded individuals. They explained that this was because they provided long-term comprehensive services in a community. They defined comprehensive services as health professionals who addressed the broader issues in their client's lives, which enabled long-term engagement to address needs and build trust. This was also proved true in this current study, as the HV based in the Children's Centre was able to recruit one first-time teenage mother because she was the HV to another

family member. However, accessing other 'hard to reach' first-time mothers without such a relationship demonstrated a limit to this approach.

Emmel and Clark (2009) described how they developed relationships with the HVs working in the area of their study. They attributed the success of recruiting participants to the fact that health professionals and researchers shared similar 'cultural capital', which resulted in the HVs being able to convey the value of the research to prospective participants (Emmel and Clark 2009). In this current study, the HV based in the Children's Centre proved more successful in recruiting participants than the HVs based in GP practices. Therefore, as well as a shared cultural capital, other factors, such as having regular discussion of the study appeared to have contributed to the recruitment of participants.

In response to the poster being displayed in the Children's Centre, two first-time young mothers were also recruited to the study. This was very fortuitous: as I was finding a place to display a poster, I asked a passing attendee where she felt a recruitment poster could be displayed. She then volunteered to be interviewed, and gave me her contact details. A week later, I contacted her to ask if she would still be interested in being interviewed. She consented and I arranged for the study information to be sent to her. Following her successful interview, she also recruited a friend to take part in the study. This was an example of recruiting through a technique called 'snowballing', a technique also recommended by Faugier and Sergeant (1997) to reach 'hard to reach' research participants. This technique resulted in contact with a service user who was rarely going to any services for pre-school children.

Overall, the recruitment process was very slow, and after six months only three first-time mothers with babies aged between six weeks and nine months of age had been recruited to the study. A further participant had given birth to her first child 14 years earlier and had agreed to be interviewed. Emmel and Clark (2009) described their recruitment process as 'negotiating messy boundaries' as it involved making decisions with regard to recruitment and ethics during fieldwork. Barbour (2008) believes that the ability to change and adapt is a recognised strength of qualitative research (Barbour 2008).

Purposive sampling includes characteristics of a setting or a population (Ritchie and Lewis 2003): the recruitment to interviews was the final method to be employed. By this time, I had begun to realise that first-time 'hard to reach' mothers living within the reach of this Centre was a small cohort and, more importantly, experienced mothers could also be potentially 'hard to reach'. A second modification to the original ethics application was then applied for. The original application detailed that the researcher intended to recruit into the study 15 to 20

first-time families who were described by HVs as ‘hard to reach’. The modification aimed to widen the recruitment of participants to include families with more than one child, with the most recent baby being under eight months of age at the time of recruitment. Following the granting of the modification (Appendix 2), a further four women were recruited to the study (Table 15, p.120).

The process of recruitment had taken eight months and whilst potential participants had agreed to take part in the study, in reality conducting the interviews even after agreeing to participate was not straightforward. For example, two interviews had been arranged on the same day. The first participant was not at home when I visited at the arranged time and date. On arriving at the second participants’ house, I discovered that the appointment had been forgotten. Fortunately, on this occasion it was possible to conduct the interview. Unfortunately, due to equipment failure, this interview was not recorded and notes were made of the interview.

Table 15: Demographic information of interview participants

	Work Paid/Unpaid	Accommodation	Age at first pregnancy	No of children
Liz	Full-time mother	Moved house during pregnancy	Age 15	9
Lily	Maternity leave	Moved house during pregnancy	Age 15	2
Karen	Full-time mother	Moved house during pregnancy	Age 19	1
Sue	Part-time paid work	Moved house during pregnancy	Age 19	1
Alex	Part-time paid work	Living between addresses at present	Age 18	1
Vanessa	Full-time mother	Moved house a month ago	Age 19	3
Jane	Part-time paid work	Lived at this address for two years	Age 24	2
Emma	Full-time mother	Seven months at this address	Age 15	3

All of the interviews took place in the participants’ homes, and the appointments were held at a time suitable to them. The interviews lasted for 45 minutes to one hour and followed a

Topic Guide (Appendix 11). As found in other studies (Kirkpatrick et al. 2007), interviewing vulnerable women was challenging. For Kirkpatrick this was because arranging appointments was not straightforward and, similarly, in this study appointments had to be rearranged on several occasions. Furthermore, interviewing was also challenging as gaining responses from the participants was difficult at times. For example, following the last interview with Emma, I had noted in my field notes how it appeared that the participant was not used to having her opinions heard and she had difficulty verbalising her thoughts. Secondly, all of the interviews took place in the participants' homes with their children or babies present. Often the interviews were interrupted by their partners or children and this appeared to support the notion that the women interviewed had very little time for themselves. On one occasion, the interview was conducted with the participant's three young children present. As we talked, one-by-one the children fell asleep and, on completion of the interview, I was able to leave knowing that the participant might have had a few minutes to herself. All the participants agreed to be audio recorded and the tapes were transcribed verbatim. Thumbnail sketches including immediate impressions were also made following the completion of the interviews. In recognition of their time given to the study, the participants received a voucher to the value of £20.00

6.5.2 Limitations of the interviews

The cohort of eight participants who were interviewed demonstrated a small cohort of four young parents and four more experienced mothers who were all under the age of 30; six of the participants had lived in the area since they were children and all were white British. Therefore the voices of other possible participants were not included; however, given the difficulty and time and resources taken to recruit this purposive cohort of one segment of the population, a sample of eight was deemed sufficient. Future studies could include a sample made up of other groups that are described as 'hard to reach': fathers, ethnic minorities families, traveller families, families with specific health factors such as physical health or mental health issues, families where the mother works full-time or has involvement with social services.

On reflection, more participants may have been recruited if local service users had been trained and employed to carry out the research interviews. In future, research into users' views of child health services should involve service users.

The study aimed to interview participants who did not engage with the local child health services in order to include the voices of the 'seldom heard'. A limitation of this approach was that themes identified such as 'self-sufficient family' cannot be taken as evidence solely

in relation to non-use of services. Further research is required to investigate how regular users view services in relation to the theme of 'self-sufficiency' in parenting. This would then allow for this theme to be investigated further.

6.6 Data analysis

This section will examine the process of analysis in this study. As with many qualitative studies, the amount of data generated during the single-case study was large. To summarise, the data analysed included:

- The transcripts of audio recordings from three focus groups with HVs.
- Field notes from participant observations of meetings; activities within the Children's Centre; spatial maps of 10 sessions of the Well-Baby Clinic; field notes and transcripts from the audio recordings of a further nine sessions of HV/client encounters from Well-Baby Clinics; field notes and transcripts of audio recordings of interviews with HVs, midwives, who attended the Centre.
- Seven in-depth interviews with clients/participants living in the area who did not attend the Well Baby Clinic. One in-depth interview with a client who did use the centre.

At first the data analysis was organised according to each separate activity. The focus group data was analysed in relation to how the participants conceptualised the term 'hard to reach'. However, the analysis was hindered by the diverse/tacit understandings to the concept. So, whilst HVs recognised how women experiencing domestic violence, or women in temporary accommodation were members of known 'at risk' groups of clients and considered in government policy and in practice to be 'hard to reach', they also discussed the concept in relation to the facilitators and barriers to partnership work with individuals on their caseload. The key analysis began with the micro-analysis of the audio recorded clinic encounters: here, thematic analysis was guided by Gee's (2005) method of critical discourse analysis.

6.6.1 Rationale for Gee's method of critical discourse analysis

My interest in discourse analysis began when I started to assign preliminary codes to the focus group data. Barbour (2008) recommends that when analysing focus groups, the analyst should pay attention to the process of transcription and include in the analysis the body language within the group and to make a note of important aspects of the audio recording, for example, the tone of participants and how they were speaking. Including this in the analysis acknowledges the activity of the focus groups when the audio recordings are

transcribed. Barbour's (2008) intention appeared to prioritise the context of what was being spoken, to keep it in the analysis. She described this contextual data as important supplementary evidence and her approach appeared to recognise the importance of 'what' was said, and 'how' it was said. Bearing this in mind, carrying out thematic analysis on the focus groups became problematic. Firstly, as previously mentioned, the data from the three focus groups was insufficient to clearly answer how HVs understood the term 'hard to reach'. Instead, a variety of meanings and perceptions of the term was gathered and the preliminary analysis revealed that HVs were discussing the concept within a discourse of 'partnership'. Examining 'how' HVs were talking enabled the identification of partnership working. However, the subject of partnership was very familiar to me, so was it my professional bias that made this category prominent? This reflexivity made me realise that my analysis might benefit from an analytical framework or way of thinking about the topic that would:

"render Discourses with which we are familiar strange so that even if we are members of these Discourses we can see consciously how much effort goes into making them work and indeed seem normal, even right to their members."
(Gee 2005 p.102).

The initial planning of the research project proposed thematic analysis as a suitable method of analysis. As mentioned, thematic analysis of the focus group material did not appear to be enhancing a critical analysis of the data. One suggestion from my supervisors was that I was researching an area with which I was very familiar. Therefore, I began to explore the possibility of using discourse analysis and, before choosing Gee's method, I explored different methods of analysis. At first, it seemed that conversation analysis would be suitable. Conversation analysis has enhanced knowledge on the Doctor/Patient relationship (ten Have 2007, Silverman 2005), has highlighted the unequal power relationship between HVs and mothers (Heritage and Sefi 1992, Kendall 1993) and how health professionals maintain power relationships within the rhetoric of women-centred care (Lomax and Casey 1998). However, a limitation of conversation analysis is that it has been criticised for omitting the wider context of the interaction. Conversation analysts acknowledge this but argue that context relates to the conversation as it occurs (Silverman 2005).

This appeared to be a narrow definition of context relating only to the particular episode: the focus of the analysis remains within the context of the conversation rather than in the context of the wider situation. In this study, understanding the wider context appeared important to understanding the concept of 'hard to reach'. For example, in the clinic encounters, the HV appeared to greet the mothers differently, and how they were greeted depended on whether they had met before or were meeting for the first time. Also, how clients engaged with HVs

differed, and why this occurred appeared relevant to this study and understanding 'hard to reach' at the micro-interaction level.

I became interested in Gee (2005) for three reasons; firstly, he viewed language as a resource and he described how spoken language was a resource that will affect interactions. Gee (2005) and Bloomaert (2005) also are interested in discovering more about how people communicate as they believe communication is related to the power they have in their lives:

"This is where language leads us directly to the heart of social structure: an investigation into language becomes an investigation into the systems and patterns of allocation of power symbols and instruments, and thus an investigation into basic patterns of privilege and disenfranchisement in societies. Looking at issues of resources makes sure that any instance of language use would be deeply and fundamentally social contextualised: connections between talk and social structure would be intrinsic." (Bloomaert 2005 p.61)

Gee describes discourse analysis as the '*analysis of language in use*' (2005 p.5) and explains that his interest in discourse analysis is to examine how language is used as a "*social practice*" or resource. Like Bloomaert, he believes that some languages are privileged over others. He gives the example of how educational research has demonstrated the social and political advantages that middle-class children gain over other children and achieved this by speaking in a way that is valued by schools (Gee 2005). A great deal of Gee's work has been undertaken in educational settings. Gee's approach to discourse analysis does appear to have an application in health: medical 'talk' is often privileged over lay concepts of health (Mayall and Foster 1989). Another important advantage of using Gee's discourse analysis is that it allowed for the identification of the discourse models that were prevalent during encounters and how they affected the relationship between the mother and HV.

Secondly, his approach has been described as a 'bottom up' approach (Rogers 2004). He describes his framework as a 'soup' and he has been influenced by Foucault and Bourdieu and Goffman to make the 'taste' of his soup (Gee 2005, p.6). Gee believes that his method can be used by linguists and non-linguists because it is concerned with how language is used to build/expose social practices; his approach to discourse analysis is concerned with language and meaning in certain social situations. It is:

"concerned with talk, talk about social interaction and activities, and talk about society and institutions" (Gee 2005, p.7).

As well as being interested in the form and function of language, his approach takes into account how language and meaning are derived from “social practices”. He defines social practices as involving routine day-to-day activities, such as talking to parents or talking to friends. In this, it would seem that attending a Well-Baby Clinic was a social practice. Gee (2004) points out how critical approaches to discourse analysis,

“treat social practices in terms of their implications for things like status, solidarity, distribution of social goods, and power” (Gee 2004 p.33).

Gee (2005) also discussed his interest in observing how what he calls, ‘communities of practice’, or how Discourses with a capital ‘D’ occur within encounters, interviews or policies, and this appears to fit with an ethnographic approach. He discussed how his framework differed slightly from other forms of critical discourse analysis. He attributes the difference to being concerned with understanding the relationship between power, status and solidarity and how they influence social practices (Gee 2005). His method has been described as a bottom up approach to critical discourse analysis (Rogers 2004). Gee acknowledges his method as a postmodern approach examining how language is used to create meaning, for example, how a client’s reflections and understandings on past experience or perceptions of the health visiting service will help to shape and create the identity presented to the HV. He argues:

“a situated meaning is an image or a pattern that we as-sembled “on the spot” as we communicate in a given context, based on our construal of that context and on our past experiences” (Gee 2005 p.94).

Gee’s method thus fits this study, which takes place within the domain of a broadly social constructionist viewpoint - one that examines how and why meanings are assigned, in this instance, within the context of health visiting. Furthermore, Gee made the point that his method can be used by non-linguistic researchers and, whilst attention to the spoken language is important, he stated that it is equally important to pay attention to the ‘*non language stuff*’ (Gee 2005). He also explained how little ‘d’ or ‘d’iscourse is important to his framework because the language ‘bits’, the grammatical packaging (Rogers 2004) presented at the micro level messages are analysed within the context of a social practice and they will have a meaning in that situation.

Thirdly, he stated that his approach could help render familiar discourses as new or strange. Therefore as an ‘insider’ - i.e. being a HV - I was finding it difficult to carry out an ethnographic study and to observe and analyse critically. This approach offered a critical

method of analysis concerned with understanding how power, language and status affected relationships within a “*social practice*”. The following section will explain the framework for discourse analysis.

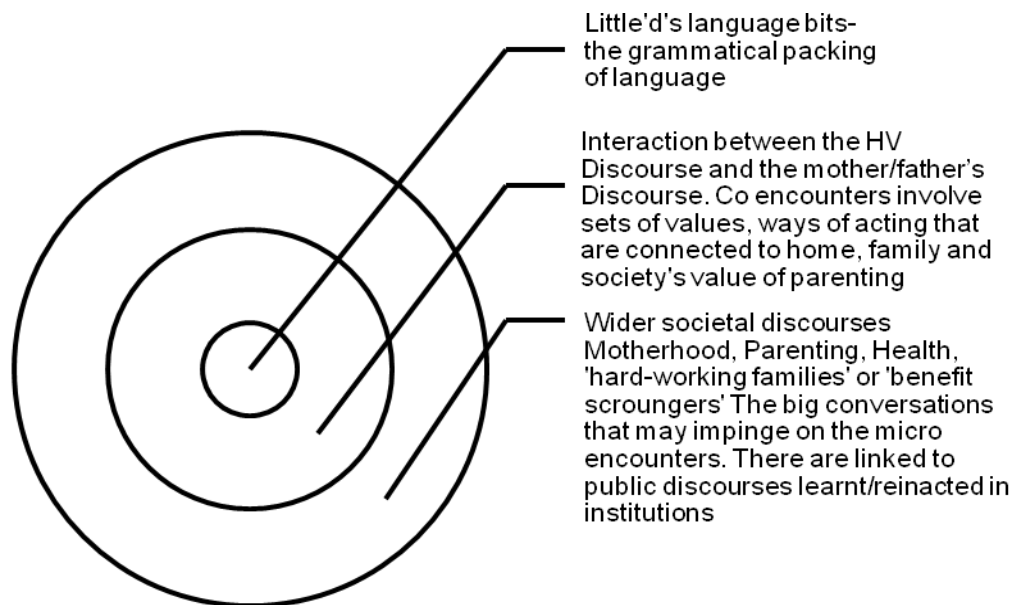
6.6.2 Framework for discourse analysis

In developing a systematic method for the analysis I followed Gee’s (2005) framework for discourse analysis (see Appendix 14). Firstly, he suggests choosing a piece of data of interest that will illuminate the research question. After one clinic, the HV identified a number of clients whom she described as ‘hard to reach’ and gave the reason of their ‘own agenda’ as to why they were ‘hard to reach’. Following Gee’s guidelines, I began to question the data. Firstly, I paid attention to turn-taking and the use of “I”, and ‘how’ people spoke to see if there was any employment of deference/disrespect or formality/informality of the words spoken. I also observed how people acted within the space of the Well-Baby Clinic with regard to the symbols and artefacts; for example, how the personalised child health record book was utilised.

Secondly, Gee recognised the importance of the co-construction of the encounter, whether between the HV and mother or between a researcher and interviewee. He calls this “connection building” and within this were several activities concerning identity or ‘ways of being’, which also related to wider societal discourses of politics and social goods. In this current study, motherhood and parenting and partnership working were recognised as social goods as they have a moral value. For the clinic encounters, this co-construction became an important part of the analysis: it highlighted the taken-for-granted power relations essential in positions of authority or expertise.

Thirdly, Gee discussed ways of identifying how people represented themselves and what they believe in (this is similar to Chouliaraki and Fairclough’s (1999) term for discourse analysis style). For example, how the individual HV or client represents themselves within the clinic, and the effect this has on the encounter. I was also interested in finding out whether the wider discourses of society impacted on the HV/client interaction.

Figure 5: Schematic diagram of 'd'iscourse, Discourses and Conversations influences on the Client /HV encounters. From Gee 2005 and applied to the Well-Baby Clinic



6.7 The process of analysis

As discussed in Section 6.6 (p.122) The analysis involved transcripts from the audio recordings of Well-Baby clinics; focus groups; and interviews with clients who didn't attend the children's centre and field notes of the participant observation.

Initially the transcripts were read and reread using Gee's (2005) seven building tasks of language and I interrogated the data by asking the questions formulated by Gee and described in Table 16 (p.128). The coding was also guided by Gee's (2005) seven building activities and the 26 questions to ask were linked to the building tasks (Appendix 14). The initial codes were descriptive codes used to identify the behaviour or attitude of the client or HV (Table 19, p.133) and related to the concept of 'hard to reach'

Table 16: Gee's (2005) 7 Building Tasks

Building Significance	What was important to each participant during the encounter?
Building Activities	What is the activity being attended to within the Well-Baby Clinic? Is this the normal activity within the clinic?
Building Identity	What identity or roles are the participants building in the encounter?
Building Politics	Related to 'social goods', Gee explains how respect is a social good. Speaking and acting respectfully and deferentially is a way of demonstrating respect. This would imply that when working in partnership, clients are treated with respect, their questions being considered as important, as normal, as an 'insider'.
Building Relationships	How is the relationship being built through the use of language?
Building connections between the client and the health visiting service	I examined the encounters for 'synergy' or 'dissonance'
Building Significance	Sign systems and knowledge which knowledge base was being privileged by the HV and the client?

Using this approach I was able to identify variations in the clinic encounters. The client in Table 17 (p.129) was an 'experienced' mother and knew the HV, and both demonstrated polite behaviour to one another; yet their encounter appeared business-like. The HV was clearly leading the conversation by asking questions, and then asking further checking questions. The HV appeared to be carrying out health surveillance of the client and her care. In contrast, the client appeared to be building/demonstrating her identity as a 'good mother', presenting a picture of a coping, caring mother with a recently ill child. By forgetting the PCHR -Red Book and discussing her GP and local pharmacy as part of her resources, she demonstrated a lack of connection with the health visiting service. Prior to the clinic encounter, the client had mentioned the involvement of social services; this fact was not mentioned in the clinic encounter. In this instance, wider contextual influences, not evident in the conversation, may be affecting the co-encounter. The wider context of other agencies being involved with the family appeared to be a barrier to a more partnership approach. This was reflected in the HV's style becoming slightly more authoritarian and the mother appearing to be concerned with reporting her actions and responses to her child's illness to the HV.

Table 17: First coded Clinic Encounter

HV /Client Encounter	Open coding
<p>HV: Right let's get, where's the paper gone here it is, just put the paper on the scales</p> <p>C: I think, I'm not 100% sure but I think I've left her red book at home</p> <p>HV: Ooh, don't worry</p> <p>C: I've got either hers' or his</p> <p>HV: Ooh</p> <p>HV: Do you remember what she was last time?</p> <p>C: 13 13½ I remember because it was close to a stone</p> <p>HV: OK and has she been okay?</p> <p>C: She's had this cough and it just got progressively worse and worse so I wanted it to be supportive and I went into Boots last week because George had it as well and she was really bad as well. I went and picked up... well I asked at the Pharmacy what to give her because obviously you can't give them cough medicine until they are six now, and they have given me (long Proprietary name) I think</p> <p>HV: OK</p> <p>C: but I've got the bag</p> <p>HV: But they've given to you the right age appropriate medicine?</p>	<p>Formal approach</p> <p>Forgotten red book</p> <p>Use of questions by HV : HV leading the encounter.</p> <p>Client building her identity by demonstrating her care for her children</p> <p>Client discusses her connection with other health services</p> <p>Client providing proof</p> <p>HV asks a checking question</p>

As a contrast, another clinic encounter is included (Table 18, p.130). In my field notes the client was also attributed with the characteristic of an 'experienced client'. She clearly demonstrated her awareness of the clinic routine, immediately on entering the room; the client went to the changing mat and, in preparation for weighing, began to undress her child. Simultaneously, the HV sat down at the desk and started to complete the Clinic Contact Form. Then without being asked, the client handed over the PCHR - Red Book from the back of her baby's buggy. The HV opened the Book in relation to the paperwork and asked for the baby's date of birth, prepared the weighing scales and invited the client to place her baby on the scales.

Table 18: Second Coded Clinic Encounter

HV /Client Encounter	Open coding
<p>HV: (talking to baby on scales): Ooh you look a bit worried, no not worried</p> <p>Very good boy, its clever isn't it, to get weighed like that and not cry</p> <p>C: Yes he's tired because it's his sleep time</p> <p>HV: Is it?</p> <p>C: Yeah I'm surprised he's not whinging more</p> <p>HV: it's the 30th today isn't it? So he was born on the 10th of July So he is 21 weeks.</p> <p>C: Yeah</p> <p>HV: That's gone fast</p> <p>C : Yes I know</p> <p>HV : How is your (Health problem)?</p>	<p>HV makes a positive statement, reflecting weight gain and behaviour</p> <p>Client refers to baby habits and routine, starts connection building between HV and Client</p> <p>HV defers to Client's knowledge</p> <p>HV deference checks the date with Client</p> <p>HV changes focus from baby to Client</p>

The second excerpt demonstrates a very different encounter. It appeared that the HV was comfortable with the mother's approach and organised manner, and all the comments to the mother and baby are positive. Whilst the HV led the conversation, and it follows in a question and answer style, her tone of voice was deferential and polite. A reference was made by the client about the baby's normal routine, in recognition of the effort made in bringing him to clinic at this time; the HV responds by deferring to the mother's knowledge of her child, and recognising/connecting that 'sleep time' is an informal reference to the language of more formal child care and routines offered within the 'good mother' discourse. Therefore they are able to co-construct a shared discourse around mothering.

The HV and client have met before; the client discusses her child's routines and as such demonstrates her use of the 'language of the clinic'. The HV knows the client and is able to build the relationship by asking how the client is; this marks a shift from the baby's health to the mother's health and is the beginning of a more in-depth consultation on the baby's behaviour.

6.7.1 Critique of Gee's approach to discourse analysis

Gee's method of critical discourse analysis became a useful tool for thematic analysis when I developed a framework based on his tools of inquiry (Table 19, p.133), and the framework became a process by which I could critically interrogate the three data sets. Gee's method had made me aware of the nuanced use of language and how different meanings (situated

meanings) and different social languages were applied throughout the data sets. Gee's approach to analysing distanced me from the data whilst acknowledging my background as a HV. I began to see how HVs promoted a certain language: 'health talk' in clinics and 'the language of partnership' in the focus groups. I also observed the variation in the client's responses to this approach, how some clients also used 'health talk' whilst others did not and how this affected the level of engagement in the clinics, how in the interviews the participants did not discuss partnership work with HVs in their daily accounts. This approach formed the basis of my analysis. The above excerpts of data are examples of two different types of co-construction of the social practice within the Well-Baby Clinic. I was able to see how and why the clients and HVs were responding differently. Gee's (2005) framework offered a systematic approach in developing themes. The examples presented aimed to demonstrate how the clinic encounters were co-constructed between the HV and client and were also affected by individual contexts.

6.7.2 NVivo 8 as a tool for discourse analysis

Gee (2009) acknowledges how the focus on his earlier editions is on the use of the tools rather than the method for critical discourse analysis. Therefore, understanding and developing a version of his method that fitted my research took a long time and, although I began the analysis in the field, the development of the framework into a working tool took much longer. Initially, NVivo 8 was used to code but this was at an early stage and, when entering codes, this process appeared to fracture the text, a recognised difficulty when coding text and using critical discourse analysis (Bazeley 2007). Consequently, I returned to using pen and paper and developed Gee's six building blocks as headings and examined each encounter as a case. I then recorded each case in tabular form, as a way of keeping a sense of each encounter (see Table 19, p.133, for an example). The development of the framework was a useful way of recording similarities and differences between the individual encounters. The main points of each case were summarised under the headings of Gee's six building blocks. In this study relationships and connections were combined into one category in the table

The next step in the analysis involved separating the cases into 'first-time' and 'experienced' mothers and the different cases were again compared for examples of 'synergy' and 'dissonance' as these seemed to be the major differences in HV/client encounters. In this way, the cases were compared and contrasted for the development of themes. This approach is similar to the pattern matching approach described by Yin (2003) and involved identifying themes to answer the research questions. This enabled the data to be analysed

and interrogated in a systematic way. The discovery of cases where synergy occurred appeared to meet the criteria of a 'negative' or 'rival finding' (Yin 2003, p.118). Cases of synergy were included into the analysis as it appeared important to understand why and how this occurred. It also enhanced the process of analysis as it was used to understand further the concept of 'hard to reach' in relation to clients within a universal health visiting service.

At this stage in the process, I returned to the computer software package NVivo 8 because I was aware that I needed to be able to analyse and develop themes from all the different parts of the study. At this point, all of the separate parts of the study were loaded onto NVivo8 and initially coded as separate data files.

Table 19: Experienced mothers' dissonance and synergy in relationships

Case No.	Building Significance	Building activities	Building Identities	Relationships/ Connections	Politics/ Social Goods	Sign Systems and Knowledge
20/4/10-1	'like being a single mum' 'children are my life' Client on HV caseload No children present	Hardworking Client Client offloading HV actively listening (HV less powerful in relation to Health Promotion (HP)) Wanted a form signing	HV as a sounding board Mothering is a big part of her identity Demonstrating how she is mothering in adversity	Synergy – HV knows and remembers other children In parenting talk Resistance by Client to HP suggestions for herself HV is a gatekeeper to resources	Mothering is threatened Agencies involved with family Stigma of having lots of children Obligation	Client has knowledge of parenting language time out Fatalistic in response to her health Therefore a barrier to HP by HV
20/4/10-2	'he said to me about getting her checked for anaemia' Client on HV caseload	Referred by GP, mum came for reassurance, to discuss recent GP consultation and letter from school: HV rebuilding relationship Client also came for vitamin drops HV chooses not to weigh as no Red Book	Single parent with support from partner Building a picture of a Client who is trying to provide a healthy life style Identifies barriers to this child's behaviour - refusing to eat 'meaty food'	HV rebuilding relationship, told to come by GP Client dropped in to clinic Deference in how Client is speaking HV seen Dissonance with other health professionals HV mediator role	Mothering threatened by health professionals HV is powerful: can decide actions of Client not to weigh baby without the book sends her back to the GP HV uses language of the Client to discuss food choices	Client tutored by HV as to what to say to GP with regard to the child's behaviour. Lack of a Red Book meant that Client could not be engaged without it Advice is in relation to a medical issue
4/5/10-5	HV and Client know each other	Weighing Client reporting a rash HV giving an opinion HV writing in Red Book HV charting weight Discusses weight Discusses feeding but doesn't mention type Talks about times rather than amounts M is breastfeeding	Client presenting as coping Carrying out surveillance of the baby New second time Mother HV concerned with Health of Client are you OK asked x4	Synergy HV and Client know each other still deference to HV 'just wondered' HV able to change a future appointment with the Client HV able to discuss wider health needs of Client and baby	Share similar beliefs Client carrying out surveillance wanting baby weighed M expert but wanting HV reassurance	

Case No.	Building Significance	Building activities	Building Identities	Relationships/ Connections	Politics/ Social Goods	Sign Systems and Knowledge
30/03/10 -1	HV knows Client Client knows system of the clinic. Hands over Red Book moves to changing mat starts to undress baby HV in synchrony completes her paper work	Client wants baby weighed Mum chats to baby whilst undressing HV prepares the scales HVs surveys and chats to baby in scales Reads out weight charts in Red Book	Efficient experienced Client capable caring seeks the reassurance of the HV HV role is reduced to weighing baby initially however HV recognizes Client's health work	Dissonance at first then synergy: HV and Client connect over Client's health work. Client then confides in HV re her concerns about her child's behaviour	Child brought to be viewed but concern with physical weight of baby. Client discusses individual care of baby	Client an expert in her baby but this baby not responding to her preferred method of weaning; to 'stretch them out' language is social not medical Beginning to see health advice as helpful for herself
02/02/10 -1	Just for weighing HV and Client known to each other	HV asks if it is just for weighing Client replies yes and her concern Main activity then is on client concern, weighing is seen as secondary	HV perceived by Client as gatekeeper to services Client experienced knowledgeable HV refers to service also demonstrates her knowledge on the subject	Synergy HV and Client know each other; Client aware of clinic and role of HV however deferential to HV Politeness to each other Other issues also discussed building on Client's ability for health surveillance	Health is a social good health prevention for baby care. Client able to give a clear history	Client uses medical language and describes a history and evidence of her surveillance But uses social language to describe her concern "It's a bit lazy" Baby referred by HV

6.7.3 Development of codes and themes

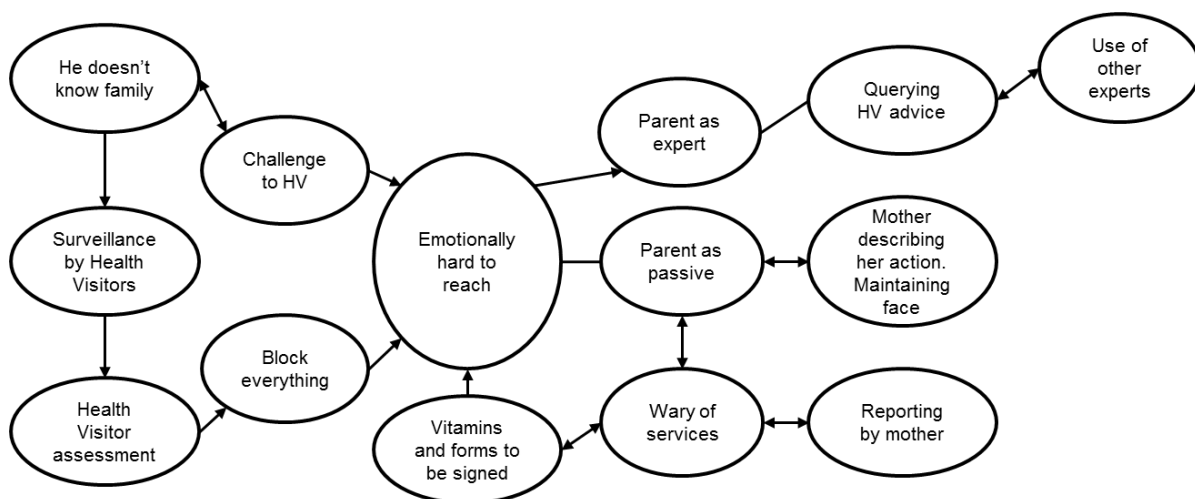
The next section describes the process of entering the data sets onto NVivo 8. I was guided in this process by Bazeley (2007). She recommends that discourse analysis requires an approach which focuses on relevant sections in the whole text. Starting with the clinic encounters where 'synergy' or dissonance had been noted, each encounter was then open coded for descriptive examples of synergy and dissonance and, after coding several of the encounters, I had produced 43 different descriptive codes (at the level of the node). As I had already carried out a lot of analysis on paper I wanted to use NVivo8 to develop the codes into more advanced codes and themes which grouped the codes together. Bazeley (2007) describes a process for gaining conceptual clarity and order to the open codes in NVivo 8, and this second stage involved the use of tree nodes. Again following the process described in Bazeley (2007), the tree nodes were organised to hold together the codes on the same themes. These guidelines were helpful in managing the data set through NVivo 8. Using the tree nodes meant that I was able to identify and begin to categorise the nodes and codes in relation to answering the research questions. I then replicated the process with each data set, beginning with Gee's Framework for analysis, which was again coded with descriptive nodes. The whole process was an iterative process and shifted between NVivo 8 and the transcripts and fieldwork notes, to working on large pieces of paper to collect themes and codes together. This resulted in the collection of many codes which were either discarded or used only if they supported or added to the developing themes across the wider data set.

During this process, some tree nodes were developed but discarded as they did not appear across all the data sets or did not appear relevant to answering the research question. For example, the routes into clinic were discussed by clients in the encounters and, for a time, codes relating to this were collected together into a tree node named 'Routes'; however, this tree node was discarded and the relevant codes moved to the main categories. The category of 'easy to reach' was developed into a tree node as there were many open codes relating to successful accessing and engaging with clients. In contrast, the category of dissonance was large and further analysis of this large category was helped by an early remark made in one of the first focus groups: one HV in the focus group had identified the category of 'emotionally hard to reach', although she was not able to describe fully her perception and it was not mentioned in the same way in the following focus groups, but it was an interesting description. During the clinic sessions and interviews, descriptive codes developed in relation to clients' perceptions of the service, their attitude and how they used the service, and from this a key theme emerged from the data.

What was extremely helpful in developing a more conceptual approach was the development of models, a facility available in NVivo8. Modelling allowed individual codes to be taken across free and tree nodes and applied in a model; it also helped moving away from the process of description to explaining the differences between the themes. Using the modelling process I was able to organise the attributes further around the central explanatory concept or themes (Figure 6, p.136) (Bazeley 2007). .

For example, the type of 'emotionally hard to reach' contained attributes that related to how a client would present herself to a HV, and how health visiting was perceived from focus groups, through the observation and interviews (See Figure 6). This process appeared similar to pattern matching (Yin 2009) or pattern coding (Miles and Huberman 1994) in order to produce robust findings and the emergence of four main themes.

Figure 6: Early model of a theme



The analysis of the data sets was over a long period of time and the use of NVivo 8 was my first experience of data inputting. A benefit of persevering with NVivo 8 was that it helped to gather all the information together under one project and to move from description to bringing attributes together in order to produce themes. The cost of using it was that it was very time consuming. I did not use NVivo 8 at the beginning of the study and, as a result, all the data was entered at a later date and certain aspects of the study, such as the fieldwork notes around the use of artefacts, seemed in danger of being lost. This resulted in my reverting to using a combination of paper and NVivo 8 to collate the final themes of the Typology. I would therefore recommend the use of NVivo 8 early on in a project, and the development of clear codebook guidelines before beginning to enter codes into NVivo 8.

6.8 Triangulation

A major strength of this current case study was that the research methods were chosen to provide a thorough examination of the concept. This resulted in data from the different sources of evidence being analysed, and explaining the multidimensional nature of the concept of 'hard to reach' in relation to health visiting.

Yin (2009) describes this as triangulation. He supports triangulation within his case study design as a method of bringing the evidence together in a systematic way (Yin 2009). It is worth noting that there is growing scepticism on the use of triangulation in qualitative research. Moran-Ellis et al. (2006) are critical of the use of triangulation as an all-encompassing term. They have recognised that the concept of triangulation can have many meanings and can be in relation to either the outcomes of a study and/or the research process. Furthermore, the use of triangulation to improve validity has also been challenged and refined on pragmatic and epistemological assumptions (Moran-Ellis 2006, Hammersley 2008). Therefore it appeared necessary to describe the approach taken in this current study. The researcher's broadly constructionist methodology fits with the approach to triangulation, as taken by Yin (2003, 2009). Here the rationale for the triangulation of multiple methods is to capture complexity and multiple contexts of the phenomenon being studied (Moran-Ellis 2006).

Yin (2009) describes data triangulation as the collection of information from multiple sources with the aim of corroborating the same facts or phenomena. It would appear that Yin's belief in triangulation is concerned with increasing the validity of the research findings and the level of confidence in them (Moran-Ellis 2006). As discussed in Chapter 5 Yin uses terms generally associated with quantitative research, but Yin (2009) appears to be discussing construct validity in relation to both the construction of the case and the methods used to answer the research question, a similar approach to qualitative researchers (Mason 2002, Morse et al. 2002). Following Yin's case study approach has led to the development of a flexible case study which continued to be developed and refined during the study.

Yin (2009) advocates aligning the research approach with the research questions and the development of the case study report includes a description of how the case study was organised and analysed (Yin 2009). Therefore, the researcher can adapt Yin's approach to fit their own study; my approach included the incorporation of qualitative methods in every stage of the research design, which fits with an approach described as the integrated method of analysis (Moran-Ellis 2006).

In this current study, analysis occurred both in the field and on leaving the field. For example, the terms used by HVs in the focus group to describe clients' behaviour influenced the data collection in the fieldwork stage. The plan was to analyse each data set separately, and then to develop the themes with the strongest evidence. This meant discarding some themes that were mentioned in one part of the study, but not others. For example, in two of the focus groups, HVs discussed clients who over-utilised the service. However, there was no other evidence of this phenomenon in the focus group in the study area the clinic encounters or the participants' accounts. Therefore, this finding was interesting but unsubstantiated within this case study within a disadvantaged area, and therefore it was not possible to be included in the findings.

Each research method was given equal weight in the planning and operational aspects of the study. In analysis, the findings developed from each data set which were initially analysed separately. The focus group findings informed the initial and later fieldwork themes and the interviews added to the perspective of the clients, which were also corroborated in the other methods. In this way, the different aspects of the study were captured and included in the analysis. This then enabled the development of the themes and dimensions of the concept.

6.8.1 Limitations to the study

This chapter set out to demonstrate how Yin's research design provided a rigorous yet flexible framework for the study, and how the choice of methods and data analysis were suitable to answer the research question.

However, it is worth mentioning that the small number of participants recruited to the focus groups and interviews may be a limitation of the study. Also, it is worth noting that Children's Centres were set up from SSLP and each programme was based in a relatively disadvantaged neighbourhood which was defined locally (Barnes 2007). This has resulted in many different forms of SSLP and Children's Centres (Barnes 2007). This study's findings relate to the case study under investigation. I will argue in the following chapters that the findings are applicable to the current and future role of health visiting in engaging with families living in disadvantaged areas

In qualitative research, the quality of a study is also measured by its trustworthiness and is related to the credibility, transferability, dependability and confirmability of the research process, especially in relation to the research findings (Morse et al. 2002, Mason 2006). The data analysis incorporated a robust approach which included pattern matching and the

formation of a rival explanation. A limitation of the analysis was that it did not systematically set out to feed back the findings to all of the participants of the study: with over 60 participants, this would have been very difficult to have achieved. Furthermore, during the planning of the study whilst attending the workshops on Focus Groups, member checking as a way of increasing validity was challenged. The facilitator discussed her experience of member checking where the participants did not agree with the themes identified by analysis and the researcher then changed the findings in accordance with their wishes; this approach used late on in a study would in itself affect the validity of the study (Barbour 2008, Morse et al. 2002). The literature on member checking as a process for validity also appeared quite sceptical (Mason 2007). Instead, it was recommended that, where possible, early findings and thoughts could be incorporated into the study at each stage and discussed during the fieldwork (Mason 2007, Morse et al. 2002). This occurred in this study; for example, following consultation with supervisors, the topic guides in the focus group and interviews were adjusted and refined. During the fieldwork, areas of interest that arose were discussed with HVs in the clinics, in subsequent focus groups and in interviews with participants. Emerging findings were also discussed both with supervisors and at a workshop on data analysis held for PhD students at the University of Hertfordshire. Preliminary findings were also presented for feedback and discussion at local and national conferences for HVs, and were received positively.

To further increase the external validity or trustworthiness of the study's findings, the discussion chapter aims to locate the findings in the relevant health visiting literature on partnership and client engagement.

6.9 Conclusion

This chapter set out to demonstrate the robustness of the application of Yin's (2003) case study research method when underpinned with a broadly social constructionist approach and ethnographic methods. This chapter included a reflective and reflexive account of how my experience as a HV affected relations in the field, and also has enabled acknowledgement of how data was generated, firstly by prolonged engagement in the field and secondly, not only by the researcher, but through the activity of all involved. Both data generation and analysis involved a critical approach, which also aimed to demonstrate reliability and validity of the process. This critical reflexive approach has also highlighted the limitations of this case study.

The section on analysis described the processes involved in applying Gee's (2005) method of discourse analysis and how, because there was little known on the subject in relation to health visiting, developing the framework using Gee's building tasks/tools of inquiry was an important part of the process of analysis. The robustness of the process of analysis was demonstrated through the individual case analysis; pattern matching of data within data set; the identification of themes and triangulation of themes across the whole data set. The identification of the type of 'easy to reach' enabled a disconfirming case to emerge from the data set, thus challenging the notion of 'hard to reach' as applying across a whole community in an area of disadvantage, whilst providing further contrast and analysis of the concept under investigation. The analysis of the different data sets, firstly through discourse analysis, and secondly within and across cases, enabled integration of the data produced using different methods. The goal of using the multiple sources of evidence was to seek corroboration and to strengthen or reject findings. This was useful as it enabled themes to be developed across the different data sets at different times during the analysis. The limitations of the study have also been discussed, and recommendations for future research in this area in order to address those limitations have been suggested

Importantly, the use of Gee's method of critical discourse analysis led to the identification of the variation in the reach of health visiting and enabled a greater understanding of how being able to ask for help in public encounters was not equally distributed within HV/client interactions. The typology emerged as a way of bringing order to the concepts or attributes of 'hard to reach'. Developing the typology identified four dimensions which demonstrate the facilitators and barriers to the reach of current health visiting practice. It was a way of successfully capturing the multidimensional nature of the concept of 'hard to reach'. The emergence and finessing of the proposed typology will be discussed further in the findings and discussion chapters.

7. Findings

7.1 Introduction

The main research question was to understand how HVs conceptualised and operationalised the term 'hard to reach' in practice. This question was answered by examining key elements of health visiting practice through discussion with HVs in focus groups, clients in interviews and with participant observation, enabling direct evidence of first hand practice and allowing an exploration of the relationship between espoused practice and practice reality. As explained in Chapter 6 above, the interviews with service users were undertaken to provide data on their perceptions of the service. There was no overall consensus on how the concept of 'hard to reach' was conceptualised or operationalised. Instead, understanding of the term appeared to have developed individually from HVs' experience of working with individuals from within a caseload derived from a GP practice population or a geographical area. This chapter will discuss the findings from each data set separately. The final section will draw together the findings from the different data sets.

7.2 Findings from the focus groups

The initial analysis of the focus groups revealed that there was little consensus on the term 'hard to reach'. This appeared an important finding, and the variety of understandings demonstrated how HVs' practice remains informed by their caseload and the demographics of the caseload. This chapter will begin by demonstrating the diversity of views and contested nature of the term in health visiting. Several themes emerged from the focus group data set and these will be discussed in this first section. These themes are the contested nature of the term; influences on the client; influences on the health visiting service.

7.2.1 Contested nature of the term

Participants in the focus groups appeared uncomfortable and critical of the view of 'hard to reach' relating only to families with potential social problems:

'So far as the government is concerned 'hard to reach' are the families who cause society problems' (HV1, Focus Group 1).

This HV explained that her present caseload consisted of many affluent families and how, in her experience, the 'most hard to reach' families were 'professional women' who had returned to work. So she argued that the term was very broad and could apply to many

families within a caseload. Another HV described the term as *'nebulous'* and that it did not mean the most vulnerable families on a caseload.

HV1: 'It's a bit nebulous the term really'

HV3: 'I think it is a bit personal to your caseload as well. It probably differs from each surgery, it doesn't necessarily mean, the most vulnerable in some caseloads' (Focus Group 3).

The idea of 'hard to reach' being applied across the whole of the spectrum of universality was also discussed:

HV1: 'There are groups but there are also people that perhaps don't fit into those groups who are equally hard-to-reach there are clear groups you mentioned your DV I think there are groups you can identify but that doesn't mean there aren't people outside those groups' (Focus Group 1).

The HVs also discussed how the notions of vulnerability and 'hard to reach' were complex and intertwined. It was difficult for the HVs to explain these perceived nuanced differences. For example, one HV explained that the term would not be used to describe all vulnerable families because some families would be known to the HV or another statutory service. She explained how the term could be applied broadly, that it was not applied only to vulnerable clients, it was also dependent on other lifestyle factors which acted as a barrier to services:

HV1: 'But it's quite tricky. You can have vulnerable families that are 'hard to reach' because of their lifestyle. But you can also have families that you would never perceive as being particularly vulnerable but because of their lifestyle, which might be quite busy, they are also 'hard to reach'. Does that make sense?' (Focus Group 3)

Analysis across the focus groups suggested that it was clients who were difficult to access, or who were choosing not to engage in a service that whilst universal was not compulsory, that were 'hard to reach':

HV1: 'Families that are difficult to access, HV2 Don't engage' (Focus Group 2).
HV2: 'Well I think hard-to-reach are those that don't seem to respond to you those who are not attending for immunisations you phone them, talk to them remind them and they still don't come so that sort of is one element of hard-to-reach and the other element is those who will see you don't engage perhaps they will come along to everything but are not sort of actively taking on board

what you are doing or what you are saying and they are sort of emotionally hard-to-reach' (Focus Group 1).

The quotes above highlight how 'hard to reach' was discussed in relation to access and engagement. Some clients were described as 'hard to reach' because they were difficult to access whilst others were 'hard to reach' because it was proving difficult for the HVs to engage with the clients on an emotional level within a therapeutic relationship. The majority of the HVs in the focus groups discussed 'hard to reach' within the context of client relationships, and the importance of not only access to but engaging with clients within such a relationship as a way to promote health effectively.

In contrast, a HV working in a Children's Centre offered an alternative view of the term and suggested that it was not clients who were 'hard to reach', but instead the term was turned around and applied to the accessibility of the service:

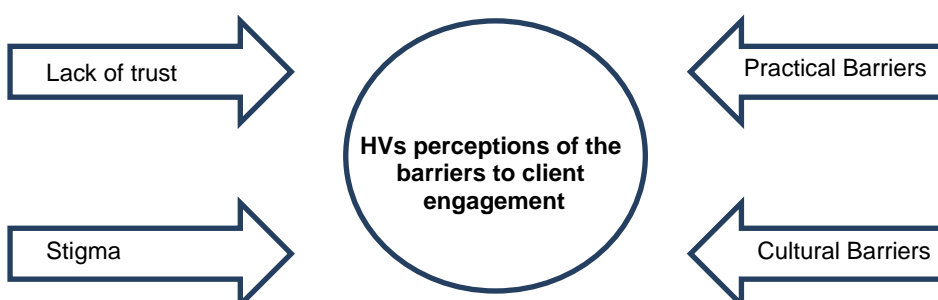
HV 3: 'the CC manager doesn't really like the term. She said, they are not 'hard to reach' but we are hard to access' (Focus Group 2).

This alternative view was mentioned only once in all three focus groups, and was used as an example of how other services had had to make changes to become more accessible. The HV who mentioned this approach realised that the reduction to home visiting within the HV service might be affecting client access. In the main, it appeared that the majority of HVs were basing their understanding of the term in relation to their experience of accessing and engaging with clients from their caseload. Their conceptualisation of the term related to the barriers to client engagement that were preventing the development of relationships.

7.3 HV perceptions of the barriers to client engagement

The HVs also discussed how in their view clients held certain perceptions about the service, which, in their experience, could act as a barrier and interfere with the process of relationship building. Four themes were developed in relation to this (Figure 7, p.143).

Figure 7: Barriers to client engagement



7.3.1 Lack of trust

Analysis also revealed that, in areas of disadvantage, the HV service could be perceived or had been experienced as a service that represented authority and had the power to remove children from the home. The HVs in all groups discussed clients who had experienced social services involvement as children and how this experience could be a barrier to engagement when they themselves became parents:

HV4: 'a lot of my families who were 'hard to reach' have had previous experience of social services as children. And that is often why they have found it difficult to trust and to re-engage. It was perhaps a very different experience of social services that they had 15 or 20 years ago than they would have today or have had today' (Focus Group 2).

This resulted in non-engagement with the service because the clients were wary and untrusting of state sponsored services:

HV1: 'some of the families that I have seen working in the CC's they have really struggled trusting health professionals and because you wear a name badge they just are automatically very distrusting and I see that time and time again' (Focus Group 2).

The HVs in all the focus groups discussed the importance of building trust with families who may have experienced services as punitive or critical rather than supportive and helpful. Lack of trust was considered the biggest barrier to building relationships with clients living in disadvantaged areas.

7.3.2 Stigma

As well as not trusting services, some HVs felt that clients did not use services because there was a stigma attached to some services in disadvantaged areas. As a consequence, some clients might not access services because of the stigma of being a family who had asked for 'help' from a statutory service:

CSN: 'There is also the stigma, the fact that as soon as you hear of anybody in authority, or anyone with a title behind their name, they instantly clam up. And there is the stigma of anything connected with health or anything connected with children. That could involve taking your children away or things

like that. Those people are difficult to reach because of their own thought of what authority is about and whatever they might have had or experience in the past' (Focus Group 2).

In all three focus groups, women experiencing domestic violence (DV) was perceived by the HVs as a barrier to access and engagement.

HV 5: 'I think domestic violence is an issue, People do not want to be seen as much if there are issues of domestic violence' (Focus Group 2).

This was professed by the HVs as being due to the stigma of experiencing DV. Consequently, it was recognised by HVs that, in general, clients experiencing DV were more difficult to reach or access because of the stigma of being a victim of DV and, as a consequence, they may avoid the service for fear of being judged as a bad mother, or be afraid that their children would be removed into care:

HV2: 'Domestic violence are often 'hard to reach' because I think they avoid the questions and they avoid, certainly if they have been hit, they avoid being seen. And I have spent a long time trying to access, because they have avoided it, they don't want to speak about it. They are not ready to do anything about it being they are fearful about being judged and fearful for their children (Focus Group 3).

Two of the focus groups also discussed just how isolated those women experiencing DV could become, and how they may be prevented from taking part in everyday activities, such as attending a clinic, by their controlling partners:

HV6: 'They are 'hard to reach' because of their controlling partners as well and this is when you are wanting them to come to clinic, in a safe place without their partners. But how do you tell them that if their partner is always there. So they are 'hard to reach' (Focus Group 3).

The HVs in this focus group appeared to be expressing limits to the delivery of the service to clients who were experiencing difficulties in their lives. One of the most common difficulties was when HVs were attempting to access families who were living in difficult and transient circumstances.

7.3.3 Practical barriers

HVs in the focus groups discussed how there was a barrier to accessing clients living in temporary accommodation or moving from place to place. When HVs were unable to make contact with or access such families, they were considered 'hard to reach'. In these instances, the term was used to describe families who were living in temporary accommodation, who belonged to Traveller communities or who had moved to a domestic violence refuge. The HVs in this study were generic HVs rather than specialist HVs and so, within their generic caseload, they would meet a range of families. Families living in temporary accommodation and Traveller families were described as hard to access:

HV2: 'Travelling families are 'hard to reach', just because of how transient they are. One minute they are on the site and the next minute they are not on the site' (Focus Group 3).

As were families living in temporary accommodation:

HV1: 'There are other 'hard to reach' families that are moving around all the time going from one place to another place and when trying to make an appointment with them, they have gone off to stay somewhere else' (Focus Group 1).

Whilst HVs described their service as being a supportive, helping service, they also recognised how some groups of clients did not share this understanding of the service. They described how certain groups, such as homeless families, also did not understand the service and how it could support them:

'I think our homeless families who don't understand why we are there. Why we (The HV ALL) should be going to see them, they are 'hard to reach' because they don't have a concept of our role and how we could possible help them' (HV1 Focus Group 3).

7.3.4 Cultural barriers

The HVs also explained how families from other countries with different health care systems could also be described as 'hard to reach'. The main reason given was that many new immigrants from Eastern European countries or South East Asia were perceived as not understanding the UK HV service:

HV5: 'Some ethnic groups that don't understand the service' (Focus Group 2)

The HVs discussed how this was due to many different reasons. For example, experience of a different child health system and a lack of written translated resources impinged on their ability to reach families who did not speak English, or for whom English was a second language:

HV2: 'In Europe each child has a paediatrician, sees a paediatrician, there isn't a HV role. So you struggle to explain what it is you are there for and what you are about and there is minimal translation, in terms of literature print of the immunisation schedule.' (Focus Group 1)

HV1: 'So yes cultural differences are huge I think in terms of 'hard of reach' and to impart information that we are obliged to impart' (Focus Group1).

Another perception was that some clients were reliant on husbands or family members for transport to appointments. When HVs were aware of these barriers - when they '*knew the family*' - they tried to accommodate for these differences by offering a flexible service:

HV5: 'Well obviously with a family that you know, a family where the father works as a taxi driver or works in a restaurant and comes home late. Then for a visit you would make it later in the afternoon ... we do try and be as flexible as possible immunisations don't necessarily have to be done in the Clinic they can be done in the surgery at other times' (Focus Group 2)

Here the HVs were again discussing how they developed a service that was based on their knowledge of clients within a caseload; how they tried to offer a flexible service to help the family to navigate the child health system.

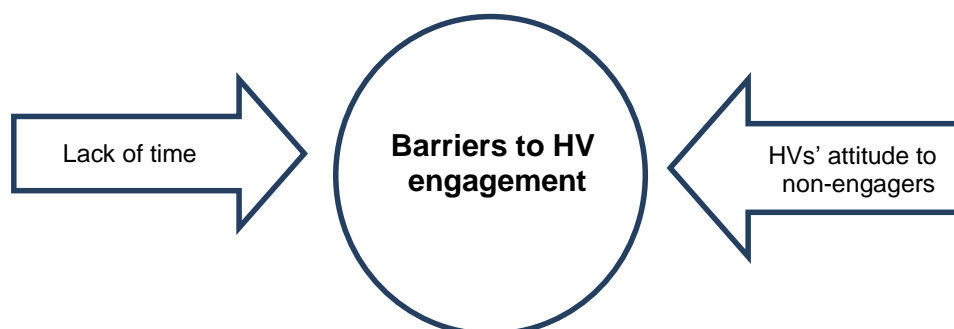
This section has highlighted four themes in relation to why clients might not engage with the service. These barriers consisted of lack of trust, stigma, practical barriers and cultural barriers.

7.4 Barriers to engagement – the HV service

This section will discuss the service barriers to client engagement as perceived by HVs in the focus groups. The theme of time in relation to building relationships was mentioned in all focus groups. The amount of time required to connect with some clients, the frustration when clients did not attend for appointments and when clients presented but did not seem to trust the HV were also themes identified as barriers to client engagement and which resulted in

the themes of negative attitudes of HVs and a lack of trust shown by HVs to some clients (Figure 8, p.148)

Figure 8: HV perceptions of the service barriers to client engagement



7.4.1 Time

The time required to build and develop relationships with families who appeared difficult to engage with the health visiting service was identified as a barrier to relationship building:

HV1: 'For the service to see how much time we are putting into these families because we know how incredibly labour intensive with all the DNAs and the missed appointments' (Focus Group 2).

As a result, HVs in the study discussed how difficult it was to maintain connections with families when families moved or changed addresses, and how much of their work in trying to maintain contact was hidden. For example, the amount of time required to develop relationships with families who appeared reluctant to engage with the service was not being recognised by HV managers. In the quote below, the first 'they' relates to the operational managers:

HV2: 'I think that also with these 'hard to reach' families they [operational managers] don't seem to recognise that they need to have a lot of time spent with them building up relationships and some of the families that I have seen working in the Children's Centre they have really struggled trusting health professionals' (Focus Group 2).

There was also a sense of a lack of time to build relationships with 'hard to reach' families because the HVs had to direct their work to the most vulnerable. The quote below is from HVs who were explaining how they had to prioritise the most vulnerable families with known factors of vulnerability as opposed to families with some vulnerability factors:

HV1: 'Not one that you know that I am very, very worried about they are a bit vulnerable but I am not that worried about them

R: Yes so

HV3: There are degrees of vulnerability and working in the practice you've got to prioritise that' (Focus Group 3)

The HVs described their individual methods of prioritising the workload within a caseload and this was often dependent on vulnerability factors in relation to safeguarding. As the quote above demonstrates, HVs felt obliged to respond to the 'most vulnerable' on a caseload rather than the 'hard to reach'. In doing so, 'hard to reach' families appeared to be slipping through the net. There did not appear to be a strategic approach to working with 'hard to reach' families: it appeared to be the responsibility of each HV to decide how she would work with the 'hard to reach'.

7.4.2 HVs' attitude to non-engagers

HVs discussed how frustrated they felt at how much time was wasted in trying to set up appointments with families who did not have a settled address, or with those who had 'chaotic' lifestyles. For families who did not respond to invitations and appointments, the HVs felt that they faced a dilemma: they wanted to deliver a service but also had to balance this with the needs of managing the day-to-day work generated from a caseload. Whilst some HVs were happy to try to contact clients prior to an appointment, others described this as '*hand holding*', and the need to provide a service resulted in a dilemma because health visiting was a limited resource. Some HVs felt that reminding clients of appointments was time consuming and that the responsibility to attend lay with the client:

HV 2: 'How much should we do? How much reminding should we do? How many phone calls should we make? And I find that quite difficult, sometimes because I'm thinking, No I phoned you yesterday to remind you about this. I don't need to phone you again. I shouldn't need to phone you again. They've got to take some responsibility for their own children's health' (Focus Group 1).

Rather than being viewed as requiring a different approach, families who did not attend were labelled as chaotic and irresponsible by some HVs in the focus group:

HV1: 'Yes, so each time they said they really wanted my visit, you know and you rearrange stuff but they are still not around, very chaotic family' (Focus Group 1).

One HV also mentioned the worry of the 'dependency culture': how doing things for a parent may lead to dependency on services for this and future generations:

HV2: 'How much hand holding? Like you were saying, how much hand holding do you do? Because it is going to be right through the child's life, isn't it, and is that going to help the child to be responsible for its own action and not to become a 'hard to reach' family in the future' (Focus Group 1).

The HVs' attitudes to clients who did not attend for appointments was one of frustration and was a dilemma because there was little guidance on how to reach clients who did not attend for appointments.

7.4.3 Lack of trust

In delivering a core child health service, the HV service had changed from being a primarily home visiting service to a progressive universal service, reliant on clients accessing the service via the clinic or telephone. The HVs spoke about how this change in service delivery had affected their ability to build relationships and search for health needs. One HV suggested how, in the Well-Baby Clinic it was difficult to assess and support families who were on a child protection plan. She advocated the importance of HVs being able to visit families at home. However, the reason behind the visit was for extra surveillance to find health needs and risks rather than to build relationships:

'HV2: 'I sort of think and is there an indication for 'hard to reach' families that the drug abusers and domestic violence where you actually do make it a little bit... Shouldn't we be as a service trying to influence policy? That we see those people more at home, so that we have a real look?' (Focus Group 3)

The quote above is included as it describes the frustration of a HV who is trying to get to know a family but who can only do so when the family present to a Well-Baby Clinic. Sections 7.9.4 and 7.9.5 in this chapter discuss the findings of the participant observations of the Well Baby Clinic and find how some clients 'blocked' the HV by their presentations in Clinic. Time and 'having time' was considered an important resource for building relationships with clients who were wary or did not trust the HV service. The lack of time to build relationships appeared to be an area that caused frustration and, as a result, HVs labelled families whom they did not know and who did not respond to appointments as irresponsible and 'chaotic' or untrustworthy. In contrast, in response to the question, "Who was easy to help?" the HVs positively identified the skills required in both clients and

themselves to achieve client engagement. The final theme to be discussed from the focus group is 'easy to help'.

7.5 Easy to help facilitators to service delivery

Figure 9: Facilitators to Client/HV engagement



The focus groups enabled the HVs to describe the facilitators to client engagement. A HV from the second focus group described how her approach to clients was to work in partnership, an espoused model of health visiting that promotes relationships in order to reach and help clients to promote health. Here it was interpreted as helping with problems:

R: 'If you could talk a bit more about partnership if you want to so I understand what you mean by partnership'

HV1: Where it becomes a two way process, where you both are working towards same goals and those goals are set by the clients or the families. So, so it's always solution focused, where they have found their own problems, work out their own solutions and together do it on a very stepped approach' (Focus Group 2).

A partnership approach in health visiting is designed to promote health by listening to parents and working alongside them as a guide rather than an expert. The HVs identified the importance of listening and recognising and building on the strengths of families:

HV 4: 'Basics like praise, you know, maybe doing things that are maybe simple but they are doing well. Listening, actively listening to people, what they are actually saying rather than focusing on your agenda. All the basic sort of consultation things that are important across the board, 'hard to reach' families 'easy to reach' families' (Focus Group 2).

The HVs also professed how clients who used the service valued the HVs advice and expertise. In these instances, the focus of the HV shifted from assessment to listening and working out solutions with the family. The importance of building a relationship was to help clients with any problems or issues that the clients identified. In describing a partnership approach, the data from the focus groups also identified the qualities or skills required in clients to achieve partnership.

7.5.1 Client skills and qualities

This next section describes the qualities of 'easy to help' clients: these qualities related to help seeking. The skills mentioned which helped to facilitate a relationship are related to a parent carrying out health surveillance of their own child and then asking for help. These clients were able to articulate their child's health needs in a timely manner; they trusted the HV and were ready to make changes to their parenting. In contrast to explaining 'hard to reach', the HVs could easily articulate an 'easy to help' client and there was a great deal of similarity across all three groups. In reply to a question about whom they had found easiest to help, the HVs described clients who were accessible, whom they had a relationship with, who attended clinic and appointments and who demonstrated the behaviours of responsible parents:

HV1: 'They phone up and say, 'Hello its J' and I think I know which J you are. I find that quite satisfying, really that sort of client

HV2: The ones who trust your advice

Yes

HV 1: The ones who phone you before anyone else

HV 3: Yes it's sort of timely access isn't it, before it gets too bad

Yes, those are by far the easiest to help actually those ones who time it quite well' (Focus Group 1).

The ideal client was described as carrying out health surveillance on their child and then seeking help by accessing the HV service to prevent those problems from becoming more serious.

The data from the focus groups indicated that accessing the HV service was possible for a group of clients labelled in policy documents as 'hard to reach'. In discussing how teenage mothers were contacting the service, the HVs were acknowledging that identified 'hard to reach' groups were not homogenous in their behaviour: within any group there was a range of clients with different health needs and perceptions. The HVs described the teenage

mothers they were working with as being 'less vulnerable' and able to seek help from a service:

HV2: 'The less vulnerable I suppose some of our young teenage mums have been really good about being accessible

*Yes that's right *(All HV's)*

HV2: And you know wanting help and asking for it and being in' (Focus Group 3).

7.5.2 Health talk

HVs in the focus groups described an ideal client as one who was able to articulate their child's health needs. A caring parent was demonstrated to the HV by the time they spent on noticing changes in their children's behaviour and on accessing the health visiting service for advice. HVs described a good parent as responsible, one who was able to identify a problem and seek help and who, with information and advice provided by the HV, would be able to rectify the problem:

HV2: 'She came this morning, bright, middle class women, heavily into her children. Sorted, not a problem from that day and they are not usually that easy obviously. So I have quite a few clients, ok who demand quite a lot, they will come to me straight away, as soon as they've got a behavioural problem but actually they want it sorted they want to know what kind of things you can do' (Focus Group 1).

7.5.3 Referrals from other agencies

HVs in the focus groups perceived how working with other trusted agencies such as GPs or Children's Centre staff would help build relationships with reluctant clients. For example, a CSN described how a parent who previously did not engage with the HV service was encouraged by a GP to ask the HV service for help with a specific issue:

CSN: 'And they were 'hard to reach' and access and the parents came to the GP and GP said "actually I need to discuss this with the HVs". And then because there had been issues in the past it was suggested that maybe we get in there, see what happens. Fortunately the outcome was extremely positive indeed but that was working with everyone else' (Focus Group 2)

Whilst several examples of interagency working were given in the focus groups, this quote was selected as it demonstrates how help seeking may be hard for some clients, but if they have trust in one service they can be introduced to another service. During participant observation, clients were also observed attending the Well Baby Clinic because they had been advised to do so by another health professional.

7.5.4 Summary

The findings from the focus groups identified that 'hard to reach' was conceptualised differently both in and across the groups. Some HVs contested the term whilst others felt it applied to clients who did not access or engage with the HV service. The focus group data also identified groups of clients who were more difficult to engage with within a generic caseload. These clients were similar to groups identified as being at risk of the new social risk of social exclusion, women experiencing DV, homelessness, new migrants and ethnic minorities and some teenage parents. However, the HVs also identified some professional women as another group of 'hard to reach' clients. Reaching all clients within a caseload was recognised as challenging due to barriers at the individual client level: practical barriers, cultural barriers, and clients' experience of the service as supportive or authoritarian. HVs relied on developing from their experience knowledge of how to reach clients, and the amount of time they had to follow up with families was in line with competing priorities of the most vulnerable within a caseload. The qualities and skills required by both HVs and clients, which enhanced access and engagement in partnership work, were also discussed and multiagency partnership work was also identified as a positive approach when working to engage 'hard to reach' clients.

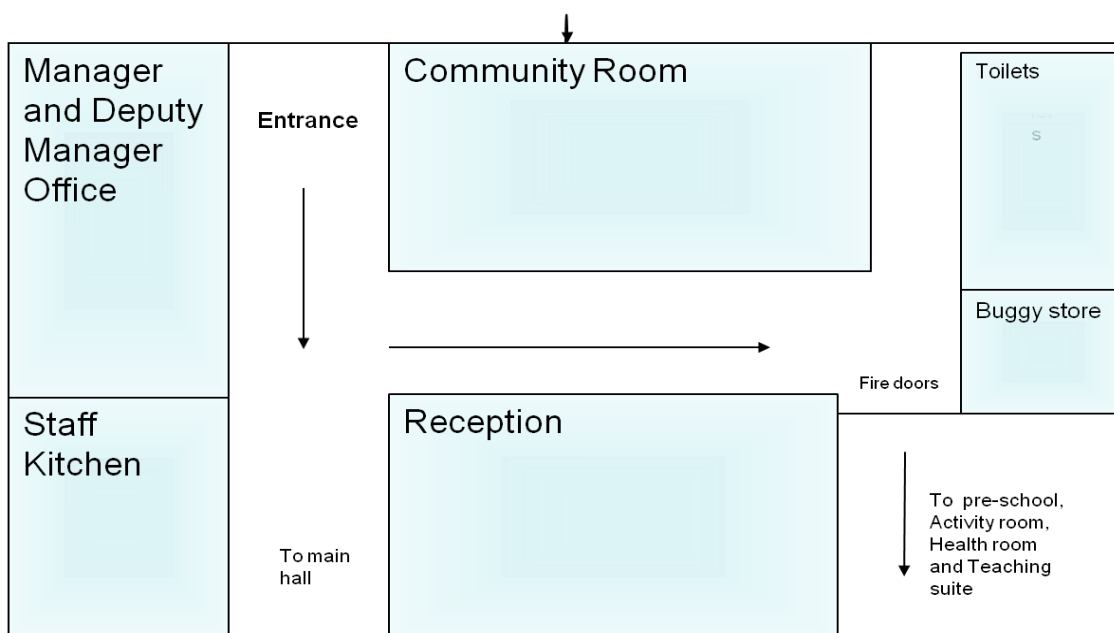
7.6 Findings from the field site

The ethnographic study took place within a Children's Centre. The previous chapter discussed the demographic details of the area. This section will begin with a description of the setting which aims to provide a grounding or understanding of the context of the study. It also aims to demonstrate how the co-location of part of the health visiting service within another service facilitated service delivery or unintentionally produced new barriers . It will then evidence how HVs operationalised the term in clinic encounters.

7.6.1 Context

In 1998, the Children’s Centre began as a Sure Start Local Programme and was based within Portakabins on the site; today the Portakabins have been replaced by a purpose-built building. The Children’s Centre was observed as the base for a wide range of professionals. It aimed to provide a one-stop shop service for children and families living in the area. During my Orientation to the Centre, several staff members would point out pictures of how the Centre was built. Children’s Centre staff, who had worked from the Portakabins, appeared to be proud of the new building and the facilities on offer to the community.

Figure 10: Spatial Map of the entrance and reception area of the Children’s Centre

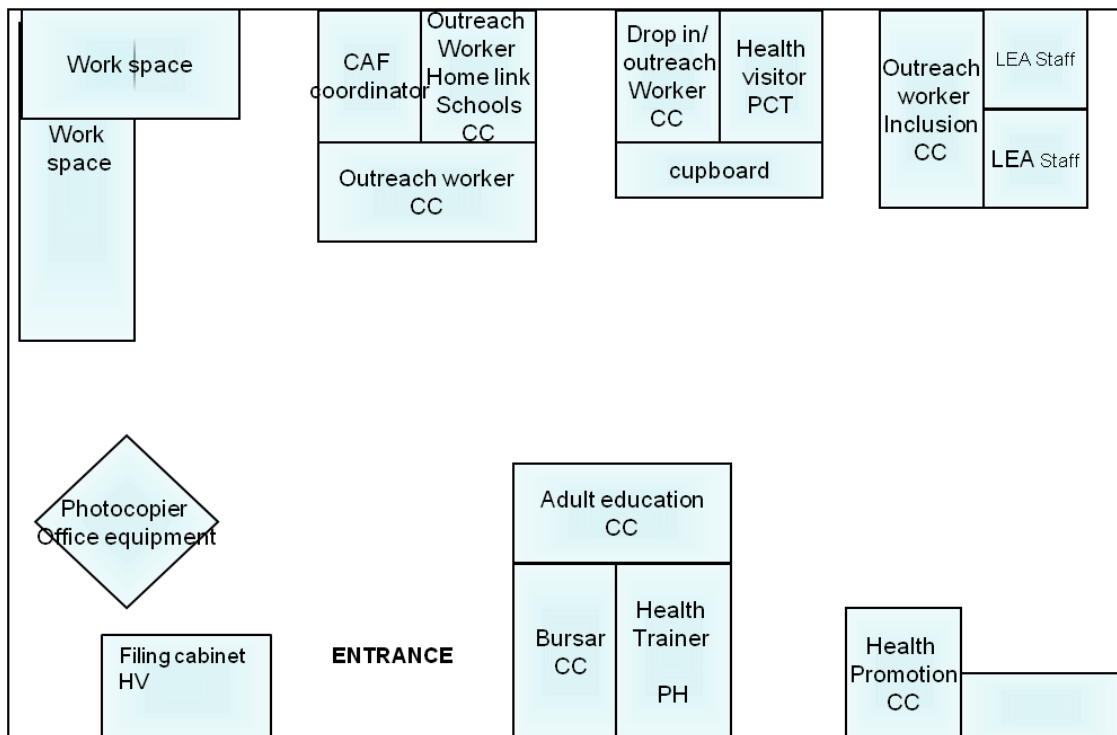


On entering the building, to access the facilities you had to pass an open door; this was the Manager’s and Deputy Manager’s office. The next office was the reception area, manned by the receptionist or, during her absence, by another member of staff. On my first day, I approached and spoke to the receptionist, who was expecting me; she asked me to sit and wait in the corridor. When the HV arrived came, she was friendly and welcoming. As we walked upstairs to her office, the HV explained the layout of the centre (Figure 10, p.155). Initially, the building was quite disorientating: it was a large building, and it consisted of a main corridor with doors leading to rooms or areas where activities could be held. All the doors were locked and entry could only be gained by using an electronic key, which was held by permanent members of staff. The entrance to the pre-school nursery, for children aged 2-5 years of age, was also on this corridor. This was followed by the door to the health room. On the opposite side of the corridor, there was an interactive display for parents and

children and an entrance to a playroom for pre-school activities. At this point, stairs led up to the first floor staff area, the corridor continued to the right to a meeting room and a teaching room with computers.

The staff area, at the top of the stairs, was accessed through two locked doors. Once inside, I faced a large, open plan office where the remaining staff, including the HV, had a workspace (Figure 11, p.156).

Figure 11: Spatial map of Staff Office



Employers

- CC: Children’s Centre
- PCT: Primary Care Trust
- PH: Public Health
- LEA: Local Education Authority
- CAF: Common Assessment Framework
- HV: HV based in the centre (HVCC).

The Children’s Centre was deceptively large; I had not realised that a day nursery would be an integral part of the Centre nor that it would have such a wide variety of staff based there.

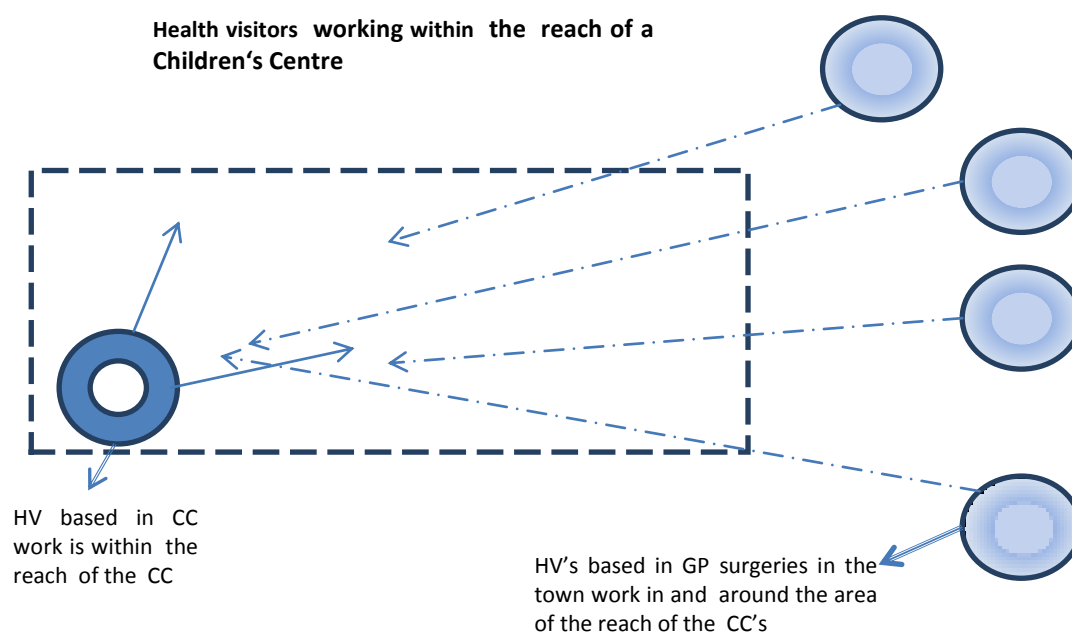
7.6.2 Children's Centre staff

At the time of the study, the Children's Centre employed twenty-two members of staff, which included Centre Managers, outreach workers, a teacher, day care and nursery staff. A further fourteen external agencies used the Centre as a base from which to see clients. Some external agencies, i.e. health employed staff members, were co-located and worked from the Centre; at the time of the study this included the HV and a health trainer. Figure 10, p.155, is a spatial map of the office demonstrating the variety of employees who were based in the Children's Centre and their different employers. It also describes the multiagency setting of the Children's Centre.

The HVCC based in the Children's Centre held a dual post role, which included a generic HV role and a public health role. Through the generic role, the HV provided a locality health visiting service to approximately 400 children aged from birth to five years of age (the cohort of children in this age group who lived within the reach of this Children's Centre was approximately 900). This role also included the provision of a locality Well-Baby Clinic for the families living within the area. The HV's caseload was derived from the practice population of two local GP health centres. It consisted of families with a child less than five years of age who lived within the assigned geographical reach of the Children's Centre (Field notes, 22.10.09). The HVCC was also employed by the Public Health department of the local Primary Health Care Trust (PCT). This was in line with recommendations within the Public Health White Paper, *Choosing Health* (DH 2004) to improve access to services within disadvantaged areas. The HVCC was employed to hold a caseload and to develop services to promote children's health, i.e. breastfeeding, immunisations and smoking cessation in an area of significant health inequalities.

The HV service to the Children's Centre was supplemented by HVs who worked in the locality but who were based in health centres (HVGP). Their caseloads consisted of families with children less than five years of age, taken from the GP practice population and regardless of where they lived. In this study, the majority of GP surgeries were in the town centre, approximately 1.6 miles from the Children's Centre. This resulted in some families, receiving their core health visiting service from the HVCC, whilst other families received their health visiting service from HVs based in health centres in the town centre (Figure 12, p.158). The HVGP's, also provided regular 'cover' for the locality Well-Baby Clinic, held in the Children's Centre, when the HVCC was on annual leave.

Figure 12: Health visiting service provision within the reach of a Children's Centre



7.6.3 Access to the Centre

The ethnographic study highlighted the division of labour between the HVs working in the area but based in GP practices and the HV based in the Children's Centre (Figure 12, p.158). Within the ethos of 'access for all', there were certain restrictive barriers or factors, which may have confused the service to clients:

1. Any client living in the town could access any Children's Centre for universal services such as the Well-Baby Clinic.
2. To have a named HV who was based at the CC, clients had to be registered to certain health centres which made up the HV (CC) caseload.
3. To attend certain courses, facilities or trips, parents had to be living in a designated postcode reach of the Children's Centre.
4. HVs based in GP surgeries also held Well-Baby Clinics in GP surgeries; these were for clients registered with a specific GP surgery.

From the above mentioned points, it appeared that the intention to provide services within a locality was strategically concerned with improving access; yet the HVs and Children's Centre staff were involved with not only access to services but were also working to engage parents, to encourage their participation. One way that this was attempted was through the provision of weekly activities, such as the Well-Baby Clinic.

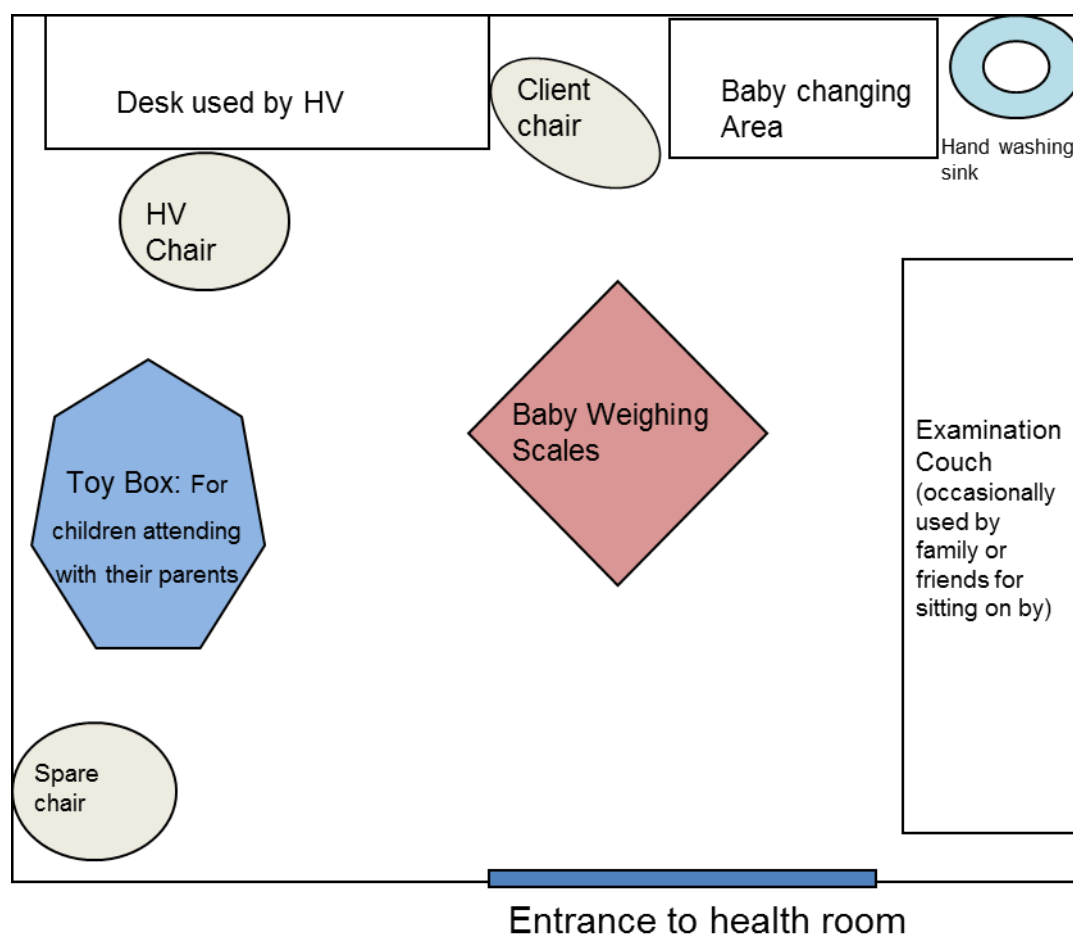
7.6.4 Female environment

As well as the Children's Centre being a purpose-built facility, it also appeared to be an environment populated by women. All employees, apart from one male worker, were women. At the beginning of the participant observation in the Centre, I observed a variety of activities and, although the Centre encouraged men to attend, they were an exception. In the mornings, the activities I attended were largely populated by women from a range of different backgrounds. As explained in Chapter 5, this Centre was successfully reaching a range of clients from the area and I observed activities attended by teenage or young mothers, first time mothers, recent migrants, experienced mothers and child-minders. Men who attended the Monday to Friday activity sessions explained that they were able to attend only because they were experiencing long term illness, they worked shifts or because they were looking for work. Several fathers who could not attend during the week attended 'Saturdays', a group run by the male worker in the Centre. I also observed a total of 17 clinic sessions, of which 10 were audio-taped. Consequently, as discussed in Chapter 5, the Well-Baby Clinic provided a rich environment for the collection of data on a wide range of HV/client interactions that demonstrated the variation in consultations between the HV and the client. The health clinic was mostly attended by women with their babies (Figure 14, p162) and the health room with its posters of breastfeeding women and babies appeared to be promoting female activities of child care such as breastfeeding.

7.6.5 The Well-Baby Clinic

The Well-Baby Clinic was a weekly event held in the health room, the health visiting service had a priority booking for the Well-Baby Clinic. At other times the health room could be booked by any member of staff or service who had access to the Children's Centre. As well as the HV, the room was also available to the midwifery service, voluntary organisations that used it for counselling, and the Children's Centre staff also ran aromatherapy and baby massage sessions. The health room was a multipurpose room for health activities; it was a small room and was furnished for clinical, multipurpose use. Its furniture consisted of a desk, a baby changing station, a sink and an examination couch (Figure 13, p.160). Each week, in preparation for the clinic, the room would be organized by the HV. Midwifery or aromatherapy equipment would be tidied away, a place would be cleared at the desk, and the blinds over the glass door and windows would be drawn. Surfaces were wiped and the health visiting equipment of baby scales and changing mats would be laid out. Over the weeks of observation, I noticed how different HVs prepared the room to fit their individual approach; some would place the scales on the floor, others would place them on the examination couch.

Figure 13: Spatial Map of the Health Room



7.6.6 Overview of the clinic encounter

On arrival, clients would register with the Children's Centre's receptionist who, in exchange for their personal details, handed over a numbered disc and directed them to the Community Room to wait to be called. Once the clinic room had been prepared, the HV would walk to the Community Room, greet the waiting mothers and enquire who was first. After speaking and introducing herself, the HV would invite the first client to accompany her to the health room.

7.6.7 Activity in the health room

The handing over of the Red Book, the Personal Child Health Record (PCHR), appeared to mark the formal start of the consultations. The client would start to undress the baby and, simultaneously, the HV would sit at the desk, complete the clinic attendance sheet and open the PCHR in readiness to record the baby's weight. The baby would be placed on the scales and observed by both the mother and the HV. The HV would announce the weight and then the client would again be invited to discuss any concerns she might have. The weight would

be recorded in the PCHR and shown to the client; a discussion would follow in relation to any concerns raised by the mother or - on some occasions - by the father.

7.6.8 Impressions of the clinic

The clinic appeared to be the HV's domain: clients had to wait to be invited in to discuss their concerns. The clinic in this Children's Centre gave the impression of health as an activity, and the space had to be formally booked and run within the guidelines of the Children's Centre. The names collected by the receptionist were not shared with the HV: the names of attendees were also collected by the HV. The symbols of health visiting - the personal child health record and the weighing scales - were present and played an important role in demonstrating the expertise/formal aspect of the HV to users of the clinic. As the spatial diagram demonstrates, the health room was quite small and, because of this, the weighing scales and changing mat were prominent and visible. The clinic layout and function appeared to me and the HVs who 'covered' the clinic in the absence of the HVCC to be very formal and traditional.

The pie chart (Figure 14 p.162), demonstrates how clients accessed the clinics; some first time clients attended on their own, others came with partners, friends, sisters or mothers. Many clients attended with their older children, especially if they were not yet at nursery or were attending a clinic during the school holidays. On one occasion a father attended with his child, and on another occasion a pregnant client attended.

On entering the health room, the HV would routinely ask the client for their reason for attending, and request the Red Book. Often clients would say it was '*just for weighing*'; however, during the encounter, many other reasons for attending were elicited. For example, for health advice; for practical reasons such as collecting healthy start vitamins, or to have an application for healthy start vouchers signed; for referral to another agency; to discuss their child's ill health; or to discuss their own maternal well-being (Table 20, p.163).

Figure 14: Clinic Attendance during period of participant observation

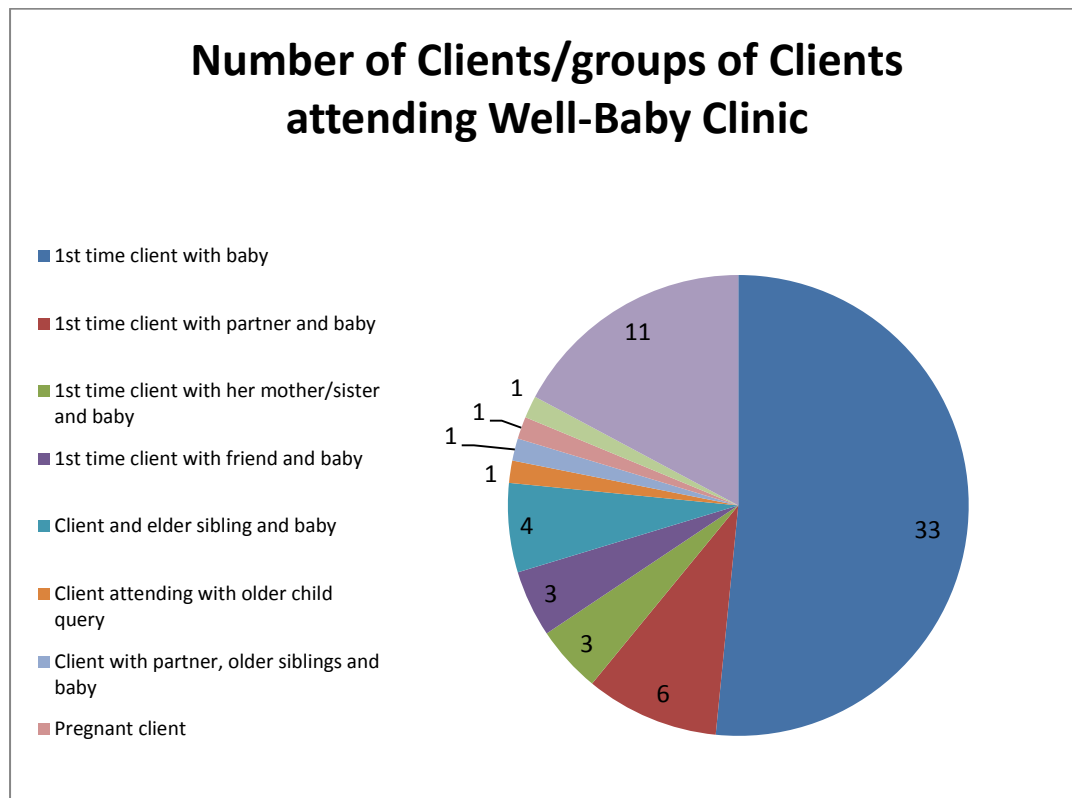


Table 20: Reasons for attending clinic (audio-recordings)

Clinic date and client reference number	<u>x</u> indicates clients who only had their child weighed)	Health Promotion (feeding, crying weaning)	Vitamin Drops	Sign a form/ advice re healthy start benefits	Referral To Other Health/ child service	Health Advice Re illness, condition	Other Agency involved with family
02.02.10-1					x		
02.02.10-2						x	
08.02.10-1	<u>x</u>						x
08.02.10-2						x	
08.02.10-3						x	
02.03.10-1	x	x				x	x
02.03.10-2	x						
02.03.10-3	x					x	x
02.03.10-4	x					x	x
30.03.10-1	x					x	
30.03.10-2	x					x	
30.03.10-3	x					x	
30.03.10-4	x					x	
30.03.10-5	<u>x</u>						x
06.04.10-1	x				x	x	
13.04.10-1	x	x					
13.04.10-2	x		x				
13.04.10-3	<u>x</u>						
13.04.10-4	x	x				x	
20.04.10-1			x	x			x
20.04.10-2						x	
20.04.10-3	<u>x</u>						x

Clinic date and client reference number	Just for weighing <u>x</u> indicates clients who only had their child weighed)	Health Promotion (feeding, crying weaning)	Vitamin Drops	Sign a form/ advice re healthy start benefits	Referral To Other Health/ child service	Health Advice Given	Other Agency involved with family
20.04.10-4		x		x			
20.04.10-5	x	x				x	
27.04.10-1	x	x					
27.04.10-2	x	x		x			
27.04.10-3	x	x		x		x	
04.05.10-1	x						
04.05.10-2	x	x					
04.05.10-3	<u>x</u>						
04.05.10-4	x	x					
04.05.10-5	x	x					
04.05.10-6	x	x					
25.05.10-1	x	x					
25.05.10-2	x				x	x	

My initial impression of the health clinic was that it appeared to be very traditional and, whilst co-located in the building, the health visiting service was a guest in the Centre. This positioning appeared to restrict the development of the Well-Baby Clinic and, as a consequence, its main function was as a representation of Health as an activity. This approach fitted with the Centre's one-stop shop approach, based on providing local activities for families. However, sharing a room with other activities restricted the development of the clinic. For non-health staff, '*weighing the baby*' was understood to be the main health activity on offer: this was because the majority of clients who attended mentioned that they were attending with the intention of weighing their baby. '*Just for weighing*' was also the phrase most often spoken by either the client or the HV at the inception of the consultation. Table 20 (page 163) demonstrates how most of the attendees came and weighed their babies. Weighing the baby is a well-recognised, traditional aspect of the health visiting service. During participant observation, it was observed that '*just for weighing*' was an acceptable reason to attend. A good weight gain appeared to acknowledge the physical health of children and successful mothering. The role of the HV was a traditional expert role, promoting health by acknowledging the babies' growth and alertness.

More importantly, the mundane practice of weighing the baby was often the introduction or first stage in the consultation and, if it progressed to the parent's satisfaction, the reason for the attendance would then be discussed. In these cases, it was a confidential space for mothers or fathers to discuss their emotional or physical health concerns. This second part of the role was observed in some but not in all encounters. Observing this wider role also demonstrated the variety of reach within the clinic encounters and highlighted the facilitators and barriers to clients accessing and engaging with the HV service.

7.7 Organisational barriers to client engagement

The relocation of one part-time HV based in the Children's Centre resulted in the provision of a locality Well-Baby Clinic. The intention was to provide improved access for clients living in a locality previously underserved with health services, because the majority of health centres and HVs were based in the town centre. Whilst this was a welcomed improvement, the change in service provision resulted in a more fragmented health visiting service for some HV clients. This next section will discuss the unintentional consequences of providing a locality service.

7.7.1 Fragmentation of services

When discussing partnership, the HVs in the focus groups had described established partnerships and successful relationships with clients. In contrast, the observations of clinics demonstrated a variety of relationships. Clients who attended clinic would not always know the HV covering clinic that day; often they were meeting the HV for the first time and it was noticeable that a partnership approach and client engagement was not enhanced in these circumstances. The HVCC was present on five occasions; the remaining times were covered by the HVs who worked in the locality. A HV who regularly facilitated the clinic in the absence of the HVCC commented on the difficulty of connecting with clients who were not from her caseload, who she was meeting for the first time in the clinic. Providing a more targeted locality clinic had resulted in the services being covered by HVs who did not necessarily know the clients who attended, and this also applied to the HVCC when clients from other HV caseloads attended.

The importance of relationships and ‘knowing the client’ in the provision of an effective service was discussed by a GP-based HV. Reflecting on the clinic session she had attended, she described the difficulties of providing a service when she did not have a relationship with the clients. She explained how not knowing the family diminished the level of service she was able to provide because she felt obliged to carry out an assessment on the client in the encounter:

‘But I find it quite difficult at some times because you are starting from a very low base, because quite often I’ve never met these mums before. So you are trying to assess a situation very quickly, in a short clinic session, so that is a challenge. So I think in terms of what you offer clients it can be quite compromised and I think I can provide a better service to families that I know in my own clinic’ (Field notes from interview with HV, 29.09.09).

7.7.2 Function of the locality Well-Baby Clinic

The HVs who regularly ‘covered the clinic’, also questioned the purpose of the locality clinic, how this clinic was different from the ones held in GP surgeries because they did not know the clients; it appeared that this clinic’s main function was ‘just for weighing’. In their surgery-based clinics, they had developed a two track system; if clinic attendances were ‘just for weighing’ then clients self-weighed their babies. If parents identified a problem, then they could access a member of the health visiting team:

'A HV who had arranged to meet a mother at the Children's Centre talked about how she felt this clinic was different. She explained how a lot of the mums came for weighing. "I wouldn't be able to offer that at my clinic". Instead they asked people to come to clinic with issues and if they wanted to weigh their baby's mothers were encouraged to self-weigh' (Field notes from interview with HV 29.09.09).

However, all HVs appeared to promote the traditional weighing function, especially when they were meeting a client for the first time. The development of the locality clinic without a clear strategy to its function appeared to be a barrier to service delivery. For example, a HV meeting a client for the first time asked the client if her reason for attending was 'just for weighing', and whilst the baby was being undressed, she began her assessment. The HV led the conversation and the client replied using single word sentences. Although the HVs had previously mentioned the importance of having a friendly approach, in practice this friendly and smiley approach was combined with a formal assessment that consisted of information-gathering questions:

HV: 'So have you got any questions or queries or worries about her at all or did you just want to see how much she weighed?

Client: How much she weighed, yeah.

HV: And how is she feeding? What do you give her?

Client: She has six... well; she's just gone onto six every three to four hours still.

HV: Right and she's quite settled between, is she?

Client: Yeah.

HV: And what milk do you give her?

Client: SMA.

HV: SMA what?

Client: Gold.

HV: SMA Gold, brilliant, yeah, and you want to stay with the SMA Gold for as long as you can really, and there's no reason why she can't be on SMA Gold until she's a year'. (Clinic recording, 2.3.10-2).

The approach of the HV was to ask the client her reason for attending clinic, but she framed her opening sentence as a closed question of, 'Or is it just for weighing?' to which the client replied that, yes, it was to see how much she weighed. The HV and client did not appear to have a

relationship; there was no acknowledgement or recognition of each other. Rather than use the encounter as an opportunity to find out why the client was attending, on this occasion the HV began an assessment on the feeding routine of the baby, which resulted in the client participating by answering questions and the HV offering unsolicited advice on the type of formula feed being offered. It appeared that the clinic had been set up to provide a traditional HV service which limited the reach of the clinic to weighing and physical tasks.

7.7.3 The PCHR as a tool for health professionals

On occasions when the client and HV were meeting for the first time, I observed HVs ask for the PCHR and then spend time reading through comments made by other health professionals. The quote below demonstrates how the HV used the recently plotted weight to inform the parents that the baby was growing well. However, rather than asking the client their thoughts on their child's development, the HV built her knowledge of the child from the PCHR. This approach resulted in the HV again leading the conversation and concentrating on the physical health of the baby. Subsequently, the opportunity for the client to participate in the consultation was reduced and the downward tone on the last "yeah" by the client suggests that the client was unable to be heard because the HV was concerned with an assessment of physical health:

HV: 'And may I have a look? (opens PCHR)

Client: Yeah.

HV: And he's healthy and happy in himself?

Client: Yeah, he's really content.

HV: And this has just been happening while we've had this hot weather?

Client: Yeah.

Partner: He's been drinking a lot more sort of like...

HV: Oh well it's a good weight gain though isn't it?

Partner: He has been drinking a lot more sort of like fluids and things.

HV: Yeah, well water is obviously... sorry how many weeks is he now?

Client: Six weeks tomorrow.

Partner: Six.

HV: And what time does he have his, why he's cracking up here then..... So there he is, he's on that nice curve there and he's just working up just lovely. I wouldn't worry about it at the moment, he's

a good size, he's got lovely skin, and he's alert, weeing and pooing?

Client: Yeah' (Clinic recording, 25.05.10-1).

Whilst the locality clinic improved local access, it also highlighted how a clinic provided in a locality where the client and HV were meeting for the first time often reduced the role of the HV to a traditional expert approach. The HV service was used as a drop-in clinic primarily for weighing and for health advice relating to a deficit model of health.

7.7.4 Rushed for time

As with the focus groups, another barrier to developing relationships with new clients was the lack of time. In this instance it related to the time given for the organisation and the running of the clinic. The HVs in the study site, when attending the clinic, were often 'rushed for time'. This was especially noticeable when the HVGPs had to cover the clinic for the HVCC or when the HVCC was delayed because an earlier consultation had overrun. At other times, the HVCC was disturbed during a consultation to speak to a SW or for the receptionist reporting on the number of clients waiting to be seen. The locality clinic had been set up in addition to the HV Clinics held in GP premises and cover for the clinic had to be fitted in with all the HVs' normal caseload commitments. To manage this extra work the HVGPs would arrive just before the start of clinic and leave as soon as clinic was over. In one set of field notes I had recorded that there was a theme of the HV being '*rushed for time*' (13.04.10). On this occasion I had arrived at 9.40 and, although the clinic wasn't due to start until 10.00, the HV had started to see clients, and a further three people were already waiting in the family room. The nature of the Clinic was that it was a 'drop in' clinic; clients could attend without an appointment. Clients arriving early and waiting to be seen was a very regular occurrence and was described as a challenge by one HV. This was because, although seeing clients individually, the HV was aware that there were several others waiting to be seen, which meant she had to manage each consultation to ensure that all attendees would be seen:

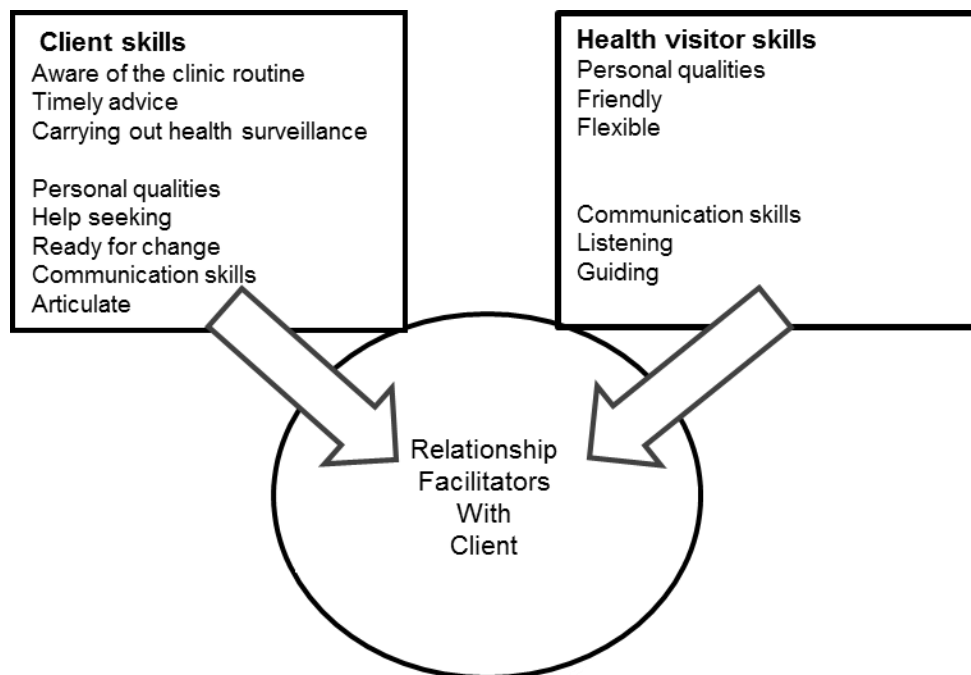
'I think drop-ins are a bit of a challenge because nobody, everybody arrives at once, so people can be kept waiting for a long time' (Field notes from interview with HV, 29.09.09).

The HV being rushed for time, feeling pressured by the number of clients waiting to be seen, and not knowing the clients who attended, all appeared to result in a more fragmented service where client participation was minimised. Whilst access to services appeared to be improved, providing locality services did not necessarily lead to improved engagement with clients in the area.

7.8 Co-encounters in the clinic

During the period of observation the following themes emerged from the data in relation to the facilitation of access and engagement between the HV and client in the clinic encounters. As discussed in Chapter 4, much of HV research into relationship building has been concerned with findings related to the role of the HV in engaging clients. Similarly, this current study identified qualities in the HVs that influenced and encouraged client engagement. Gee’s method of analysis also highlighted the qualities in the client that facilitated access and engagement with the HV. The themes identified in the facilitation of engagement by client will be explored below (Figure 15, p.170).

Figure 15: Facilitators to relationship and engagement



7.9 Facilitators and barriers to relationship and engagement

This next section will firstly focus on the skills required by clients that enhanced their ability to present their concerns to the HVs in clinic. Figure 15, p.170 above, demonstrates the qualities identified in a client for a successful clinic encounter. Secondly, it will provide evidence of the approach and skills of the HV that appeared to promote a relationship in the clinic.

7.9.1 Client aware of the clinic routine

The analysis identified two different approaches to participation by 'easy to help' clients, the first time parent and the more experienced client. Clients who were experienced in the clinic routine often had more than one child. First time clients would wait for the HV to request the Personal Child Health Record (PCHR) and responded by either giving the HV the book or by giving permission to take the book from where it was being kept. With more experienced clients, the PCHR was handed over before the HV had requested it. Their handling of the PCHR demonstrated that clients were aware of the routine of the clinic and of the need for expedience. This appeared to symbolise a client's expertise in the clinic procedure and an action that required acknowledgement from the HV:

Client: on entering the health room clinic, 'Book' (gets it out of back of buggy and hands it over to the HV)

HV: 'Book' (to mum) takes the red book and opens it

(Clinic recording on 30.03.10-1).

7.9.2 Help-seeking in clinic

The findings from the focus groups discussed how there was an expectation from HVs that parents would carry out health surveillance on their child and attend clinic for help when they had identified a health problem. Thus a normal expectation of the role of a parent involved being able to identify problems with their child's health and well-being. This approach assumed a parent had some knowledge of child development and, more importantly, that they would attend the health visiting service to discuss concerns. Table 20 p.163 demonstrates how a parent's attendance at the clinic was focused on weighing their child and discussing a related physical health concern, such as a recent illness, or a problem with breastfeeding or behaviour.

Two different ways of help-seeking were identified in this study. The first was when clients attended 'just for weighing'. Analysis of these encounters also identified that this was often the first stage in help-seeking; the second stage involved the client then asking for help with an issue in relation to her child's health; the third stage was the HV offering advice in relation to the presenting problem which was then acted upon. The second way of help-seeking was when the client had consulted another health professional and was attending the clinic for clarification or to discuss an ongoing issue. These different routes will now be demonstrated.

The first route to help-seeking was when clients attended because they had identified a health need or problem:

HV: 'Is it just for weighing?'

Client: It's just for weighing and a worry about her eye' (Clinic recording, 02.02.10-1)

The client was able to verbalise her reason for attending and the weighing of the baby was the entry into the clinic. Attending with a worry about her child's vision was considered a legitimate reason for attending the Well-Baby Clinic and resulted in a referral by the HV to another service.

For some clients it was not so straightforward to ask for help, especially if it was related to a behavioural issue. On these occasions the client needed their parenting expertise to be recognised. Once their experience and competence had been acknowledged, the client then shifted from weighing the baby to a problem she was concerned about but had been reluctant to discuss. This appeared to be related to the client presenting herself as an 'experienced' client; however, asking a question might mean that she lost 'face' and become viewed as a 'novice mother'. On several occasions, the listening techniques of the HVs persuaded the client that it was safe to ask for help. During one consultation the baby was weighed and the client was asked about her own health issues; after charting the weight in the PCHR, the HV said 'GOOD', in a louder voice, signalling that the consultation was drawing to a close. The client took this as a signal and began to talk about how she was finding her latest baby's behaviour more difficult than that of her other children at this same age. The client related his behaviour to his feeding. She informed the HV how his behaviour had improved when she stopped introducing solid foods. The HV responded by listening to the clients' actions and supported her in her decision-making. As the client confided her worries about her baby's behaviour and routines, this demonstrated to the HV how this client had undertaken health surveillance work. The HV then shifted her approach from offering advice to listening to the client:

HV: *'GOOD (HV signalling that she has finishing the weighing task)*

Client: *I have completely took him off solids*

HV: *have you?*

Client: *Yeah*

HV: *Is he just on milk*

Client: *Yes, He was having like three little meals a day and he wasn't settled at night he was a nightmare*

HV: *hmm*

Client: *He would sleep solidly till 2 and that was it, he would be up moaning and whinging. I took him off the solids and he was fine*

HV: *hmm*

Client: *Don't know if it was too much for his little tummy*

HV: *Could have been*

Client: *I wasn't giving him anything obscure it was literally like Rusk, pureed vegetables and stuff. It was weird' (Clinic recording, 30.3.10-1).*

The HV then framed her support for the client's decision making within the latest health advice on infant weaning. This health education advice was unsolicited and quite risky for the relationship; because of this the partnership dynamic changed from being led by the client to being led by the HV. For a few seconds, in the conversation, the client became more passive:

HV: *'Given that he's 21 weeks now, so by 26 weeks another 5 weeks he can go on and start again. But if you start late you need to do it a bit faster overall yeah*

Client: *Right ok*

HV: *So if you start them at like 17 weeks, which isn't advised if you can help it, but some people do. Then you just do the one thing a day a little bit*

Client: Yep

HV: You know, over a longer time. But if you start them at 6 months you need to go that bit

Client: Right

HV: faster because they need a bit more'

As the conversation ended the client again demonstrate her knowledge to the HV

'Client Yes, Ok they run low on their Iron and stuff

HV: Yeah and once he is 6 months, he can have what you have but don't add salt or sugar.

Client: No and he can't have cow's milk as a drink can he?

HV: No he can't have cow's milk as a drink till he's one he can have it in cooking

Client: But he can have it in cooking' (Clinic recording 30.3.10-1).

Through her use of the PCHR and by having her baby weighed, this client has demonstrated her expertise in clinic procedures and her competence in caring for her baby. After the 'formal' part of the clinic was over, the client, who had initially come 'just for weighing', was able to discuss areas of her baby's behaviour that she was finding difficult, 'a nightmare'. The HV, by listening, established the 'side by side' approach to partnership, described earlier by the HVs in the focus group. This encounter was very significant as it identified the work undertaken by both the client and the HV, and how the expertise switched between them during the encounter. It also demonstrated how the client was ready to act on the advice being given by the HV and was adjusting to the new advice on late weaning.

The ideal or 'easy to reach' client in a disadvantaged area would attend 'just for weighing'. If this was conducted to their satisfaction, the client would then introduce an issue. In these examples of help-seeking, the HV in the clinic knew the clients, they were on her caseload and had older children. Both encounters also aim to demonstrate the tentative nature of the relationship, how it had to be re-established at each encounter. It appeared important that the HV recognised the

clients' skills and expertise in parenting. These encounters also identified how these clients had the skills to articulate their child health needs within the public space of a Well-Baby Clinic.

The second route into the clinic was through a referral from another agency or health professional. Here, the focus was on the presenting problem. On several occasions, the HV would be asked to explain terminology used by other health professionals, or to tailor information and advice given by another health professional to fit the needs of the family and build on a family's knowledge. Two examples will now be given to demonstrate this.

A client was referred to the HV by a GP and she presented as wanting to know more about anaemia. The HV explained how anaemia in toddlers was a recognised occurrence in children of this age and then went on to give dietary advice and to arrange to see her for a follow-up appointment:

Client: 'but it was just the anaemia thing that...

HV: Yeah.

Client: So why would he like suggest that?

HV: Because a lot of children at this sort of age, toddlers have low iron we call it children's anaemia' (Clinic recording 20.04.10-2)

Again, this quote aims to demonstrate how the traditional role of the HV is valued in this community, because here the client had attended to discuss with the HV what the GP had said and to gain further understanding and advice on their child's issues

The next example aims to demonstrate how the HV was involved in listening to the client. This resulted in an asymmetrical conversation; with the client leading the conversation, the HV's listening skills encouraged the client to present her issues in a way that made sense to her. The client explained how she was used to attending the clinic at her GP surgery. Following her recent house move she had been advised to attend the nearby Children's Centre Well-Baby Clinic. She had never met the HV before but as soon as they entered the clinic room, she asked the HV the function of the Well-Baby Clinic. The HV replied by saying it was whatever the client wanted. Instantly, the client began to discuss a problem about her baby's health. In the extracts below, the HV encouraged the mother to tell her story. The mother spoke very rapidly and her voice was filled with anxiety and concern for her child's well-being. The HV responded to what

the mother was saying but also listened to how she was saying it shown by offering a normalising statement in a calm voice:

'A client pushed her baby into the room saying that she had never been before and how did it [the clinic] work

HV: Well, anything you want really, you can have your baby weighed, if you have any questions

Client: My questions is he has been having diarrhoea and we have seen the GP

HV: Ok

Client: And he kind of says just let it out

HV: Yes

Client: But I'm just thinking what can I feed him he's a lot better now

HV: Yes

Client: And he is probably doing two or three runs of diarrhoea today

HV: Yeah

Client: And it is much better but it was so bad we couldn't go out of the house

HV: Oh dear

Client: Because he needed his nappy changing every 5 minutes

HV: Do you know so many, so many little ones have had this gastroenteritis with this nasty diarrhoea and vomiting bug (Clinic Recording 13.04.10-3).

In the quotes above both clients were able to discuss their concerns, both presented as caring mothers, both had already been to the GP, but both required further general advice to understand why children became ill. The ability of the clients to use 'health talk' appeared to aid communication between the HV and client and appeared to be an important factor in the partnership work within the public space of a Well-Baby Clinic. In the clinic, 'health talk'

appeared to be a mix of medical terminology, i.e. 'diarrhoea', 'anaemia', and then a description of what action had been taken and how their daily routines were being affected. Because both clients were able to articulate their child's health needs, they fitted the focus groups' earlier description of an 'easy to help' parent.

It appeared important that clients were able to communicate about their child's or their own health needs to the HV. The client was then recognised as actively caring for their child by asking for professional guidance and support from the HV. Clients who were able to communicate their child's health needs in this way viewed the HV as a resource. In doing this, they also presented as being actively involved in the individual surveillance of their babies' health and well-being.

Analysis of the clients in clinic encounters demonstrated how they were easy to help if they were:

1. Building their practical knowledge of caring for a baby on a day to day basis
2. Carrying out surveillance of their baby and attending the clinic to discuss their concerns
3. Able to articulate their health concerns through the language of the clinic
4. Viewing the HV as a resource whom they could trust
5. There was a degree of respect between the HV and the client.

Clients who participated in this way were rewarded by being recognised as the experts in their baby. They were encouraged to continue to develop their skills and knowledge, which were in line with the expectations and public health goals of the HVs. Specifically concentrating on the encounters where synergy had been observed resulted in the above findings. Therefore, in the context of the study, women who worked in partnership with the HVs appeared easy to help and reach. The reduction in home visiting had resulted in the health visiting service being reliant on the agency of the client to attend the clinic voluntarily. The HVs managed the unpredictability of the clinic by focusing on problem-solving the presenting problem. This procedure was enhanced if the client had a trusting relationship with a HV, or if they were capable of asking for help within the public arena of the clinic.

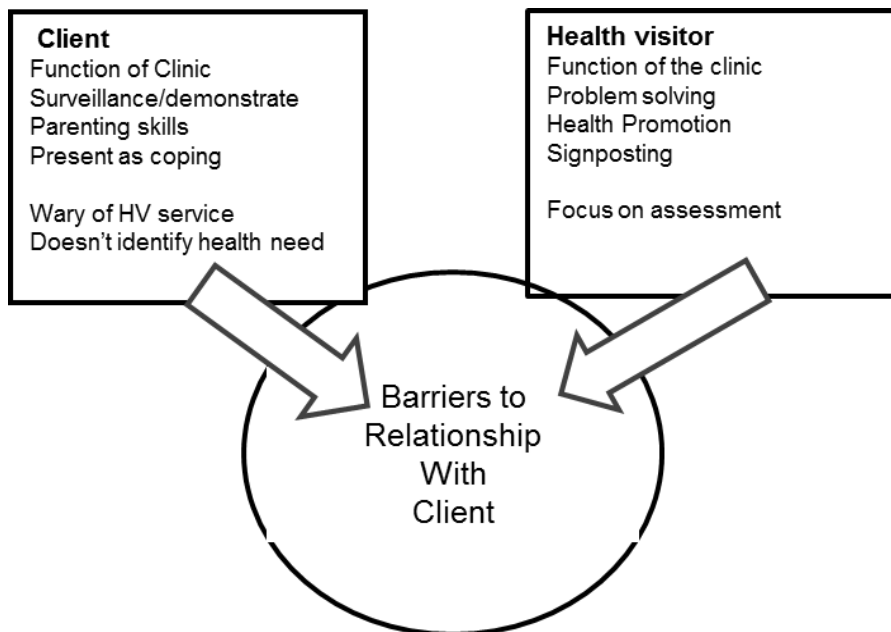
'Easy to help' clients also appeared to share the same values in child care as the HV. This was demonstrated by clients attending clinic to discuss breastfeeding, infant weaning, behaviour or the development of their baby's health and wellbeing, often discussed through routines and order. This group of clients also discussed in the encounters their support networks; such as

family and friends, or attendance at other mother and baby groups provided in the community. Clients mentioned their economic resources by discussing maternity leave, child care arrangements, planning to return to work or if they were actively looking for work.

7.9.3 Barriers to client/HV relationships

The HVs in the focus groups discussed how they recognised 'hard to reach' clients as those who did not, for a variety of reasons fully engage with services. The ethnographic approach enabled the discovery of barriers to engagement with clients not only at the organisational level but also at the individual, interpersonal level. Figure 16 (p.178) demonstrates the factors which impinged on the development of a relationship between the HV and client. In these cases dissonance was observed, and will be evidenced in this section.

Figure 16: Barriers to relationships



The two main routes into clinic were when parents chose to attend either to have their child weighed and then to discuss their child's health/behaviour, or else to ask for help and advice in relation to a medical diagnosis. I also observed a third route into the clinic and this was when clients had been invited to attend following an invitation from the HV or a social worker. This, in itself, was unusually as, generally, the HV did not know who would be attending. These

encounters were often more challenging for the HV, and provided me with the opportunity to observe resistance to the approach of the HV. In four encounters, this resistance appeared to be due to the stigma of having a social worker involved with their family. To demonstrate the difficulties faced by the HV in engaging in the clinic, three encounters will be discussed.

7.9.4 Clinic encounter 1 - 'everyone knows my business'

During the first week of the ethnographic study, a client had been invited to attend clinic by the HVCC and consented to my observing the consultation, saying that it was alright because, "everyone knows my business". I had recorded in my field notes how wary this mother was in the clinic, and everyone knowing her business meant that she felt that she was being treated differently:

"In making this comment it appeared that the mother was aware that she was different from other mothers. To her, the Children's Centre clinic was a place where her parenting was being viewed and scrutinised, by the HV and the Children's Centre staff. In this encounter the HV focussed on the mother's concerns, she appeared supportive, alluding to past issues and reminding the client of 'how far she had come'. Towards the end of the encounter, the HV also chose to gently ask the mother about a missed appointment with another health department. This request for information from the HV supported the mothers' claim of everyone knowing her business. It also demonstrated how the HV had taken over the health surveillance role from the mother, as she had failed to attend an appointment for her child's development and well-being. Afterwards, the HV described the client as being 'hard to reach' because she was not accessing the services, taking up the offers of help as much as she could do". (Field notes of clinic encounter, April 09).

The smooth running of the clinic rested on the assumption that the HV viewed herself as a resource to help and support families. However, at times this opinion was challenged. It appeared that, for some clients, the health visiting service was a judge of a client's ability to mother and this was noticeable even when the client and HV had a relationship. The client also attended the clinic on a second occasion during the period of observation and gave further written consent for the encounter to be recorded. The observations from the field notes demonstrate how the HV and client appeared to have a long-standing relationship. The client,

knowing that the HV knew her, without any explanation or introduction began to talk about her family members; she also appeared comfortable in the presence of the HV:

“Clinic started and the first client came in and sat down and immediately started talking to the HV about how pleased she was with one of her daughters. She sat at the desk, and had come to see the HV but had not brought her children’s PCHR. Both parties’ body language was very relaxed and they appeared comfortable with each other. The HV sat back in her chair, both sat around the desk and their body language mirrored each other on several occasions. For example, their legs crossed pointing towards each other and when the HV was filling in the form they both leant on the desk around the form. The client appeared to be a busy woman and had attended to have the form signed” (Field notes of clinic encounter, 20.04.10-1)

The consultation began with the client sharing information with the HV. However, when the HV tried to begin a health assessment, the client politely blocked the HV by answering with a positive response.

HV: ‘Are you eating all right?’

Client: Yeah, I don’t stop eating, I eat constantly.

HV: Yeah but is it good stuff or is it?

Client: Yeah, I eat everything; I don’t just eat like junk food.

HV: Fruit and Veg?

Client: I have to have a bottle of coke a day but I eat toast in the morning, that’s for breakfast and I’ll eat fruit all day long.

HV: Good.

Client: Because I like fruit anyway and then with each meal I’ll probably have vegetables nearly every night anyway and I’ve started eating liver and I hate liver but I started eating it because I was really like, you know, down and that but I just, nothing works for me, I’m just run down too much and when you run yourself down and you don’t, you know, you don’t recover from it, you don’t rest, nothing works, it’s just not going to work’. (Clinic recording 20.4.10-1)

This blocking of the HV's attempts to assess was an effective strategy in resistance. The notion of partnership work with this particular client was also highlighted as she had not brought the PCHR. The handing over of the PCHR to the HV appeared important in the HV/client relationship. The PCHR appeared to symbolise varying degrees of partnership working between the easy to help client and the HV. In contrast, the lack of the PCHR appeared indicative of an unplanned visit to the clinic or a lack of partnership with the HV. The encounter above took place without the Red Book. Forgetting the Red Book was carried out by a minority of clients. During the period of observation, there were only four occasions when the wrong book had been brought in or it had been forgotten. In the field notes I had noted the HV had difficulty assessing this client's health and well-being. This was because, when the HV enquired about how she was maintaining her health in pregnancy, the client blocked her attempts to assess her health. Instead she appeared to make sense of the service as a place where she was judged and under surveillance. In this encounter, the client responded by resisting the HV's attempts to search for health needs, instead choosing to use the opportunity to demonstrate her knowledge of the subject of healthy eating, and her belief that nothing worked for her was a barrier to further engagement on this subject. At the end of the consultation the HV described this client as 'hard to reach' because she 'had her own agenda' which blocked her attempts to promote health.

7.9.5 Clinic encounter 2 - presentation of mothering skills

In this next encounter, the client had been asked to attend by her social worker; she attended with her baby and younger child and had come to have her baby weighed (Field notes 8.02.2010). The encounter between the HV and client was constructed very differently when compared to other clinic encounters. Rather than asking for advice, the client demonstrated her mothering and her ability to cope to the HV. In her consultation, this client cited her support networks, the GP and local pharmacy. In doing so, the role of the HV was reduced to one of monitoring and checking:

Client: 'She's had this cough and it just got progressively worse and worse so I wanted it to be supportive. But I went into the pharmacy last week because had it as well, and she was really bad as well. And I went and picked up, well I asked at the pharmacy, what to give her. Because obviously you can't give them cough medicine until they are six now and they have given me (long Proprietary name)

HV: OK

Client: but I've got the bag so

HV: But they've given it to you- the right age appropriate?' (Clinic recording 8.2.10-1).

The client continued to demonstrate her knowledge of mothering throughout the consultation. In the quote above, the client demonstrated to the HV how she had cared for her children since their last meeting. Throughout this encounter, the client appeared actively to resist any suggestion of advice offered and the HV's role was reduced to checking on the mother's behaviour. When the HV asked the client if she had any problems, the client would mention a problem and how she had solved it. Every time the HV attempted to begin to discuss the subject, the client blocked her by demonstrating her knowledge and expertise in childcare:

Client: 'Because I mean put Bonjela on her, on her gums...

HV: She's probably chewing on them, they put their hands in their mouths anyway but at this age she probably is.

Client: Well I've got this teething ring, I went and bought them, yeah so she's dribbling loads, all over everyone, ain't you?

HV: Yeah, dribbling is a sign isn't it?

Client: Yeah because I mean with her (nodding at her other child), she was the only one I noticed it with because her gums were, like weren't clear when she was getting her teeth through and then, by then her teeth had popped out' (Clinic recording 8.2.10-1).

This client expressed herself using everyday language and, although she mentioned routines, she used the notion of routines to demonstrate her expertise as a mother:

Client: 'Well we've got her into a routine now, half past 7, bath and get into bed.

HV: That's good.

Client: And she's in bed by 8 o'clock, half past 8 at the latest it was half eight last night because mummy was tidying wasn't she, yes' (Clinic recording 08.02.10-1).

7.9.6 Clinic encounter 3 – 'I'll be guided by you'

The third example is in contrast to the previous two encounters and is an example of many clinic encounters where the client and the HV had an established and trusting relationship. Here the HV is used as a resource to listen and to problem-solve in partnership with the mother. In this encounter, which followed the previous encounter, the mother discusses her son's recent illness and how his feeding behaviour is described as unsettled. She is asking the HV for advice and the HV responds by asking questions that summarise and clarify her understanding. This extract is part of a consultation that lasted 25 minutes. It is included as it demonstrates the trust of the client in the service and also her ability to articulate her child's routines and how they have changed. She had also consulted the GP but it is from the HV that she requests help with his behaviour:

Client: 'So I'll be guided by you really,

HV: He's feeding frequently throughout the day so...

Client: Yeah, yeah he stills goes about 3½ to 4 and then he'll snack and that, um, he sleeps, he has sleeps during the day. He can sometimes go down and stay down from 7 o'clock or like last night he went, well he went down about half six and then was just unsettled, we kept having to re-settle him. So yeah we just settled him and fed him at... he didn't make it 'til 10 o'clock, he didn't make 4 hours but he did 3½, fed him at half 9 and then he was down until half 5 this morning, and then he went back to sleep...

HV: He went right through?

Client: Yeah which is, he does, he's dropped the 2 o'clock sort of that time of night feed, if he goes down I before... if he doesn't feed as late as 9 o'clock I will... if he's fed at 7 and gone down I often feed him at about 10, 11 o'clock so he's still getting that feed but he fed quite last night probably about half 9 and then slept through 'til half 5 so he keeps, at

night he can go for sort of 6, 8 hours between feeds and not wake up for them.

HV: That's good, that's good.' (Clinic recording 08.02.10-2)

In this encounter the client begins with, 'I'll be guided by you'; in response the HV asks questions in relation to the presenting topic. In this instance, the client's response to the HV is different. Instead of giving a short confirming answer, this client, a first-time mother, responds by answering in depth and in detail. This is an example of partnership work and the client fits the description of an 'easy to help' client, as described by the HVs in the focus group. The client demonstrated a good understanding of the supportive function of the HV service; she was also able to articulate her concerns about her child's health needs to the HV. As with the previous two clients, this client was also known to the HV. In contrast to their blocking of the HV questioning approach, this client appeared to appreciate being listened to. In this instance, the questions and clarification asked for by the HV demonstrated to her the supportive, listening role of the HV.

The earlier encounters demonstrated wariness in trusting the HV service. For example, presenting as 'coping' meant that the client was difficult to engage with in the clinic when the norm was to ask for help. The blocking of the HV's approach occurred when clients appeared not to trust the friendly approach of the HV. In contrast to the third encounter where the client engaged with the HV, the first two encounters showed resistance to the HV's questions and her attempts to engage in health promotion work. Instead they presented themselves as experienced, caring mothers who were coping with day-to-day activities, even though they were both facing adversity and upheaval. They appeared to view the health visiting service as a necessity rather than a resource. The client in the second encounter established how she was capable of using other health agencies for support - the GP and the pharmacist - and reported their advice to the HV. The two encounters highlighted some of the limits to partnership work based solely on the interpersonal qualities of the HV. When there were child protection issues and social worker involvement, the clinic was not perceived as wholly supportive. Instead it was perceived as being based on surveillance of their mothering/parenting skills, to detect problems, and they were wary of the service. As a result the offers of health promotion were blocked and the approach by the HV was viewed as a barrier to the clients.

In the first two examples, the clients' perception of the health visiting service as authoritarian resulted in dissonance and resistance to the HV when she tried to offer advice or promote health. In contrast, the third example was of a client, a first-time mother, who did not have social services involvement with her family, and who viewed the health visiting service as supportive. Whilst the client said at the beginning of the encounter that she would be guided by the HV, the HV's input was to support the mother's decision making and actions. This was a different approach from the two earlier encounters where more questions were asked by the HV on a range of topics. Throughout this third encounter the HV did not give advice; instead she recognised the client as an expert in her child and gave reassurance, which was in turn accepted by the client. The outcome of this encounter was an agreed follow-up visit at home, something that was not negotiated in the previous two examples.

7.9.7 Function of the Well-Baby Clinic

The earlier part of this chapter has demonstrated how the provision of a locality clinic had resulted in the fragmentation of care and how the HVs, when meeting parents for the first time, had focused on an assessment of health needs which had resulted in reduced client engagement. The findings from the focus groups indicated how the function of the health visiting service was a barrier to clients who did not understand the service (see section 7.3.4). This next section builds on the finding by exploring how the HVs' understanding of the function of the clinic can also be a barrier to reaching clients. As has been demonstrated, clients attend clinic with issues that they have identified as needing help with. They attend the clinic because they see it as meeting a need, to ask for help and advice and to develop their knowledge base. When the approach of the HV was one of 'problem-solver', the focus of the encounter was often on the presenting physical issue. In some instances, the client was signposted to another service. As a consequence, the opportunity to address the broader health concerns and emotional aspects of help-seeking were lost. The encounter below (with my emphasis in bold) demonstrates how the HV became concerned with a problem associated with early breastfeeding, which resulted in the client being signposted to a specialist breastfeeding café:

"HV: But what I'm concerned about is that you're getting sore and I'm just wondering..."

*Client: See **I'm trying to express** to give me nipples a break...*

HV: A rest.

*Client: But I do a bottle and then I've used the bottle by the afternoon **and I'm not full** most of the time **while I'm trying to express** so I can only get **like small amounts** and it doesn't matter how I do you know. He wants a feed so I was **trying to express**.*

HV: I wonder whether... do you want to continue expressing?

Client: Yeah.

HV: You do. So it works for you?

Client: Yeah, because then that way if his dad wants to.

HV: Yes, yes that's fine, that's absolutely fine, yeah' (Clinic recording 27.05.10-2).

In future, this client may not see the need to attend and engage with the health visiting service because the HV was taking a problem-solving, signposting approach but had not clearly identified with the client if the concern was physical or was related to the wider issues of breastfeeding for the first time, and the responsibility of feeding a baby. If it was the second issue, this could have been addressed in this clinic.

Client engagement was also affected when clients and the HVs held different views on the function of the clinic. In this clinic, the main reason that clients attended was for weighing the baby and for help and advice. It was also a place to demonstrate how well the child was being managed. In contrast, the HVs perceived the clinic as a place for problem-solving or the opportunity to promote health. The lack of clarity on the function of the clinic provided the opportunity for conflict:

'Client: And she's just gone onto a quarter of a Rusk as well because she's so hungry (laughs).

HV: Right.

Client: She's doing well.

HV: The only thing is that... I'll just mention about Rusks, it's not something that we'd recommend quite so young...

Client: Okay.

HV: If you could possibly eke it out until she's nearer 17 weeks that would be good, just because little babies' digestive systems aren't really very mature at this age.

Client: Oh right, it's only the last two days that I've started the Rusk.

HV: If I was you, I'd try not to give it to her until she's a little bit older, ideally, until she's about 17 weeks.

Client: Okay.

HV: Because there's quite a lot of research that suggests that babies' digestive systems aren't quite mature enough to cope with solids at this age.

Client: Oh right, it's just like my boyfriend said that was the advice several years ago.

HV: 'Yeah, we used to recommend that, absolutely, but I think we're learning all the time about how babies' digestive systems work, so if you can perhaps leave that for a while. She's doing lots of lovely smiles, isn't she?' (Clinic recording 02.03.10-2).

The clients' disclosure of early weaning, and how as a result her daughter was thriving, demonstrates the different perceptions of the clinic function. The client wanted to show her care of her child; instead she was met with polite disapproval. The HV explained how the early introduction of solid food was not recommended anymore and backed up her knowledge with research. As a consequence, this approach blocked any further discussion because the client countered the 'evidence-based' practice with her own knowledge and practice which was supported by her family and friends.

7.9.8 Invisible clients

The findings from the focus groups highlighted that HVs were aware that families at risk of the new social risks of social exclusion and health inequalities were often the most difficult to reach. For example, families experiencing domestic violence, homelessness, those who were teenage mothers, or who did not speak English, were discussed in relation to not attending for routine appointments, at Well-Baby Clinics but how HVs were tailoring the service within their

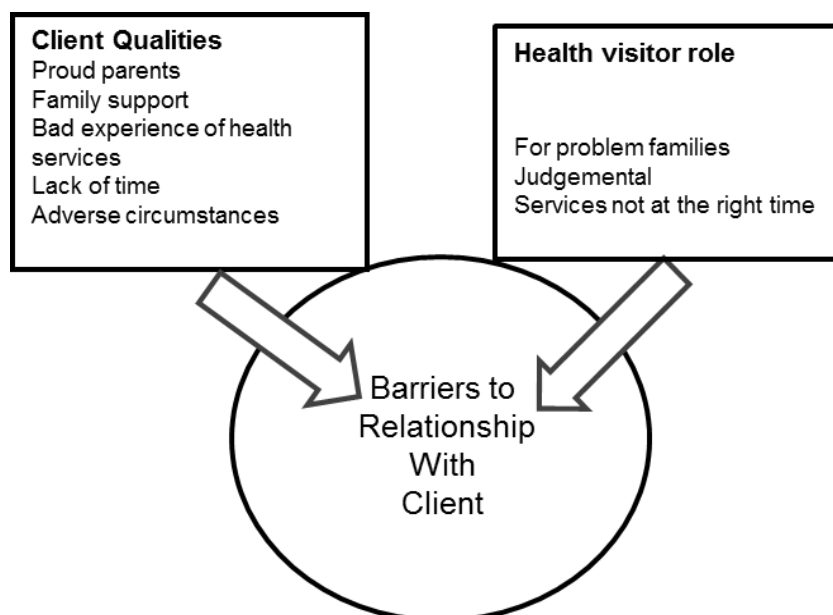
caseloads to engage such families. It was also noticeable that, in clinic encounters, clients or HVs rarely discussed the wider social structures or family circumstances affecting their health; so it was not possible to identify whether clients at the greatest risk of health inequalities were using the clinic. During the period of observation, only two non-English speaking clients attended the clinic and on both occasions they attended with a friend or family member who acted as a translator. Therefore, providing a locality Well-Baby Clinic is only one part of client engagement for the 'hard to reach'.

The observations in the field identified how the organisation of a locality clinic can facilitate access to services. It also demonstrates how the function of the clinic has to be clearly defined and strategically managed. Without this approach, the Well-Baby Clinic can lead to further fragmentation of services and potentially reduce client engagement. As well as the clinic setting, different types of clinic encounters were observed; these findings supported the data from the focus groups and identified qualities in both clients and HVs which enhanced or reduced client engagement in health promotion. The final section will now consider the themes identified in the interviews with clients.

7.10 Interviews with clients

The findings from the interviews with clients added to the findings in relation to the reasons why clients were reluctant to engage with the universal children's services (Figure 17, p.188).

Figure 17: Clients views of themselves and the HV service



7.10.1 Approaches to parenting

The participants in the interviews were accepting of the routine aspect of health visiting, yet they rarely contacted the HV for help and advice. Four themes were identified as barriers to asking for help from a service and related to the participants' experience and perception of family life and the health visiting service.

1. Self-sufficient families
2. Perception of parenting as common knowledge.
3. Practical reasons
4. Perception of the health visiting service as judgemental

7.10.2 Self-sufficient families

Several interview participants described themselves as self-sufficient, and evidenced this by saying that they or their partner were working. One of the younger mothers, Alex - a first-time mother, described herself and her partner preparing to be 'proud parents':

'Obviously we didn't know that was going to happen we thought we were going to be proud parents together but it worked out completely different'
(Alex).

The idea of being 'proud parents together' indicated a sense of self-sufficiency and seemed to be very important to this participant. However, when circumstances surrounding the birth prevented the self-sufficiency from happening, this participant discussed how she was able to call on her family for help.

The reality of becoming a mother, and her subsequent ill health, meant that rather than be self-sufficient, she became more dependent on her and her partners' families to provide day-to-day practical help. At the time of the interview this participant was living between her partner's parent's house and that of her parents. She had also recently returned to part-time work and the baby was being cared for by family members whilst she went to work:

'But I think now he is back at work I still get a lot of help but I went through an illness as well so that was quite hard to feel like I couldn't cope on my own and stuff and it was really getting to me. Now her Nan is like great here, she will get on with her in the morning she will have her all weekend for me' (Alex)

The birth and subsequent illness meant that, rather than coping on her own, she had to learn to rely on family for practical help and support.

Being financially independent was also important to this group of women; they did not want to be labelled as being dependant on the state:

'I was a teenage mum with C I was only 15 when I had her and as soon as I turned 16 I didn't want people to think,' Oh look there's another one taking our taxes'. So I made a big point of always working' (Lily mother of two children).

Or being reliant on others:

'I'm pretty much an independent person

R: Can you sort of explain a bit about what you mean by independent?

I don't mix very well with peopleI'd rather do stuff on my own than invite friends, I don't have many of them and I don't see them very often I just like getting on with it' (Vanessa).

Self-sufficiency also related to asking for help. This group of women valued practical help and advice from trusted sources. They considered trusted sources to include family, friends, magazines, the internet and supermarkets.

'So if I have day when I'm feeling tired or a bit stressed he's always, he can cover. So if I am tired and don't want to feed him, my partner can feed him, and my partner really does help out.....So my family support is really quite good my sister is brilliant because when I come out of hospital.....it was really difficult... to pick him up. My sister come round most nearly every day to see if I wanted anything or just to help out with bottles' (Lily)

'Oh my god my mum is like my online doctor she is absolutely fantastic... she has got seven grandchildren so she has been through it all.... so everything I learnt from her. I don't really I only see the HV or people like that when they are supposed to do their thing and then they sort of go and I don't need you anymore but I know the HV is on hand if I need her' (Vanessa).

One young first-time mother discussed the range of support she could access.

'My mum, my mum has had three kids, works in a school used to be a child-minder she has been around kids all her life. So generally it's my mum who I go to, don't tend to need to go to anyone else. She usually has the answers so it's like the other day obviously he can't have peanuts but I wondered whether he could have peanut butter... so I went and asked my mum, she weren't quite sure about that so I would have to go and ask someone else so I would go and ask the health visitor at the centre' (Karen)

Interestingly, none of the participants in this small sample had heard of Net Mums; instead they relied on websites such as NHS Direct:

'Yes I go on like the NHS Direct as well because I have rung them once because she was a bit poorly because she couldn't go to the toilet...very well. So I rang up and asked for help, so modern things as well' (Vanessa).

Or they had signed up to multinational companies who would send vouchers and coupons to reduce the cost of baby products:

"Well because all the foods do them, like her milk do them, SMA, they do stuff, and then Heinz and Cow & Gate. I've signed up to all of those because they send you out loads of stuff, and like little money off vouchers. And then the Bounty pack....So I've just signed up to anything that I can". (Sue)

This section has demonstrated the range of support that was available for participants living in a disadvantaged area. In this group, six of the participants interviewed had family living close by. One participant would contact her family daily by phone and one would be in contact with her family on a weekly basis. None of these support systems were mentioned by the HVs in the study. This section has found that the women interviewed who did not attend the Well-Baby Clinic were concerned with providing a healthy start for their children and would use services that built and supported their approach to child care. These clients would and had used the health visiting service when the help they required was more medical or related to updating their knowledge.

7.10.3 Parenting as ‘common knowledge’

A barrier to the development of relationships in the Well-Baby Clinic was when the HV’s and client’s approach to parenting was different. The HVs in the study based their knowledge on an ‘expert’ evidence-based approach. Sometimes this approach was at odds with the clients and resulted in dissonance and resistance. The parents who were interviewed discussed how they had learnt childcare from experience or from family members. In some instances, caring for children had been part of their lives since their childhood. For example Liz - a mother with nine children - explained how she had learnt to look after children:

‘I’ve always been used to them I suppose. When I was 12, I used to look after these little twins... I used to skive school just to look after them..... So I suppose I’ve just learnt from them and my sister’s kids really, when she had kids, I used to look after them, so I suppose it’s just picking up’ (Liz).

Caring for children and learning about child care was described as ‘*common knowledge*’ by one participant, learnt through babysitting for close family members or friends and this knowledge was developed when they themselves had children. They also wanted their children to be healthy; all of the interviewees were able to demonstrate and explain what being healthy meant to them, they were able to discuss eating fruit and vegetables, the ‘five’ a day, not smoking around children and carrying out exercise. They also discussed how they built their knowledge. Participants who were first-time mothers found the health information given in the ‘Birth to Five’ Book and leaflets helpful and demonstrated how they had used the book to help them solve a problem or concern:

‘I don’t really... because I’ve always grown up around kids, like my little cousins and my friends have had kids; it’s always kind of been common knowledge. It’s just other, if there’s other little bits that I’m not sure about. I remember I got given a book from my HV just after I’d given birth, so I looked through that because that’s got stuff about feeding them and if anything’s wrong with them, all the checks to do, so I just look at that if I need to’ (Sue).

However, one participant felt overwhelmed .by the amount of information she was given; she felt she was being ‘told what to do’, especially as it was different and new information from her own way of doing things:

Researcher: 'And do you remember any of the information that she gave you any of the leaflets or

Participant: She did give me a lot of leaflets I don't remember reading then though, I think that when you are a mum they tell you... what to do. You just want to do it your own way; you know you need to learn your own way'. (Alex)

For participants who had more than one child they found the information given out by HVs as less informative:

Participant: 'Sometimes, I used to read them but sometimes I didn't because I felt, well I know this already, I suppose you do, don't you, when you've had several' (Liz).

7.10.4 Practical reasons preventing clients accessing services

Many of the participants in this study discussed how they lacked time to engage with universal children's services. For one participant, she did not want to commit herself to attending as she did not feel she would have the time to invest in attending on a regular basis because she planned to return to work:

'I just find it a bit too difficult to get down there when I'm working and stuff. So I don't want to commit myself to anything. I know they do, like my other friends they did computer courses and stuff like that, extra maths down there. So I don't want to commit myself to anything when I can't guarantee I can go all the time'. (Lily)

Participants who were planning to return to work or who were caring for several children cited a lack of time for attending clinic or the Children's Centre. In these instances it was often one of many other competing commitments in their lives. This was especially so for women who had more than one child and whose lives appeared to revolve around the school run, especially if their children attended school and nursery:

'Yeah, they have their sandwiches, so now it will be changing because it will be taking X to nursery every day, like five days a week, so we'll have to, probably be out the door by about 12, if I was walking to take her. So then just come back and tidy up again (sighs) and then you go and feed the baby and

then be back up the school for a quarter past three to pick them all up. And then come back home, rush around getting them something to eat ...' (Liz)

Another client did not attend the Children's Centre as she had difficulty making friends and felt that the formality of a group would be difficult for her to feel comfortable with; instead she preferred to pay for her children's activities:

'As I said, I'm quite difficult in making friends, and I wouldn't like to go somewhere where it's sort of put on you to sort of try and talk to people. I quite like the fact that if you're just left in a room to get on and make friends as and when, like when the kids go up to each other and start talking, the parents might end up talking to each other, which I think is better than sitting everyone down and sort of saying 'This is Hayley, this is Rebecca', you know, and making them talk. I'd probably end up I wouldn't go again, because I don't like being forced into that sort of thing' (Jane).

Only one participant, Karen, spoke about attending a course at the Children's Centre.

'Tuesday we are generally out of the house all day and that's when I go over to the Children's Centre ... I do the 'young mums to be' course'.

7.10.5 Perception of the health visiting service as judgemental

In contrast to the above participant who enjoyed attending the services, one barrier to attending was the perception that the health visiting service had the authority to take children away from their parents:

Researcher: 'What do you understand about the job of the HV like you've mentioned that she is a bit nosy and prying and I just wondered if you wanted to say any more about that?'

No, they are there to do a job and to make sure the baby's OK and the kids are OK in the future because you have seen what has happened if nobody does. So I just think they are there to do their job and they do their job and then they go. That's it, if they leave me alone, they know that I am doing OK, they're OK that I'm doing OK but I know they are there, that they will answer any questions.

Researcher: and if you rang up with a question you would feel happy that they would?

I probably would feel funny, like I said about the leaflet they should do one; it would be nice to have one with playing up children. But if I rang them up and said I'm having a bit of a problem here, what should I do?, then all of a sudden social services are going to come at my door and take the kids away. Because that is how I feel because if anybody's got any control it's the HVs. And I think, I don't want them, I want some advice I don't want them at my door every week and that's what I feel they would do.' (Vanessa)

As demonstrated in the earlier section of findings from the field site, when clients felt judged in Well-Baby Clinic by health professionals, or when other professionals were involved with the family, attempts to assess a family's health needs were often blocked. This also happened during one of the interviews when I asked a question about health. The participant was also resistant to attempts by the HV to discuss her emotional health as she considered that to be prying. Instead she chose to discuss her physical health:

Researcher: 'And when I said health, what does that mean to you?'

Health? As in the way I feel with the kids? Like the HVs always sort of pry into that. Oh I'm fine apart from a bit of asthma I'm absolutely fine' (Vanessa).

Whilst two participants expressed how much they had appreciated the involvement in their pregnancy of the Teenage Midwifery Service (TMS), they also discussed how unhappy they were on discovering that they had been judged to be too old for the service and were consequently referred to the normal midwifery service when they became twenty years old. They were also able to demonstrate how the experience of the TMS had empowered them to contact the TMS to ask for help and, as a consequence of their actions, the service was reinstated to them:

'I had one Midwife that come just as I was due, and she wanted me to change my Midwife, because I had a 'young mum' Midwife, because when I was pregnant I was 19, and they wanted me to change, and I was just like 'Yeah, alright then', but then they didn't bother with me, I didn't get no letters and I became overdue, so then I had to ring my old Midwife, 'Well I'm overdue, what

shall I do?’ and then she carried me on... I thought that was a bit bad because I was at due point and they wanted me to change to people I’d never met before, but I managed to go back with my old one’ (Sue).

The interviews with clients have again highlighted facilitators and barriers to services: some of these build on the other findings in the study, whilst some have offered further insights into clients’ perceptions of the services they have encountered. The final section will now pull the findings together.

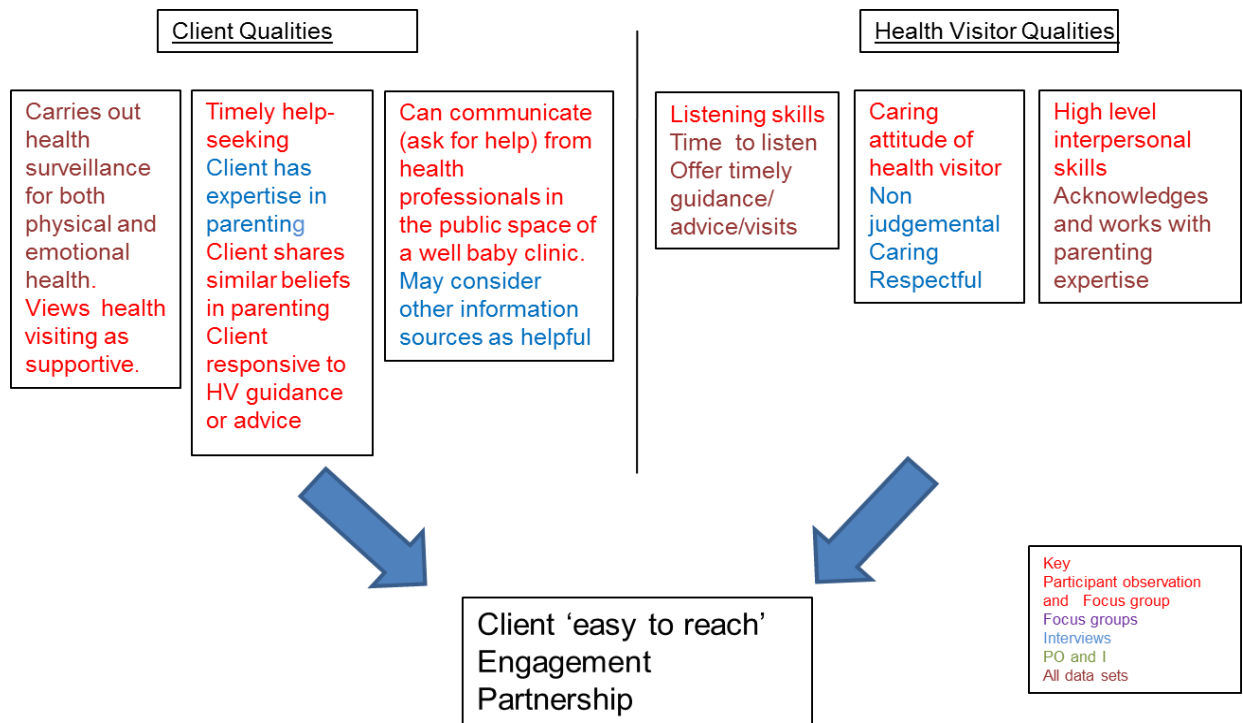
7.11 Emergence of a typology of the reach of the health visiting service

This chapter has demonstrated how HVs’ understanding of the term was influenced by the culture of health visiting and individual clients’ circumstances; how HVs strived to work in partnership with clients to promote the health of their children. The discourse around ‘easy to reach’ clients was of particular interest because it highlighted characteristics of the ideal client within today’s approach to child health promotion and help-seeking. Importantly, it was possible to identify a number of different dimensions with regard to HVs’ understanding of the term ‘hard to reach’.

7.11.1 ‘Easy to reach’ client

The HCP (2009) discussed working in partnership to promote health with new parents, and the ‘easy to reach’ client epitomised this ideal. The data analysis identified the characteristics of ‘synergy’ in successful HV and client interaction. Figure 18, p.197 highlights the key themes identified for a successful HV/client encounter. As well as sharing similar beliefs on child rearing, they viewed the health visiting service as supportive, as an accessible resource to be utilised. Clients were able to access help in clinic with problems they encountered with breastfeeding, weaning and child development and began to mention the emotional and social health of the child and themselves. During the clinic consultation this group of clients would often discuss the other resources that they were able to draw on to support their parenting: partners, friends, family, and a wider network of approved support, such as the NCT, breastfeeding support or attending classes at Children’s Centres.

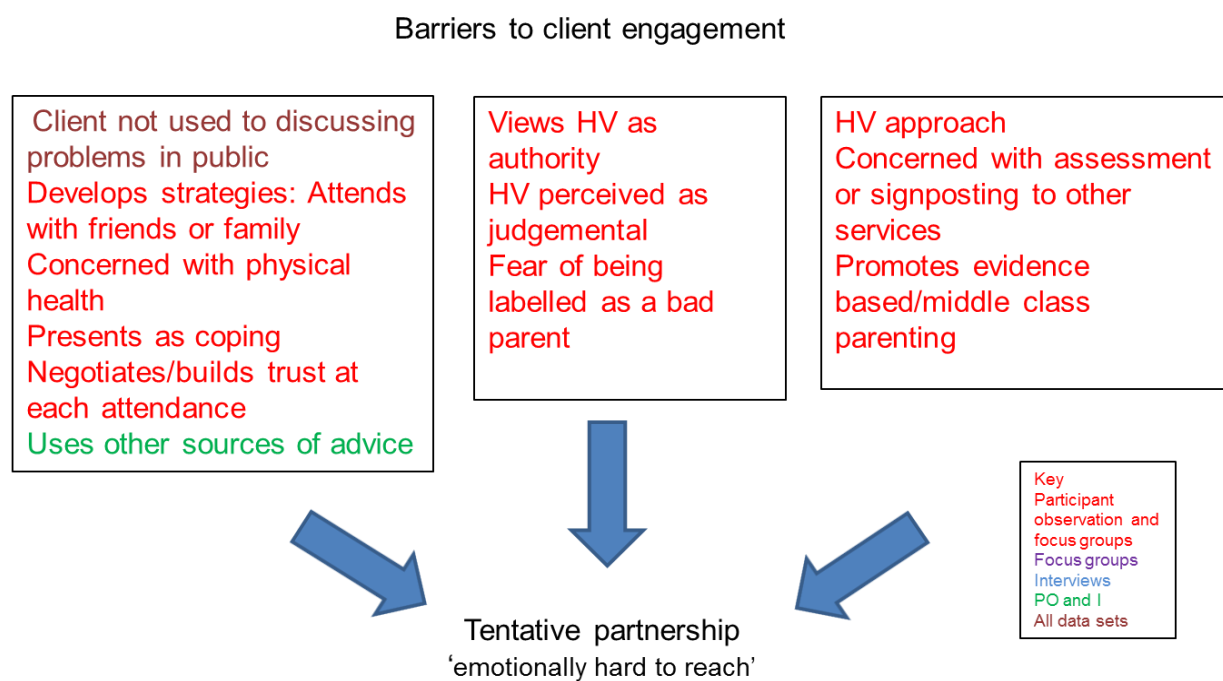
Figure 18: Easy to reach



7.11.2 'Emotionally hard to reach' client

The emotionally 'hard to reach' client was originally identified from the focus group data and related to negative individual attributes such as being 'chaotic' and resistant to the help being offered by the HV. Figure 19, p.198 demonstrates why and how clients appeared resistant to the HV in the clinic encounter and highlights the many different barriers that can prevent /HV/client engagement in the clinic.

Figure 19: Barriers to client engagement: 'emotionally hard to reach'



In the clinic encounter, an emotionally 'hard to reach' client was identified when there was dissonance in the co-encounter between the HV and the client. This dissonance was most apparent in the asymmetrical type of conversation. It appeared that some clients were not used to discussing their problems in public and often clients would develop strategies to help them when attending the clinic. They would attend with family or friends, focus on physical problems or present as coping. With a client who was wary of health visiting, each clinic attendance involved negotiation and renegotiation. In these circumstances, the HV approach was important. The data presented in sections 7.9.4 and 7.9.5 highlight how the clients' perceptions of the HV service as an authority, was a barrier to client engagement. This perception was further compounded when conversations were led by the HV, who was primarily concerned with assessment and searching for problems. In these situations, the client would resist suggestions or offers of help and either give her own solutions or present her decision-making on qualities that she considered important in a mother. The emotionally 'hard to reach' client often had other agencies involved with her family, such as social services or solicitors. The main aim of the client in these encounters appeared to be to present themselves as caring and coping, and to gain recognition for their caring.

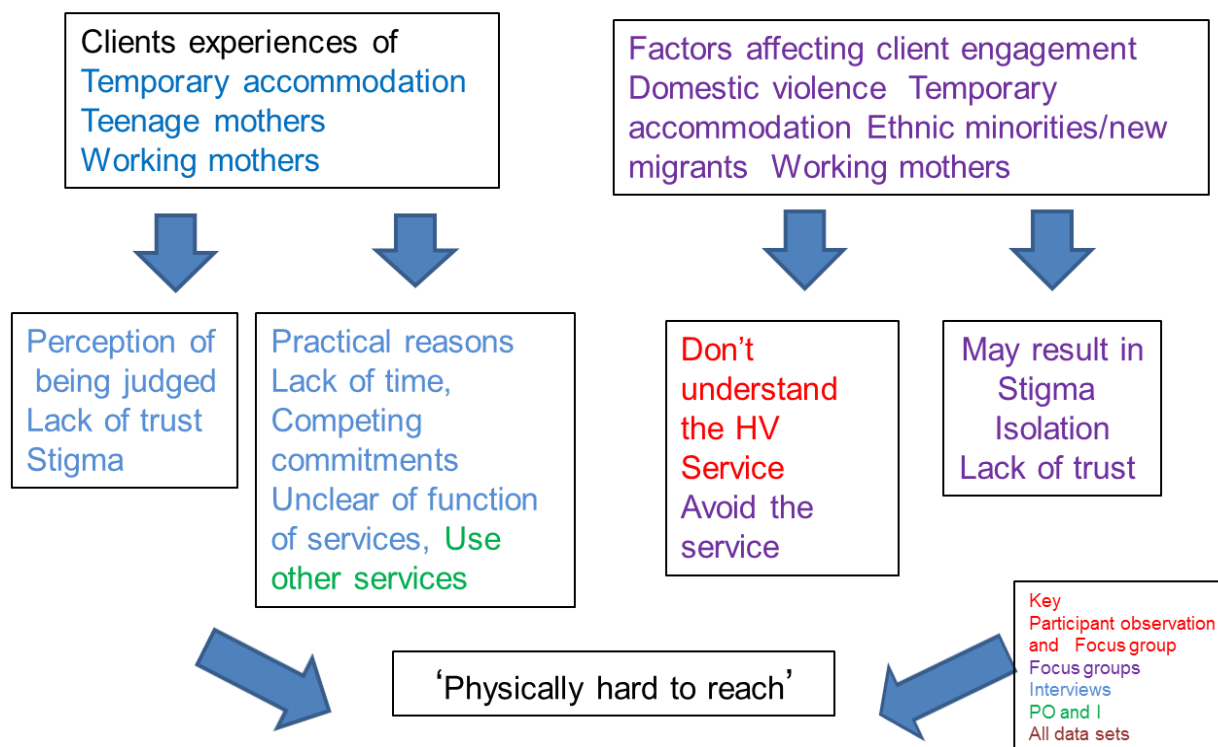
Further barriers to engagement in clinic encounters occurred when beliefs and attitudes towards parenting were different between the HV and the client, especially when both viewed themselves as an expert. Finally, the shift from discussing a child's physical health to include and discuss the mother's emotional health appeared to be quite new in this area and the offer of emotional surveillance was resisted by some clients. Emotionally 'hard to reach' clients only felt safe when discussing the physical aspects of child health. Breaking through and reaching clients at an emotional level in clinic appeared very difficult, especially when HVs used the opportunity to carry out a health needs assessment or to give unsolicited health advice, and this often resulted in the minimising of the HV role by the client.

7.11.3 'Physically hard to reach' client

This 'physically hard to reach' client was discussed by the HVs but was rarely seen at the Well-Baby Clinic; in this situation they were 'invisible' clients. The focus group analysis revealed how this client group may be experiencing vulnerability factors but they were not considered to be the most vulnerable within a caseload and often would not meet the service criteria for home visiting because health needs had not been identified.

In contrast to the 'easy to reach' client, the data analysis identified that some families living within a disadvantaged area were wary of the HV service and, as a consequence, were more difficult to reach and engage with. Figure 20, p.200 sets out the findings from all the data sets.. Analysis of the focus group identified how, instead of describing client qualities, risk factors were used to describe families who were difficult to engage with. Examples of the labels used to identify families who were difficult to engage with were homeless families, families in temporary accommodation, or families experiencing domestic violence. The analysis also revealed how HVs perceived that there could be several reasons for non-engagement: this was due to a lack of understanding of the service, a negative perception of the service, or that engagement with the service was the parents' responsibility.

Figure 20: Barriers to partnership work: 'physically hard to reach'



The interview analysis added credence to the HVs' beliefs that families who were living in adversity or who had vulnerability factors were less likely to access services. The cohort of women interviewed had experience of being teenage mothers, of being homeless or they had moved away from their support networks as they became a parent. The analysis revealed the private nature of parenting, how some parents felt they were self-sufficient 'proud parents', and therefore would not consider asking public agencies for help, although they would attend for the core contact appointments. The analysis also revealed how some parents felt they were 'at risk' of being judged by universal services. Importantly, the analysis identified a number of practical reasons that prevented access to services. Alternative sources of support were used and these included private play facilities that were more anonymous or perceived as being less judgemental; healthcare advice was gathered from the internet, from magazines or from 'supermarket-based support' such as money off vouchers, all of which could be accessed as required.

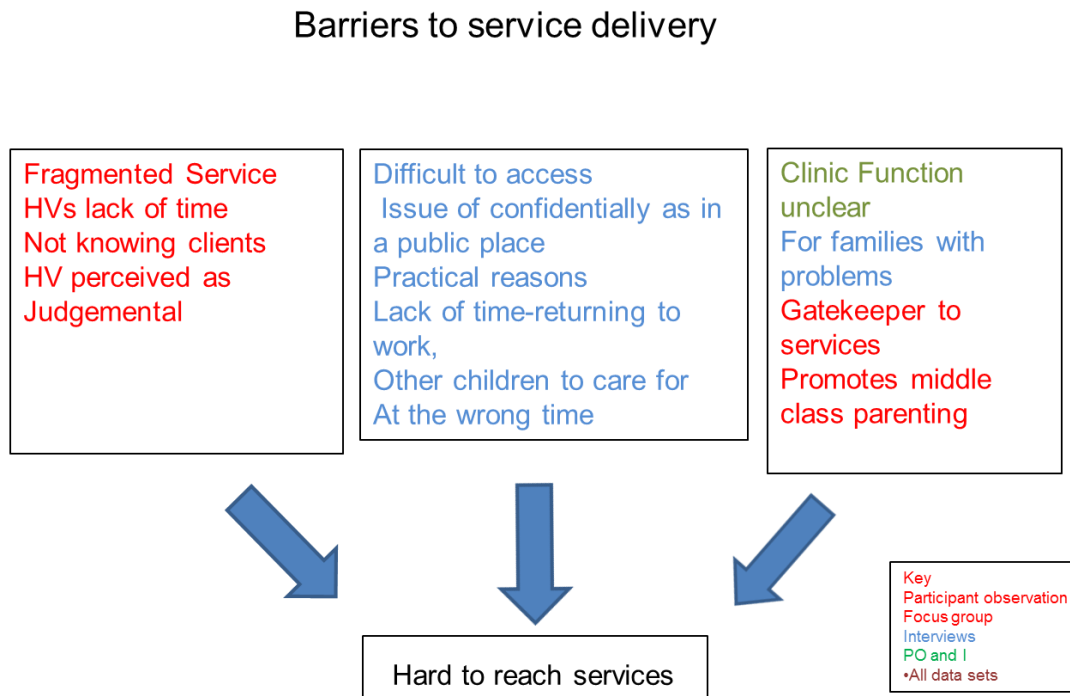
7.11.4 'Hard to reach' services

The findings have demonstrated how HVs enabled families to access services. The analysis and presentation of the findings has also identified a number of barriers to client engagement.

Figure 21 p201 illustrates the barriers to client engagement in the case study, in this instance, how clinic was being provided and delivered to all clients. The HVs and Children's Centre workers all discussed how they were providing a service which was aimed at listening to the client and working at the pace set by the client. In the locality Well-Baby Clinic barriers to inclusive client engagement were identified. These barriers related to the organisation of the Well Baby clinic as discussed in section 7.7 of this chapter and are supported by the themes identified in the analysis of the interviews (section 7.10 below).

The themes identified in relation to the service highlight the need for a clear strategic approach to address the provision of a Well-Baby Clinic in an area of disadvantage.

Figure 21: Barriers to service delivery: 'hard to reach' services



7.11.5 Typology of the reach of health visiting

This final section will amalgamate the four different dimensions identified from the original concept of ‘hard to reach’ in relation to health visiting. The typology of the reach of health visiting in a disadvantaged area offers a framework to provide clarity to the contested nature of the concept. The typology is structured around four dimensions to describe the ‘reach’ of health visiting; it incorporates the clients’ viewpoints and systematically brings together the multidimensional findings discussed in this chapter.

Table 21: Typology of the reach of health visiting

<p>Easy to reach Client views HV as a supportive resource Client carries out health surveillance for both physical and emotional health Able to communicate in the public space of the clinic Request timely help Responsive to advice and information</p>	<p>Emotionally hard to reach Views health visiting as an authority Lack of trust , fear of being judged Attends with family or friends Presents as coping Concerned with physical health Expresses different ideas of child rearing Resistant to health advice being offered</p>
<p>Hard to reach services Fragmented Gatekeeper to services Too authoritarian/in a public place HV services appear judgemental, Services are for problem families not for all. Promotes a middle class view of parenting</p>	<p>Physically hard to reach Experience of risk factors Resist the offers of service Don’t understand the service Feel stigmatised Non engagement Living away from supportive networks Lack of time May be working or have other commitments</p>

7.12 Conclusion

This chapter set out to demonstrate the findings in relation to the research questions of how HVs conceptualised and operationalised the term ‘hard to reach’. It also aimed to develop a definition of the term ‘hard to reach’, to identify the facilitators and barriers experienced by

clients and their perceptions of the service. This research found that whilst health policy influenced how HVs understood the term, the HVs' primary understanding was developed from the demographics of their caseloads within a culture of partnership working. Although the term was contested and described as nebulous, it was used by practitioners to describe clients who were 'difficult to engage' within the confines of a changing health visiting service.

Partnership work was viewed as a way to build relationships with clients and from that the concept of an ideal client- the 'easy to reach' client - was developed. Barriers to partnership work through resistance and dissonance in the clinic encounters added to the development of the type of emotional 'hard to reach' clients. The type of physically 'hard to reach' captures the transient nature of some clients' lives and how structural factors are a barrier to partnership work. Finally, the data analysis acknowledged that the health visiting service was itself 'hard to reach'. The multi-dimensional nature of the term resulted in the emergence of the typology that aims to promote understanding of the reach of health visiting in practice. The typology and the themes of client engagement and partnership will be discussed in greater detail in the following chapter.

8. Discussion

8.1 Introduction

The thesis was concerned with answering the research question, How is the term 'hard to reach' conceptualised and operationalised in health visiting practice? The analysis and findings revealed a lack of consensus in how HVs related to and constructed the term 'hard to reach' and, as a result, there was little evidence of the term being operationalised strategically or systematically. Instead, the findings suggest that the term appeared to be conceptualised by individual HVs in relation to their caseloads and experience of partnership work with families. As a consequence of this individual approach, a variety of access and engagement was observed and ranged from easy to difficult to rarely reached. As a result, it was not possible to develop a single definition of the term; instead the multidimensional nature of the term was captured. The variations in the term were systematically grouped together and from this the typology of the reach of health visiting was developed. The HVs' perceptions of the concept of hard to reach will be discussed in this chapter.

The HVs in the study discussed how they worked in partnership to try and engage with 'hard to reach' families. The development of a professional client relationship has been recognised as important in health visiting since the 1980s (Robinson 1982, Bidmead and Cowley 2005b) and the interpersonal skills of HVs has been identified as a key factor in influencing the engagement and subsequent participation of clients in health visiting (Bidmead 2013); and evidence of these skills were also found in this current study. Findings in the thesis also suggested how some barriers to client engagement, at the interpersonal level, were influenced by a discourse of parental responsibility found within recent government Child Health Policy documents. The findings also clearly demonstrated that within an area of disadvantage there was a wide range of responses to the service from clients. Some clients clearly demonstrated their ability to communicate with health professionals and having these assets meant that they were able to discuss in public their health needs and requirements. In contrast, some clients found approaching formal services for help far more problematic. The perceptions and experiences of the service held by the client were also found to be highly influential on how the client utilised child health services. Importantly, the study identified how asking for help from either family or professionals was not an everyday occurrence for some clients. Instead, a range of help-seeking was discovered; the type of 'easy to reach' demonstrates how a client's trust in child

health services enhanced service delivery. Importantly, being able to communicate and ask for help in public was identified as a facilitator to enhanced HV/client engagement. This chapter aims to discuss successful approaches to HV/client engagement, especially in the light of client qualities that enhance the relationship.

Findings have also identified how for some clients the services were 'hard to reach'. Not knowing how to ask for the service nor understanding how a service may be supportive rather than judgemental were some of the factors which led to the development of the 'emotionally hard to reach' type, and the identification of barriers to engagement with the service at the interpersonal level. The type of 'physically hard to reach' was developed as this type identifies the wider contextual barriers that prevented engagement and which were often beyond the control of the individual client or HV. The development of the four types of 'hard to reach' (Table 21 p.2) demonstrates the multidimensional facilitators and barriers to client engagement. Investigating the concept of 'hard to reach' has also highlighted the variation in the reach of health visiting. The reach of health visiting relates to more than the provision of a universal service or physical contact between the HV and client, it also relates to successful client engagement to address health inequalities.

This Chapter will discuss the findings in relation to HV policy documents, in particular the HCP (DH 2009), the Health Visitor Implementation Plan (2011), and HV, public health nursing and non-HV literature on barriers and facilitators to client engagement.

8.2 Health Visitor's perception of 'hard to reach'

The data analysis in the current study revealed how HVs lacked a clear, strategic understanding of the term. Instead there were wide variations of interpretations based on individual HVs' experience and practice. The findings suggested that HVs understood the term as being very broad and ambiguous with many possible meanings. Non-health visiting research on providers' understanding of the topic of 'hard to reach' families has been undertaken in education (Doherty et al. 2003, 2004, Evangelou et al. 2008, 2009), in voluntary organisations (Barrett 2008), in local government (Bracketz 2007), and social policy (Edwards and Gillies 2004, Katz et al. 2007, Cortis 2012) and all concurred with this finding. Yet they also remarked on how it had been a useful exercise as they had gained a greater insight into understanding the concept of 'hard to reach' within their area or context.

The findings in the thesis also identified how the term was discussed in relation to a range of client behaviours from non-engagement with the service to partial engagement, to disengagement or avoidance. Client groups who were more difficult to engage with were also acknowledged. These groups consisted of homeless families, ethnic minorities, new immigrants, clients with mental health issues, or experiencing domestic abuse or abusing drugs or alcohol. This finding was not surprising; these groups had been previously described as vulnerable, i.e. families who may be at greater risk of infant mortality or child protection (Appleton 1996, Hall and Elliman 2006); and now these same families are identified as at risk of the 'new social risks of social exclusion and health inequalities (HCP DH 2009).

8.2.1 Policy influences on health visitors

It appeared that the HVs' perception of the concept had been influenced by their understanding of risk factors in relation to child protection from the Hall Reports (see 3.4.1 above). Importantly, in child health policy documents (Hall and Elliman 2006, HCP DH 2009) and the recent health visiting scoping exercise (Cowley et al. 2013), the term 'hard to reach' had been used interchangeably with many different synonyms, such as 'vulnerability', 'hard to access', 'minority groups', 'invisible', 'underserved' or 'seldom heard'. These terms are used to describe families at greater risk of child protection issues and groups of families at risk of social exclusion and health inequalities; which indicates that, whilst the nature of risk is redefined, the problem of reach remains within certain types of family.

Families with five or more risk factors are described in the HCP as the 'most at risk' of disadvantage and social exclusion (DH 2009) and the most in need of help. As discussed in Chapter 3 above, the new 'social risks' of social exclusion found in the HCP (DH 2009) offers a broader reach to health visiting, as it accounts for the social structures of poverty and inequality within society. Evidence from the data analysis suggests that when HVs had a relationship with clients, they became aware of these wider structural barriers and were able to offer solutions, and address the broader health needs at the community level as well as the individual level. However, at the time of the study, the service had been commissioned to provide a core service and a more targeted service for areas with greater incidence of child protection, teenage parents or lower rates of breastfeeding. This implies that the service as a whole is not being commissioned to reach families in order to address more general child health inequalities associated with the broader 'new social risks' and parenting in adversity.

As well as the HCP (DH 2009), there are other more recent policy influences on health visiting, which appear to affect how HVs are managed as an organisation and influenced as practitioners. One such policy, The HVIP (DH 2011) is concerned with transforming health visiting into a progressive universal health visiting service. However, the document appears to support the normative assumption that individual help-seeking is the action of responsible parents:

“the new health visiting service will be in place when the local community knows that it exists and knows how to ask for it” (DH 2011, p.16).

In this model, parents are expected to take responsibility and ask for help by attending clinic/contacting the service with child-related problems. This appears to mark a further shift away from structural reasons for health inequalities and, in this respect, the problem of non-engagement appears to lie with the clients. The data analysis revealed that when clients did not engage with the service, the term ‘hard to reach’ was applied negatively as a label. HVs in the focus groups used this approach when they had made numerous unsuccessful attempts to make an initial or follow-up appointment. In these instances of perceived non-engagement, the data analysis uncovered HVs’ feelings of frustration and helplessness and resulted in families being labelled as ‘hard to reach’, ‘chaotic’, ‘irresponsible’ or untrustworthy. Here the concept was concerned with non-engagement, and the labelling mentioned above resulted in the client being blamed for non-attendance. On these occasions, labelling of clients revealed the limits to the reach of a universal service that was/is reliant on clients responding to invitations, or help-seeking with parenting issues. The Audit Commission’s (2010) latest report on access to maternal and child health services suggest that the reach of the services has not improved, as their research indicated that young parents still felt the service was judgemental. Yet this report did not take into account how the service was being reduced nor how society’s expectations in relation to help-seeking appear to be changing.

‘Help-seeking’ as a normal behaviour has been challenged by feminist critiques of government policy (Davies 2004, Condon 2005, Broadhurst 2007) who have argued how this approach continues to promote a style of parenting and parental support that is more suited to the middle class style of parenting (Cornwell 1984). Edwards and Gillis (2004) found that working class families often did not routinely turn to formal services for support: instead they would rely on the advice of family or friends. Yet policy documents supporting the notion of parental responsibility and help-seeking as expected behaviour may result in a reduction in service provision, and non-

attendance is simply interpreted as irresponsible mothering rather than a need for a different type of service (See 8.4. for further discussion)

This section has discussed how policy discourses of parental responsibility and ‘risk factors’ appear to have influenced HVs’ understanding on the concept of ‘hard to reach’. Chapter 3 highlighted how, from 1997, government policy developed a broader, social inequalities approach to defining risk, and how this influenced Child Health Policy which began to include a discourse of early intervention, how families with a combination of five or more ‘new social risks’ would mean that some parents may require more help with parenting. Also included in child health policy is the discourse which promotes help-seeking behaviour as normal responsible parenting (DH 2009, DH 2011). These shifting and multi-layered discourses appear to have resulted in unclear guidance and a lack of a strategic approach to working with ‘hard to reach’ in practice. The findings in this thesis suggest that HVs’ understanding of the term ‘hard to reach’ appears to be influenced by the normative attitudes, as expressed in policy documents, in relation to parental responsibilities and help-seeking. The next section will examine the caseload influences on the concept of ‘hard to reach’.

8.2.2 Caseload influences

The data analysis identified several reasons why individual families on a HV caseload may be ‘hard to reach’. For example, women in full-time employment who did not attend for appointments were included, as a group, as meeting the HVs’ criteria of ‘hard to reach’ . In these instances, the HVs were concerned because the children were described as being at risk of missing out on routine health reviews. This finding demonstrates how the term had a very broad application and could be used to describe almost any family, given the right circumstances, which would then make it difficult for individual HVs to target the service to the ‘most disadvantaged’ in a universal service.

This strongly suggests that HVs conceptualised the term broadly to describe both individual clients and groups of clients who were difficult to reach and engage with in routine health visiting. In this respect, the concept of ‘hard to reach’ was not a useful tool for practitioners to use to develop their practice in addressing health inequalities. Subsequently, many HVs were critical of the term; they perceived it as an unhelpful label applied to families living in disadvantaged areas. This criticism of the term by providers of services has been found in other

studies (Doherty 2004, Barrett 2008) and, as with other studies into the concept (Doherty et al 2003, Barrett 2008), this current study was unable to develop a single definition of the term.

Doherty et al. (2004) took into account the diverse views of service providers and developed a typology with three broad definitions of 'hard to reach' which demonstrated the great diversity of clients within the umbrella term of 'hard to reach'. Doherty et al. (2003) described three types of 'hard to reach' families (see Chapter 4.3.1) who were eligible to attend the 'On Track' programme. Whilst Doherty's typology informed this current study, the typology was concerned with client engagement in a new service and recognised the difficulties services were experiencing in achieving client engagement. Doherty's typology could be applied to health visiting. For example, Type A - defined as the 'traditionally underrepresented' - could apply to homeless families who did not keep appointments or engage with the health visiting services. Type B - a hidden population - could describe a small number of clients within a general caseload, such as new migrants or teenage mothers. Type C - 'resistant' clients - have been described in many studies examining HV practice (see Chapter 4). However, Doherty et al.'s (2003, 2004) typology does not appear to contain the relational aspects of the barriers or facilitators at the interpersonal level, a core component of health visiting practice.

In this current study, front line practitioners were consulted on their perceptions and experience of the service. HVs discussed 'hard to reach' clients at the individual 'micro' case level and identified how the term was difficult to define in a meaningful way: instead it was considered a 'nebulous' term, being applied in many different ways depending on the context of the HV caseload and experience. Clients discussed their perceptions and experience of the service, and encounters in the Well-Baby Clinic were observed. The extensive literature review and subsequent analysis revealed how, in the context of health visiting, the term appeared to be an umbrella term for groups of clients who did not engage with services as they were being presently provided. The process of analysis has attempted to capture these multiple definitions and this has led to the development of the typology of the reach of health visiting.

8.3 Development of the Typology

Hammersley and Atkinson (2007) describe typologies as a means to organise and demonstrate the descriptive categories that have emerged from the data. In this study, it was not possible to arrive at a single definition of hard to reach that captured the multidimensional nature and application of the term. The emergence of the four types captured the wide variations in client

engagement at the micro or interpersonal level within the culture of health visiting. The typology developed from the accounts of the participants and represented how the perceptions and experience of clients and HVs affected the acceptance and delivery of the health visiting service. The data analysis revealed the strategies undertaken by individual HVs and clients in engagement/avoidance, and the typology captures the variation in perceptions of clients living within an area of disadvantage. As a result, the typology begins to explain the barriers and facilitators and the current reach of health visiting practice within an area of disadvantage. Yin's (2003) case study design argues that one goal of a case study is to build an explanation that fits with the findings of the study. The typology demonstrates the reach of health visiting and, in particular, highlights the engagement of clients in partnership with HVs. This then leads to the discussion of the typology within the research literature on engagement and partnership in health visiting

8.4 Successful approaches to client engagement

The typology includes the category 'easy to reach'. This was an important finding as this client group was identified within the case study amongst families living within a disadvantaged area. Furthermore, understanding why clients do use the service helped to gain a greater understanding of the barriers and facilitators of the delivery of the health visiting service in an area of disadvantage. The construct of 'easy to reach' served as disconfirming evidence of 'hard to reach' and, as such, enabled further and deeper understanding of the barriers and facilitators to client engagement. Luker and Chalmers (1990) in their work on client engagement briefly mentioned how building relationships with clients was on a continuum from easy to difficult, and described how to build a successful relationship with clients who are able to accept the health visiting service.

Since Robinson's (1982) seminal evaluation of HV/client relationships, many studies have concluded that client engagement and participation is enhanced by collaborative relationships, and is concerned with empowering clients to feel in control during interactions with HVs (McIntosh and Shute 2006). Since 1982, HV literature has developed a body of knowledge on the qualities required by HVs to enhance relationships (Robinson 1982, Kendall 1993, De la Cuesta 1994, Mitcheson and Cowley 2003, Jack et al. 2002, Bidmead 2013). The recent review into key HV interventions, process and outcomes for children (Cowley et al. 2013) identified how a salutogenic approach of 'valuing the person' was a core feature of health visiting practice. It

described how this approach was aided by HVs proactively seeking out health needs and working with the family to address those needs. This approach appears to relate to client engagement: Jack et al. (2002) describe successful engagement happening when 'mutuality' is achieved between the client and health practitioner. They define mutuality as:

"an alliance created between the practitioner and the client and it occurs when the client feels respected and valued for their contributions" (Jack et al 2002).

This definition of mutuality appears similar to the concept of synergy described in this current study (see Chapter 8.5). Mutuality and synergy also alludes to the work required by clients and professionals to build and develop relationships. Client engagement appears to be a crucial first step in partnership work and the typology of the reach of health visiting lends greater understanding to how the characteristics of clients and HVs can build or can be a barrier to engagement.

8.4.1 Partnership and health visiting

As discussed in Chapter 4.1.1 above, there is a long history of the health visiting service being set within a model of partnership, and the importance of a relationship as the basis of health visiting work (Robinson 1982). The 1970s saw an increasing emphasis on client participation to promote health (WHO 1978), and the development of a more equal partnership between the HV and the client has been strongly advocated (Goodwin 1988, Mitcheson and Cowley 2003, Bidmead and Cowley 2005a). This has been endorsed by the medical profession (Hall and Elliman 2006) and by many HV researchers (Kendall 1993, Bidmead and Cowley 2005a).

In all aspects of the present study, the HV informants discussed working in partnership with clients to promote health. Furthermore, HVs appeared to define the term 'hard to reach' in relation to the reach of partnership work. Partnership work is the espoused model of health visiting (see Chapter 4.1.1) and is based on developing relationships with clients. Whilst partnership in health visiting is an expected part of the HV's role, how it happens in practice remains unclear (Bidmead and Cowley 2005a). In the current study the level of partnership and participation by clients was found to be varied, and will be discussed in relation to the reach of health visiting.

Empirical health visiting research has strongly promoted a universal, relational approach (Chalmers 1992, de la Cuesta 1994, Elkans et al. 2000, Cowley et al. 2013), where

relationships with clients are built, and services and support are provided over time. The focus of relational health visiting research has been on the proactive engagement of clients in order to develop a therapeutic relationship and promote health in response to the families' identified health needs (Luker and Chalmers 1990, Kendall 1993, Jack et al. 2005). Research into partnership work with clients has mostly focussed on home visiting and has promoted the importance of time to build trust and encourage participation and partnership with clients.

To develop a proactive partnership approach, HVs are encouraged to develop interpersonal skills, traditionally associated with caring and empathy (Bidmead et al. 2002, Bidmead and Cowley 2005a, Kirkpatrick et al. 2007). Alongside this research there is a growing body of evidence-based knowledge developed by the medical profession (Hall 1996, Davis and Day 2010, Olds 2006) which supports home visitors in taking a partnership approach 'with the most 'at risk of social exclusion' (DH 2009). This medical research argues that the personal style and attitude of home/HVs is paramount for the development of a 'helping relationship'. Subsequently, a caring and empathetic role has been described as essential to build a trusting relationship with clients (Davis et al. 2005, Barlow et al. 2006, Kirkpatrick et al. 2007).

The Family Partnership Model (Davis et al. 2005) emphasises the need for home visitors to demonstrate qualities of empathy, respect and humility in order to establish partnership working, and for parents to feel supported and able to ask for help with issues they have identified (Barlow et al. 2005, Kirkpatrick et al. 2007). The partnership model in health visiting (Bidmead and Cowley 2005a, 2005b) is similar to the Family Partnership Model (Bidmead et al. 2002, Davis and Day 2010): both are based on Rogerian psychotherapy. In this technique, HVs encourage participation by taking a non-judgmental approach demonstrated by genuineness, empathy and unconditional positive regard toward a client. Clients are thus encouraged/empowered to find their own solutions to their problems. In this current study, whilst HVs discussed partnership in Rogerian terms, this model appeared to be subsumed within a deficit model of health, which appeared to allow a degree of client participation but also involved the HV in persuading and encouraging clients to adopt certain health behaviours.

In the Family Partnership Model (Davis et al. 2010), the HV is described as being situated within a 'helping process', and specialist training was given to those HVs participating in the home visiting study (Kirkpatrick et al. 2007). The HVs in the current study were also observed to be carrying out partnership work in terms of recognised female qualities of caring and empathy, aiming to put people at ease. In some encounters this approach appeared to be achieving

'mutuality' (Jack et al. 2002) and 'valuing the client' (Cowley et al. 2013) and the reasons for this will be examined.

8.4.2 Partnership and Participation

As discussed in Chapter 3, health promotion is central to health visiting. Health promotion has been described as being based on a dialogue, involving people as they make decisions about their health supported by professionals (Naidoo and Wills 2005, Eriksson and Lindstrom 2008). To achieve client participation through an enabling partnership approach is important (Kendall 1993). Bidmead and Cowley's (2005b) definition of partnership also relates to the attribute of 'participation'. Other health visiting research (Appleton 1996, Bidmead et al. 2002, Appleton and Cowley 2003) has also demonstrated how client participation is essential to both partnership and health needs assessments. Partnership is advocated as an approach that will lead to client participation:

"However, there seems little doubt that health visitors who are given the opportunity to develop a more open style of working can enable partnership working, client participation and the identification of needs" (Mitcheson and Cowley 2003 p.423).

The majority of the health visiting literature appeared to place the responsibility of engagement onto the health professional. At the onset of the study there was little literature found on the role of the client in health promotion work. The findings in this current study have identified the important role that the client plays in the development of the relationship and the client qualities as a very important factor in engagement in the clinic. The emergence of the four types within the typology identified a range of client qualities that enhanced or acted as a barrier to engagement.

8.5 Qualities in the client that enhanced participation

The emergence of the type of 'easy to reach' was important for two reasons. Firstly, it provided evidence of how clients living in an area of disadvantage were a diverse population, and not all were 'hard to reach'. Secondly, 'easy to reach' clients had qualities that appeared to enhance the practitioner-client interaction. In the Findings Chapter above, I referred to observing synergy in the co-encounters: this was when the HV and the client demonstrated a connection. For

example, sharing a similar parenting culture appeared central to enhancing client participation and engagement. Gee (2005) describes this as sharing sign systems and knowledge.:

“Sign systems and knowledge: in any situation, one or more sign systems and various ways of knowing are operative, orientated to, and valued and disvalued in certain ways” (Gee 2005 p.101).

This way of knowing was described as synergy in my study and is defined as:

“Joint working, co-operation”. (OED 2009)

This definition was chosen as it appeared to fit with Bidmead and Cowley's (2005b) definition of effective partnership working and also implied shared values and a way of working together.

8.5.1 Help-seeking

The client viewing the health visiting service or clinic as helpful was a facilitator to client engagement. This helpfulness was demonstrated in the current study when a client identified a problem and attended clinic to ask for help; or when clients were actively seeking advice on the latest evidence-based guidelines on child rearing. The service being perceived as helpful has been identified in other studies in universal health visiting in the clinic (Mayall and Foster 1989) and in the home (Appleton 1996, Roche et al. 2005).

The role of a parent in the Well-Baby Clinic also involved being able to identify problems with their child's health or well-being. This approach assumes parental knowledge of child development and, more importantly, attendance at a health clinic to discuss concerns. The activeness and agency of the client is now recognised in health policy as a protective health factor (DH 2009). In this current study, engagement was achieved in the Well-Baby Clinic when clients appeared to understand the role of the health visiting service as supportive. The 'easy to reach' 'made sense' of the clinic as a source of help and advice in relation to physical health or ill health and support for coping with being a new parent. In these instances, clients appeared to be able to seek help and discuss their concerns with the HV, who responded in a respectful, meaningful way (Pearson 1991, Jack et al. 2005). Clients attended with questions relating to their child's ill health or behaviour associated with feeding and sleeping. Here the HV's role was to give advice in relation to the presenting problem, which might include promotion of evidence-based practice in relation to weaning or infant feeding. In the clinic the main role of the HV was

to facilitate the health needs identified by clients which fits in with the first principle of health visiting - the search for health needs in partnership with the parent:

“Searching for health needs is therefore an activity that should involve ‘working in partnership’, recognising that clients as well as health professionals, may be equally knowledgeable in finding identifying and solving health issues” (Chalmers 1993).

When this occurred, synergy was observed between the HV and the client, albeit in a very traditional model of health, the deficit model of health.

The deficit model of health has been defined as being concerned with problems at the individual and population level (Morgan and Ziglio 2007). As a result, this model promotes the search for health needs in relation to problems or deficits. When clients were help-seeking, or when health issues or problems were identified by clients, the HVs would respond by listening to the presented concerns of the parent and offering advice or suggesting a solution. The focus was often on the physical health of the child - in response the HV would offer advice, write a medical prescription, refer the child for vision or audiology screening, refer the client back to her GP or HV or offer the support of services within the vicinity.

8.5.2 Communication skills

The Findings Chapter demonstrated how the communication skills of an ‘easy to reach’ client positively influenced the co-encounter. By communicating their children’s health needs, clients in the study were in general actively participating in the encounter. I called this ‘health talk’, a certain way of talking in clinic that was recognised and used by those ‘easy to reach’ clients attending clinic. In the Findings Chapter, I demonstrated this through ‘easy to reach’ clients’ use of the ‘language of the clinic’, how they would discuss their child’s health problems using medical or nursing terms. The HVs in a recent study into effective relationships (Bidmead 2013) also recognised the importance of clients having good communication skills. The ‘easy to reach’ client appeared to view the health visiting service as a resource. They were able to access the support because they were able to articulate their need for help in the public or formal space of the Well-Baby Clinic.

The initial hypothesis in the case study stated that the health visiting service was a resource to families living in disadvantaged areas. The development of the ‘easy to reach’ client implied that

many families were able to access and participate in local services because they made sense to them as a source of help. The HV appeared to be the first port of call for several clients in the study who attended regularly and, similar to other studies (Mayall and Foster 1989, Appleton 1996, Roche et al. 2005, Bidmead 2013), clients attended because they were able to communicate their specific health needs, and in response they received support and reassurance in their parenting.

8.5.3 Trust and reciprocity

Parental trust has been identified as a key factor in relationship building, and parental trust resulted in reciprocity in the interaction between the client and the HV in the clinic encounters. Health visiting research in the home (Chalmers 1993, 1994, de la Cuesta 1993, 1994, Jack et al. 2005) have also evidenced trust and reciprocity as qualities that enhance health visiting relationships with parents. Bidmead (2013) explained how giving and receiving is a well-known way of explaining reciprocity in the health visiting process. Chalmers (1992) described how giving and receiving in HV/client encounters was a way of ameliorating power within relationships. A client sharing information about her situation and being listened to by a HV is an example of reciprocation. Conversely, the HV or client withholding information can be interpreted as a form of control and non-engagement (Chalmers 1992). In the current study, reciprocity was observed as 'giving and receiving' between the two agents in the 'easy to reach' encounters. Reciprocity was marked by the HVs responding to 'easy to reach' clients by taking time to listen, and encouraging the client, often a first-time mother, to voice her concerns and thus feel in control.

8.5.4 Feeling in control

Feeling in control of consultations with professionals and the help they are receiving has also been described as a key factor in clients engaging with services (Billings and Cowley 2005, Jack et al. 2002). In a partnership approach the aim is for the client and health professional to achieve a more equitable relationship (Bidmead 2013). In this current study, 'easy to reach' clients were able to engage with the HV when the client felt in control. For example, attending for weighing often resulted in problems or questions being asked and could be described as an initial or entry level of participation as the client was asking for help in adapting to parenthood, a traditional use of the health visiting service.

In these instances, 'easy to reach' parents were help-seeking in line with government policy in order to support their practical adjustment to parenting. Jack et al. (2002) described how vulnerable women in their study would weigh up the unknown risks of participating against their need for support, and develop strategies to protect themselves from the risk of engaging with health services. Asking for help with practical or physical problems appeared to be a strategy employed by clients in the current study. 'Easy to reach' clients were accessing the health visiting services as a means of support, with problems, or for parenting advice and reassurance from a service they understood and trusted. Both clients and health visitors shared similar beliefs on child development and care.

'Easy to reach' clients appeared to value and trust the HV role and were at times able to extend their requests for help. On occasion in the Well-Baby Clinic, the HV was approached for requests for help in accessing other parts of the health services. This has been called fringe work (De la Cuesta 1993), activities that involve giving the client a service outside of the normal remit. In this current study it was used by HVs to improve access to other health services, for example, by the HVs advocating and negotiating for clients who had asked for help with a medical issue over which they felt they had little control.

8.5.5 Language as a resource

The 'easy to reach' client was often a first-time mother, perhaps living away from their traditional support networks or who was the first of their family to breastfeed. These clients were often parents who were coping with new challenges in their lives - either becoming a parent for the first time, or experiencing a problem with their child's behaviour or ill health. In the clinics they would often discuss their support networks and how they were able to access resources that would best meet their needs in this new situation. Often 'easy to reach' clients appeared not to be the most disadvantaged in the area. During consultations support networks were discussed and these could include work, their attendance at other local groups, support provided by the NHS, voluntary organisations or Children's Centres, or by their extended family who were involved in their day-to-day lives.

In the USA, research into family assets and resources in disadvantaged families (Orthner et al. 2004) is attempting to understand why some families are able to access services and are 'easier to reach' than other low income families. Some UK studies (Cowley and Billings 1991, Belsky et al. 2006) have acknowledged how wider family resources appear to enhance access

and participation in universal children's services; yet these UK researchers were unable to explain how or why those resources helped families. The current study uncovered families living in an area of disadvantage who had good communication skills with health professionals, who carried out health surveillance for both physical and emotional health, who asked for help and trusted the advice they were given. They were also much more likely to access support from a range of sources including family, friends, health professionals and Children's Centre staff. Orthner et al. (2004) identified the importance of families having good communication skills, a connection to community services, social support and access to additional economic assets such as child care grants. Having these assets meant that clients were more able to meet their families' needs to promote family well-being: these findings have also been demonstrated in this current study.

'Easy to reach' clients appeared to find formal services helpful in developing and managing the transition to parenthood. Examining the concept of 'hard to reach' has highlighted how the delivery of the universal aspect of the health visiting service, the Well-Baby Clinic, was very dependent on clients' perception and experience of statutory services. If clients had the qualities described in the 'easy to reach' type, they appeared to be more likely to carry out self-surveillance and to ask for help, and to make sense of the service as helpful and supportive. In these cases, partnerships formed through a friendly empathetic manner from within a biomedical model of health care was very successful in reaching some clients who met the expectation of the health visiting policy and practice.

Many 'easy to reach' clients participated in the clinic with a wide range of health needs, from seeking help with building their knowledge to accessing a supportive service for reassurance. For the majority of the time HVs gave advice on the presenting problem. This resulted in the HVs responding to the health needs of clients - working with a group of clients who were considering behaviour change and health promotion - because they were able to do so. However, it meant that the focus of the clinic was on individual health needs and was dependent on clients' help-seeking advice from the service. The development of the typology also recognised that some families found approaching the health visiting service for help was more problematic.

8.6 Emotionally ‘hard to reach’

The previous section aimed to explain how ‘easy to reach’ clients were able to participate in the health visiting service. In contrast, the term ‘hard to reach’ related to a disconnection from services. HV informants described some clients as ‘emotionally hard to reach’. In this current study, Gee’s method of discourse analysis was instrumental in highlighting how this dissonance or ‘blocking’ of conversations was in part due to the many influences on the HV and client. The identification of the type of ‘emotionally hard to reach’ clients can begin to explain the influences on the reach of partnership and participation within an evidenced based model of health. This section will discuss how the type of ‘emotionally hard to reach’ brings together and develops health visiting literature about barriers to client engagement in face-to-face encounters. This type was found to occur in the encounters where the health promotion and assessment role of the HV resulted in dissonance. This occurred in three ways: in the presentation of the client to the HV; in the different perspectives held by HVs and clients in relation to health promotion; and in the wider contextual influences on health promoting practices.

8.6.1 Presentation of the client

Client engagement appeared more difficult when clients’ experienced and perceived the health visiting service as an authoritarian service; in these instances, clients appeared to have developed strategies to help them to cope with the HV service. For example, as demonstrated in Figure 14 (p.162), clients would attend the Well-Baby Clinic with another person, a family member, a friend or other children. In the current study, when this strategy was observed in the clinic, it appeared to work positively for the client because the HV listened and responded to all parties in the encounter. In their home visiting study, Jack et al. (2002) described how involving a family member was a strategy used by clients to protect themselves in situations when they were unsure of the purpose of the home visit. They felt that the health professional would be less likely to judge them or make negative comments about their parenting when a supportive family member was present, and so felt safer.

Another strategy seen employed in this current study was for a client to attend the clinic ‘just for weighing’, a way in which clients could publically demonstrate their care for their child. The point of entry to the clinic room and the handing over of the PHCR became a key focus of my analysis because, at this point, the majority of ‘emotionally hard to reach’ clients actually were interested in their child’s weight. The number of clients who attended the Well-Baby Clinic ‘just for

weighing' was of interest because it was unexpectedly common. The HCP (DH 2009) supports the physical, emotional and social health of children. In the area where the study was based parents attended initially for weighing and this behaviour was noted by the locality GP-based HVs as very different from that seen in other clinics. The category of 'emotionally hard to reach' clients developed because it indicated a partial or tentative partnership between HVs and their clients, a partnership concerned with physical health. When the HV tried to encourage help-seeking, either by health needs assessment or by giving advice, they often met with resistance and the health advice was 'blocked'. Blocking of HVs' attempts to engage with clients has been found to be a barrier to client engagement in the home:

"some clients may permit entry into their homes but not permit the health visitor to carry out much of the work that she has come to do" (Luker and Chalmers 1990 p.75)

Reasons for the lack of client participation with the HV service are well known. Health visiting has been perceived as a form of social control or surveillance of their parenting (Dingwall 1977, Robinson 1982, Bloor and McIntosh 1990, Peckover 2002, Mitcheson and Cowley 2003), or as judgemental (Kirkpatrick et al. 2007, Audit Commission 2010) rather than as the helping service it strives to be (Broadhurst 2007). In support of these previous research findings, 'emotionally hard to reach' participants who attended the Well-Baby Clinic also appeared to have a negative sense of the health visiting service.

As a result, clients in this current study appeared to be actively limiting the reach of the health visiting service during the actual consultation. In clinic encounters, 'emotionally hard to reach clients' would engage with services tentatively, choosing how and when to attend and participate. This was achieved by maintaining an outward appearance of coping, or by knowing and participating in the clinic procedures and limiting the conversation to their child's physical health. Peckover (2002) and Jack et al. (2002) discuss similar strategies that were used in their studies to reduce involvement with home visiting services.

8.6.2 The different perspectives held by health visitors and clients in relation to health promotion

One area in which this tentative or partial participation was most noticeable was in the clinic encounters where the latest infant weaning practice was introduced by the HV. If the client had

started to wean her child earlier, the HV's advice was being offered at the wrong time and was therefore resisted. This practice can be viewed as an example of a cultural barrier to health promotion and to the development of relationships

Social barriers have been defined as the institutional or cultural structures known to prevent participation in services (Katz et al. 2007). In health visiting, these barriers have related to parenting in poverty (Blackburn 1996) and cultural barriers have also been identified in child care and parenting advice (Bloor and McIntosh 1990, Mayall and Foster 1989, Barlow et al. 2004). It is well recognised that most child care advice originates from middle class parenting values which do not recognise different cultural attitudes towards child rearing (Edward and Gillis 2004). Bloor and McIntosh's (1990) research explained how working class women's resistance to the advice of HVs was due to their holding different parenting views. This ideological dissent occurred when participants considered mothering to be a practical and common sense skill, developed through experience under the guidance of close female family members. Pearson's (1991) work into health beliefs also demonstrated how holding different health beliefs led to dissonance and failure to make a connected relationship.

In this current study, one area of contention occurred when HVs offered unsolicited evidence based advice on the subject of infant nutrition. As previously stated, the clinic appeared to have a traditional function as a place to promote certain health behaviours through health education. In these instances, client participation was an opportunity to achieve behaviour change in line with government policy rather than a just health dialogue (Eriksson and Lindstrom 2008). Oakley (1989) and Hall (1996) describe this as persuasion, a professionally-led initiative where clients are supported in behaviour change initiatives in the area of breastfeeding support, and infant feeding initiatives were promoted through discussion and the handing out of leaflets. A weakness of this approach is that it appeared to blame the client for their failure to respond to the latest health advice and ignored the cultural and social factors behind the choices being made.

8.6.3 The wider contextual influences on health promoting practices – difficult work

Chalmers (1994) seminal study discussed HVs' construction of difficult work. A difficult situation was defined as:

“an interaction with a client in which the health visitor experienced problems in trying to carry out the work of health visiting as she considered it needed to be done.” (Chalmers 1994 p.171)

The clients in Chalmers' study were described as 'blocking' the attempts of the HV to discuss the work the HV considered necessary. In the Well-Baby Clinic, difficult work occurred when the HV and client had different understandings of the provision of the Well-Baby Clinic and different beliefs in child rearing. Two vignettes have been constructed from the field notes and findings from the clinic encounter (Figure 22, p.222, Figure 23 p.226): they have been devised to represent the factors that can act as barriers to communication in the HV/client encounter. The first vignette aims to demonstrate how 'blocking' or resisting health advice can occur: in this instance, the client is given unsolicited information on weaning foods after she had mentioned that she had begun to introduce family foods. The unsolicited advice-giving by the HV appeared to challenge Jean's presentation as a 'good mother', one who had brought her child to the clinic to be weighed because a weight gain would confirm her success as a mother.

Figure 22: Emotionally 'hard to reach'

Jean was a 23-year-old mother who had three children. She was attending clinic to have her son Henry weighed. As she was dressing her son, she spoke about how she was involved with Social Services and legal services with regard to her eldest daughter and how she had little family support. She had no health concerns about Henry and she informed the health visitor, whom she had never met before, that her 17-week-old son was fully weaned. When the health visitor advised her to go slowly with the weaning, Jean responded by saying how much her son was enjoying her food, how she had introduced her eldest daughter to solid food at this age and her partner also encouraged it. She also mentioned how she had received promotional deals through the internet for money off vouchers on baby foods from four months. Jean was happy with her son's weight gain.

A successful weight gain was required to provide proof of her ability to mother and may have been requested by the other agencies involved in Jean's family life. She presented to the HV as an expert in her child's needs. Her cultural perception of child rearing appeared to relate to her child's enjoyment - he wouldn't eat if he did not enjoy his food. Jean's action would fit the description given by Bloor and McIntosh (1990) of common sense. This was a very different approach to the HV who, from an evidence-based approach, recognised the health benefits across the life course¹ to weaning at six months.

The vignette illustrates how the encounter was seen by the HV as an opportunity for health education rather than support. However, the advice when offered was politely but overtly resisted by the client, who mentioned her support and expertise for her actions from her informal support network. Lyotard (1984) explains how some people live in complex situations and, because of this, giving health information is far from easy. Instead, giving health advice becomes a struggle where people advance different points of view and try to persuade each other through their language and actions (Latimer 2004). The vignette (Figure 22) is an example of different points of view, how each party is attempting to persuade the other. The HV was using a rational and expert approach; the client was basing her argument on her understanding of previous experience and her child's response. Here, neither party was able to convince or persuade the other of the benefit of their approach. The HVs described these clients as 'emotionally hard to reach'. 'Emotionally hard to reach' meant that the client was physically present but had her own ideas and beliefs which were different from those of the HV and were viewed as a barrier to the latest evidence-based advice.

In the vignette, Jean and the HV attempted to demonstrate their own expertise in the encounter, and dissonance occurred because they held opposing views; and this was in contrast to the give and take observed in the 'easy to reach' encounters. Whilst the process appeared to be client focused, the whole encounter was HV-led. On receipt of the new information the client actively defended her position, and there was no opportunity for a convergence of ideas (Kendall 2003). The barriers to the encounter were cultural and institutional. The parties were meeting for the first time and the HV offered unsolicited advice which related to a public health model of evidence-based practice. Giving standardised advice is known to result in a lack of opportunity for clients to participate (Kendall 2003), especially when the client is feeling alienated because her parenting is being judged negatively (Bloor and McIntosh 1990, Elkan 2000). This shift in a HV from facilitative to authoritarian behaviour has been noted in other studies (McIntosh and Shute 2006) and results in an acknowledgement of the limits of the present partnership approach. It also raises the key question about how to maintain an empowering approach in order to build and encourage client participation with all clients.

Health promotion research (Lupton 1997, Naidoo and Wills 2005) describes how the presentation of an alternative view to health promotion ideals can be viewed as 'risky', a 'wrong' lifestyle choice. Grahams' (1993) research into women smoking demonstrated that there are many different views of risk, and lifestyle choices are made in relation to coping and managing the demands of living in poverty (NICE 2007). Graham (1993) also found how choosing the

'wrong' choice may be viewed by practitioners as lacking in willpower, resulting in the labelling of a client. Naidoo and Wills (2005) argue that the labelling of individuals means that strategies are not developed that would change practice for those parents living in disadvantaged areas. In health visiting, a lack of service evaluation for clients in disadvantaged communities has meant that, rather than recognising the limits to individual behaviour change and the need for a different approach, resisting the latest parenting advice is viewed as irresponsible mothering, as victim blaming, and as a result the responsibility to change remains with the parent.

The HVs in the study were individually trying to implement the latest weaning advice. NICE guidelines (2005) into behaviour change for people living in disadvantaged areas promote a strategically planned approach. In the current study there was no evidence of local planning; instead, behaviour change was being carried out on an individual basis. As a consequence, clients who did not feel listened too would withdraw from the encounter and the client would then not meet the threshold for a more individual service delivery or for their health needs to be identified (Condon 2005, Peckover 2005).

8.6.4 Communication skills

The ability to communicate with family and health professionals is beginning to be considered an important health-promoting skill for clients. Orthner et al. (2004) found within their study that the ability to communicate was unevenly distributed into assets held by disadvantaged families. They discovered that some participating families were not able to, or did not, discuss problems within their immediate family. Consequently, they did not know how to talk about their problems in a meaningful way outside of the family. Evangelou et al.'s (2008) UK study examining disadvantaged parent's attendance at pre-school facilities found families who wanted to attend but who did not appear to know how to engage with services. Evidence from the current study also discovered a variation in communication skills in clients attending a Well-Baby Clinic. This finding has implications for how HVs communicate equitably and encourage interactions with all clients in public and private spaces.

8.7 Physically 'hard to reach'

When clients appeared to 'avoid' or did not attend invited appointments they were described as 'physically hard to reach'. Broadhurst (2007) defined 'hard to reach' as people who did not engage with services, and this was also the most common reason identified by HVs in the data

analysis. The health visiting service is a mix of home visiting and the provision of clinics. HV participants in the focus groups discussed clients whom they did not see either at home or in the clinic, and who they felt avoided or resisted the service. 'Physically hard to reach' was a wide-ranging type: it included working mothers, women experiencing domestic abuse, drug users, traveller families, ethnic minorities and new immigrants. The type of 'physically hard to reach' also included clients who attended for routine appointments but who did not engage with other services, such as clinics or groups provided in Children's Centres. The reasons for this type were multifaceted.

8.7.1 Personal circumstances as barriers to engagement

In relation to non-engagement of services by users, there have been many studies examining barriers to attending services outside the home (Murray et al. 2003, Doherty et al. 2003, Katz et al. 2007). There is a growing body of research explaining why families do not engage with services in health-related services. This often relates to personal circumstance or characteristics, such as not having enough time, or not thinking the service was for them (Kirkpatrick et al. 2007), a lack of education, or being younger (Murray et al. 2003). Self-exclusion from offered extra support has also been noted as not unusual (Murray et al. 2003). Murray's (2003) study into non-attendance for women with postnatal depression indicated that a combination of the above factors made women less likely to engage with health services. Furthermore, structural barriers such as housing relocation (Allen and Bourke Dowling 1998) have also had an effect on service uptake following childbirth. Allen and Bourke Dowling's research begins to explain the complexity of families who become out of the reach of services.

The second vignette in Figure 23 (p. 226) was developed from a combination of client presentations demonstrated in the Findings chapter, and it aims to highlight how not engaging with services may be due to many practical reasons, in this instance, to illustrate how multiple factors and changes in circumstances can prevent a client from attending her recently found support group at the Children's Centre.

Figure 23: Physically 'hard to reach'

Susan was 18 years old and following her son's birth she stayed in hospital for ten days recovering from a Caesarean section. She found the whole experience very stressful and took early discharge to recuperate at her family home. She was visited at home by the health visitor on several occasions and when her son was eight weeks old she agreed to attend clinic for further support. She attended once and was accompanied by her mother who talked to the health visitor and requested help with a problem that resulted in a prescription.

Susan had been offered counselling for postnatal depression but she had decided that it wasn't for her. After being introduced to the Children's Centre outreach worker, Susan began to attend the mother and baby group at the centre, a joint initiative between the Children's Centre outreach worker and the health visitor. One week Susan arrived late and said that she had suddenly moved into temporary accommodation as her ex-partner was harassing her. That day she had taken two buses to get to the Centre. She felt it was important to attend, describing the group as being part of her routine. However, this was her last attendance as she was moved to new accommodation and it was too expensive to attend any more.

The vignette describes the complexity of life events that can occur and were evidenced for families during the current study. This current study also discovered that some families did want to engage with services but were prevented from engaging because of their changing circumstances over which they had little control. Being ill or moving into temporary accommodation are two life events that are beyond the control of the individual, yet they greatly affect the ability of individuals to participate in normal day-to-day activities.

The concept of 'new social risk' is useful in understanding how structural factors can affect how clients engage or do not engage with services. Neale et al. (2007) suggests that, rather than risk factors being static, they are multidimensional and dynamic. So, whilst factors or problems (lack of stable housing, poor health, poverty) exist, they can also help us to understand how multiple factors can cause further social exclusion. Models explaining how these social factors can affect individuals are well known in health visiting. For example, Bronfenbrenner's (1979) ecological model of health is a way of understanding how many factors can affect a child's health and development. The model has been adapted in health visiting to improve relationships between individuals, local communities and neighbourhoods (McIntosh and Shute 2007).

Including an explicit model of wider influences on health is proving highly successful with vulnerable disadvantaged clients in improving client engagement in research studies (Barlow et al. 2005, McIntosh and Shute 2007, FNP 2010), yet it appears to be difficult to achieve in everyday HV practice (Peckover 2003, Barlow et al. 2005). This may be because there is a moral aspect

to help-seeking which also acts as a barrier to families who already have experience of social exclusion.

8.7.2 Moral aspect to help-seeking

Broadhurst (2007) describes how help-seeking in policy contexts is viewed as a purely rationale decision-making process and she argues that this had resulted in a neglect of the moral aspect to help-seeking. Edwards and Gillies' (2004) research into working class families has identified how help-seeking for emotional problems is different from help-seeking for physical health. Whilst working class families may seek professional help with physical problems, emotional problems were addressed within the wider family (Edwards and Gillies 2004, Broadhurst 2007). This current study discovered a cohort of parents who described themselves as 'self-sufficient parents', who would turn to family and friends for help and support with their parenting issues rather than use outside agencies. Cowley and Billings' (2001) research into HV clients' resources and help-seeking behaviour also found that family members were considered as very important resources for help and advice. Peckover's (2003) study into women experiencing domestic violence highlighted how being self-sufficient in a disadvantaged area was not necessarily synonymous with having a supportive network and could lead to isolation. Similarly, not all participants in the present study were able to access family support or attend clinic for support.

Gillies (2005) argues that disadvantaged families are described negatively in policy documents, and as disconnected from mainstream values and aspirations and this is caused by a lack of individual agency rather than by parenting in adversity. Often families who do not engage with services are described as the most vulnerable and the most disadvantaged, and are increasingly the focus of government interventions (Chapter 3 above). Yet this study interviewed a range of clients living in a disadvantaged area who worked but were 'physically hard to reach' because they did not help-seek or engage in the more public aspects of universal services, such as clinics or other activities provided by the Children's Centres. They would attend only for routine appointments.

These informants discussed how they would seek help first from their own social networks. Interestingly, these participants would meet the Coalition government's description of 'hard-working families'; for example, the women who were full-time mothers were very busy taking

children to and from school, or to have contact with their fathers, or to attend hospital appointments.

8.7.3 Stigma attached to universal services

The provision of targeted universal services has resulted in a reduction of universal home visits, an increase in targeted work, and more surveillance of families in disadvantaged areas (Canvin et al. 2007, Peckover 2011). Families living in disadvantaged areas are often aware that they are 'at risk' of being judged negatively. As a result, universal services may be viewed as critical rather than supportive (Power 2005, Canvin et al. 2007, Peckover 2011). Canvin et al.'s (2007) study into individuals living in a deprived area found that the prevailing view amongst participants was that encounters with public services were 'risky'. For many of the interviewees and participants in this current study, health visiting and the Children's Centre were also viewed as 'risky', because they might be reported to social services or judged as being 'bad' mothers, or seen as having 'postnatal depression'.

The small cohort of women interviewed in this study perceived statutory services as being for 'others', families with '*problems*', '*teenage mothers*' or '*older mothers*', and therefore not for them. Interestingly, as in Bloor and McIntosh's (1990) study, they described the HV's role as involving social control, '*checking up*' on families. They viewed HVs as providing a necessary service of child protection, '*doing their job*' or as experts who '*told you what to do*'. Some of the informants in the interviews described experiences with health professionals where they had felt blamed and judged for a child's illness. As a result they avoided services and resisted attempts by the local HV to engage them in partnership work (as described in the Findings section). As in Bloor and McIntosh's typology (1990), they would resist the service through concealment and avoidance.

They also perceived themselves as self-sufficient families, capable of promoting their family's health without any professional help. Whilst all the participants knew how to contact the health visiting service, they would first ask family or friends, or would 'check out' the internet. They appeared to be employing strategies to protect their families and to sustain their health and wellbeing within the constraints of living in poverty (Graham 1996, Orthner et al, 2004). One of the strategies mentioned was support from family members who lived nearby. Several of the informants interviewed also mentioned that they did not receive any extra financial support. Orthner et al. (2004), in their USA study into the resilience and strengths of low-income families,

discovered how working, low-income working families were less likely to seek help because they did not know what help they needed or were entitled to. They were also worried about invasions of privacy. Orthner et al. (2004) advised that services for low-income families should be more proactive in informing families of the support available. Their research identified the importance of a safety net of services in supporting families. Services that provided practical financial support and help to low-income families were identified as being especially important to families who were in low-paid work.

Being 'physically hard to reach' and avoiding services has been shown to have direct and indirect consequences for the health of disadvantaged families. Direct consequences may result in children not receiving immunisations or developmental reviews (Hall and Elliman 2006). An indirect consequence may be that parents are not aware of childcare opportunities or financial help for families on a low income. Peckover (2011) explains that the aim behind the development of a progressive universal service was the early identification of families. This aim may be difficult to achieve if parents do not access services voluntarily because they see the service as labelling and stigmatising. However, as with this current study, research into family assets (Orthner et al. 2004, Syvertsen et al. 2012), discovered that respondents from low-income families that had become established in a community were not socially excluded but instead reported to be functioning well.

8.7.4 Invisible work

The typology developed by Doherty et al. (2004) became a strategic planning tool used by providers of 'On Track' to tailor their service to reach previously unreachable clients. In the current study, HVs discussed different strategies that they had developed individually to engage with families, and these varied according to circumstances; they ranged from more home visits, to having a named HV, or to texting to remind 'chaotic clients' of appointments. These strategies were reported as being met with some success. HVs were also aware of how social circumstances, such as moving house or living with a partner who was critical of formal services (Robinson 1982), may be affecting a client's ability to attend, participate or help-seek in a clinic environment. The gendered nature of health visiting work, carried out by women and often in the home, has been recognised as a factor in making this work invisible (Peckover 2011). In the current study the gendered nature of health visiting meant often resulted in individual HVs developing time-consuming strategies that were not recognised as essential aspects of relationship building for families living in adversity; this requires further investigation.

8.7.5 Health needs assessment and community approaches

There is growing recognition that community development work is an important way to improve health outcomes (Bryar and Orr 2012, Cowley et al., 2013). In the past individual HVs undertook a health needs assessment (HNA) or community profile of their locality and were able to develop a more tailored service from the evidence it provided. The focus on individual core work and increased caseloads size has meant that there has been reduced time for HVs to carry out community development work and strategically develop the service from the bottom (Bryar and Orr 2012, Cowley et al., 2013). The HVIP and recent investment in Continued Professional Development (DH2011, 2013) aims to support HVs regain or learn new community development skills. In this current study the data analysis identified that the majority of HV clinical time was taken up with working with individuals. With 'emotionally hard to reach' and 'physically hard to reach' individual ways of working were not proving effective. Yet strategic individual or community 'bottom up' approaches to commonly identified issues that would improve the reach of the universal health visiting service were not being developed.

8.8 Services are 'hard to reach'

The health visiting service has undergone an extensive redesign and has changed from being a universal home visiting service to a progressive universal health promoting service (DH 2011). Its aim is to deliver:

- Community: This level is concerned with building community capacity to improve health outcomes and lead the HCP for a population
- A universal service to all families with children under the age of five years.
- A universal plus service that includes 'packages of care' for clients with identified health needs such as postnatal depression.
- Universal partnership plus, for families at risk of social exclusion, to promote parenting (Olds 2006, Barlow et al. 2008, DH 2009, DH 2011).
- Child Protection

In this current study, clients living in an area of disadvantage had improved access to the service through a universal Well-Baby Clinic-based system. This has led to the identification of the health visiting service as a 'helping' service there to help and respond to parental requests for help with their parenting issues or child health problems.

This shift in the delivery of the service appeared to be redefining the health visiting service within the Clinic as one concerned with 'problems' either defined by the client or defined by public health. The Well-Baby Clinic appeared to have a traditional function as a place to promote certain health behaviours through health education, and client participation offered an opportunity to achieve behaviour change in line with government policy rather than as a health dialogue (Eriksson and Lindstrom 2008). Oakley (1989) describes this as persuasion, a professionally-led initiative where clients are supported in behaviour change initiatives; in this area breastfeeding support and infant feeding initiatives were promoted through discussion and the handing out of leaflets which, whilst welcomed by some, also appeared to result in some clients not attending. A further limitation of the study was that the clients interviewed who did not attend clinics were not asked about their infant feeding methods. This should be included in other studies to determine whether the promotion of breastfeeding was perceived as helpful to all clients in an area.

8.8.1 Fragmented service

In relation to the recent development of the health visiting service, the period immediately before and during this study was a demoralising time for HVs. This was evidenced by the falling numbers of HV practitioners and the developing evidence base which only supported the provision of a minimal or core service (Cowley et al. 2004). These changes to practice have led to the HCP being criticized as a lean programme, reliant on parents accessing the service (Broadhurst 2007). Furthermore, as Children's Centres and increased provision for the under-fives developed, health visiting was at this time recognised as losing its support from government (Cowley et al. 2004).

It was also noted that, despite the growth in evidence of the importance of early child development to future health (Acheson 1998, Marmot 2010, Allen 2011), health visiting as a service was struggling to define itself as an effective, broad based, generic public health service (Lowe 2007). Research into access to midwifery services (Garcia et al. 2003) demonstrated how families living in disadvantaged areas experience and use formal services in a very fragmented way. Murphy (2010) explained how health visiting practice is not a continuous form of health surveillance; instead, it relies on families contacting or accepting the service. She argued that a strength of a universal home visiting service was that it was convenient for many families living in disadvantaged areas. In recent years there has been a reduction in the service away from routine home visiting to a delivery of a core service, with families encouraged to

access local clinics with their problems. A barrier to partnership work and client participation identified was the fragmented nature of the service and how access to the HV service was through the Well Baby Clinic or by telephone. Consequently, while improving local access to the health visiting service, the lack of additional organisational support for an extra clinic in the area had resulted in the service being staffed by a variety of HVs. The fragmented nature of the service was felt by HVs to be reducing the effectiveness of the service and several encounters with vulnerable clients appeared to be hindered by the HV and client meeting for the first time.

Up until 2010, it was recognised that there had been a lack of government support for health visiting (Cowley et al. 2004, Condon 2009), and there has been little commissioned research into health visiting (Elkan et al. 2000, Bidmead and Davis 2004, Cowley et al. 2004, Cowley et al. 2013) or on how to work with 'hard to reach' families. Perhaps as a consequence of this, there was little evidence or insight from practicing HVs into how health visiting services were difficult to access, or examples of how services were being evaluated with clients living in disadvantaged areas. Instead, HVs would tell valedictory stories of how they had succeeded in working with parents, or would suggest a lack of parental responsibility or their being 'chaotic' as a reason for not attending.

At the same time, experienced HVs' informants in the study acknowledged that Primary Health Care Services and Children's Centres were perceived by clients as 'hard to reach'. In these instances, HVs would often aid client participation by acting as a gatekeeper to other services in the area. De la Cuesta (1993) discussed fringe work and how it was an important part of health visiting. Fringe work can be interpreted as a metaphor for a service being on the edge. In one sense, the search for health needs and the advocacy work of HVs has demonstrated how health visiting has survived by providing a bridging service between the medical approach focused on 'risk' and health promotion with its emphasis on access and participation to services. However, it appeared that individual HVs' narrative accounts of helping clients to navigate health services was evidence of learning through trial and error, rather than being developed from best practice, research or collective knowledge.

8.8.2 Changing times for health visiting

In 2011, the Coalition government published "The Health Visitor Implementation Plan 2011-2015: A call to action" (DH 2011a), a document which gave its support to health visiting as a modern service and also provided planned investment in the service. The reason for this

change in policy was the result of cross-government commitment to early intervention (Allen 2011). This publication continued the development and improvement of services for young children that had started with New Labour in 1997. Early intervention as a way of improving health and social inequalities is now well established and is viewed as a positive way to break the cycle of disadvantage (Marmot 2010, Field 2010, Allen 2011).

The HVIP (DH 2011a) aimed to improve health visiting service by developing a four-level service based on progressive universalism which was to be provided to individual families in response to an assessment of the health needs of the child and their family by a HV. There is also clear evidence that using a tiered model of service provision, such as progressive universalism, can lead to better engagement with families who are most in need of assistance (Marmot 2010). In order to achieve these objectives, the numbers of HVs in England were to be increased by over 50% from a record low of 8,000 in 2010 to 12,000 in 2015 - a figure that has nearly been achieved to date.

The purpose of the HVIP was to recruit more HVs and also to transform the service. It has also included evidence-based training that encourages HVs to involve their clients in partnership work in order to improve the service coverage and promote child health and well-being. HVs are now being trained in strength-based models such as the Solihull Approach, an evidence-based programme that promotes partnership work with families in order to identify as early as possible those families with multiple risks. In the recent evaluation of the progress made in transforming the HV service (DH 2013), recognised progress has been - and is being - made. For example, in Greater Manchester some families that had previously 'slipped through the net' and missed out on services (DH 2013) are now connecting with health initiatives. The findings in this current study support this view and, whilst the term 'hard to reach' has become defunct in policy documents, the findings in this study clearly demonstrate a great deal of variety in service provision for families living in disadvantaged areas and whilst the study was carried out at a time when HVs were reduced in numbers it does importantly highlight the variety of issues and factors associated with client access and engagement.

8.9 Conclusion

The literature review in Chapter 3 above discussed how, since the 1970s, the health visiting service had been influenced by the changing construction of risk and child health promotion; and how the most recent change occurred from the late 1990s with the construction of 'new

social risks' of social exclusion and health inequalities in child health and health inequality documents (Healthy Child Programme 2009, Marmot 2010). This latest construction of risk offers a much broader platform for health promotion than that which had been recognised in previous child health programmes. In the UK, a review of health visiting (Lowe 2007) argued how HVs with their public health background had experience in targeting and working with the 'hard to reach' (Lowe 2007). Targeting services towards groups with greater health need is considered an example of proportionate universalism (Marmot Review 2010), a way of redistributing resources and improving access to services for disadvantaged client groups. These groups consist of people who historically had been considered as underserved or 'under-utilisers' of preventative services such as the health visiting service.

At the same time, the health visiting service was being redesigned and has now changed from a universal health-promoting service to a model of progressive universalism. This model has been described as an effective way to address widening health inequalities and to facilitate access to parenting support for a wider population (Broadhurst 2007, DH 2011a). Progressive universalism is also viewed as a way to improve fairness, access and equity to clients living in disadvantaged areas (Marmot 2010). At the time of the study's inception, little was known about how these changes would affect HVs' understanding or ability to reach the 'hard to reach' in practice. This thesis adds to the body of knowledge about client engagement and specifically in relation to developing relationships and client participation in community facilities such as Well-Baby Clinics.

The emergence of the typology has led to the identification of the facilitators and barriers to the reach of the partnership model of health visiting within a bio-medical deficit model of health. The typology has identified four different types, each relating to the reach of the health visiting service and which are a way to redesign a service that is more proportionate to those with the greatest health inequality.

'Easy to reach' clients living in a disadvantaged area enjoyed greater participation, not only with the health visiting service but also with the services provided within the community. They were 'easy to reach' because they shared the same ideological beliefs towards child rearing and viewed the health visiting service as supportive and non-threatening. They were able to communicate with health professionals in a way that helped them to seek help and yet remain in control of the advice and support they were being offered.

'Emotionally hard to reach' clients attended clinics and chose to participate in some aspects of the health visiting service. These aspects were in relation to their child's physical health, and HVs were often viewed as a gateway to other services or to reassurance when they had an unwell child. 'Emotionally hard to reach' parents appeared to have a different approach to parenting, or their choices were perhaps influenced by adversity in their day-to-day lives. Here, partnership and participation were polite yet tentative, and the relationship with the health visiting service was still developing. When the HV tried to assess a client's health needs or to offer evidence-based advice, it appeared to be a barrier to client engagement. Instead, , it seemed important to promote listening in these situations and to encourage client participation.

'Physically hard to reach' emerged as a type to describe clients who did not attend for appointments or were unknown to HVs. This type included many groups or families with 'new social risk' factors - factors which are known to be a barrier to service engagement and also a risk to a child's health and well-being.. Research into 'hard to reach' access to services has often included groups who did not engage with services (Doherty et al. 2003) and, whilst enabling a discussion on the barriers to services, they also tend to replace the term with other negative labels.

The typology developed in the current study developed from the language of HVs and at times also focused on negative personal attributes, especially in this type. The growing body of literature on parenting in adversity has critically examined and challenged this viewpoint. Multiple risk factors or the 'new social risks' identify how structural factors can result in non-engagement with services, especially when the client has little control over their health or circumstances. Barlow et al. (2005) have considered these wider complexities as barriers; for example, the home visiting intervention had time to develop relationships and look at how this approach proved less stigmatising, and resulted in reaching some 'traditionally hard to reach' clients. The recent Institute of Health Visiting response (Cowley et.al. 2015) to the consultation on the development of a formula of staffing for a 0-5 children's public health service (DH 2015) continues to call for a well-resourced health visiting service (Cowley et al 2015) as a way to address the range of health need across the population as well as more targeted interventions such as the FNP.

This thesis has identified how generic HVs were also able to reach some clients living in disadvantaged neighbourhoods. Critically investigating the concept of 'hard to reach' has identified the range and complexity of the concept in the context of HV/client engagement and

has led to the development of the typology of the reach of health visiting. The final chapter will discuss the contribution to knowledge and the implications and recommendations for practice, policy and further research.

9. Conclusion

9.1 Introduction

The case study set out to investigate the concept of 'hard to reach' in relation to the health visiting service and the delivery of the Healthy Child Programme within an area of multiple deprivation. This final chapter will highlight the key findings of the study, and its contribution to health visiting practice and education. It will also outline further areas for research and practice that emerged from the analysis and findings of the case study.

This qualitative case study research design has answered the overriding research question and the four research objectives

9.1.1 How is the term 'hard to reach' conceptualised and operationalised in health visiting practice?

HVs' conceptualisation of the term was wide-ranging: some simply described it as a synonym for 'non-engagers'; others tried to explain how the term was broad and could be used to cover a range of clients on their caseloads. The majority of HVs expressed their dislike of the term, describing it as a nebulous term, and it was also perceived as a negative label. However, there was evidence that the discourse of 'hard to reach' in health visiting was conceptualised in relation to clients who did not easily engage with the health visiting service. As a result, HVs operationalised the term to express how they found some clients to be 'difficult to engage' within the current service provision. They also described how having a relationship with individual members of a known 'hard to reach' group meant that, for that individual the term did not apply. For example, when HVs understood the cultural barriers that prevented access to services, they were able to provide a more tailored service, achieve health goals and develop care pathways. This was considered to be the normal work of knowing the clients within a caseload rather than targeted practice. Consequently, targeted work was in relation to child protection and safeguarding, and strategies to promote inclusion for the 'hard to reach' appeared dependent on individual HVs' knowledge and experience.

9.1.2 To develop a definition of the term ‘hard to reach’ in relation to families and the child health promotion programme?

It was not possible to capture the multidimensional meanings within a single definition. Instead, a typology developed of the reach of health visiting within a disadvantaged area. The benefits of such an approach meant that the variety of factors which affected access to the universal health visiting service as a whole, were clearly captured. Previously, HV research has focused more on specific disadvantaged groups within the community and the barriers identified had then been associated with that group (see Chapter 4). In contrast, the typology clearly identifies the variety of reach of a universal health visiting service across an area of disadvantage. It demonstrates how some clients are able to reach the service whilst others find the service difficult to access for a variety of reasons. Consequently, it is recommended that the term ‘hard to reach’ should not be used in relation to a service user. Instead it is recommended that the typology be used to develop the reach, and the engagement of clients, within a universal health visiting service. (see 9.2 below - implications and recommendations for health visiting practice)

9.1.3 To explore with ‘hard to reach’ parents their health needs and requirements from child health services during early parenthood

Understanding how clients perceived and had experienced child health services was an important aspect of this study. Chapter 7 discussed how finding and recruiting participants to interview required perseverance and a flexible approach. The eventual recruitment of a small sample of clients enabled the study to include the voices of service users who did not take up everything on offer from local services. It is worth noting that the latest literature review on health visiting (Cowley et al. 2013) prefers the term ‘seldom heard’ rather than ‘hard to reach’. This study was able to include a small sample of ‘seldom heard’ voices of clients who lived in a disadvantaged area. Rather than seeing themselves as problematic ‘non-engagers’, these participants described themselves as being ‘self-sufficient’ and as ‘experts in parenting’, showing how it was difficult to ask for help from outside agencies who might be judgemental of their parenting expertise. Consequently, they wanted to be listened to and valued, to be able to access familiar, non-judgemental services, and to have access to services when they needed them: they found that the services did not always meet their requirements in this respect. The inclusion of clients’ perceptions has provided new information about the service and has also resulted in the identification of a variety of client qualities that enhance engagement with HV services. Importantly, it has identified how more space must be given in formal settings to

enable clients to find their voices, and how clients in an area of disadvantage want to be treated with respect: they required a trustworthy service that listened to them and promoted health on an individual level in a timely way.

9.1.4 To develop an understanding of the barriers and facilitators for ‘hard to reach’ families

The study has developed an understanding of the many and diverse barriers and facilitators in the current reach of health visiting and will be discussed in the next section about the implications of the typology.

9.2 Implications of the Typology

The findings from this study clarify the concept of ‘hard to reach’ in health visiting work. The typology (Table 21 p.202) clearly demonstrates the multidimensional nature of the concept of ‘hard to reach’ at the ‘micro’ or individual level of health visiting. Importantly, the typology does not present a static model; instead it intends to be a representation of the reach of health visiting. The variation of factors identified within the typology strongly suggest that a single model of service delivery, based on a professionally-led deficit model of health, is unlikely to work equally well for all families living within an area of disadvantage. The typology makes visible the facilitators and barriers to service delivery that were previously hidden under the umbrella term of ‘hard to reach’; it highlights the need for flexibility and for different approaches in order to extend the reach of the service, if it is to become more effective in addressing health inequalities. The typology has been fundamental in drawing together existing empirical research on client engagement and partnership and adds to the body of knowledge by further evidencing how an open, facilitative style can enhance client engagement in disadvantaged areas

The identification of ‘easy to reach’ acknowledged that clients living in an area of disadvantage were able to reach the generic health visiting service. Consequently not all families living in a disadvantaged area were ‘hard to reach’. HVs have long been aware of families living in disadvantaged areas who access informal or formal support resources. and this view is supported by the category of ‘easy to reach’. This study has found that ‘easy to reach’ clients viewed HVs as a trusted resource; they made sense of the health visiting service as helpful to their health needs. The Well-Baby Clinic was seen as a place to go to for support in gaining information that would improve their health.

This was achieved through the presentation of the HV whose facilitative style created favourable conditions in which to promote partnership. More importantly, the findings demonstrated how 'easy to reach' clients were able to communicate their health needs and to discuss their personal circumstances in a public space. Using the language of the clinic, they were able to discuss their concerns. In the clinic, client engagement was enhanced when parents were able to communicate effectively with health professionals. In response, HVs listened to the concerns presented by the client and offered suggestions or guidance. As a result, clients were able to make informed decisions about how to maintain and improve their health. This was evidence of a positive development in health visiting practice and is in comparison to Kendall's (1993) study where she suggests that parental expertise was frequently not recognised by HVs. The category of 'easy to reach' provides evidence of partnership work and implies a shift from the traditional model of professional dominance towards a partnership model, and the achievement of identified health issues identified by a parent (Bidmead and Cowley 2005a).

Trust and participation have been described as crucial factors in developing the HV/client partnership (Bidmead and Cowley 2005a). This thesis identified that trust and a clear understanding of the HV service are necessary for client engagement as the first step in developing a trusting relationship. Approaches to developing a partnership have importantly concentrated on developing the communication skills of the health professional in order to build trust (Bidmead and Cowley 2005a). This study supports these findings, and also offers evidence that participation may actively be limited by the client who uses strategies to prevent engagement in a professional relationship.

The 'emotionally hard to reach' client accessed the service tentatively for the physical health of the child and 'weighing the baby'. The presentation of a friendly, supportive, skilled professional appeared to be very different from the perception held by the client of an expert, authoritarian. Attempts by the HV to lead the conversation in order to assess a client's emotional health, or to find out how they were coping with the baby, were blocked. On these occasions, the HV was perceived as an authority or 'expert' figure and resulted in clients resisting the reach of the health visiting service. The findings in this current study demonstrated how clients did not value this approach and would challenge actively any unsolicited evidenced-based advice. Instead, the client as an 'expert' would report her mothering and block the attempts of the HV to determine a problem through assessment. This approach highlighted the challenges faced by the HVs who were thus unable to 'find a way in' by using traditional methods of assessment in order to search for problems or health needs.

The type of 'emotionally hard to reach' also demonstrated the different expectations and understandings of the function of the clinic. The HVs perceived Clinic as a place in which to seek help with a problem, or advice or reassurance, or, indeed, as an opportunity to assess health needs or to 'problem solve'. In contrast, 'emotionally hard to reach' clients attended for more concrete functions; to have the baby weighed, or to be referred to another service. The clients also employed strategies to readdress the perceived authority of the service, which could involve attending with relatives or friends or resisting the expert advice being offered. Clients in this category were perceived as challenging to HVs and this demonstrates the limits to a service based only on the identification of problems and on helping. The category of 'emotionally hard to reach' also highlighted how some clients found it difficult to ask for help in a public space.

9.2.1 Discourse of non-engagement

The physically 'hard to reach' type developed as a result of examining critically the HV's perspective of 'non-engagement' with 'hard to reach' families. The reasons for non-engagement were multidimensional and involved a combination of reasons:

1. The wider social determinants of health or 'new social risks' were acknowledged as a barrier to participation in the health visiting service. For example, Clients' circumstances changed, or they were moved away from their known networks. They may have moved because of domestic abuse, homelessness, or because they were part of the traveller community
2. Clients' attitude or knowledge of the service affected their participation, for example, a perceived negative attitude towards the service by clients or their partners, or because clients did not understand the service (this was especially so for newly arrived migrants).
3. Clients did not have time to attend: working mothers were included here. This last reason also led to HVs labelling non-attendees as 'irresponsible' or 'chaotic'.

The Findings and Discussion chapters demonstrated how HVs' understanding of physically 'hard to reach' developed from risk factors associated with vulnerable families (Hall Report 1996, DH 2009) at risk of child protection, rather than from the broader definition of families at risk of social exclusion (SETF 2007). The findings appear to identify how HVs seemed to be discussing 'the physically hard to reach' more critically, because they were perceived as not meeting their expected parental responsibility. The use of labels has been recognised as a depersonalising and stigmatising mechanism: labelling the non-attende as 'irresponsible'

suggests that the individual is being blamed (Brackertz 2007, Barlow et al. 2005). Here, the HV perception is on the individual and their lack of responsibility in participating in the offer of the service. This approach does not take into account how the wider societal structures may impinge on or be a barrier to accessing services. The notion of parental responsibility demonstrates the wider societal norms and how health visiting may be viewed as representing the mainstream norms of society. It is also an example of the moral underclass discourse identified by Levitas (1998), where the blame for non-engagement is on the client rather than on the services being provided. The label of 'non-engagers' highlights how a narrow interpretation can reduce the reach of health visiting. Families living in adverse circumstances, or belonging to an 'at risk group', continue to perceive that they are 'at risk' of being judged by services. This is a known barrier to access and engagement that continues to be cited as reasons for not accessing health services (Audit Commission 2010).

This also suggests that the HVs in the study area did not have a clear understanding of the broader definition of the 'new social risks' as defined in the HCP. This broader definition is concerned with the redistribution discourse to 'target those most in need'. However, the discourse is in competition with the normative dimensions of a universal healthy child programme. The main discourse in the HCP appears to be on the responsibility and obligation of a parent to comply with service expectations of parents to attend appointments in order to ensure their child meets their full potential, both as a child and in later life (DH 2009a). Health visiting literature has tended to present compliance with child health surveillance programmes as unproblematic and morally neutral (Wilson 2002). In this respect, investigating the concept of 'hard to reach' has exposed this normative moral obligation as problematic to the delivery of a progressive universal service. The category of 'physically hard to reach' highlights barriers to help-seeking that are physical and which also involve a moral component requiring an understanding of how parents living in adversity do seek help

There is a growing body of evidence in health promotion work on the effectiveness of relationships with families at risk of social exclusion (Marmot Review 2010). Yet the 'new social risks' of health inequality, as a commissioning criterion for a more tailored service, is being applied strategically only to certain groups. For example, the Family Nurse Partnership model for teenage mothers is providing evidence of how this group is being recruited and reached (Barnes 2010). Findings presented in this thesis have indicated that, within the current universal services, some families were being reached whilst others were not. The FNP demonstrates how

investment in a new service can provide a more equitable service. Yet this approach requires time, a reduced caseload and a facilitative, strengths-based approach.

9.2.2 Access to services

The final category of 'hard to reach' services developed for two reasons. Firstly, it acknowledges the perceived barriers to engaging with services. Secondly, it includes the wider organisational factors which affect access and participation that are beyond the control of the individual HV or client. The introduction of the locality clinic resulted in improved access to services, but several factors prevented greater engagement locally. These barriers were the large geographical reach of the clinic, staffing by locum HVs, and the drop-in nature of the clinic. These factors resulted in a fragmented service, and services were not being used by those it was intended for, as has been found in other studies (Condon 2008, Roche et al. 2005). The development of this category also demonstrates how a commissioned service has reduced the health-promoting health visiting service to a service delivering the healthy child programme, promoting public health targets and responding to help-seeking initiated by clients. Importantly, working within a purely deficit model of health means that the health visiting service as a resource - and the work required to engage clients - continues to remain unrecognised and invisible. The work of client engagement continues to be discussed by experienced HVs as extra or 'fringe work' (de la Cuesta 1994) necessary to gain a client's confidence and trust.

9.3 Implications and recommendations for health visiting practice

The health visiting service is being commissioned to lead and deliver the Healthy Child Programme (DH 2009, DH 2011) within a model of progressive universalism. At the time of the study, progressive universalism appeared to be interpreted within a reductionist 'risk-based' deficit model of health that focused on the provision of the core service, on improving identified public health targets and on child protection. The thesis has focused on the universal aspect of the health visiting service, and has found that HV participants discussed the universal service and services to vulnerable families in relation to safeguarding rather than to reducing health inequalities. The recent scoping exercise on health visiting (Cowley et al. 2013) placed 'hard to reach' families at the 'universal partnership plus' level of service. This is an interesting development because, on one hand they recognise how multidimensional, structural barriers may require a multiagency approach to address health inequality, yet on the other hand, this

continues the traditional approach of labelling families with multiple risk factors as families who require a Common Assessment Framework (CAF) and the involvement of multiple agencies in relation to parenting and safeguarding (DH 2009a).

The recognition of the barriers and facilitators found in the typology demonstrate that the generic health visiting service also has the potential to continue to develop approaches that are acceptable to clients who are wary of being judged or who are not used to asking for help. Call for Action (DH 2011) and The National Health Visitor Plan (DH 2013) supports the need for an improvement in the reach of health visiting. Following on from the success of the early implementer sites, training is now being rolled out to provide training for HVs to develop their skills in reaching clients who previously may have missed out on service provision (DH 2013) and also begin to demonstrate how a transformed HV service can reach more clients at the individual level.

The typology supports the notion of different approaches and providing a flexible service to meet the diversity of health need at both the individual and community level. It also fits with the HCP (DH 2009a), the Marmot Review (2010) and the HVIP (DH 2011) and the discourse relating to targeting of service and progressive universalism. In this context, 'targeting of service' is redefined as the redistributing of resources. i.e., providing a broader health-promoting service, progressively redesigned to meet the needs of families at risk of social exclusion and health inequalities.

Chapter 3 explained how since the 1970's the health visiting service has made several attempts to improve the reach of the service whilst being threatened with change and new approaches to service delivery. It also discussed how health visiting had been influenced by risks to child health and well-being. The new 'social risks' of social exclusion have identified how a small percentage of the population have multiple health need which can prevent access to services. The typology organises the multidimensional factors preventing access into types and provides a framework to examine and address the reach of health visiting in a systematic and measurable way. The typology provides a means of improving services at the level of HV/client interactions. It also offers a means for HVs and managers systematically to take into account the different circumstances and perspectives that are known to facilitate - or be a barrier to - the health visiting service. The model of progressive universalism and partnership is concerned with improving access by building relationships with all families as this approach aims to enhance health at the individual and community level. For example, communities with negative

experiences of the health visiting service will require a flexible, non-judgemental approach to help to reduce mistrustful relationships.

The intermediate level of 'universal plus' appears to provide an opportunity to develop services and thus improve the reach of health visiting. There was evidence in the study of new services being implemented to promote public health goals. For example, increased breastfeeding support for mothers living in disadvantage areas was an example of a universal plus service: HVs and peer supporters were trained to promote breastfeeding and to provide more services. In contrast, there was little evidence that the needs of formula fed babies were being discussed alongside this. The typology could be used in these instances as a tool to identify and involve a range of families in the development of services concerned with infant nutrition and feeding..

This study proposes that the typology would be a development framework for a generic health visiting service working with a variety of families living in disadvantaged areas. The 'universal plus' level would be the pathway for the redistribution of resources for practitioners, and the different resources and perceptions that individuals hold about the service would be the starting point of engagement with clients. The focus would then shift away from tackling established problems only when they reach a threshold of concern towards developing a service which builds on engagement and relationship building.

9.3.1 Community level

During the observation of health visiting practice, a barrier to participation occurred when HVs offered information on evidence-based best practice which required a change in child care practices by parents often resulting in the offered advice being resisted by the individual client. These instances demonstrated how difficult it was to promote participation and engagement by a well-meaning but essentially 'expert' health promotion practice. In these circumstances, HVs working in an area of disadvantage may find it useful to involve clients with changes to health promotion advice. Building Community Capacity (DH 2011a) is a community development model that is beginning to be incorporated into the health visiting service. In this model, the responsibility for health promotion shifts away from resting solely on individual HVs towards a more strategic approach involving HVs, clients and partner agencies. The typology may be an appropriate tool/framework for collecting a range of client views and then developing services from the findings; for example, it could be used to collect views from a range of service users in relation to modernising the Well-Baby Clinics.

'How can health promotion information in Well-Baby Clinics become more meaningful to the community of parents and children under five in this area?'

This approach would involve the community and local services, and address the barriers to the design and delivery of the Well-Baby Clinic in order to improve access, participation and partnership working.

9.4 Implications and recommendations for health visiting education

Research has centred around the term 'hard to reach' and, whilst the term has been criticised as a negative term (Cowley et al. 2013), examining the concept in relation to the health visiting service was a very useful exercise. The confusion, misunderstanding and lack of research into the concept appear to have contributed to the development of a service which continues to target clients on assessment and professional judgement mainly in relation to safeguarding. At a time of a reduction in the service, the identification of the 'new social risks' in relation to 'hard to reach' appeared confusing to HVs because they had previously understood the identification of very similar risks in relation to infant mortality and safeguarding. Consequently, the service reduction led to a narrow focus on the core work and targeting in relation to safeguarding.

The HVIP (DH 2011a) is an impetus to develop the health visiting service as well as to provide a greater number of HVs. The curriculum for HVs training and programmes for established HVs is influenced by the developing evidence-based body of knowledge on early interventions for the most vulnerable families such as the FNP (DH 2013).

The typology of the reach of health visiting adds to the growing body of knowledge of engagement of vulnerable clients living in disadvantaged areas. The typology has potential to be developed as a tool to evaluate service delivery and to help in beginning to shift the beliefs and attitudes of HVs that are themselves a barrier to client engagement. The typology could also be used in clinical supervision because it would aim to shift the discussion away from 'hard to reach' towards 'how to improve the reach of health visiting' for all families living in disadvantaged areas.

9.4.1 Strength-based communication skills

If the term 'hard to reach' is to be replaced by the synonym 'seldom heard' (Cowley et al. 2013) then it is imperative that HV students and practising HVs continue to develop good communication and interpersonal skills, and, specifically, their listening skills when working alongside clients. To achieve this, it is recommended that the curriculum develops training in explicit communication skills for working alongside disadvantage families. The Family Nurse Partnership, a strengths-based approach, is proving successful in relationship-building with vulnerable teenage mothers (Chalmers 2012). The Home Visiting Study (Bidmead and Davis 2008), promotes partnership working with parents, and is also based on a strengths model and involves listening to the client. Both studies have demonstrated the importance of having time to build relationships by listening to the health needs and identifying the strengths of clients, some of whom may be living in adverse conditions and may be initially suspicious of traditional universal health visiting (Kirkpatrick 2007). The findings of this study support the development of communication skills based on a strengths model within a facilitative non-judgemental approach.

9.4.2 Leadership skills

The teaching of participatory methods to help to engage communities would also enhance HVs' skills in community development work and leadership. A growing body of public health literature (Cowley and Billings 2001, Lindstrom and Eriksson 2005, Morgan and Ziglio 2007, Marmot 2010, Cowley et al 2013), supports a salutogenic or strengths-based approach to health promotion. The focus is on building individuals' and communities' resources, and thus their capacity to improve their own health. Participatory methods also aim to build on the strengths within a community, and to develop a collaborative process where both the HVs and communities learn about each other (Dalziel 2007). The typology could be utilised as a framework for profiling an area, with the aim of identifying and including a range of clients living within a community. Partner agencies and stakeholders should also be involved in the profiling process in order to discuss the barriers and facilitators that they face in promoting health with different communities.

9.5 Implications and recommendations for research

The typology developed from the single case study and requires further testing and refinement. This could be achieved through a wider study examining the reach of health visiting post 2015. The typology developed in this study could be used as a key criterion in the sampling process to recruit people to the study. For example, people from each category 'easy to reach' emotionally hard to reach' 'physically hard to reach' and those who viewed the service as 'hard to reach' would be purposively recruited to the study. The typology could also be tested and developed further through the process of analysis during this new study.

The recent scoping review of the health visiting literature (Cowley et al. 2013) supported health visiting in its attempts to continue to develop its orientation to practice, based on the strengths model described above. However, the thesis identified little health visiting literature or research on client strengths or qualities. The category of 'easy to reach' within a disadvantaged area clearly demonstrated how clients' qualities of trust, help-seeking and communication helped to promote more effective client participation, partnership working and health promotion encounters. Therefore, it is recommended that a systematic approach is needed to develop health visiting research into building knowledge of the clients' perspective of the health visiting service. It is suggested that health visiting researchers should work collaboratively to develop a plan of research in this field:

- For example, the first stage would be a systematic review of home visiting and strength-based partnership approaches. The typology developed in this study could provide a framework of factors affecting the reach of a service that could be considered in the design of the systematic review.
- The typology developed from the views both of HVs and service users. Including the voices of service users was very important to understanding the reasons for service uptake in the area. A limitation of the study was the small number of participants recruited to the interviews. There is growing support for community-based participatory research (CBPR) with the 'hard to reach' as a way of including the voices of the 'seldom heard'. CBPR involves practitioners and service users at all stages of the research process. Therefore, it is recommended that future research with 'seldom heard' families in health visiting should incorporate these methods from the outset.

Dissemination Plans

Production of 2-3 papers from the study:

Proposed titles: Social Inclusion or parental responsibility: competing discourses in child health policy.

Understanding the concept of 'hard to reach' in relation to health visiting and disadvantaged families: Implications for practice.

'Hard to reach' or 'seldom heard': Interviews with health visiting clients living in a disadvantaged area.

This study has demonstrated that the concept of 'hard to reach' as enacted by HVs in their practice is multidimensional and can be represented by a typology which recognises assets in 'easy to reach' clients that enable them to help-seek and access the health visiting service. For the not 'easy to reach', it has also identified that these resources were not evenly distributed amongst the study participants. Furthermore, how participants made sense of the health visiting service could either enhance or deter their engagement with the service. Finally, some participants experienced life changing events that were beyond their control and resulted in their being unable to access the service. The typology will be an important contribution to the development of health visiting education and practice that increasingly draws on strength-based approaches to addressing health inequalities.

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Appendix 1: Search Criteria

Population	People described as 'hard to reach, disadvantaged, marginalised, underserved, vulnerable
Relevance to	Health inequalities, Access to health care, service delivery within a universal health service
Coverage	UK, Scandinavia, Europe and USA,
Study period	1994- 2014
Conference abstracts	Acceptable
Study design	Any

Search Terms

Search Strategy

British Nursing Index 1994-

- #1 Health visitors
- #2 Health Visiting DE And Children-service DE
- #3 Health Visiting DE AND MOTHERHOOD DE
- #4 Health Visiting DE AND MOTHERHOOD DE AND HEALTH INEQUALITIES DE
- #5 Health Visiting DE AND HEALTH INEQUALITIES
- #6 Disadvantaged Families
- #7 Health Visiting DE and Parenthood
- #8 Health Visiting OR Community Nursing and Parenthood
- #9 Health Visiting DE and Health Inequalities
- #10 Social Exclusion
- #11 Hard to reach*

Cochrane Database of Systematic Reviews

- #1 Home visiting
- #2 Disadvantaged Mothers

Allied and Complementary Medicine Database 1985-2007

International Bibliography of the Social Sciences 1951 to December week 4 2007

PSycINFO 1970 to weekly 2008/01

- #1 Special Populations ME
- #2 Community health nursing ME
- #3 Special Populations and Community Health Nursing
- #4 Maternal near health
- #5 Hard to reach

- #6 Hard-to-reach
- #7 Hard to reach* and community health nursing ME
- #8 Postnatal
- #9 Postnatal and (hard-to-reach)
- #10 Parenting
- #11 Parenting and (hard to reach)
- #12 (community health nursing) and (hard to reach)
- #13 (community health nursing) and (hard-to-reach)
- #14 social exclusion near children

Cinahl Databases 1982-Jan 2013

PubMed databases

- #1 (Hard to reach)
- #2 (Hard-to reach)
- #3 Community Health Nursing ME
- #4 Community Health Nursing ME and Vulnerable Populations
- #5 Community Health Nursing ME and Special populations ME
- #6 Disadvantage*
- #7 (difficult to reach)
- #8 Health care quality Access and Evaluation ME
- #9 Health care quality Access and Evaluation ME and Community Health Nursing ME
- #10 Health care quality Access and Evaluation ME and vulnerable populations
- #11 Vulnerable populations and Community Health Nursing ME
- #12 Community Health Nursing ME and Special populations ME and (Medically underserved area) or “Health services Accessibility”
- #13 Mother near health and (Medically underserved area) or “Health services Accessibility”
- #14 Social Exclusion near Children
- #15 Social exclusion near Mother

Databases searched

CINAHL 1982 to Jan 2008, IBSS 1951-Dec 2007, ASSIA to Jan 2008, KINGS FUND 1979 to Jan 2008 , PUBMED to March 2008, PSYCINFO 1970 to Jan 2008, BRITISH NURSING INDEX 1984 to Jan 2008 , DARE to Jan 2008, COCHRANE DATABASE to Jan 2008, ZETOC to Jan 2008..Google Scholar 2008-2013

Google scholar 1970-2014

#1Underutilisers	Child health policy documents
#2Reaching the unreachable	Health visiting policy documents
#3Partnership and health visiting	Health visiting literature reviews
#4Participation and health visiting	Author searches -specific
#5Hard to reach	RSS feed on 'hard to reach' families set up on google scholar

Appendix 2: Ethics Approval from NMSWCJC Ethics Committee

UNIVERSITY OF HERTFORDSHIRE ETHICS COMMITTEE

for

NURSING, MIDWIFERY, SOCIAL WORK, CRIMINAL JUSTICE AND COUNSELLING FEEDBACK

Applicant: *Kathryn Mumby-Croft*

Study: *The future role of the health visitor in supporting 'hard-to-reach' families.*

Reference Number: NMSCC/12/08/6/A

Date of REC: 11 December 2008

Overall comments. Thank you for submitting the information requested by the Committee. Your study is now approved. On behalf of the Ethics Committee for NMSCC may I wish you all the best with your study.

Ethics Committee for NMSCC decision:

Approved

Your study is registered with approval number: NMSCC/12/08/6A

Minor amendments required - subject to Chair's action

Major amendments required - resubmission to REC

Not approved

Please note that if any significant changes are to be made to the methodology the Committee must be informed. The enclosed Quality Monitoring Form must be completed and returned to the Secretary to the Committee, Post-graduate Office, 1F264, Wright Building, Hatfield Campus, immediately the study is finished.

Kim Goode

Chair of the Ethics Committee for Nursing, Midwifery, Social Work, Criminal Justice and Counselling

Minor Modification to an existing Protocol Approval (Audio Recording of the clinic)

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE for NURSING, MIDWIFERY, SOCIAL WORK, CRIMINAL JUSTICE AND COUNSELLING FEEDBACK

Applicant: *Kathryn Mumby-Croft*

Study: *The future role of the health visitor in supporting 'hard-to-reach' families.*

Reference Number: NMSCC/12/08/6/A

Date of REC: 11 December 2008

Your request for a minor modification to study NMSCC/12/08/6/A has been approved as detailed below by you:-

Details of modification: The original application detailed that the researcher intended to use ethnographic methods including participant observation and the keeping of field notes as a means of data collection. The researcher now wishes to include in audio recordings of the 'baby clinic'. As described (in section 8a) in the original application, the health visitor at the baby clinic will explain the researcher presence and gain permission from each parent attending the clinic for the researcher to be present and for the consultation to be audio recorded, Furthermore, this conversation will be carried out by the health visitor in private with the parent and prospective participants will be able to refuse the recordings or the presence of the researcher. The researcher will also continue to be guided by the health visitor on which consultations can be observed/recorded (Silverman 1993). Confidentiality and anonymity of the original ethics application will be adhered to in relation to all audio recordings.

Justification for modification: This modification will enable the collection of better quality data (Hammersley and Atkinson 2007). The audio recordings will provide a reliable record of the 'naturally occurring' interaction between health visitor and parent and offer a highly reliable record which can be returned to by the researcher (Silverman 1993) It will also allow the researcher to concentrate fully on observing the interaction between the health visitor and parent.

Hammersley, M., & Atkinson, P. (2007) *Ethnography: principles in practice*. Routledge. London.
Silverman, D. (1993) *Interpreting Qualitative Data*. Sage. London

Please note that if any significant changes are to be made to the methodology the Committee must be informed.

The enclosed Quality Monitoring Form must be completed and returned to the Secretary to the Committee, Post-graduate Office, 1F264, Wright Building, Hatfield Campus, immediately the study is finished.

Kim Goode

Chair of the Ethics Committee for Nursing, Midwifery, Social Work, Criminal Justice and Counselling

11 January 2010

Minor Modification to an Existing Protocol Approval

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE

for

NURSING, MIDWIFERY, SOCIAL WORK, CRIMINAL JUSTICE AND COUNSELLING

MINOR MODIFICATION TO AN EXISTING PROTOCOL APPROVAL

Applicant *Kathryn Mumby-Croft*

Study *The future role of the health visitor in supporting 'hard-to-reach' families.*

Reference Number: **NMSCC/12/08/6/A**

Date of REC 11 December 2008

Many thanks for your request for a Minor Modification to Protocol **NMSCC/12/08/6/A**. The Minor Modifications are listed below:-

Details of modification:

The original application detailed that the researcher intended to recruit into the study 15-20 first time families who were described by health visitors as 'hard to reach'. The modification aims to widen the recruitment of participants to include families who have more than one child with the most recent baby being under eight months of age at time of recruitment.

Justification for modification:

The ability to adapt and change to gain a true picture is one of the strengths of qualitative research. An aim of purposive sampling is to reflect diversity (Barbour 2008), therefore it appears important to broaden the original sample criteria to recruit participants who are illustrative examples and characterize 'hard to reach' in a wider context.

The Minor Modification has been approved.

Please note that if any significant changes are to be made to the methodology the Committee must be informed.

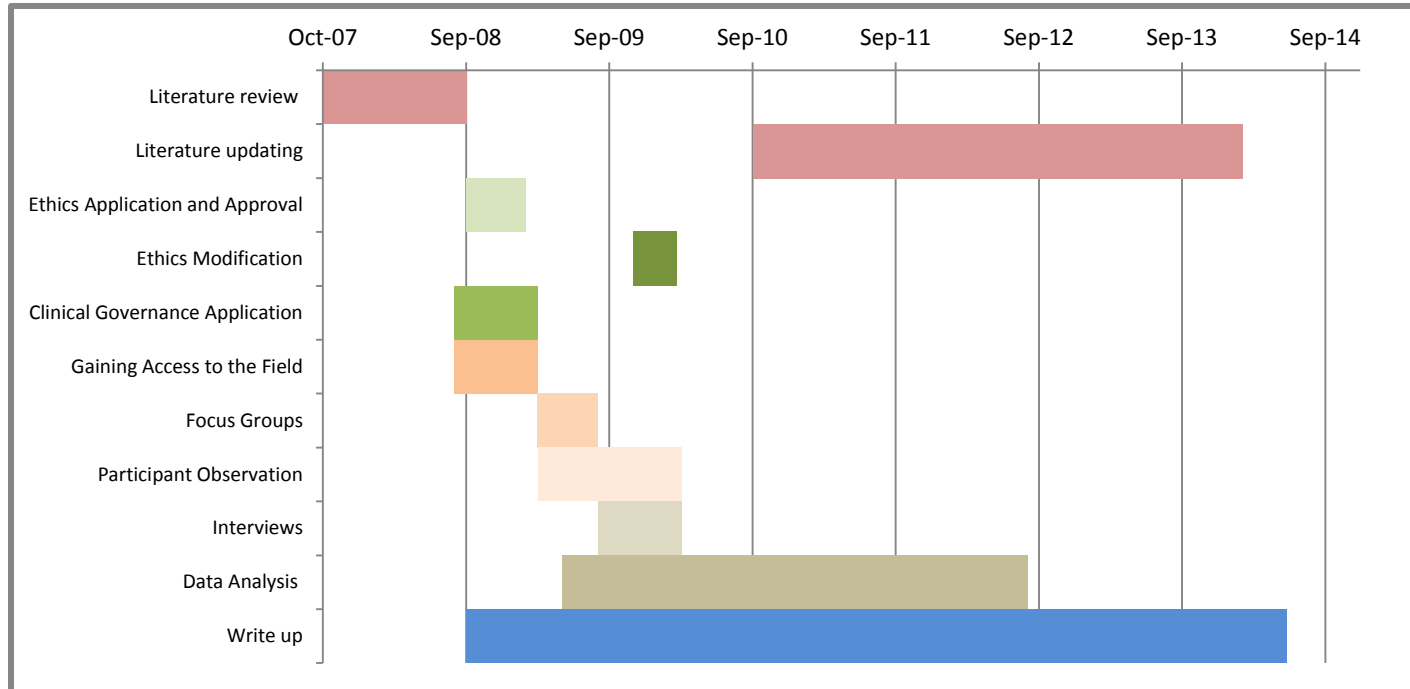
The enclosed Quality Monitoring Form must be completed and returned to the Secretary to the Committee, Post-graduate Office, 1F264, Wright Building, Hatfield Campus, immediately the study is finished.

Kim Goode

Chair of the Ethics Committee for Nursing, Midwifery, Social Work, Criminal Justice and Counselling

18 March 2010

Appendix 3: Time line of research study



Appendix 4: Information and Consent form for Focus Groups



Health Visitor Information/Access to Children's Services Study

You are being invited to take part in a focus group.

This focus group is part of an evaluation study and is concerned with health visitors, children's centre and the provision of services to 'hard-to-reach' families

What is the purpose of this study?

I am interested in how health visitors are working with 'hard-to-reach' families and how the term is defined/used in practice. The aim of the focus group is to develop a definition of 'hard-to-reach' which relates to families and the child health promotion programme. This will then inform the study.

Why have I been asked to take part?

You have been invited to take part because you are working in a community health team in Oxfordshire and part of your workload includes families who live within the catchment area of a children's centre.

What is involved?

You are invited to the focus group which will last no longer than an hour. I will ask questions relating to developing a definition of 'hard-to-reach' in relation to the child health promotion programme. I am interested to hear your views on this topic. With your permission the meeting will be audio-taped.

Will my taking part in the study be kept confidential?

Yes, I will follow ethical and legal practice and all information will be handled in strict confidence. The study has approval from the University of Hertfordshire Ethics Committee for Nursing, Midwifery, Social Work, Criminal Justice and Counselling, to carry out the focus group.

The audiotapes will be transcribed onto a password-protected computer. Only my supervisors and I will have access to the transcriptions. The tapes and any written documentation will be kept in a locked filing cabinet at my place of work and the files will be wiped following write up of the study. The transcribed scripts will be kept for five years.

The researcher will take great care to protect participant anonymity therefore any identifiers of individuals will be removed during the transcribing process.

Do I have to take part?

Taking part is entirely voluntary. It is up to you to decide. You will be asked to sign a consent form.

Findings and further information

The findings from the focus groups will be used to produce conference reports, academic papers and as part of my PhD thesis.

How can complaints or comments be made?

If you have any concerns or comments about any aspect of this study, please speak to Kathy Mumby-Croft on

Who is organising and funding the research?

I was awarded my research fellowship through the Healthcare Foundation and the Burdett Trust both charitable trusts involved with promoting nursing research. I am based in the Centre for Primary and Community Care (CRIPACC) at the University of Hertfordshire.

Thank you for reading this information sheet



Consent Form for Focus Groups for Health Professionals

Title of Study: Access to Children's Services

Reference Number: NMSCC/12/08/6/A

To be carried out by:

Name of Researcher Kathy Mumby-Croft

I confirm that the researcher has explained the purpose of the study to me and that I have been informed of the details of my involvement in the study.

I confirm that my questions regarding involvement with this study have been answered to my satisfaction.

I confirm that I understand that I am not obliged to participate in this study and that I may withdraw from the study at any stage without the need to justify my decision and without personal disadvantage.

I understand that any personal information I consent to provide will be treated as confidential and will not be made publicly available.

I agree to take part in the study

Name	Date	Signature
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Name of Researcher	Date	Signature
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Appendix 5: Demographics of Focus Groups

First focus Group

Years Qualified as a HV	Job Title Time in Post	Caseload	Experience of working with 'hard to reach'	Connections to a Children's Centre	Any other comments
27 years	9 years	550 children for 1.05 whole time equivalent (WTE)	Yes	Yes Children's Centre	
10 ½ years	7 ½ years	Corporate caseload of 850 children on 1.4 (WTE)	Yes A range of families from 'chaotic', mental health concerns, working families, 'apathy'	Several	
33 years	25 yrs.	100 for 0.2 (WTE)	Yes	Yes	

Second focus Group

Qualified as a HV/ Community qualification	Job Title/ Time in Post	Size of caseload	Experience of working with 'hard to reach'	Connections to a Children's Centre	Any other comments
5 years qualified 9 years in post	Locality Lead- 1 year School Health Nurse-5 years	8 Schools	Yes constantly	Yes up to 4 in area	Work in close liaison with HV's and schools
24 Years	HV 7 years	Corporate caseload covering a GP practice with 16,000 patients	Definitely-can be any class or culture. Need to build trust. Challenging –good to reflect with team using available resources	1 Children's Centre	
Paediatric Nurse 13 Years	Community Staff Nurse 5 years	As above	Yes	1 main contact 3 others nearby	
HV 20 Years	21 months	As above	Yes, both within HV caseload and in a Children's Centre		
Nursery Nurse	17 years	Corporate caseload	Yes, my concept of hard to reach families is: when working for many weeks with family and they have not moved on or taken on board some of the things we have talked about	1 Children's Centre	

Qualified as a HV/ Community qualification	Job Title/ Time in Post	Size of caseload	Experience of working with 'hard to reach'	Connections to a Children's Centre	Any other comments
HV 27 Years	HV 8 years	Corporate caseload 16, 000 patients over two GP Practices	Yes, can be challenging to work with but satisfying when you can gain trust but this can take a considerable time	3	
HV 21 Years	HV 2 years 10/12	Corporate caseload	Yes	1	
HV 5 1/2 Years	HV 2 years	Corporate caseload	Yes -lots	1	
HV 18 Years	HV 2 ½ years	Corporate caseload	Yes working in a significantly deprived area	1	

Third Focus Group

Qualified as a HV/ Community qualification	Job Title/ Time in Post	Caseload	Experience of working with 'hard to reach'	Connection's Centre	Any other comments
HV 12 years	HV 10 years	450 or 19000 GP population	Yes families with addiction issues, domestic abuse, homeless travelling families	4	
HV 6 years	HV 6 years	450 Or 19000	Yes travelling families, low level educational achievement, homeless, ethnic minorities	4	'hard to reach' differs from area to area and practice to practice
HV 10 years	HV 7 years	As above	Yes – young teenage parents homeless families Polish and Asian families and those that do not see the need for a HV	4	

Appendix 6: Topic Guide for Focus Groups

Preamble: Thank you very much for agreeing to take part in today's focus group. Firstly, let me explain a little about myself and this work. I was awarded a research scholarship to examine the role of the health visitor in relation to working with 'hard to reach' families in the context of a multi-agency setting – Children's Centres. I am interested in how HVs are working with 'hard to reach' families and how 'hard to reach' is defined in practice. The information gathered from today and other focus groups will add to my understanding of the topic and will inform my research. Any questions?

What are your thoughts on the term 'hard to reach'? How does the term apply to health visiting and health visiting clients?

Could I now ask you to share your experience of assessing the health needs of 'hard to reach' families? In your experience of providing services to parents and families have you found any particular group or groups of families harder than others to reach? *If yes probe for characteristics of families. Probe around different terms used to describe such as vulnerable families, marginalised or isolated.*

Do you have any ideas about which families might have the most difficulties in accessing services that you offer?

Have there been families that you have found it difficult to work with for any reason? *If yes can you describe what the difficulties were? Probes: only partially engaging/poor attendance? Having more than one service involved with the family?*

Did you find any solutions to these difficulties?

Which families have you found easiest to help? What is it about these families that make them easier to work with?

Have you found families who appeared happy to engage but have been difficult to move forward? *If yes have you ever managed to develop strategies to help with these families?*

Have you been involved with work specifically aimed at reaching 'hard to reach' families? *If yes, what did it involve?*

To recap, what helps in working with 'hard to reach' families? What hinders you working with 'hard to reach' families?

How do you evaluate how you are working with this client group?

Before we finish is there anything else anyone would like to add?

Thank you for taking part.

Appendix 7: Poster Information displayed during participant observation



Access to Children's Services Study

Information for parents and carers

BABY CLINIC

Today there will be a student researcher present. Her name is Kathy Mumby-Croft; she is also a health visitor.

She is not collecting information about the people attending. Instead she is looking at the activities and practices in the Children's Centre.

However, if you do not wish her to be present then please speak to Fiona or Kathy.

Appendix 8: Poster to advertise and recruit interview participants



Have you just become a mum or dad?

Would you be willing to talk with Kathy a researcher, who is really interested in hearing about what Mum's and Dad's think of health and children's services.

If you want to find out more please ask
a member of the Sunshine Centre or call/text
Kathy Mumby-Croft on

cripacc Centre for
Research in
Primary and
Community Care

University of
Hertfordshire **UH**

Appendix 9: Information for Interview participants



Access to Children's Services Study/ Parents information

You are being invited to take part in an interview. Before you decide you need to understand why the research is being done and what it will involve for you.

Please take your time to read the following information carefully.

Talk to others about it if you wish.

What is the Purpose of this study?

I would like to find out about you and your baby's experiences of local services provided for children and families.

Why have I been asked to take part?

I am asking you to take part because you are a new parent and you live near a children's centre. I am interested in your important views on the services that you have received.

What is involved?

I would like to talk to you on two separate occasions. I will arrange to meet at a time and in a place that suits you. When we meet I would like to find out about your experiences of health services and other local services for families in your neighbourhood. I am interested in your opinion; there are no right or wrong answers. This meeting will be as short or as long as you want it to be.

With your permission the meeting will be recorded

Do I have to take part?

Absolutely not, it is up to you to decide. No one is taking part in this study that doesn't want to. Even if you say yes, you only have to answer the questions you want to and you are free to stop at any time.

Is it confidential?

YES, it is important for me to guarantee both confidentiality and anonymity. Everything you say will be treated in strict confidence and in accordance with university guidelines. Your comments may be used as quotations within the study findings but will be anonymous and you will not be identified. All the tape recordings will be kept in a secure place and information stored on a computer will be password protected. Only my supervisors and I will have access to it. At the end of the study the recordings will be destroyed

The only time I would have to break confidence is if someone is at risk of serious harm.

PIS interviews version 2 17.02.09 NMSCC/12/08/6/A

Will I receive payment for taking part?

You will receive a voucher or phone top up card to the value of £20.00 for taking part in the study. This is a thank you to you for giving your time and expertise to this study

Findings and further information

There are unlikely to be any benefits to you for taking part but what you tell me may help to improve services in the future.

Who is carrying out the study?

My name is Kathy Mumby-Croft. I am a student researcher at the University of Hertfordshire. My supervisors are Professors Fiona Brooks and Sally Kendall at the Centre for Research into Primary and Community Care. University of Hertfordshire. I have been through Enhanced Criminal Records Vetting Procedures (police checked) and therefore it is safe for you to meet with me.

What do I have to do now?

If you agree to take part in the interview, simply sign the form at the end of this leaflet and return it to me in the pre-paid envelope. Or you can contact me by text or phone. My mobile number is 07990 123456

What if there is a problem?

If you agree to take part and then have a concern about any aspect of the study, you should ask to speak to Kathy Mumby-Croft or contact Professor Fiona Brooks at CRIPACC on 01438 251111

Thank you for reading this information sheet

For more information about this study please contact:

Kathy Mumby-Croft
Centre for Research in Primary and Community Care
University of Hertfordshire
Mobile 07990 123456

Appendix 10: Example of a Consent Form for In-Depth Interviews



Consent Form for In-Depth Interviews

Title of Study: Access to Children’s Services

Reference Number: NMSCC/12/08/6

To be carried out by:

Name of Researcher Kathy Mumby-Croft

I confirm that the researcher has explained the purpose of the study to me and that I have been informed of the details of my involvement in the study.

I confirm that my questions regarding involvement with this study have been answered to my satisfaction.

I confirm that I understand that I am not obliged to participate in this study and that I may withdraw from the study at any stage without the need to justify my decision and without personal disadvantage.

I understand that any personal information I consent to provide will be treated as confidential and will not be made publicly available.

I agree to take part in the study

Name	Date	Signature
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Name of Researcher	Date	Signature
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Appendix 11: Topic guides for Interviews

Interview Schedule

Access to Services

Introduction

Hello, I'd like to tell you a little about myself, my name is Kathy Mumby-Croft – show id badge - and I am a student researcher at the University of Hertfordshire.

Thank you for agreeing to talk to me. This interview is part of a study that is aiming to find out about people's thoughts and experiences of health and children's services available in this area since you have become a parent.

You will have received the leaflet (show leaflet) is there anything that you would like to ask me? Everything you say is confidential as per the leaflet. You do not have to answer all the questions I ask you and we can stop the interview at any time.

I would like to tape record the interview, this means that I can listen to what you say to me. I now need to explain about confidentiality. The tape will be given a number and any mention of your name will be removed, I will type up the interview and it will be stored in a locked cupboard and on a password protected computer. I will discuss the recording with my supervisors. This is standard practice. Are you happy for me to continue?

Average day

To begin with could you describe to me 'an average day', since having your baby what do you do on a average day?

Staying healthy since becoming a parent

Since becoming a parent, how healthy do you feel? What are your thoughts on your health and your family's health?

What helps you stay healthy? How do you find out about keeping your baby healthy?

We all have difficult days especially after having had a baby. Are there days when you feel you need a bit more help? What sort of help do you need? Who do you talk to/ go if you are not feeling well or sure about things to do with your baby?

Where do your family and friends live in relation to yourself? How often do you see friends and family? Is that the same/different since becoming a parent?

Have you ever seen a health visitor or midwife at home? Can you remember what that was like? Can you remember if they gave you any information? What did you think to the information? Have you used any of it since? Was there some other information that would have been helpful?

What do you understand about the health visitor?

What was helpful/unhelpful about seeing them? Do you know how to contact them now? Do you think you would get in touch with them again?

Questions about the Area

How long have you lived here for? Why did you move to this area? What is this place like to live in? How do you feel about living here? What do you like /dislike?

What sort of image does the area have? Is there anything around here that affects your health?

Do you have any contact with your neighbours? Do you know any other mums in this area that you see? Do you know of any local activities for parents and babies?

Attending formal events

What do you understand about the local children's centre? Have you received any information about it? What sort of information?

Do you take part in anything at the children's centres? Or attend any health clinics or children centres? When you visited what was your experience, understanding?

Are there any reasons why you do/don't take part?

Is there any suggestion that you could make that would encourage more people to attend? If you were promoting the children's services, what would you suggest?

The Future

What are your hopes for yourself?

What are your hopes for your daughter/ son?

Background

Can you tell me a bit about yourself

Who lives here with you? (Your home address)

Household composition, tenure of property, ethnicity, marital status,

Employment status, occupation, qualifications, income, access to a car or telephone

Thank you very much for taking part in the interview is there anything else you would like to add?

Appendix 12: Information/consent Audio recording of Baby Clinic



Access to Children's Services Study

Parents information

For more information about this study please contact:

Kathy Mumby-Croft

Email:

What is involved?

I am planning to observe baby clinic today and with your permission to observe and record the meeting between you and the health visitor

Do I have to take part?

Absolutely not, it is up to you to decide. No one is taking part in this study that doesn't want to. Even If you say yes, you are free to stop the recording at any time.

Is it confidential?

YES, everything you say will be treated in strict confidence and in accordance with university guidelines. Your comments may be used as quotations within the study findings but will be anonymous and you will not be identified. All the tape recordings will be kept in a secure place and information stored on a computer will be password protected. Only my supervisors and I will have access to it. At the end of the study the recordings will be destroy

Who is carrying out the study?

My name is Kathy Mumby-Croft. I am a student researcher at the University of Hertfordshire. My supervisors are Professors Fiona Brooks and Sally Kendall at the Centre for Research in Primary and Community Care. University of Hertfordshire.

What do I have to do now?

If you agree to take part, simply sign the form at the end of this leaflet

What if there is a problem?

If you agree to take part and then have a concern about any aspect of the study, you should ask to speak to Kathy Mumby-Croft or contact Professor Fiona Brooks at CRIPACC on.

Thank you for reading this information sheet

Consent Form for Audio Recording during Baby Clinic

Title of Study: Access to Children's Services

Reference Number: NMSCC/12/08/6

To be carried out by:

Name of Researcher: Kathy Mumby-Croft

I confirm that the health visitor has explained the purpose of the study to me and that I have agreed to have my clinic session with the health visitor tape recorded

I confirm that my questions regarding involvement with this study have been answered to my satisfaction.

I confirm that I understand that I am not obliged to participate in this study and that I may withdraw from the study at any stage without the need to justify my decision and without personal disadvantage.

I understand that any personal information will be treated as confidential and will not be made publicly available.

Name	Date	Signature
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Name of Researcher	Date	Signature
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Appendix 13: Audio recording poster displayed in the Children's Centre



Access to Children's Services Study

Information for Mums and Dads

BABY CLINIC



Today there will be a student researcher present. Her name is Kathy Mumby-Croft; she is also a health visitor. **She would like to tape record this session.**

She is not collecting information about the people attending. Instead she is looking at the activities and practices in the Children's Centre.

However, if you do not wish her to be present then please speak to the health visitor or receptionist.

Appendix 14: Tools of Inquiry from Gee 2005 (pp.110-111)

Essentially, discourse analysis involves asking questions about how language at a given time and place, is used to construe the aspects of the situational network as realised at that time and place and how the aspects of the situation network simultaneously give meaning to that language (remember reflexivity). (Gee 2005 p.110)

Building significance

How and what different things mean – the sort of meaning and significance they are given is a component of any situation.

1. What are the situated meanings of some of the words and phrases that seem important in the situation?
2. What situated meanings and values seem to be attached to places, times bodies, people objects, artefacts and institutions relevant in this situation
3. What situated meanings and values are attached to other oral and written texts quoted or alluded to in the situation (intertextuality?)
4. What Discourse models seem to be at play in connecting and integrating these situated meanings to each other?
5. What institutions and or Discourses are being (re)produced in this situation and how are they being transformed in the act?

Building Activities

Some activity or a set of activities is a component of any situation (the specific social activities in which the participants are engaging; activities are in turn made up of a sequence of actions

6. What is the larger or main activity (or set of activities) going on in the situation?
7. What sub-activities compose this activity?
8. What actions compose these sub activities and activities?

Building identities

Any situation involves identities as a component, the identities that the people involved in the situation are enacting and recognising as consequential

9. What identities (roles, positions with their concomitant personal, social and cultural knowledge and beliefs cognition), feelings (affect) and values, seem to be relevant to, taken for granted, or under construction in this kind of situation?
10. How are the identities stabilised or transformed in the situation?
11. In terms of identities, activities, and relationships, what Discourses are relevant and irrelevant in the situation? How are they made relevant (irrelevant) and in what ways?

Building Relationships

Any situation involves relationships as a component, the relationships that the people involved in enact and contract with each other and recognise as operative and consequential

12. What sort of relationships seems to be relevant to, (irrelevant) taken for granted in, or under construction in the situation?
13. How are these social relationships stabilised or transformed in the situation?
14. How are other oral or written texts quoted or alluded to so as to set up certain relationships to other texts, people or Discourses?
15. In terms of identities, activities and relationships what Discourses are relevant and irrelevant in the situation? How are they made relevant and irrelevant and in what ways?

Building Politics (the distribution of social goods)

Any situation involves social goods and their views on their distribution as a component

16. What social goods (e.g. status power aspects of gender, race and class or more narrowly defined social networks and identities) are relevant (and irrelevant) in this situation? How are they made relevant (irrelevant)? And in what ways?
17. How are these social goods connected to the Discourse models and discourses operative in this situation?

Building connections

In any situation things are connected or disconnected relevant to or irrelevant to each other in certain ways

18. What sorts of connections- looking backwards or forwards are made within and across utterances and large stretches of the interaction?
19. What sorts of connections are made to previous or future interactions, to other people, ideas, texts, things, institutions and Discourses outside the current situation(this has to do with intertextuality)
20. How is intertextuality used to create connections among the current situations and other ones or among different Discourses?
21. How do connections of the sort in 18,19,20 help together with situated meanings and discourse models to constitute coherence and what sort of coherence in this situation?

Building significance for sign systems and knowledge

In any situation, one or more sign systems and various way of knowing are operative orientated to and valued or disvalued in certain ways

22. What sign systems are relevant or irrelevant in the situation (e.g. speech, writing images and gestures) how are they made relevant In the situation? How are they made relevant (irrelevant) and in what ways?
23. What systems of knowledge and ways of knowing are relevant or (irrelevant) in the situation? How are they made relevant and (irrelevant), and in what way
24. What language in the sense of national languages are relevant (irrelevant) in this situation?
25. What social languages are relevant in the situations How are they made relevant (irrelevant) and in what ways?
26. How is quoting or alluding to other oral or written texts used to engage with the issues in questions