



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

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

3

4 **Abstract**

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

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

23

24 **Introduction**

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

34

1 Health visitors are UK public health practitioners who provide a universal service to
2 families with children under five years of age and targeted services for more
3 vulnerable families (Cowley et al., 2015). The three core practices of health visitors
4 are home visiting, relationship formation, and health needs assessments (Whittaker,
5 2014; Malone et al. 2016). Home visiting is essential for being able to tailor
6 intervention for families' needs (Doi et al. 2017). A strong, trusting relationship is of
7 utmost importance when working with families (Myors et al. 2014; Whittaker, 2014),
8 especially when introducing targeted services (Marshall et al. 2014).

9

10 Health visitors have always provided advice for parents (Doi et al. 2017; Hogg et al.
11 2013a) and are ideally placed to deliver interventions for children with behaviour
12 problems (Myors et al. 2014; Cowley et al. 2013). Parents report positively on the
13 health visiting services and especially value their knowledgeable advice on parenting,
14 child behaviour and development (Brook and Salmon, 2017). It is of concern,
15 therefore, that many parents report reducing service levels over recent years with less
16 visits from health visitors, less time to support families, and high rates of staff
17 turnover (Brook and Salmon, 2017; Glasper, 2017; Whittaker et al. 2015). This
18 appears to be due to increasing caseloads, more complex cases, and public health
19 funding cuts (Appleton and Sidebotham, 2018; Glasper, 2017). Parental concerns
20 about their child's behaviour is a strong predictor for increased service use putting
21 increasing pressure on the health visiting service (Wilson et al. 2013). Health visitors
22 are reporting large and growing caseloads of children with behaviour difficulties.
23 Wilson et al. (2008a) found that 34% of health visitors had 10 or more child
24 psychological, emotional and behavioural cases in their current caseloads, the most
25 common problems being externalising behaviour problems. They also report spending
26 a lot of time dealing with these cases, with 20% spending more than four hours a
27 week with families of children with behaviour problems (Wilson et al. 2008a).
28 Working with children aged 3-5 years is more time-consuming and complex than
29 infants (Myors et al. 2014). Many report feeling ill-equipped in assessing the parent-
30 child relationship and want more training (Kristensen et al. 2017; McAtamney, 2011;
31 Wilson et al. 2008b).

32

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

1 suggests that people learn through observing others (Furlong et al. 2012; NCCMH,
2 2013). A number of health visitor-led interventions for parents of children with
3 behaviour problems (e.g. conduct problems, hyperactivity, sleeping and eating
4 problems) have been reported, however evaluations have tended to have small
5 samples and are frequently conducted within one service setting (e.g. see reviews by
6 Public Health England, 2015; Whittaker, 2014; Cowley et al. 2013).

8 **The Enhancing Parenting Skills Programme**

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

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

1 **Aim of Current Study**

2 The aim of this study is to report participant feedback regarding the usefulness of the
3 training, and various course components, of the revised EPaS training with health
4 visitors in north Wales and Shropshire. A separate paper reports on the benefits to
5 families in terms of significant reductions in child behaviour problems (Williams,
6 2017).

7

8 **Methods**

9

10 **Design**

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

15

16 **Ethical approval**

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

20

21 **Participants**

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

34

1 **Materials**

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

12
13 The EPaS feedback questionnaire (also developed as part of the EPaS programme)
14 was used to gather health visitors' feedback on the training after completing the EPaS
15 programme with a family. The questionnaire consists of three sections: 1) views on
16 how helpful the course teaching was on various components; 2) confidence in their
17 knowledge and ability to apply the EPaS approach; 3) general feedback on the course.
18 There was also an option to give any further feedback. The questionnaire was
19 completed by health visitors after they finished delivering the programme with a
20 family and returned to the research team through the post or email.

21
22 **Procedures**

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

- 27 1) assessment phase – introduces a standard assessment procedure that includes a
28 range of tools including questionnaires, interview schedules, and observation skills.
29 These were used to collect information about the family, their current circumstances,
30 specific child problem behaviours, child's skills and strengths, and parents' goals;
31 2) case analysis phase – teaches how to produce a case analysis based on the
32 information collected in the assessment sessions. A case analysis is an aid to
33 understanding the problem, its history and current function, the assets available in the
34 situation that will support change, and potential short and longer-term goals for

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

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

18 Results

19

20 Demographic Data

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

25

26 Current Use of Behavioural Techniques

27 Health visitors were asked about their current use of behavioural techniques. Table 1
28 reports numbers and percentages for health visitors that used the techniques always or
29 often. Table 1 also provides a comparison with data from Lane & Hutchings (2002).
30 Health visitors reported varying rates of the different techniques in their work with
31 families. Most often used were teaching parents to reinforce alternative behaviours
32 (75.7%) and discussing specific factors in the home environment (83.8%). Compared
33 to Lane and Hutchings (2002) the least used technique was providing written

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

3

4 Table 1

5 *Baseline questionnaire results*

Use of behavioural techniques¹	Lane & Hutchings (2002) (N = 11) n (%)	All (N = 37) n (%)
Record what is happening during observation	3 (27)	19 (51.3)
Design record sheets and ask to keep records	6 (55)	12 (32.4)
Provide written summary homework tasks	5 (45)	4 (10.8)
Provide written agreements for specific goals	2 (18)	5 (13.5)
Provide star charts and record sheets	5 (45)	15 (40.5)
Use observation/records to determine what works best as best reinforcement and punishment	4 (36)	11 (29.7)
Provide specific feedback based on observations/records	7 (64)	21 (56.7)
Teach to reinforce alternative behaviour	6 (55)	28 (75.7)
Discuss specific factors in home environment	7 (64)	31 (83.8)
Mean use of techniques	5.0 (45)	16.2 (44)

6 ¹ Represent those who answered ‘always’ and ‘often’

7

8 **Confidence in Using Techniques**

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

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

10
11 Eighteen (62.1%) health visitors had both baseline and follow-up data (see Table 3)
12 and all had delivered EPaS programme with a family. There was a significant change
13 in confidence with 100% reporting that behavioural approaches were useful to
14 families ($p < .001$). For the two other questions, there were mean increases in
15 knowledge and confidence but these did not reach clinical significance.

16 17 **Health Visitor Feedback on EPaS Course**

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

22
23 Feedback was very positive with 90.5% rating the teaching of all behavioural
24 techniques as 'very helpful' or 'a little helpful'. The general course feedback was
25 positive with all respondents reporting that they would continue to use the course
26 methods. The majority (88.9%) were satisfied with the written material. For the
27 overall course, 72.2% were satisfied and two-thirds (66.7%) would recommend it to a
28 colleague. Some health visitor added comments put these percentages into
29 perspective.

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- 1 Table 2
- 2 *Baseline levels of confidence*

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

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1 Table 3
 2 *Change in confidence*

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

3 *Note: * significant at p < .001*

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- 1 Table 4
 2 *Feedback on course (N = 18)*

Teaching of behavioural techniques on course	Helpful¹ n (%)
Record what is happening during observation	18 (100)
Design record sheets and ask to keep records	18 (100)
Provide written summary homework tasks	15 (83.3)
Set homework tasks in reading	14 (77.8)
Provide written agreements for specific goals	17 (94.4)
Provide star charts and record sheets	14 (77.8)
Use observation/records to determine what works best as best reinforcement and punishment	17 (94.4)
Provide specific feedback based on observations/records	16 (88.9)
Teach to reinforce alternative behaviour	17 (94.4)
Discuss specific factors in home environment	17 (94.4)
Course feedback	n (%)
Overall course	
Satisfied	13 (72.2)
Neutral	4 (22.2)
Dissatisfied	1 (5.6)
Written material provided	
Satisfied	16 (88.9)
Neutral	2 (11.1)
Continue to use methods	
Likely	18 (100)
Recommend to colleague	
Likely	12 (66.7)
Neutral	4 (22.2)
Unlikely	2 (11.1)

3 ¹ Represent those who answered 'very helpful' and 'a little helpful'

- 4
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 6

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

22

23

Discussion

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

34

1 The need for clinical supervision from clinical psychologists was highlighted in the
2 post-course feedback. Clinical supervision is an important part of effective
3 programme implementation and is recommended by the Royal College Nursing
4 (2014). For the current study, clinical supervision from local clinical psychologists
5 was planned but, due to scheduling difficulties, this did not happen. Future research
6 should explore the feasibility of adding clinical supervision.

7 8 **Limitations**

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

15 16 **Conclusion**

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

26 27 **Acknowledgements**

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29 in the research.

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