

## MENTAL HEALTH CARE

# The Solihull Approach: changes in health visiting practice

Health Visitors in Solihull now have access to systematic approach to working with children with behavioural problems. The authors, HAZEL DOUGLAS and MICHELLE GINTY, explain the background to the approach and some of the benefits it brings into practice

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The Solihull Approach is a psychotherapeutic and behavioural approach for health visitors working with children with sleeping, feeding, toileting and behavioural difficulties. It has been developed over the past three years by project groups of health visitors, child psychologists and child psychotherapists. Other professionals have also contributed their expertise when necessary.

The project began in response to a request for sleep clinics. All health visitors in the area had children with sleep difficulties on their case-load and they required resources and training to support them in managing these children. Following a literature search and extensive networking across the country, a resource pack was compiled. Project group members supplemented this with training for their colleagues. The approach was so successful that the health visitors requested that the same process be carried out for children with eating, toileting and behavioural problems.

As the work evolved in response to the needs of health visitors in improving practice, it became clear that the project was in step with national initiatives, for example, Sure Start<sup>1</sup> and the consultation document *Supporting Families*.<sup>2</sup>

## Theoretical Model

The project resulted in the evolution of a strong theoretical model, together with a comprehensive resource pack. The theoretical model is intensely practical, in that each component informs practice. None of the theory is new, but what is new is the combination of different theoretical ideas into one model and the extension of them all into practice.

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The theoretical model has three components:

- containment
- reciprocity
- behaviour management

### Containment

This is a theory from the psychoanalytical tradition. It was developed Bion,<sup>3</sup> based on the work of Freud and is the most influential concept with psycho-analytical theory.<sup>4</sup> Containment describes the process whereby the parent is able to help the child process intense emotions and anxiety, rather than the child being overwhelmed by them.

This helps to develop the child's capacity to think. The idea of applying this theory to the work of health visitors became accessible through the work of Dilys Daws,<sup>5</sup> a child psychotherapist who worked in a baby clinic with families with children with sleep problems.

She found she could often work with the parents and child to resolve the difficulty within a few sessions. The containing function of the health visitor works by containing the anxiety and overwhelming feelings of the parents, restoring in them the ability to think. This often empowers the parents to solve the problem for themselves.

### Reciprocity

This is a theory from child development research. It was first described by Brazelton *et al* in their ground-breaking work *The origins of reciprocity: the early mother-infant interaction* and has led to many theoretical developments by other child development researchers. It describes the process whereby the parent and infant actively develop their interaction to be in tune with each other. This sounds deceptively simple, as it forms the basis for language<sup>7</sup> and relationships.

Tronnick<sup>8</sup> has highlighted the negative effects for babies of mothers who suffer from post-natal depression, as the mothers capacity to participate actively in this interaction with her baby is severely compromised.

Health visitors are able to observe mother-child interactions and deduce the level of reciprocity between them. It is then possible for the health visitor to give feedback about whether the parents are helping and encouraging the child when the child is ready or whether they fail to respond adequately to the child's cues by dominating the interaction or by being distant and unavailable. The health visitor can also observe the level of reciprocity between the parent and her/himself, both as a measure of how the therapeutic relationship is developing and as another clue to the relationship between parent and child.

### Behaviour Management

Based on learning theory is probably the most familiar concept of the three. Behaviourism, which originated in the early 1900s, concentrated purely on observable phenomena in order to understand behaviour. This led to the development of learning theories such as classical conditioning<sup>9</sup> and operant conditioning.<sup>10</sup> There is now a huge and influential body of research on stimulus-response learning in people. Mayer<sup>11</sup> proposed that 'behaviour therapy and child rearing have much in common'. Parents use reinforcement all the time for desired behaviour. They praise and give attention. They punish undesirable

behaviour with an immediate and strong 'No'. For example, they shape a child's behaviour, helping the child gradually to develop new skills, chaining or linking together actions towards the final skill of, for example, getting dressed. They try to be consistent. They have clear rules and expectations. They act as role models. The health visitor can help a family by observing if this process has gone astray and by making suggestions, when the parents are in a sufficiently confident state to put them into practice.

Using this model together with the resource materials is already helping some families. Mary Rheeston's case-study in Douglas<sup>12</sup> illustrates one health visitor's experience of using the Solihull Approach.

**Evaluation**

The first evaluation of the effect of the Solihull Approach on the practice of health visitors has been completed. All the health visitors were sent a questionnaire which included specific closed questions related to perceived changes in practice since the introduction of the approach, covering issues such as referral procedures to the child psychology service and the usefulness of different components of the Solihull Approach.

They were provided with a short description of a hypothetical case and asked how they would have responded before and after the implementation of the Solihull Approach. The health visitors were also invited to respond to open questions asking about any perceived strengths and weaknesses of the Approach and recommendations for improvements.

As well as the questionnaire, an audit was carried out of the referrals to the child psychology service over the previous four years with regard to the number referred by health visitors and the level of difficulty of the cases.

The response rate to the questionnaire was 71 per cent, the high rate reflecting the interest of the health visitors in this model of work.

The results showed that health visitors thought that the Solihull Approach had affected their Practice (figure 1), in particular, helping them become more consistent in their approach. But the approach did not require more time

than previous interventions used.

Table 1 describes before and after the implementation of the Solihull Approach, the percentage of health visitors who would have arranged an assessment appointment for the mother described in the case-study, the mean time scheduled for the assessment and the intervention and the percentage of health visitors who would have arranged automatic follow-up appointments.

Based on Fisher exact one-tailed analysis, this table demonstrates a statistically significant shift in approach with regard to the offer of an in-depth assessment (p=0.01). This indicates that since the introduction of the Solihull Approach, health visitors place greater emphasis on assessment. In terms of times for assessment and intervention and the opportunity for follow-up appointments there are no statistically significant differences. This shows that the professional time required to intervene has not increased.

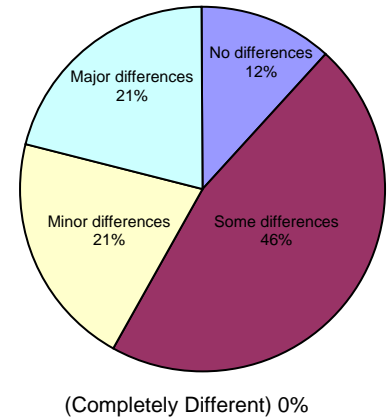
There is evidence that health visitors have developed a more consistent approach since the introduction of the Solihull Approach. In terms of the mean time proposed for assessment and intervention, each standard deviation is smaller for the 'after' group compared to the 'before' group.

In addition, there appears to be a higher level of agreement between health visitors in the 'after' group, in relation to the offer of an assessment and follow-up appointment. Eighty-eight per cent of health visitors, who responded, also reported that the impact of the Solihull Approach is uniform across the four targeted areas of difficulty.

When health visitors were asked to state three ways in which their practice has been improved, not changed and adversely affected by the introduction of the Solihull Approach, several positive themes emerged.

Health visitors perceived that the Approach's introduction has provided them with a broader understanding of how difficulties develop and a structured and consistent approach from which to help a family overcome them. Using this structure, health visitors reported they have an enhanced understanding of the role of containment and reciprocity and are able to plan their contact with families

**Figure 1: Health visitor perceptions of the level of impact of the Solihull Approach**



more effectively in terms of time and resources. Health visitors reported that by achieving this, their confidence in their own skills and practice was greatly enhanced.

As well as detailing routine aspects of work such as developmental assessments that have been largely unaffected by the introduction of the Solihull Approach, health visitors reported that, while their intervention plans may be the same, the application of these within the context of more holistic assessments improved their quality.

The data in table 1 showed no significant time differences between the 'before' and 'after' group for assessment and intervention. However, two health visitors did report the only adverse effects as being time constraints arising from the in-depth assessment. This is probably because the Approach emphasises the importance of a holistic assessment and that this becomes part of the intervention, so it may be that the assessment does take longer for some health visitors compared with their previous method of assessment.

Other health visitors commented that although initial contacts may be more time consuming, the overall contact time decreased, because a positive outcome is likely to be achieved more quickly. The data showed no significant differences in contact time.

The most useful component is judged to be the resource pack, followed by the 'handy hints' section. None of the components were considered useless by the health visitors.

**Recommendations**

Suggestions for improvements from the health visitors fell into three categories:

- Ways in which the resource pack and administration could be improved, such as how parent leaflets could be made more accessible for certain groups of parents by simplifying them.

**Table 1: Details of case management**

	Before	After
Assessment appointment	42%	92%
Mean time of assessment (minutes)	65,000 (SD 20560)	62,692 (SD10919)
Mean time of Intervention (minutes)	98,182 (SD 61615)	58,333 (SD14512)
Automatic follow-up	69%	100%

- Areas in which the Solihull Approach could be expanded, such as group work, older children and children with special needs.
- The issue of containment for health visitors' anxieties and the role of supervision.

These suggestions are being followed up. The information and leaflets for parents are being rewritten for the next (third) edition of the pack. A second volume is currently under consideration which will apply the Approach to accident prevention, child protection and children with special needs. A project is being undertaken with school nurses to develop the material for older children, with a greater emphasis on the involvement of educational staff.

Supervision and containment for the health visitors themselves is crucial, to support them in the demanding work they undertake with families. Layers of systems have been put in place in Solihull, but these can still be improved upon. If a health visitor wishes to discuss a case, there is a specific hour each week when any health visitor can telephone the specialist Child and Mental Health Service (CAMHS). Telephone calls are encouraged at other times too, as is discussing cases before referral, because in some cases a referral is not needed. Monthly case discussions have also been held.

After experimenting with the format, the most useful seems to be a further presentation on either sleeping, feeding, toileting or behavioural issues at the professional meeting, followed by case discussions in the next six months concentrating on specific topics. If the Solihull Approach has not worked sufficiently well, the health visitor can refer the family to a fast track service for under-fives run by CAMHS, where appointments are generally given within four weeks of referral. The health visitor can attend the session together with the family, if both the health visitor and the family agree.

After this, there are the usual referral systems into CAMHS, although the service has shifted by becoming more responsive to young children, which will be supported by the local Sure Start project. Multi-agency screening has also been developed, available for children under the age of five years suspected of being on the autism spectrum and for those who may have attention deficit and hyperactivity disorder (ADHD).

Other possibilities could also be explored, such as peer discussion/support groups and strengthening the place of support within general supervision.

### Changes in Practice

The most valuable changes in health visitors' practice as a result of the Solihull Approach appears to be the structure and framework it provides for encouraging a consistent approach

across health visitors towards sleeping, feeding, toileting and behavioural difficulties. Evidence in support of this is extensive. Consistency was highlighted by a number of health visitors as an improvement to practice and on the majority of closed questions the health visitors in the 'after' group demonstrated a higher level of agreement.

Another strength of the Solihull Approach is that it provides health visitors with a resource of up-to-date information related to the four difficulties targeted. Ninety-six per cent of health visitors who responded indicated that this resource was either 'useful' or 'extremely useful'. It is also clear that the resource is regularly used by the health visitors because their responses to the open-ended questions included detailed references to it.

The clinical audit of referrals did rely on subjective reports from health visitors. The previous four years of referral were audited. It showed that although changes in the overall number of referrals to child psychology and psychotherapy services is questionable, there do appear to be significantly less children being referred with the four simple difficulties targeted by the Solihull Approach, and in particular those with behavioural difficulties.

The audit suggested that they were referring children with more complex problems. This is welcome from the point of view of identifying and intervening with children with complex difficulties as early as possible. Health visitors are the professional group who are in the best position to identify and refer these children to the appropriate agency.

The Audit Commission, in its report *Children in Mind*,<sup>13</sup> showed that child and adolescent mental health services spent the smallest amount of their time on children under the age of five years. In terms of prevention this makes no sense at all. In some way, which we have not yet fully examined, the Solihull Approach helped the health visitors to be more confident about referring these children. One finding was that health visitors had a much clearer idea about the role of the child psychology and psychotherapy service.

A research project evaluating the effectiveness of the Solihull Approach with parents and their children began in May 2000.

### Conclusion

The evaluation of the effect of the Solihull Approach on health visitors' practice showed it:

- Improves consistency of approach between health visitors.
- Increases job satisfaction.
- Enable health visitors to work more effectively with children with less complex sleeping, feeding,

toileting and behavioural difficulties and these children are no longer referred to the child psychology and psychotherapy service.

- Does not increase the overall time required for assessment and intervention when using the Solihull Approach.

Suggestions from the health visitors about developing the Solihull Approach are now being taken up. One development is a joint venture between Solihull Healthcare Trust and the University of Central England to create a National, accredited open learning resource for health visitors, so that the resource pack can be used as an open learning course. This will be available later this year.

It will also be available for Primary Mental health care workers who were not part of the target audience but who have responded so enthusiastically to the approach. It is also possible that the model will be incorporated into the initial training of health visitors.

The local education service has asked for material to be developed for use by teachers and their support services. In conjunction with the local Sure Start Project and the Early Years partnership, training material will be developed for childminders and playgroup leaders.

The vision is to have a shared consistent understanding for everyone in the borough who works with children under the age of four years. This is quite an undertaking, but the enthusiasm of different staff groups and the response of parents is making it possible.

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