Health visitor views on consultation using the Solihull Approach: a grounded theory study

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Abstract
Consultation is integral to maintaining competence for health professionals and involves a collaborative relationship between specialist and primary care services. Although consultation aims to support them in their work, existing literature exploring health visitors’ experiences of consultation is limited. This study explored health visitors’ experiences of consultation in relation to their clinical practice, their experience of their work and its impact on the wider service. In all, 10 health visitors were interviewed using a semi-structured guide and analysis was subjected to a grounded theory framework. Participants’ views were influenced by a combination of factors – consultants’ training specific to their role, their communication and engagement, consultation’s support of joint-working and/or transitions, and its relevance to and impact upon practice.

Findings suggest that such interface activities require effective co-ordination, communication and structuring strategies, highlighting the importance of future initiatives in developing health visitors’ mental health role further. Given the comparative lack of evaluation of such activities, these findings may inform policymaking and service development to ensure high quality of service delivery.

Key words
Solihull Approach, health visiting, consultation, grounded theory


No potential competing interests declared.

Background

The requirement to provide early years family support reflects policies expressed in Healthy lives, healthy people (DH, 2010a) and the National Service Framework for children, young people and maternity services (DH, 2007) about the importance of family environment in ensuring that children achieve key positive outcomes. Specifically, this initiative was consistent with earlier research suggesting that difficulties in the parent-child relationship may have adverse effects on children’s emotional wellbeing and language development whilst associated with cognitive and behavioural problems and increased risk for violence and conduct disorders (Morrell and Murray, 2003; Scaramella and Leve, 2004).

Recent epidemiological data shows that most children with behavioural and emotional difficulties are managed in primary care while the prevalence rates of children accessing specialist services are much lower (Clarke et al, 2003). As a result, the Health Advisory Service (2000) emphasised that increased expertise in children’s mental health should be an intrinsic part of such agencies.

Nevertheless, one of the challenges of working with children facing such difficulties often revolves around the professionals’ lack of confidence, skills and experience to address and manage these issues (Hooijen, 1999). Consequently, the importance of training initiatives was highlighted as a key area for resource investment in order to address early manifestation of those difficulties in children. Such initiatives have thus been advocating the provision of early intervention services by supporting primary care workers in developing their mental health role further as well as identifying when a specialist referral is required (DH, 2010a).

Furthermore, reinforcing the effectiveness of mental healthcare in primary care services through interface or joint working was suggested as one of the tasks of specialist services, aiming to contribute to greater communication and shared understanding of roles at different tiers, thus delivering better services to families (Bradley et al, 2005). Indeed, the Department of Health’s commitment to improving access to psychological therapies proposed a stepped care model of care delivery requiring good communication and integration of services across primary and secondary services for optimal pathways to care (DH, 2010b).

Consultation-liaison process

Consultation-liaison is a model of interface between services, involving mental health specialists entering into an ongoing professional relationship with primary care clinicians in order to support them in their work. Although supervision is often regarded as a hierarchical process (eg consultees are often required to follow supervisors’ directives), consultation is defined as ‘collaborative problem-solving between a specialist and one or more persons, who are responsible for providing psychological assistance to another’ (Medway, 1979: 276).

Consultation in primary care is a prominent activity of specialist teams who provide indirect service delivery and help implement techniques to improve consultees’ skills in order to manage their clients’ difficulties. Nevertheless, little empirical work has been conducted concerning the role of this model in terms of organisational care and clinicians’ views toward their practice.

The role of health visitors

Health visitors provide on-going supportive contact with families by identifying problematic parent-infant relationships and child health problems and when appropriate, offering parenting guidance and effective interventions. There is substantial evidence that such service provision can have a major impact
upon children’s psychological health and family relationships. For instance, studies exploring pathways to specialist services have demonstrated that 82% of parents first discussed their children’s problems with their health visitors (Godfrey, 1998), while health visitors are the professionals most likely to identify autism spectrum disorders (Chakrabarti and Fombonne, 2005), and children at potential risk or in need of statutory protection (Ling and Luker, 2000). The health visitors’ pivotal role was also highlighted in the health visitor implementation plan (DH, 2011), which seeks to reflect how universal services have now begun to offer and access more specialist interventions.

**The Solihull Approach**

The Solihull Approach employs a theoretical model that integrates psychotherapeutic, child development and behavioural concepts (Douglas, 2007). It was developed in 1999 after a Solihull health visitor team raised their concerns regarding their limited resources and training to support their work. As a result, a theoretical model was developed from the work of Dillys Dawes (1991) and the Tavistock intervention model for under-fives (Miller, 1992), and it is often used as a brief intervention for professionals working with children with emotional and behavioural difficulties.

The model incorporates three concepts of containment, reciprocity and behaviour management (see Figure 1). Containment refers to processes by which one person ‘contains’ the perturbed emotional state of another without becoming overwhelmed and communicating this back to the person in a way that restores their capacity to think (Bion, 1993). Reciprocity refers to a shared synchronous behaviour indicated by parental ability to tune into their child’s needs (Brazelton et al., 1974). Behaviour management refers to the parental ability to work with behaviour positively whilst providing children with clear boundaries and rewards and encouraging them to self-control. The Solihull Approach implies a set of parallel processes whereby the parents’ ability to contain the infant and display reciprocity is promoted by having their anxieties contained by a professional who relates in an open and non-directive way.

**Study aims**

A specialist Parent-Infant Mental Health Team including clinical psychologists, and practitioners with health visiting and social work backgrounds trained in the Solihull Approach have been offering group and telephone consultation to health visitors within Norfolk. Consultation aims to provide health visitors with guidance on cases they may find difficult to work with by:

- Discussing their understanding of the presenting problems
- Helping them incorporate the theoretical concepts of the Solihull Approach into their work
- Identifying underlying root problems

Health visitors also discuss the appropriateness of referrals to other services and reflect on their work with the families. The process draws from the Solihull Approach by offering containment to the consultees and promoting reciprocal communication.

This study sought to explore how health visitors experience consultation using the Solihull Approach, specifically their views in relation to their clinical practice, their feelings about their work and its potential impact on the wider clinical service.

**Methods**

**Participants**

Team managers were consulted and asked to notify potential participants. Only staff working within Norfolk and accessing consultation were invited.

This resulted in 10 female participants being recruited from different teams within the region.

**Design**

Due to the exploratory nature of this study, a qualitative design was adopted and carried out within a grounded theory framework (Glaser and Strauss, 1967). Grounded theory allows researchers to develop new theories grounded in an iterative process involving simultaneous collection and analysis of data; analytic themes are therefore developed from data and not from preconceived hypotheses. With time, an understanding of different patterns underpinning the observed phenomena is built, which is firmly grounded in the concepts and theories of the individuals living in it. As grounded theory enables researchers to develop new theories in areas where there is little existing knowledge, this methodological framework was considered most appropriate.

Ethical approval was obtained from the local research ethics committee and research and development office.

**Data analysis**

Data analysis was carried out using Mason’s (2002) approach with reference to the principles of constructivist grounded theory espoused by Charmaz (2006). Although the analysis was conducted with the research questions in mind, the emergence of new constructs was encouraged by allowing participants’ accounts and interesting theoretical leads. Subsequent interviews were therefore developed around themes emerging from previous interviews.

To enhance trustworthiness and credibility of findings, several quality procedures were used. As transparency and reflexivity are important for demonstrating rigour, researcher’s presuppositions in relation to the research questions were shared with the research team and reflected on throughout the research process. The researcher also kept reflexive memos to detail decisions which were also reflected upon with the team throughout data analysis. Emerging data were triangulated with a colleague to ensure reliability and internal validity. Respondent validation was carried out with five participants to check how closely findings fitted with their experiences.

![Figure 1. Solihull Approach model](image-url)
Table 1. Themes and sub-themes by category

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
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| Consultants’ awareness of health visitors’ roles and needs | • Restrictions  
• Boundaries  
• Clients’ range of difficulties  
• Busy schedules  
• Limited time in group  
• Adaptability to health visitors’ schedule  
• Availability  
• Approachability  
• Implications of being the lead practitioner  
| Practical level – urgency to discuss in consultation  
• Emotional level – on their own feelings, feelings about families and work with their families  
| Consultants’ effective communication and engagement | • Common language  
• Consistent language, structured approach  
• Clear, shared understanding of difficulties  
• Clear, reciprocal communication  
• Listening and building empathy  
• I’m not alone, I’m being listened to, containment  
• Other people are going through what I am  
| Clear advice  
• Clear strategies and why  
| Reflecting  
• Space and time to reflect  
• My work is respected, valued, not undermined  
| I am doing the right thing  
| Valuing and validating  
| Confidentiality and ethics  
• Clear rules, safe environment  
| Handling, communicating sensitive information  
| Supporting joint working and transitions | • Make queries about raised issues  
• Specialist teams roles and responsibilities  
• Legal and procedural framework  
• Availability of other services  
• Referral rates  
| How to refer my client  
• Whom to ask and when, what happens next  
• Role of specialist services, nature of work from specialist teams, responsibilities  
| Protection and safeguarding issues  
• Which services, where, how  
• Rate of referrals  
| Quantity, quality of referrals  
| Consultation’s relevance to and impact upon their clinical practice | • Linking theory to practice  
• Evidence-based practice  
• Updating knowledge, continuous support and development in novel and familiar areas  
• Linking Solihull Approach concepts to family’s problems  
• Challenging their own representations by encouraging new perspectives  
• I am not colluding with families  
• Third or fresh perspective  
| Peer support and motivation to work with the team  
• Non-judgmental approach  
• Learning from each other  
| Safe environment  
| Identification, intervention skills  
• Holistic knowledge, approach  
| Time spent with clients, quality  
| General impact on practice  
| Assertiveness, confidence in skills and abilities  

Development of themes and categories

Open coding involved naming each transcript line, describing what it represented whilst remaining close to the data. Codes were constantly compared with those before and after it; this ‘constant comparative analysis’ method (Glaser and Strauss, 1967) facilitated the development of selective codes that were the most frequent and best captured the data (e.g. What does this represent? Why is this a representation of the idea? How else does this participant represent this idea?). Codes were grouped into sub-themes and were compared with each other and in relation to the original codes. Sub-themes were therefore collapsed, assimilated and redefined where appropriate. Each constant moving from sub-themes back to codes and vice versa ensured that the emergent sub-themes best fitted the codes. Sub-themes were reviewed to ensure they reflected the research aims and they cohered together meaningfully (‘flip-flop’ method, Glaser and Strauss, 1967). Negative cases were actively sought out to ensure that data were not reduced to a majority consensus view and sub-themes were modified to take account of contrasting perspectives.

Abstract themes were developed based upon the emerged sub-themes and were given titles that reflected the original data and the research questions. Constant comparisons were used to refine their fit with the emerging categories. Categories aimed to encompass the emergent themes and were reviewed to refine their interrelation and their fit with the research questions and the analysis process.

Results and discussion

This study explored health visitors’ experiences of consultation using the Solihull Approach in their work with families. Findings are summarised before a grounded theory account of how the emerging categories and themes fit together. Results are placed in a historical context whilst locating the findings in relation to the existing literature.

Overall, health visitors reported facing increasing demands in their work concerned with improving quality of care in several areas, including mental health. They required clear assistance on implementing improvements in their service so as to meet the aspirations of documents such as the health visitor implementation plan (DH, 2011). Results from this study suggest that such interface activities between primary and specialist services require effective
service co-ordination, communication and structuring strategies, and this highlights the importance of future initiatives to develop health visitors' mental health role further.

Health visitors' experiences were influenced by a combination of four main factors associated with broader change processes in service provision and the evolving roles of primary and specialist teams (see Table 1):

- Consultants' training specific to health visitors' role and needs
- Consultants' effective communication and engagement
- Support of joint working and/or transitions
- Consultation's relevance to and its impact on their clinical practice.

**Consultants' training specific to health visitors' role and needs**
Participants emphasised the increasing need for support compared to available consultants' capacity to take on more consultancy work. Participants felt that their schedules were further affecting their access to consultation. They reported having limited time to attend group consultation, finding it easier to arrange mutually convenient times to access consultation over the phone.

Furthermore, participants identified key areas of skills and knowledge for consultants working at the interface between services. Emergent themes identified the need for highly skilled consultants not only in relation to their knowledge about child mental health issues and teaching skills, but also their understanding of the specific nature of their work, their unique roles working with families and their wider work contexts:

"[The consultant] knows my job... boundaries... restrictions... our difficulties of working with families... exactly what you face really... so it makes it easier to pick up the phone" (Participant 3).

Other skills identified were consultants' ability to work flexibly and remain approachable, supporting that this specialist role requires advanced practitioners with heightened sensitivity to the needs of individual consultees (Lacey, 1999).

Health visitors also reported that regular consultation and containment for staff was crucial to support them in their increasingly demanding work undertaken with families. It seems imperative for the existing layers of support to be improved upon further, specifically in relation to promoting and encouraging more opportunities for both telephone and group consultation. Other possibilities could also be explored, such as peer discussion or support groups and strengthening support within general supervision.

**Consultants' effective communication and engagement**
Participants reported that accessing consultation provided them with a shared understanding of how difficulties develop and a structured and consistent approach in their work. Participants highlighted that consultation encouraged a common language, which in turn, promoted effective reciprocal communication among professionals. Participants reported that accessing consultation provided them with valuable space to reflect on their work and regarded empathy as a valuable component of the consultation process, helping them feel that their concerns were listened to:

"[Consultation] helps you reflect better on your case... because we don't have time for reflection ourselves, running from one visit to the next" (Participant 4).

However, participants emphasised the importance of consultants offering consultation in a way that does not undermine their own professional role and their work with families but rather, helps them develop their professional skills and expand their knowledge and experience in mental health issues further.

Other views that were expressed concerned ways of sharing information. Participants raised the importance of confidentiality issues and felt satisfied with consultants' handling of sharing and communicating sensitive information. Participants also valued the safe environment of the consultancy sessions and the freedom to discuss cases in a confidential manner.

**Support of joint working and/or transitions**
Participants highlighted advantages from accessing consultation in fostering an improved tiered system while advancing their understanding of respective professional roles and responsibilities as well as greater access to, and understanding of the services available. Participants were more confident to make queries about issues within their families and more aware of existing procedural frameworks, supporting that access to the perspectives of a variety of professionals may result in a comprehensive service delivery from primary care professionals (Richardson and Partridge, 2000).

Although participants emphasised joint working as a valuable way of reinforcing cross-sector working, opportunities to engage in this varied across teams depending mostly on the availability of consultants. Such limitations were reinforced by the small number of consultants across teams and their resulting difficulties in offering more joint work alongside the demands of their own specialist work. Participants reported that joint working helped them to gain a better understanding of families' problems, since consultants offered consultation from a position of having met the family. Participants also considered joint working to be a valuable training opportunity, enhancing their understanding of specialist teams' referral criteria.

Participants also felt that accessing consultation expanded their understanding of Common Assessment Framework and safeguarding procedures (DH, 2007), highlighting the importance of consultation for professionals with a high level of responsibility with regard to child protection. This is in line with recent policy initiatives and accords with Limbrick's (2004) notion of the Team around the Child, emphasising professionals' pivotal role in co-ordinated, multi-agency assessments and service delivery for and liaison with families.

Furthermore, participants reported that accessing consultation affected the quality of their referrals. They reported referring children with more complex problems to specialist teams as consultation enhanced their understanding of mental health issues, referral procedures and their awareness of appropriate services in their area:

"I can now recognise the serious problems easier... I am more aware of the available help out there... whereas I would have been stuck with some families otherwise" (Participant 6).
Consultation's relevance to and its impact on their clinical practice

Participants considered consultation an effective way of reinforcing and deepening the delivery of the Solihull Approach within their work. Specifically, accessing consultation enhanced their understanding of the role of containment and reciprocity, and how they related to their families' difficulties using an evidence-based approach. By achieving this, their confidence in their own skills was enhanced while their overall contact time with families decreased as faster positive outcomes were achieved:

'I feel more confident in my knowledge...which makes me build a better...more efficient relationship with parents...I often don't feel to spend too many sessions with them anymore' (Participant 10).

Participants reported that consultation was beneficial in improving their skills in both familiar and novel areas of their work. They also highlighted the importance of future initiatives in developing their mental health role further.

Finally, participants highlighted the value of emotional support and listening to different perspectives on their families' difficulties, which in turn lessened their sense of professional isolation. They also valued consultation's non-judgmental approach, which enhanced their sense of ease working with families and within their teams.

Implications and recommendations

Existing literature exploring health visitors' experiences of consultation offered by specialist teams is limited in quantity, scope and quality. It is therefore vital that interface activities between primary care and specialist services are being evaluated further to add to the existing evidence base.

Health visitors have an important role to play in encouraging commissioners to commission effective services, by strengthening screening, early intervention, prevention and health promotion, influencing this longer-term, positive outcomes for children and families. As there is no standard blueprint, findings from this study may provide services with an insight into what support service users are getting and what future input they would like to receive, a core component of the National Service Framework (DH, 2004), taking into account the issues presented here and available resources. Results suggest that the consultation model has been received well by the authors' local primary care trust. Findings may therefore help support and extend the model across different teams or primary care trusts.

Strengths and limitations

Given the methodological complexities of research in this area and comparative lack of evaluation of such service interface activities, the findings of this study may help to inform policy making and service development in order to ensure high quality of service delivery in future.

Nevertheless, a principal limitation of this study is its small sample size. Moreover, the sample consisted of female health visitors working within the Norfolk region. Any extrapolation to other groups may therefore remain speculative. Taking into account these limitations, this study may only provide some preliminary findings, and further research is warranted to add to the evidence base.

Conclusions

This study supports the vision for integrated service provision through the opportunity for professional partners to play to their strengths, avoid service duplication and build on capacity.

Overall, this study explored health visitors' experiences of consultation, highlighting its vital role in their increasingly demanding work with families. Results from this study identified recurring themes and highlighted areas that may impact on health visitors' experiences of using consultation and consequently, service delivery. Findings may be pertinent to inform evidence-based policy making and service provision in order to ensure high quality of service delivery within health care. This may be vital in challenging perspectives on quality improvement in mental healthcare services and in highlighting key issues for the future.

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References


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NHS Return to practice

The government's new vision for health visiting means that between now and 2015 we can expect to see more health visitors being trained and returning to practice.

The return-to-practice (RTP) scheme will run across the country, with education and training places made available in each region. Two SHAs are already running RTP pilots, and these have helped us learn about the training needs of ex-health visitors, and given other SHAs an idea of the best way to structure courses. Pilot results have been promising — in London alone, 47 people are due to return to health visiting this year.

If you know anyone who is interested in returning to practice, please tell them to contact NHS Careers on 0345 60 60 655.