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The Health Visiting service of Scotland in the context of the Getting it Right for Every Child (GIRFEC) policy approach: Finding the balance among its tensions

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Thesis submitted for the award of

Doctor of Philosophy

August, 2020

Acknowledgements

This thesis would have never been completed without the support of a number of people (especially in the middle of a pandemic!). I am very grateful for my research supervisors and advisors that have supported, encouraged and inspired me throughout my doctoral studies. Many, many thanks to Prof Helen Cheyne, Dr Maria Fotopoulou, Prof Jane Callaghan, Prof Brigid Daniel and Prof Roberta Durham for all their help. Even though I met you all at different stages of my doctoral studies, I consider myself lucky to have worked with all of you. Helen, apart from a great supervisor, you've also been an inspirational woman and a role model!

I would also like to thank all the health visitors, parents and children who participated in the study. Many thanks to the NHS Service Manager and the Aberlour Service Manager, who both helped me with participant recruitment, as well as my "link" with the NHS, Glynis Gordon – you have all been very supportive of my studies. This research was funded by the University of Stirling and NHS Forth Valley. I will be forever grateful for the opportunity you've given me. Thank you!

I would also like to thank and dedicate this thesis to my family in Greece. If it had not been for their emotional and practical support, I would have never been able to accomplish any of my dreams. Dad, I really hope this PhD experience was worth it and I promise I'll get a "real job" one day. I would also like to thank my "extended" family in Scotland, especially my partner, Miltos, and the friends I have made along the way in Edinburgh, Stirling and Glasgow. You have made my working, and mostly non-working, days a lot better. Finally, I would like to thank all the doctoral students and colleagues I have had the opportunity to meet and work with at the Centre for Child Wellbeing and Protection and at the University of Stirling. It has been a real pleasure to get to know you – you have made this PhD journey much more tolerable.

Abstract

The Getting it Right for Every Child (GIRFEC) policy approach has been developed in Scotland aiming to enhance the wellbeing of all children and young people by encouraging the provision of additional service input when needed, early intervention and prevention practices and partnership working among services and families. However, this policy approach has been relatively new both in the Scottish context and worldwide. Very little is known about the potential tensions of this policy for professionals and families identified at the ground level. These tensions relate to the thresholds between the provision of universal and targeted health visiting service to families, the balance between support and intrusion as well as the facilitators and barriers to partnership working. This research critically explores how the relevant policy documentation describes these tensions and how health visitors, parents and young children perceive and navigate them.

A qualitative case study design was used involving one Scottish NHS Health Board. Relevant Scottish Government national and local documents were analysed to better understand how GIRFEC was expected to translate into practice. Semi-structured interviews with twenty health visitors and two focus groups of twenty parents altogether were also undertaken to collect their views on the provision of the current health visiting service. Interviews with two young children using participatory techniques were conducted to examine the feasibility of obtaining their views on the services they receive. The data were analysed using thematic analysis.

Some of the key findings indicated that GIRFEC, despite its intentions, was not fully implemented due to various challenges in its design. As a result, the health visiting service was found to not have fully promoted the GIRFEC principles of early intervention, prevention and partnership working. Health visitors and parents reported to value the service but did not find it supportive enough due to these challenges. Study findings also indicated that, to make the service supportive, changes needed to be made on the way the state intervened into families' lives in light of child protection and wellbeing concerns, particularly in relation to parental consent. A direction towards the establishment of more collaborative relationships between professionals and parents in such cases was found to be imperative. Areas for improvements in policy and practice are identified in the thesis.

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List of abbreviations

GIRFEC	Getting It Right For Every Child
National Health Service	NHS
Children and Young People (Scotland) Act 2014	CYPA 2014
Universal Health Visiting Pathway in Scotland: pre-birth to pre-school	UP
National Practice Model	NPM
SHANARRI	Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included
My World Triangle	MWT
Ages and Stages Questionnaires	ASQs
General Practitioner	GP
UNCRC	United Nations Convention on the Rights of the Child
Health Plan Indicator	HPI
Health for All Children	HALL
General Data Protection Regulation	GDPR
European Court of Human Rights	ECHR
Team Around the Child meetings	TACs

1. Introduction

This Chapter provides an introduction to the study and describes the context within which the research topic of the health visiting service of Scotland in the context of the *Getting it Right for Every Child*¹ policy approach was chosen. The Chapter outlines the rationale for choosing the topic, the research aim and objectives as well as the overview of the research design.

1.1. Rationale for choosing the topic

Improving children and young people's wellbeing is currently at the heart of several worldwide policy initiatives, including the UK. This policy direction has emerged mostly due to an endeavour to offer an equal start in life for every child and young person by aiming to reduce poverty and social exclusion (Ben-Arieh and George 2006). Besides, the extent to which a state strives to promote its children and young people's wellbeing defines the wellbeing of the state itself (Mag 2015).

In accordance with the international drive to enhance the wellbeing of children and young people, the Scottish Government has been following an ambitious route to make Scotland the best place to grow up. GIRFEC in particular, was established in Scotland in 2004 (Scottish Executive 2004) to promote children's wellbeing by exhorting children's services to offer "the right help at the right time from the right people" (Scottish Government 2020b, n.p.). Within this scheme, three distinct features are identified: the offer of *extra service input* if required, the provision of *early intervention and prevention* practices as well as the *seamless collaboration* among stakeholders, such as families, educators, the police, health services and social care. GIRFEC has been also enshrined by law in the Children and Young People (Scotland) Act 2014², according to which children's services are required to offer their services to all families including those who require some extra, additional support by working in partnership and in a timely manner.

Within GIRFEC, and by extension CYPA 2014, the role of children's services in promoting children and young people's wellbeing is vital because GIRFEC has been required to be implemented by all services, including health, education and social care. This study is part of an overall project comprising of three separate Ph.D. research projects all focussed on different professional disciplines involved in GIRFEC across the disciplines of health, education and social care. My research project was developed under the aspiration of focusing on the discipline of health and health professionals in particular. In the case of pre-school aged children, the health professionals who have been primarily responsible for promoting their health and wellbeing are health visitors.

¹ GIRFEC hereafter

² CYPA 2014 hereafter

Because of the GIRFEC introduction, health visitors have been required to adapt their practices to the new legislative changes at the ground level. This means that health visitors have been encouraged post-GIRFEC to intervene as early as possible as well as to collaborate with other professionals so as to offer assistance and consistent support to all young children and their families in Scotland. In doing so, space for the provision of additional support is also encouraged for families who require further help.

Due to GIRFEC being relatively new, though, very little has been known as to how the GIRFEC principles have been perceived by health visitors and families, which creates a research gap in literature. The current Scottish framework offers the opportunity for an in-depth exploration of the way health visitors, parents and early years children perceive GIRFEC, including the offer of additional support, professionals' early intervention and prevention practices along with the "bringing together" of children's services. My study addresses this research gap by exploring the relevant policy documentation and the views of health visitors, parents and pre-school aged children on health visiting in the post-GIRFEC era.

1.2. An overview of research questions and design

This study aims to critically explore how the relevant policy documents and guidance, health visitors, parents and young children describe and negotiate the potential tensions of GIRFEC (Scottish Government 2020b, n.p.) in offering "the right help, at the right time, from the right people".

To meet the aim of the study, the following research questions were explored:

1. What are the thresholds between the provision of universal and targeted health visiting service?
2. In the context of early intervention and prevention, how is the balance between support and intrusion negotiated?
3. In the context of partnership working, what are the facilitators and barriers in the delivery of integrated services?
4. In the context of "child-centeredness", what is the role of pre-school aged children? To what extent is it possible to obtain their views on their experiences of receiving health visiting services?

To explore the research aim and questions, a qualitative case study was conducted in one Scottish Health Board, adopting a constructivist research paradigm. The study was funded by the University of Stirling and the NHS Forth Valley, which is one of the fourteen regional Health Boards of Scotland. This was a key driving factor in choosing NHS Forth Valley as the research location of the present study. Key national and local policy

documents were analysed to examine how GIRFEC was intended to be implemented by professionals. Twenty semi-structured interviews with health visitors and two focus groups involving twenty parents altogether also took place to collect their views on health visiting post-GIRFEC. Finally, interviews with two early years' children were implemented using participatory, child-friendly practices to examine whether it would be possible to collect their views on the services they receive. In regards to the theoretical framework, the study was informed by Foucault's theory of Power (1977, 1979) and Bronfenbrenner's ecological systems theory (1979).

1.3. Thesis Outline

The thesis consists of 9 Chapters. Chapters 1 and 2 introduce the research topic and provide the background of the research topic. Chapter 2 in particular presents an overview of the Scottish policy context on the promotion of young children's wellbeing from children's services, with a focus on health visiting. Exploring GIRFEC from the lens of human rights also takes place in Chapter 2 to help better understand the tensions arising within GIRFEC. These tensions refer to the role of the state and parental rights to protect children as well as the issue of information sharing among professionals.

Chapter 3 presents a review of the literature regarding families' needs assessment practices and health visiting attributes with a focus on partnership working among children's services. Chapter 4 consists of the research design, the theoretical framework and methodology of the study. The way the data were collected and analysed from all the data sources and ethical considerations are also described here.

Chapters 5, 6, 7 and 8 constitute the heart of the thesis as they present the research findings. Chapter 5 presents findings from the analysis of the relevant documentation and guidance, Chapters 6 and 7 the health visitors' findings while Chapter 8 presents parents' findings. Finally, Chapter 9 puts forward the discussion and conclusion of the thesis, including recommendations for policy, practice and further research.

2. Background

2.1. Introduction

This Chapter provides an overview of the way and the reasons why the GIRFEC policy has been developed. In doing so, the policy context of Scotland of the past decades is described. An in-depth examination of GIRFEC then follows with specific information of what this means for health visitors in practice. A description of the role of health visitors within GIRFEC follows. Finally, GIRFEC is examined through a human rights lens with particular reference to the role of the state and parents in promoting children's wellbeing and in regards to information sharing practices of professionals.

2.2. Policy shifts in Scotland

Before 1998, health in the UK policy field was a matter of collective responsibility of the UK Cabinet. However, Devolution in the UK (Government of Wales Act 1998; Northern Ireland Act 1998; Scottish Act 1998), which became effective in 1999, resulted in the development of divergent health frameworks among the four UK countries, including Scotland. As such, health has been one of the most devolved matters.

In Scotland in particular, three policy shifts have taken place in the health and early years' landscape over the past decades. These policy shifts have also taken place in England, Wales and N. Ireland; each of these three UK countries has followed its own distinctive political agenda, though, as a result of Devolution. One policy shift refers to a direction towards proportionate or progressive universalism to enhance children and their families' wellbeing. A second policy shift relates to a move towards early intervention and prevention practices while the third involves a shift in direction towards greater partnership working. These policy moves have been explored because GIRFEC is constituted by all the three of them.

2.2.1. Towards proportionate or progressive universalism

Even though the early days of health visiting have not been clearly defined, it is believed that the profession originated in the UK in the 1860s from the Ladies Sanitary Reform Association (Institute of Health Visiting 2020a). Health visiting has always been delivered universally even when it moved from the control of Local Authorities into the NHS in 1974 (Billingham, Morrell and Billingham 1996). However, in the 1990s, there was a policy direction across the UK towards a more targeted provision of public healthcare to families of disadvantaged backgrounds through intervention programmes. Debates were created, however, over the effectiveness of this approach in regards to improving outcomes for children and young people, such as families' stigmatization and, thus, lack of uptake. Furthermore, opponents of the targeted services provision have argued that "without universal surveillance it is not possible to identify those in need of a greater

health visiting input” (Elkan et al 2001, p. 117) stressing the need for the development of a different framework.

Based on the notion of Rose (1992) that it is inefficient to consider health problems in terms of either black (children at risk) or white (children not at risk), the notions of *proportionate or progressive universalism* have eventually been adopted in the UK, including Scotland. This highlights a policy shift from targeted intervention programmes to proportionate or progressive universalism. The terms ‘proportionate’ or ‘progressive’ universalism convey similar meanings in the literature even though they have different origins. The concept of proportionate universalism, in particular, was firstly introduced in the Marmot review (Marmot 2010) whereas the concept of progressive universalism was first introduced by Gwatkin and Ergo (2010) in the Lancet report. Both terms have been used to describe the provision of a continuum of support to families but with a scale and intensity that is dependent on the level of disadvantage and need. This notion has been based on the need to achieve equity of outcomes by encouraging universal service provision but also intensive support to those mostly in need.

These concepts are similar to Pauline Hardiker and her colleagues’ model (1991a, 1991b) consisting of different levels of children’s needs and practices designed to meet these particular needs. They are underpinned by the principles of universalism but with space for intensity that is proportionate to the level of families’ needs. As such, this framework helps reduce stigmatization of vulnerable groups (Wasoff et al 2006). Shonkoff, Akil and Chang (2012, p. 8) also support this indicating that “targeted interventions should be framed within larger systems that are robust, appropriately financed, and universal so that individual programmes are not isolated”. According to this framework, children’s needs are categorized into four levels:

1. Level 1: Universal services for children with no additional needs. In this level, practices are delivered to *all* children and their families including education services and health services (Horwath 2013).
2. Level 2: Targeted or early help services for children with additional needs. This level of practices refers to the children and young people who have been assessed as having additional needs that cannot be met through universal provision or, in terms of neglect, to children and families where there are indicators that the parents are unlikely to meet the needs of their child without some additional help (Hardiker et al 1991a; Hardiker et al 1991b).
3. Level 3: Specialist services for children with complex needs. According to this level, children and young people may be at risk of harm or their health might be impaired without the provision of services. With regards to neglect, there is usually evidence that the parents are failing to meet the *developmental* needs of

the child, which in turn impacts the child itself (Hardiker et al 1991a; Hardiker et al 1991b). The services at this level are often delivered by voluntary services (Horwath 2013).

4. Level 4: Specialist services for children whose needs are complex, prolonged or critical. Children who fall in this category are at risk of having the poorest outcomes and their needs are usually the result from exposure to significant harm. Examples of this level could be children of chronic neglect with evidence of their parents lacking the ability to meet the needs of their child and could involve residential or nursing care or in-patient psychiatric treatment (Hardiker et al 1991a; Hardiker et al 1991b).

In practice, the idea of proportionate or progressive universalism translates into a combination of both universal and targeted practices. This concept is based on the idea of offering a universal healthcare system for all families with opportunities for targeted support through a specialized health approach to those requiring it. This approach is based on the notion that different families may experience challenges at different stages and, thus, the provision of additional support to meet the needs of the less advantaged is needed (NHS Scotland 2018; Scottish Executive 2005; Scottish Government, 2011; Scottish Government 2015a). The provision of targeted support incorporates specific advice, programmes, workshops and learning, and support to improve well-being whereas specialist support includes intervention programmes for families and services (Scottish Government 2015b).

The principles of proportionate or progressive universalism underpin the current health visiting service of Scotland. As part of their role, health visitors are required to deliver eight home visits to all families within the first year of a child's life and three more for the time period from 13 months to the start of school. The universal 24-30 months review was also introduced following the publication of the *Health For All Children*³ guidance (Scottish Executive 2005). During home visits, health visitors are required to evaluate whether more targeted support is required for families. This evaluation is intended to be made on the basis of the relevant health visiting assessment forms, such as the Ages and Stages Questionnaires⁴, and the GIRFEC National Practice Model (Scottish Government 2015b; Scottish Government 2016a).

According to Hall4 (Scottish Executive 2005) and *A New Look at Hall4* (Scottish Government 2011), the introduction and development of the Health Plan Indicator (HPI hereafter) has also been developed and encouraged to be used by health visitors. This is to enable health visitors distinguish which families are in need of universal or extra

³ Hall4 hereafter

⁴ ASQs hereafter

help and thus determine the level of support each family would require. The health visiting support could be universal (core), universal with additional support (additional) or universal with intensive support (intensive). Based on *Universal Health Visiting Pathway in Scotland: Pre-Birth to Pre-School*⁵ (Scottish Government 2015b), however, which is the latest health visiting guidance at the time of writing, families would be allocated into the core or the additional families depending on the level of their needs. Along with the policy direction towards proportionate or progressive universalism, another move, the one towards early intervention and prevention, has also been identified in the Scottish policy over the past decades.

2.2.2. Towards early intervention and prevention

According to this policy shift, the UK governments have developed early intervention and prevention practices as part of their universal and targeted services since approximately 1970 driven by their aspiration to improve outcomes for families. The term “early” in early intervention is relative and can have a dual meaning; that is, it could either be attributed to the early years of a child’s age or to the early stages of an identification of a risk-related problem. For the Scottish Government in particular, early intervention encompasses both meanings. It has been underlined that early intervention must start in the early years, including pre-birth, but should also be extended beyond the early years for young children and adults as risks can be identified at a later stage (Scottish Government 2008a). In Scotland, the term “early years” is often used to describe the time period from pre-birth to the age of 8; this time period is divided into the following four stages: pregnancy, 0-3 years, 3-5 years and 5-8 years (NHS Health Scotland 2020).

To avoid confusion, it is imperative to distinguish between prevention and early intervention. Prevention refers to acting before a problem occurs so as to restrain the possibility of the appearance of poor outcomes for a high-risk group (Little, Sodha and Puttick 2012). Early intervention, on the other hand, is “about taking action as soon as possible to tackle problems for children and families *before they become more difficult to reverse* [emphasis added]” (Early Intervention Foundation 2016, p. 1). Early intervention is, therefore, linked to tackling the problem as early as possible once it has emerged. This, in turn, might raise questions regarding professional judgement on identifying a risk-related problem and, more importantly, on how early, early intervention should take place.

In line with the international agenda, the Scottish policy field has focused on developing early childhood intervention and prevention frameworks in four interrelated areas: maternal and child health services, early childhood education, special education and

⁵ UP hereafter

child development research (Shonkoff and Meisels 2000). For example, *Sure start Scotland* (Glass 1999; Children Schools and Families Committee 2010), *Early Years and Early Intervention: A joint Scottish Government and COSLA policy statement* (Scottish Government 2008a) and *Early Education and Care* (Scottish Government 2020a) have all been prioritising the early years and early intervention practices as a way to reduce poverty and inequalities and improve outcomes for children. All these documents have also been promoting partnership working by encouraging early education, childcare, family support and other potential services to work together. In this sense, early intervention requires partnership working to achieve its goals.

In addition, the *Early Intervention: the next steps* by Allen (2011) in England and *Joining the dots: A better start for Scotland's children* by Deacon (2011) in Scotland constitute two reports which both link health inequalities with the early years and stress the need for greater policy attention to be attributed to the early years. Similar directions are also identified in the health visiting documentation, such as in Hall4 (Scottish Executive 2005), *A New Look at Hall4* (Scottish Government 2011), *A Pathway of Care for Vulnerable Families (0-3)* (Scottish Government 2011b) and the UP (2015). These health visiting documents have been encouraging intervention practices, particularly for children of the early years, as soon as concerns are identified.

This policy shift has come about as a result of a number of factors including the growing recognition that investing in the first years of life lays the groundwork for lifelong wellbeing (Bellis et al 2014; Mistry et al 2012; Perry 2002); the inefficiency of current reactive Scottish policies and practices to safeguard each and every child (Allen and Duncan Smith 2008; Chowdry and Oppenheim 2015; Greenwood et al 1998; Selroos et al 1995); the consensus among professionals and stakeholders on the need for “something to be done” before problems appear (Allen 2011); the need to also provide help to parents who might have difficulties with their parenting (Bromley and Cunningham-Burley 2010; Mooney, Oliver and Smith 2009); and the long-term financial repercussions for the state resulting from lacking to intervene as early as possible in the early years (Allen 2011; Brown and White 2006). Apart from the policy direction towards early intervention and prevention policies, Scotland has also moved towards adopting approaches that enhance partnership working.

2.2.3. Towards working together

Finally, another significant shift in the Scottish policy context is associated with a move towards “bringing professionals together”. This prerequisites the collaboration between different partners and disciplines, such as education, social care, health services, juvenile justice, early years providers and so on to work together in a partnership (see, for example, NHS Borders 2017; Scottish Government 2017). More importantly, this shift

incorporates the idea that the weight does not fall over on simply one service (Miller et al 2012) and that multiple sectors and organisations as a whole are responsible for children's wellbeing.

Apart from the Children and Young People (Scotland) Act 2014⁶, a number of other Acts and policy documents have developed in Scotland mostly since 2000 underlining the importance of agencies and organisations working together for children and young people's benefit. For example, two key Acts encouraging partnership working in Scotland are the Children (Scotland) Act 1995 and the Public Bodies (Joint Working) (Scotland) Act 2014. The former is the first Act in the devolved Scotland which introduced the idea of integration of children's services, where Local Councils were required to consult and cooperate with other statutory and voluntary agencies through Children's Services Plans. The latter has suggested changes on the way health and social care should work providing a framework for their integration.

Various policy documents encouraging greater partnership working have also developed in Scotland to support and promote all children and young people's wellbeing. *For Scotland's Children* (Scottish Government 2001) and *Equally Well* (Scottish Government 2008c) contain a range of ways for Local Authorities, the NHS and the voluntary sector to work together by creating a single children's services system. Moreover, the *Quality Improvement Framework for Integrated Services for Children and Young People* (Scottish Executive 2006) has aimed to create a common line among children's services in regards to their quality standards. In the case of the health visiting service of Scotland in particular, *Hall4* (Scottish Executive 2005), *A New Look at Hall4* (Scottish Government 2011) and the UP (2015) all support multi-agency working as an approach promoting children's health and wellbeing.

Partnership working among children's services has also been encouraged in the Scottish context for children and young people of mostly vulnerable backgrounds, too. For example, *It's Everyone's job to make sure I'm alright* (Scottish Executive 2002) was published in 2002 and entails information aiming to improve the services for children experiencing abuse or neglect. A few years later, *Protecting Children and Young People: Framework for Standards* (Scottish Executive 2004b) was developed describing the needs and expectations of children and young people as to how they could be protected from harm, injury and abuse stressing the need for greater multi-agency activity. In a similar line, right after the CYPA 2014 legislation, the *National Guidance for Child Protection in Scotland* (Scottish Government 2014) was published to help professionals

⁶ CYPA 2014 hereafter

establish a common understanding of the procedures to be taken to support the wellbeing of all children.

The need for greater partnership working arose mainly due to the negative consequences of services failing to work in an integrated manner (O'Brien, Hammond and McKinnon 2003). Examples of such cases are the deaths of Jasmine Beckford, Tyra Henry and Kimberley Carlisle in the mid-1980s as well as the ones of Victoria Climbié and Caleb Ness in the early 2000s. This led to the *assumption* that the opposite of fragmented services, that is integration, might result in improved outcomes for all the participants involved.

While the collaboration of children's services arose as a need to initially cope with child protection issues, this approach has been encouraged in other areas in the field of childhood studies, too. More specifically, professionals involved in children's services and parents found it challenging to cope with a disjointed framework of services (Donovan 1998). This led to the promotion of partnership working in various childhood areas, such as disability (Scottish Government 2017b), education (McGeever 2018) and early years (Scottish Government 2008b). In the case of the Scottish Local Authorities, it has been suggested that they have been having difficulty in delivering the radical changes needed in children's services by their own (Audit Scotland 2011). This in combination with the state's financial benefit resulting from declining resources- both in staff and public expenditure- (Rummary 2009) constitute arguments for a greater collaboration and joint-working in an attempt to deliver more efficient services. Another reason leading to greater partnership working has involved the need to minimize frustration and workload duplication (Anderson-Butcher and Ashton 2004). Last but not least, integrated children's services have always been interlinked with the political background of a state. New Labour, which was elected in 1997, focused on the integration of children's services aiming to join services, such as, childcare and early years education provision, education and criminal justice. In other words, more focus has been given to integration of children's services through policy and practice in Scotland since 1997.

2.3. Getting it Right for Every Child

Amalgamating the elements of proportionate or progressive universalism, early intervention and prevention, and partnership working, the GIRFEC national programme of Scotland is undoubtedly a landmark framework due to its revolutionary and unique nature. This is because it encourages for the first time the collaboration of various stakeholders in a timely manner. GIRFEC combines these key features for the benefit of children and young people's wellbeing and this is what makes it so unique. To state it differently, GIRFEC is "about how practitioners across all services for children and adults meet the needs of children and young people, working together where necessary to

ensure they reach their full potential” (Scottish Government 2012a, p. 9). GIRFEC is also underpinned by ten core components and a particular set of values and principles to be adopted by all children’s services (Scottish Government 2012a) and is also in line with all the Articles of the United Nations Convention on the Rights of the Child⁷ (UNICEF 1989). Similar Acts have also developed in the rest of the UK countries, such as the *Every Child Matters* in England and Wales (The Children Act 2004; DfES 2003).

Part of the significance of GIRFEC lies in the fact that it was enacted into legislation for the first time, as in the CYPA 2014. More specifically, section 9(2) of the CYPA 2014 states that children are to be cared for by children’s services in a way which:

- (i) “best safeguards, supports and promotes the wellbeing of children in the area concerned,
- (ii) ensures that any action to meet needs is taken at the earliest appropriate time and that, where appropriate, action is taken to prevent needs arising,
- (iii) is most integrated from the point of view of recipients, and
- (iv) constitutes the best use of available resources”

A number of developments have been introduced concerning professionals’ role and practices as a result of GIRFEC introduction. These have included the introduction of the Named Person service, the Lead Professional role, the Child’s Plan and the GIRFEC National Practice Model.

- Named Person service

GIRFEC, and consequently CYPA 2014, introduced for the first time the Named Person scheme. Based on this scheme, a Named Person, that is a single point of contact for parents, children and young people, could provide information, support or advice to families (Scottish Government 2020e). A Named Person would be available for every child from either the health services (for children from pre-birth until the start of school) or from the education sector (for those aged 5-18). This means that health visitors would be the Named Person of all the children of their caseload aged from pre-birth to pre-school age.

However, the Named Person service was not universally well-received. Even though this service had been scheduled to roll out to all the Scottish Local Authorities by 31 August 2016, there was a delay in its rolling out and eventually its cancellation due to legal challenges being raised (NHS Health Scotland 2016). The Christian Institute and other campaigners were opposed to Part 4 of CYPA 2014⁸, which referred to the Named

⁷ UNCRC hereafter

⁸ See *The Christian Institute and others (Appellants) v The Lord Advocate (Respondent) (Scotland) (2016)*

Person scheme, due to concerns that it breached the right to privacy leading the case to the UK Supreme Court. In light of the General Data Protection Regulation⁹ guidance (2018), the outcome of the Supreme Court ruling was that clarifications in information sharing needed to be made, which eventually led to the scheme's repeal (Scottish Government 2019a). The scheme was already being implemented in some Scottish Local Authorities, though, but the Supreme Court ruling did not affect the continuation of the Named Person service in these Local Authorities. The Children and Young People (Information Sharing) (Scotland) Bill (Scottish Government 2019b) constituted the Scottish Government's response to the Supreme Court ruling including the changes that needed to be made in CYPA 2014 regarding information sharing. Due to the repeal of the scheme, the Named Person service has not been the main focus of the current study. However, the issue was identified in the documents analysed and by some participants and, as such, its exploration is included in the thesis.

- Lead Professional role and the Child's Plan

Another innovation resulting from GIRFEC development was the introduction of the Lead Professional role and the Child's Plan for children and families needing extra help. For children requiring additional, targeted support that was not generally available, a single planning framework, called Child's Plan, would be available. A Child's Plan could be initiated when either single-agency or multi-agency additional support would be offered. The Child's Plan would include the views of the parent and child and information about the child's unmet/met wellbeing needs, the approaches taken to tackle any concerns/unmet needs, the services involved and their role in multi-agency activity, the desired outcome, the timeline and the name of the coordinator of the activity (Scottish Government 2020c). In the cases where a Child's Plan was to be put forward, a Lead Professional would also be in place "to make sure the plan is managed properly" (Scottish Government 2020c, n.p.). The role of the Lead Professional was expected to be undertaken by a professional working with the child or family arranged by the Health Board or the Local Authority; the Lead Professional could also be their Named Person.

However, The Children and Young People (Information Sharing) (Scotland) Bill (Scottish Government 2019a) also revoked professionals' duty to participate in Child's Plan as a response to the Supreme Court ruling. Even though the Child's Plan was not included in the Court's decision, the Scottish Government decided to amend this as the Child's Plan also required information sharing. As with the Named Person scheme, though, the Child's Plan was already in use in some Local Authorities and, as such, the existing Child's Plan practice has not been affected in these Local Authorities (Scottish

⁹ GDPR hereafter

Government 2019b). Due to the legal changes, the focus of the study has not been the Child's Plan. However, as with the Named Person scheme, this matter was identified in the study data and for this reason it was explored further.

- GIRFEC National Practice Model

In addition, the GIRFEC National Practice Model (NPM hereafter) was also introduced due to GIRFEC (Scottish Government 2016a). NPM consists of three forms intended to be used by all professionals working with children, young people and their families to identify concerns about children and their families and reflect on how to tackle them. These forms are the SHANARRI wellbeing wheel, the My World Triangle (MWT hereafter) and the Resilience Matrix. The SHANARRI wheel consists of eight particular wellbeing indicators, against which every child's wellbeing is to be assessed by professionals. These wellbeing indicators are: Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included (Scottish Government 2020f), even though a particular definition of the term is not provided. In contrast with SHANARRI, which is intended to be used with every child, the MWT and the Resilience Matrix are intended to be used by professionals in the cases where extra, targeted support is assessed to be needed. Rather than constituting a list of questions to report upon, the MWT and the Resilience Matrix entail questions for professionals to reflect upon and assess whether extra help and what kind of extra help would be needed to meet families' needs.

All services working with children, young people and families have been expected to adjust their service delivery to the GIRFEC developments. For the successful implementation of GIRFEC, this has also been the case for the health visiting service.

2.4. Health visitors' role within GIRFEC

Within the GIRFEC framework, the role of health visitors cannot be overseen as they have always had an important role in supporting early parenting and preventing later health and social care issues. Health visitors (or Specialist Community Public Health Nurses) are registered nurses or midwives who have undertaken additional training particularly on promoting health and preventing diseases for all population groups (Institute of Health Visiting 2020c). The role of health visitors in the Scottish and the wider UK context has been widely contested in the literature and has included advising families on hygiene, child health promotion and welfare, social support, maternal support and mental health, raising awareness of health needs and, more recently, tackling inequalities (see, for example, the review of Baldwin 2012). In any case, a key component of their role has always included the provision of home visits to pregnant women and parents of pre-school aged children (NHS England 2016).

Within the Child Health Surveillance Programme¹⁰, GIRFEC introduction has placed health professionals at the heart of strategies to tackle health inequalities within the NHS arena and has led to the evolution of their roles. In the case of health visitors in particular, the latest Scottish Government policy document at the time of writing regarding redefining their roles and responsibilities has been the UP (Scottish Government 2015b). GIRFEC has been incorporated into the guidance of each children's service and, as such, it has also been integrated into UP. UP proposes a new framework based on the collaborative work of several disciplines to promote children's health and wellbeing. It also highlights that, all practice teachers and health visitors are fundamental to the programme's implementation and in supporting families in Scotland.

Health visitors have been required to make three main changes in their service delivery due to GIRFEC introduction. Firstly, they are required to deliver a greater number of home visits to *all* parents from early pregnancy up to the school age, in line with the timescale set out in UP (Scottish Government 2015b), comparing to the pre-GIRFEC era. For example, the Scottish Government policy guidance for health visitors existing prior to UP was *A New Look at Hall4* (Scottish Government 2011), which encouraged the provision of 9 contacts between health visitors and families at particular times. UP (Scottish Government 2015b), on the other hand, encourages the provision of 13 contacts between health visitors and families introducing new contacts; the additional contacts have included the provision of an ante-natal letter and an ante-natal contact at 32-34 weeks, two home visits at 3-5 weeks and an 8-month home visit. Another difference between the two documents has been that the neonate contact to be offered within the first 24 hours of a child's birth has been cancelled in the UP, even though it was set out in *A New Look at Hall4*. Secondly, health visitors, along with all the professionals working with children and families, have been encouraged to use the GIRFEC NPM in assessing whether families would require the minimum standard of service input or additional single-agency or multi-agency support. Thirdly, health visitors have also been required to work more closely with other services and families to improve outcomes for families.

Additionally, health visitors were also expected to undertake the role of the Named Person for all the children of their caseload and/or coordinate Child's Plans, if and when required, by undertaking the Lead Professional role. Due to the legal changes, such practices are not currently expected to be undertaken by health visitors in Scotland. Even though the scheme was not eventually successful, its development and repeal have led

¹⁰ This programme is the health promotion programme of Scotland provided by NHS Scotland; it has been universally offered to families by various health professionals, including health visitors. (NHS Scotland 2018)

to debates around the reform of health visitors' role and responsibilities. More importantly, the GIRFEC developments in general have encouraged a refocussing of and a policy orientation towards the evolution of their role. As such, tensions have been identified in regards to their role and practices as well as the overall role of health visiting and the state in promoting the wellbeing and welfare of children. For example, a tension between the medical (family/individual) and the social (community/population) focus of health visitors' role has emerged, which has been a subject of fierce debate (Craig 2000). Even though health visitors in Scotland have been so far providing support and advice to families and children, they are gradually required to undertake a more narrow surveillance role (Crisp and Lister 2004). Additionally, another tension has been identified within GIRFEC between the role of parents and the state in the delivery of single-agency service provision but also in the cases of partnership working. Such tensions have been further explored from a human rights perspective, as follows.

2.5. GIRFEC from a human rights perspective

Despite the initiative of the Scottish Government to enshrine the GIRFEC principles by law through the CYPA 2014, legal challenges have been brought up. More specifically, two main contradictory topics have been developed and identified within CYPA 2014 in regards to human rights: i) the Children's Rights and Human Rights challenge (state rights v parental rights), which extends into the role of the state in intervening into families' lives to support them, and ii) Human Rights and the EU Law challenge (rights to access information v. privacy rights). The exploration of these legal challenges follows.

2.5.1. Children's Rights and Human Rights

Publication of CYPA 2014 prompted a number of discussions on the role of the state in the enhancement of children and young people's wellbeing and their safeguarding. These discussions have extended to debates and tensions regarding policies that may be breaching children's rights and human rights. For example, Article 19(1) of the United Nations Convention on the Rights of the Child (1989)¹¹ supports the development of statutory interventions in protecting and supporting children and young people by stating that:

“States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.”

(UNICEF 1989, p. 7)

¹¹ UNCRC hereafter

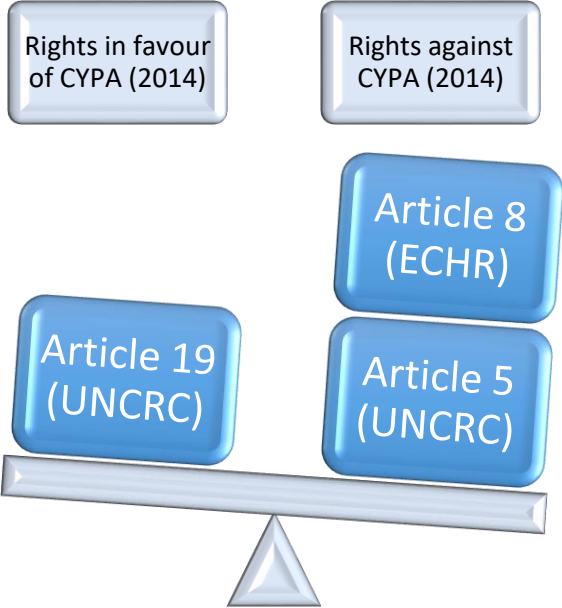
What is of great significance in Article 19 of UNCRC is that statutory interventions are encouraged in light of child protection cases, such as abuse or neglect. On the other hand, however, the Article 5 of the UNCRC argues that every state should respect the rights of parents and individual privacies, which follows:

“States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.”

(UNICEF 1989, p. 4)

The idea of respecting the rights to privacy was also enshrined in Article 8 of the European Convention of Human Rights¹² (European Court on Human Rights 1948, p. 10) stating that “everyone has the right to respect for his private and family life, his home and his correspondence”. The following figure (1.) depicts the relationship of the UNCRC and the ECHR articles with CYPA 2014.

Figure 1. The rights for and against CYPA 2014



Both the UNCRC and the ECHR have aimed to set out fundamental rights and freedoms that every child and young person (in the case of the UNCRC) and every adult (in the case of the ECHR) is entitled to. In practice, this translates into the establishment of international laws that are compatible with the rights provided in the UNCRC and the ECHR. Despite the fact that it has been made explicit that “no right is more important than another” and that “the best interests of the child” should be “the primary consideration” (UNICEF 1989, p. 4), there is a tension between the Article 19 of the

¹² ECHR hereafter

UNCRC for the right of the state to safeguard all children and young people and the Article 5 of the UNCRC and Article 8 of the ECHR for the states to respect the responsibilities and private lives of parents. To use the example used in the Schalk and Kopf v. Austria (2010) case, the child's best interests comprises of two limbs, where on one hand the child has links and personal relationships with his/her family but, on the other hand, the state is entitled to ensure the child is growing up in a safe environment, even in cases where parents fail to do so. Equally important with this tension between rights is the role of the child.

This conflict between children's and parental rights has created space for reflection on what the role of the state within a society is and where the line lies between statutory support and intrusion into families' private life. Can there be a balance between the right of the state to protect children and the rights of parents for privacy? Questions also arise in relation to the ease through which professionals can move within the wellbeing-welfare-child protection continuum; on who has the responsibility and who ultimately becomes the "carer" of children and young people to ensure their safety: the parents or the state?. Within this context, greater reflection is required on the particular criteria to discern the cases where statutory support becomes surveillance. Due to its distinctive nature, GIRFEC offers a unique opportunity for further exploration of the health visiting service in the promotion of children's safety and wellbeing; as such, it will be further explored in the current study.

2.5.2. Human Rights and the EU Law challenge

Apart from the tension between the rights of the state to safeguard and protect children and young people in Scotland and parental rights to family privacy, another challenge has emerged in relation to partnership working and the sharing of information. This eventually led to the withdrawal of Parts 4 and 5 of CYPA 2014 regarding the Named Person scheme and Child's Plan.

According to Part 26 (1) of CYPA 2014, "a service provider or relevant authority must provide to the service provider in relation to a child or young person any information which the person holds which falls within subsection". Also, Part 26 (4) of the CYPA 2014 argues that information should be shared "if the information holder considers that— (a) it is likely to be relevant to the exercise of any function of the service provider or relevant authority which affects or may affect the *wellbeing* [emphasis added] of the child or young person, (b) it ought to be provided for that purpose, and (c) its provision to the service provider or relevant authority would not prejudice the conduct of any criminal investigation or the prosecution of any offence".

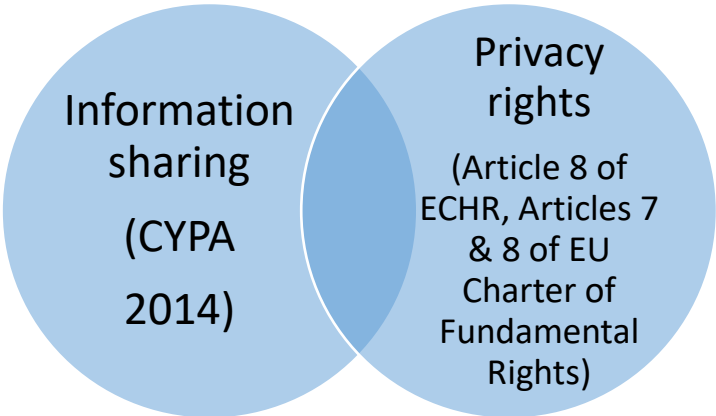
This part of the CYPA 2014, however, comes in contrast, once again, with Article 8 of the ECHR on parental rights to privacy as well as with the Articles 7 and 8 of the EU Charter of Fundamental Rights. According to Article 7 of EU Charter of Fundamental Rights (European Commission 2000, p. 9), “everyone has the right to respect for his or her private and family life, home and communications”. Similarly, Article 8 of the same Charter stresses that:

“...everyone has the right to the protection of personal data concerning him or her” and “such data must be processed fairly for specified purposes and on the basis of the consent of the person concerned or some other legitimate basis laid down by law. Everyone has the right of access to data which has been collected concerning him or her, and the right to have it rectified”.

(European Commission, 2000, p. 10)

Figure 2. represents the relationship between the information sharing practices suggested in CYPA 2014 and Article 8 of ECHR, Articles 7 and 8 of the EU Charter of Fundamental Rights.

Figure 2. Information sharing practices within CYPA 2014, ECHR and EU Charter Fundamental Rights



The idea behind the sharing of information emerges from the need for professionals to put all the pieces of the jigsaw together and see “the whole picture”, particularly for children falling through the “gaps” (Thompson 2016). This notion is based on the principle that information should be shared “not only in response to a crisis or serious occurrence” but also for “relevant changes in a child's and young person's life” (Scottish Government 2012b, p. 39). For this reason, Parts 4 and 5 of CYPA 2014 enabled professionals acting as the Named Persons to share personal data of families with other services or professionals in regards to the *wellbeing* of children, young people and/or parents. A tension between professionals' duty to promote children and young people's wellbeing and respecting parental privacy emerges, highlighting the need for a balance between the two. The role of parental consent within this framework was, however, absent.

Questions arise as to whether it would be legally and ethically acceptable for information to be shared among professionals *without parents/carers' consent*. This is where the “grey” area - depicted in figure 2.- emerges. This area represents the common ground between promoting children and young people’s wellbeing and also respecting parental rights to privacy at the same time, which could translate into professionals’ seeking parental consent. This issue extends once again to discussions on the role of the state and parents, and whether statutory interventions are seen as extra help or as statutory surveillance, even for wellbeing matters.

Eventually, Parts 4 and 5 of CYPA 2014 were cancelled due to breaching parental rights to privacy¹³. In the wider context of partnership working and information sharing of the post-GIRFEC era, the issue of parental consent can be further examined, particularly from the perspectives of health visitors and parents. It would be valuable, for example, to explore where the balance between information sharing among professionals and breaching parents’ confidentiality matters stands for professionals and families. This research area will be explored in the present study.

2.6. Conclusion

This Chapter has presented the policy context of Scotland in relation to proportionate/progressive universalism, early intervention and prevention, and partnership working, which are the GIRFEC fundamentals. It has also described what GIRFEC entails and what has been expected of health visitors in the post-GIRFEC era. When examining GIRFEC from a human rights perspective, two key tensions have been highlighted and discussed in regards to the role of state in protecting and promoting children’s wellbeing and the role of parents in professionals’ information sharing practices. However, as already indicated, greater exploration would be required of health visitors and families’ views on health visiting in the context of GIRFEC. These issues are the subject of this thesis. Chapter 3, which follows, will present the literature review to help refining the research aim and questions.

¹³ In particular, Article 8 of ECHR, Data Protection Act 1998 and EU legislation on data protection (see Kidner 2016).

3. Literature review

3.1. Introduction

This Chapter presents the findings of the literature review carried out to establish the current state of knowledge on the provision of health visiting in Scotland since the development of the *Getting it Right for Every Child* (GIRFEC hereafter). This Chapter will first describe the process I adopted in reviewing the literature, followed by a review of health visitors' decision-making practices in assessing families' needs. Exploration of the challenges health visitors face in assessing families' needs are also examined here. A discussion will then follow on the way health visiting has been universally delivered to all families. In doing so, the service elements valued and not valued by health visitors and families will be reviewed. Following this, a review of the provision of health visiting in relation to partnership working will be critically assessed. Here, the definitions and models of "bringing professionals together" will be examined, followed by a discussion around the facilitators and barriers of partnership working. Research gaps are identified in the literature leading to the development of the research aim and questions.

3.2. Review process

There can be many reasons why a literature review is conducted involving, for example, opportunities for the researcher to gain a sound knowledge on a particular topic, which will attribute credibility and integrity to the study, and to identify research gaps in prior literature (Denney and Tewksbury 2013). For the present thesis, the relevant literature was being read and reviewed for the duration of the PhD studies; however, the main review process took place at two time periods (May 2016-February 2017 and April-July 2020). This was to ensure that the review would be updated with recent studies. For the literature review process, four databases (PubMed, Web of Science, Wiley and Google Scholar) were searched. Table 1. presents in detail the terms searched in these databases. Because GIRFEC was developed in 2004, peer-reviewed articles published from 2004-2020 undertaken in the UK were mainly searched. However, some studies published before 2004 were also included in the literature review due to their high relevance with the research topic.

Table 1. Search terms and search databases

Search terms	Search databases
'Decision-making' OR 'needs assess*' OR 'assess*' AND 'health visit*' AND 'United Kingdom' OR 'UK'.	PubMed, Web of Science, Wiley and Google Scholar.
'Views' OR 'experiences' OR 'perspectives' AND 'health visit*' OR 'health visitors' AND 'United Kingdom' OR 'UK'.	

<p>'Multi-agency' OR 'inter-agency' OR 'inter-professional' OR 'collaborat*' OR 'integrat*' OR 'partnership working' AND 'health visit*' OR 'early years' OR 'children's services' AND 'United Kingdom' OR 'UK'.</p>	
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The search resulted in 176 studies, 120 of which were primary studies and 56 were secondary. Most of these studies were qualitative, very few used mixed-methods and a limited number were quantitative. The studies have been grouped in three main categories: i) ways of assessing families' needs (47 studies), ii) key attributes of health visiting delivery (53 studies) and iii) health visiting in the context of partnership working (60 studies), while some studies (16) have been used across two or all of the three categories.

Three key clarifications need to be made here. Firstly, when researching health visiting in the context of partnership working, the main focus of the review did not fall specifically on the outcomes, impact or effectiveness of the health visiting service on the health and wellbeing of children and families. Rather, the focus of the literature search was mostly confined to the perceptions and experiences of the individuals involved in health visiting, including service-providers and service-users, to assess the effectiveness of the service. Secondly, in terms of partnership working and children's services, the literature examines partnership working in relation to various issues, such as child welfare, additional support needs, mental health, social exclusion, looked after children and the early years. Because of the extensive literature on partnership working, a decision was made that studies examining partnership working particularly in relation to health visiting and pre-school aged children only would be included in the review. Thirdly, a great number of early intervention programmes have developed internationally and in the UK targeting particular families and early years' children encouraging partnership working among services and families¹⁴. The exploration of service-providers and service-users' views in regards to these programmes has been beyond the scope of the present thesis because such interventions have been targeting particular populations rather than being universally offered.

3.3. Families' needs assessment process

¹⁴ In Scotland in particular, some of these programmes have been Sure Start, Family Nurse Partnership, Starting Well, Positive Parenting Program (Triple P), Incredible Years, Dundee Families Project and Aberdeen Families Project.

As GIRFEC is based on the principles of proportionate or progressive universalism, health visitors are expected to universally provide a minimum standard of health visiting to all families with the potential for extra, targeted single-agency or multi-agency service input if required. Health visitors are therefore expected to make assessments and decide on the level of service input families need. For this reason, a literature review has been conducted on health visitors' assessment process, highlighting the process challenges.

3.3.1. Health visitors' decision-making thresholds

The literature on health visitors' decision-making thresholds, on which they make assessments of families' needs, has been extensive in the UK, particularly in England and less so in Scotland. A clear definition of the term "need" has not been provided in the Scottish Government policy documents; hence, the concept of "need" can be variable and subjective (Cowley et al 2000). For the purposes of the present thesis, the term "need" used henceforth will be referring to any health and wellbeing matters of both parents/carers and children/young people.

The bulk of evidence on health visitors' decision-making practices in the UK increased after 1990s and was mostly conducted by Cowley and Appleton (see, for example, Appleton 1997; Appleton and Cowley 1997; Cowley and Houston 2003; King and Appleton 1997). A considerable body of literature has found that health visitors' decision-making practices have been affected by various factors; however, a distinctive direction towards greater standardisation processes has been evident. In particular, one of the key factors found to be impacting health visitors' assessments of families' needs has been the use of standardized, assessment forms, as found in various primary (Brocklehurst et al 2004; Hogg et al 2012; Kendall and Bloomfield 2005; King 2016; Parker and Kirk 2006; Thompson et al 2013) and secondary (Akehurst 2015; Bidmead et al 2015; Sakellari 2012) studies. For example, the study of King (2016, p. 1901) discussed health visitors' perceptions of employing professional judgement in health visiting in England and found that the use of assessment tools was perceived as a "safety net" in assisting them with the assessments, despite their initial reluctance to use them. Similarly, Thompson et al (2013), who explored the 30-month home visit delivery to families in Scotland, found that using assessment forms may have helped health visitors to identify areas of concern, which might have not been identifiable otherwise.

The use of assessment tools was found helpful in assessing families' needs particularly for vulnerable families during the antenatal period (Brocklehurst et al 2004), in identifying neglect (Akehurst 2015) and in documenting information, particularly when using the Lothian Child Concern Model (Hogg et al 2012). Recording families' outcomes was also regarded as positive in the study of Parker and Kirk (2006) because it helped families identify when progress was achieved. Parents were also found to be receptive of the use

of a standardized forms in the study of Kendall and Bloomfield (2005), which examined the development of an assessment form in evaluating parenting self-efficacy in England. In this study, parents recommended a list of topics as necessary to be included in the form, such as discipline, play, being prepared for parenting, taking advice and child safety. The use of structured tools, which also needed to be culturally sensitive to families' backgrounds, was perceived as useful in the literature review of Sakellari (2012), particularly for inexperienced health visitors. Such tools were found to be missing but needed in also measuring the relationship of health visitors with parents, according to Bidmead et al (2015). It was stressed in their review that, in contrast with psychotherapy and other domains, no assessment tools existed to measure the therapeutic relationships between health visitors and parents, which could be problematic in "measuring" the outcomes of their relationship.

The vast majority of studies have stressed that health visitors made assessments on families' needs on the basis of a combination of factors, rather than depending solely on a single parameter. In many cases, assessment of families' needs was usually made on the basis of multiple considerations forming a holistic picture (Appleton and Cowley 2008), even though these factors differed in the various studies. For example, such combined factors included clinical skills, flexibility and intuitive factors (Jomeen et al 2013), the home environment, the way and the kind of information gathered on families' needs (Kellett and Apps 2009), the type of families' housing, children's sleep behaviours in regards to boundary limitations and the health behaviours of family members (Taylor et al 2009) and observations of parent-child interactions, being knowledgeable of key risk factors and local norms as well as using their intuition (McAtamney 2011). Wilson et al (2008) identified the same combined factors as McAtamney (2011) but also considered reflections of the health visitor-parent relationship. For Cowley et al (2013), though, apart from knowledge and observations, health visitors' interpersonal and compassion skills were also significant in assisting' assessments.

Another factor to be affecting health visitors' assessments of families' needs has been time as assessments "involved piecing together a jigsaw over a considerable time span" (Wilson et al 2008, p. 2). In several studies, assessment of families' needs has been considered an ongoing rather than a one-off process. For example, the studies of Lowenhoff et al (2019) and Cummings and Whittaker (2016) investigated the views of health visitors in delivering listening visits to families in England and they both concluded that effective identification of concerns took place through ongoing assessment. Similar findings came up in the studies of Appleton and Cowley (Appleton and Cowley 2008) and Cowley et al (2015), which examined the key attributes of the health visiting assessment process and of health visiting respectively. On the other hand, when

assessments had been instantly made, they could be misleading and inaccurate of families' needs (Kellett and Apps 2009; McIntosh and Shute 2006), particularly for the families who were most at risk (Wright et al 2009).

Ongoing assessments prerequisite the establishment of relationships between health visitors and parents. As indicated in the studies of Wilson et al (2008) and Kellett and Apps (2009), for example, time spent with parents helped health visitors form relationships with them, which was positively viewed for their assessments. Such findings were in agreement with the study findings of Selbie (2009), who investigated risk assessments in health visitors' child protection work in England. This study found that health visitors regarded their relationship with families a significant factor impacting on their risk assessments.

Another element, well-documented in the literature, to impact on health visitors' assessments has been their intuition/instinct/ experiential knowledge. Chew-Graham et al (2008) in particular investigated health visitors and GPs' views on the way they identified postnatal depression and found that many professionals referred to their intuition or instinct explaining that they did not rely on relevant assessment forms, such as the Edinburgh Postnatal Depression Scale. Similar findings came up in the study of Kellett and Apps (2009) who examined the way health, education and family professionals decided on parenting capacity in England. Many of the participants have reportedly relied on their gut instinct; it was explained that this was enhanced through time, experience and knowledge. The need for opportunities to be offered to professionals to advance their intuitive skills was highlighted in the review of Ward, Brown and Hyde-Dryden (2014), even though study professionals clarified that these skills should complement, rather than replace, the information collected by standardized assessment forms.

Finally, health visitors have been found to rely on multiple other factors as part of their decision-making. These factors have included their own personal values and life experiences, potentially extended into their personality, cultural beliefs and viewpoints; health visitors' prioritising assessments for new parents, families in need of and seeking extra service input; and the organisational principles of the service by encouraging health visitors to be looking for unmet needs in every contact with families (Appleton and Cowley 2008). An additional decision-making element has been health visitors' years of working experience, or else "professional maturity" (Baldwin 2013, p. 471), even though Appleton et al (2013) found that health visitors' years of working experience did not affect their assessments. Additionally, families' cultural background was also found to impact on health visitors' decision-making processes. It was found in the study of Kellett and Apps (2009), for example, that professionals felt the need to consider the cultural and

social backgrounds of the families they worked with and the role of children within them when assessing them.

Even though various decision-making thresholds have been found to affect health visitors' assessments, multiple challenges have also been identified in the literature to prevent effective identification of concerns.

3.3.2. Challenges in families' needs assessment

A number of multiple barriers have been found in the literature to hinder health visitors from effectively undertaking families' needs assessment. These have included: challenges in the use of standardized assessment tools, non-engaging parents and other challenges, such as ignorance of paternal health and wellbeing and the nature of neglect.

- Standardized assessment tools challenges

Even though standardized assessment forms have developed to assist health visitors in their family needs assessments, it has been highlighted in the literature that these tools were not always employed nor considered effective by practitioners. The main reasons for this involved lack of training, health visitors' resistance, not following guidelines, lack of time and not being involved nor involved in the decision-making process.

It was identified in the literature that health visitors were lacking sufficient training to help them identify concerns and problems for families. Participating health visitors in several studies explained that the use of standardized tools without relevant training on how to use these has not been effective on its own in decision-making. For example, the need for further training was highlighted by health visitors in the study of Beauchamp (2014) on how to use the Whooley questions to reach decisions. Similarly, health visitors reportedly lacked training in perinatal mental health (Ashford et al 2017; Jones et al 2015; Wallace 2016), in effectively assessing parent-child relationships and their babies (Appleton et al 2013; McAtamney 2011; Wilson et al 2008) and in observing and attributing greater role to babies when assessing families' needs, instead of mothers' behaviours only (Appleton et al 2013). Training was also found to be required around domestic abuse as in the study of Taylor et al (2013) health visitors did not feel comfortable or confident to initiate a conversation on this sensitive topic, even though participating women expressed their preference to be asked questions about domestic abuse.

Another key challenge preventing health visitors from using standardized tools in their family needs assessments referred to the perceived inefficiency of the forms in helping professionals to effectively identify concerns and provide extra support to the families needing it. In other words, the assessment tools were regarded as "not being good enough" in assessing needs, eventually leading health visitors to resist using them

(Appleton and Cowley 2004). This was found to be the case with the Common Assessment Framework (Selbie 2009), the Edinburgh Postnatal Edinburgh Scale (Silverwood et al 2019) and the Whooley questions (Beauchamp 2014).

More importantly, in many cases, these tools were considered inefficient because their thresholds for the provision of extra, targeted help to families were too high, suggesting that the bar for extra service input should be lowered. For example, some studies (Bailey 2010; Hogg et al 2012; Roche et al 2005; Russell and Drennan 2007) have highlighted that mothers might express concerns to health visitors, which health visitors may not perceive them as such due to not meeting the standards of the assessment forms. These findings indicate that there could be a lack of a shared understanding between practitioners and parents on the cases where extra input is required with the potential for tensions between the two parties. This also came up in the study of Morton and Wigley (2014), as some parents were defensive when health visitors identified and shared their concerns with them because they felt that they did not have any unmet health needs. This signifies that health visitors could be too focused on the tailoring of the service delivery to the use of assessment forms rather than parents' needs (Cowley et al 2004). According to the review of Akehurst (2015), this could be concerning and problematic particularly for the children being at risk but not being identified as such due to not meeting the statutory thresholds of abuse and neglect.

In addition, it has been found in the literature that health visitors could also resist the use of assessment forms due to fear of negatively impacting on their relationships with families. For example, Cowley et al (2013) in their review stressed that standardized assessment tools were not always helpful not only because they did not support health visitors with their assessments but because they also hindered the establishment of relationships with families. This was also found in the study of Pettit (2008), where most health visitors were not willing to share the assessment tool with the parents in advance of their contacts because they feared that it would negatively impact their relationships with them. Similar views were also expressed by parents participating in the study of Roche et al (2005) in England who investigated their views of health visiting. In the study, many parents considered the use of assessment forms as excessive, tick-boxing paperwork entailing some inappropriate questions.

Some other reasons why health visitors were not receptive of the use of standardized tools were also presented in the literature. For example, not following agency instructions was one of them as, in the study of Cowley et al (2004), health visitors reported completing forms in a tick-box manner, which was not in line with managers' guidelines. Similar findings came up in the review of Lowenhoff et al (2017) examining health visitors' role in delivering the NICE guidelines and found that assessments should not be limited

to the standardized forms and “yes/no” answers but should expand on broader questions of various topics that could affect both parents and babies. Other studies (Astbury et al 2016; Cummings and Whittaker 2016) have also highlighted that the discussion between health visitors and parents during assessments has been equally important to the use of assessment forms in encouraging parents to open up.

Finally, inadequate time to conduct observations and complete the relevant forms (Holland and Watkins 2015; Pettit 2008), health visitors’ lack of involvement in the development of the forms (Appleton and Cowley 2004) as well as mothers being stressed by the assessment process (Hogg et al 2012) have also been considered to prevent health visitors from using standardized forms.

- Non-engaging parents

Apart from challenges in the use of standardized tools, another key barrier in assessing families’ needs refers to parents who have been unwilling to engage with health visiting, as found in primary (Kellett and Apps 2009) and secondary (Akehurst 2015; Ward et al 2014) studies. In particular, Kellett and Apps (2009) found that, the most challenging group of people to work with was families who had turned down every opportunity for relationship-building with services. This was also stressed in the review of Akehurst (2015), according to which the lack of engagement and/or hostile attitudes of parents constituted a key challenge in the identification of needs, particularly for neglectful parents. Similarly, the study of Ward et al (2014, p. 11) in England clarified that parents cannot be forced to engage with services and that change “will not happen unless parents are proactively engaged”. These findings highlight the need for the provision of incentives for parents to enhance their motivation in working with services. Finally, another difficulty in professionals’ assessments was found to be the syndrome of “disguised compliance” of parents (Akehurst 2015, p. 41), where parents try to appear as if they engage with services but this could be misleading and takes place on a short-term basis only, hence delaying the identification of concerns.

- Other challenges

Two more challenges in assisting health visitors make assessments have been identified in the literature. These lie in the nature of nursing and health visiting as well as in the nature of neglect. In particular, maternal and child health has been the focus of health visiting and nursing, omitting the role and concerns of fathers. The critical literature review conducted by Perryman and Appleton (2016), for example, examined the role of male victims in domestic abuse in relation to health visiting and indicated that greater focus on paternal health and wellbeing should be attributed by health visiting during contacts. Moreover, in the case of neglect, Akehurst (2015, p. 39) in her literature review

also stressed that the identification of risk factors, rather than neglect per se, could be easily identifiable and “seen”; as such, risk factors “act as pointers to an increased potential, which professionals can be alert to”. In other words, the review explained that professionals could not be certain about the existence of neglect, due to its “disguised” nature, which could prevent professionals from effectively identifying it.

Overall, studies on health visitors’ decision-making practices for family needs assessments have been well-documented. However, most studies have been conducted before the introduction of GIRFEC and in England, rather than Scotland. Even though GIRFEC has introduced new assessment forms¹⁵ to be used by health visitors, research exploring health visitors’ thresholds in making decisions on whether families require universal or targeted service provision has been extremely limited. This thesis will address this research gap by collecting and analysing the views of health visitors and service-users on health visitors’ assessments of families’ needs. Apart from the GIRFEC assessment forms, though, changes in some of the key attributes of health visiting delivery have also been introduced by GIRFEC including, for example, the frequency of contacts and the service delivery venue. The following part of the thesis will present the literature review on service-providers and service-users perceptions of the key attributes of health visiting delivery.

3.4. Health visiting delivery

Early intervention and prevention underpins GIRFEC. As such, health visiting has undergone changes in its universal delivery aiming to reflect the preventive nature of GIRFEC. A review of the literature was therefore conducted on the key attributes of the service that have been valued and not valued by both health visitors and families. This will help to better understand whether GIRFEC changes in the health visiting delivery have been positively or negatively perceived.

3.4.1. Attributes valued in health visiting

The literature in relation to the way health visiting in the UK, including Scotland, has been perceived by health visitors and parents has generally been positive. Most studies have identified positive views of both health visitors and parents highlighting, however, the need for improvements.

More specifically, in the case of health visitors, it has been demonstrated in several studies that the establishment of relationships between health visitors and parents was considered significant for health visitors (Drennan and Joseph 2005; Lucas et al 2019), along with the availability of space for professional autonomy to enable flexibility in

¹⁵The GIRFEC National Practice Model and the Child’s Plan.

service delivery (Condon 2011; Cowley et al 2018a; Cowley et al 2018b; Whittaker et al 2017). Other attributes found to be significant in the service were making health visitors' role explicit to families (Doi et al 2017) and developing empathetic and listening qualities (Seal 2013).

In the case of service-users, studies on their experiences of receiving health visiting in the UK have been greater in number and mostly involved mothers. In general, parents' views were similar to health visitors' with some slight differences. The factors identified by parents as positive in receiving health visiting were mostly linked with relationship-building, health visitors' attributes and the venue of service delivery. For example, parents explained that receiving advice and information from health visitors presupposed the establishment of relationships between health visitors and themselves (Cowley et al 2018b; Donetto et al 2013; Normandale 2001; Roche et al 2005). Delivering antenatal home visits in particular was considered by mothers to be helpful in building relationships and rapport early on in the study of Olander et al (2019). Parents also valued particular attributes in health visitors, such as being caring, knowledgeable of childcare issues and skilled (Bailey 2010; Brook and Salmon 2017; Donetto et al 2013; McHugh and Luker 2002; Plews et al 2005), reassuring and non-judgemental (Donetto et al 2013), friendly and interested (Knott and Latter 1999), and also acquiring communication skills so that parents would feel understood and able to open up (Seal 2013).

In regards to the venue of the service delivery, parents' perceptions were not in consensus. In the qualitative study of Bailey (2010), for example, first-time mothers found home visits more helpful than clinic visits during the first few weeks. The 8-week health check by their health visitors was also considered supportive by parents in the study of Roche et al (2005), due to its informative role. However, in the studies of Marshall et al (2012) and Hogg and Worth (2000), parents valued being able to attend child health clinics and group activities outside the home because it helped them to avoid social isolation. Instead of choosing one service venue over the other, though, the studies of Doi et al (2017) and Donetto and Maben (2014) found that parents preferred a combination of home visits with child health clinics. This was because health clinics augmented their autonomy (Donetto and Maben 2014) and opportunities for social networking and for having their baby weighed regularly (Doi et al 2017) while home visiting enabled health visitors to give more attention to each family (Donetto and Maben 2014). Research on the effectiveness of child health clinics has been extremely limited, as found in the systematic review of Webb (2016).

Other positive factors that parents appreciated in health visiting referred to developing and maintaining collaborative relationships between health visitors and themselves. This was because working in collaboration with health visitors presupposed greater parental

empowerment, involvement and participation in the health visiting relationship (Donetto et al 2013; Normandale 2001). Other factors perceived as positive in the service were service accessibility (Doi et al 2017; Institute of Health Visiting 2020b; Worth and Hogg 2000), service availability by enabling parents to reach out to health visitors over the phone (Doi et al 2017; Plews et al 2005; Worth and Hogg 2000), service responsiveness and professional autonomy for health visitors to tailor the service around families' individual needs (Institute of Health Visiting 2020b). Increase in the health visitors' workforce capacity in line with the Health Visiting Implementation Plan 2011 of England was also welcomed by parents, as found in the qualitative study of Brook and Salmon (2017). Parents also appreciated the role of health visitors acting as a point of contact for families and as coordinators by referring families to other services if needed (Cowley et al 2018b; Donetto et al 2013).

3.4.2. Attributes not valued in health visiting

Even though health visitors and parents were generally satisfied with health visiting, most studies indicated that a number of changes needed to be made for the service to improve. For example, service deficiencies were identified by health visitors in some studies. These referred to insufficient workforce and retention problems (Abbott 2004; Condon 2011; Hogg et al 2014; Miller and Barton 2013) and lack of sufficient training (Cummings and Whittaker 2006; Lucas et al 2019; Spencer 2006; Tennant et al 2006). The lack of training was found to be particularly problematic by health visitors in the case of parents of non-British cultural backgrounds, such as Pakistani and Chinese mothers (Hogg et al 2014), Orthodox Jewish parents (Abbott 2004) and refugee women (Drennan and Joseph 2005). Health visitors also expressed their preference for cultural competence training in the study of Knight-Jackson (2007) in England to reflect the needs of the service-users but also of themselves on the basis that health visitors may be of various cultural backgrounds. The significance of knowing the family background and structure so as to tailor the service around each family's needs was also considered important in the study of Worth and Hogg (2000). In addition, some studies (Deave 2003; Doi et al 2017; Miller and Barton 2013) concluded that the number of universal home visits offered to families was not seen as positive as wide gaps existed in between the visits.

Similar views were also expressed by parents. Despite the positive aspects of health visiting, participating parents of some studies demonstrated great variation in service delivery, which was identified in the content, the number of contacts offered, the continuity of care and the venues of contacts (Bailey 2010; Bowns et al 2000; Deave 2003; Institute of Health Visiting 2020b). Service variation was found to be dependent on the geographical location of families (Donetto et al 2013; Institute of Health Visiting

2020b). Variability of the service across the country also constituted a key finding in the review of Christie (2016). As such, studies have demonstrated that parents were dissatisfied with some particular service characteristics. These inefficiencies referred to the advice and information given by health visitors, which was found to be inappropriate (Bowns et al 2000; McHugh and Luker 2002), insufficient (Deave 2003), not evidence-based (McHugh and Luker 2002) and culturally inappropriate for Pakistani and Chinese mothers in the UK (Hogg et al 2014). Disappointingly, parents in some studies (Donetto et al 2013; Institute of Health Visiting 2020b) were found not to be aware of what health visitors did nor what the service entailed, which highlighted the need for information about the service to be disseminated more effectively to families, starting from the antenatal period (Knott and Latter 1999; Olander et al 2019). Similar findings came up in the review of Christie (2016), according to which parents need to be better informed about the service before they gave birth.

Other attributes of the service that were dissatisfying for parents were the existence of poor relationships between health visitors and parents (Abbott 2004; Brook and Salmon 2017; Russell and Drennan 2007), the lack of sufficient support and reassurance from health visitors (Bowns et al 2000; Roche et al 2005), health visitors being judgemental and ignorant of parents' needs (Brook and Salmon 2017; Knott and Latter 1999; Seal 2013) and lack of personalised care (Institute of Health Visiting 2020b; Knott and Latter 1999), particularly for the hard-to-reach families (Morton et al 2015). Mixed views were also expressed by parents in regards to their preference for the frequency and number of universal home visits offered. For example, in a number of studies (Bowns et al 2000; Doi et al 2017; McHugh and Luker 2002), parents perceived an increase in the number and frequency of home visiting for all positively, particularly during the first few weeks of their babies' lives. However, in the mixed-methods study of Deave (2003), mothers expressed dissatisfaction about having greater contact with their health visitor. Similarly, in the qualitative study of Roche et al (2005) parents considered the 8-month health check by health visitors as bureaucratic and less reassuring.

Finally, health visiting was not seen as helpful by some parents due to the role of health visitors. In the study of Menzies (2019), for example, the views of fathers were collected on their experiences of receiving the service. Findings stressed that health visitors were seen as a form of police and surveillance because they were "checking" on families. However, it was concluded in the study that such perceptions resulted from masculinity barriers as nursing has been related to maternal responsibility. Similar findings came up in the study of Peckover (2002), where the relationship of health visitors to or with mothers was found to be a complex one and wavered between welfare and surveillance. However, recent studies on parents' perceptions of health visitors "policing" role have

been extremely limited. Similar views were expressed in the critical review of Peckover and Appleton (2019), according to whom health visitors' safeguarding role has been largely unquestioned and should be made clearer.

Although the overall findings of health visitors and families' perceptions of the core health visiting elements have been insightful and important, the vast majority of the studies explored health visiting by collecting the views and experiences of mothers. Studies aiming to collect the views and experiences of health visitors were much less in number while views of fathers and children are almost absent, particularly in the post-GIRFEC era. This gap in knowledge will be addressed in the present study by collecting the views and experiences of health visitors, parents and young children. This will help to form a more holistic understanding of whether health visiting and health visitors' role have been considered supportive or intrusive by health visitors and families, particularly in conjunction with the changes introduced in the service by GIRFEC. GIRFEC, though, has necessitated that health visiting would function in partnership with other children's services as well as families. As such, the concept of "bringing professionals together" needs to also be discussed.

3.5. Working in partnership

A key tenet of GIRFEC is partnership working among professionals and families. This concept involves the collaboration between families and different partners and disciplines, such as education, social care, health services, juvenile justice, early years' providers etc. so as to work together in a partnership. As such, a review of the literature was carried out on the seamless provision of children's services focusing particularly on health visiting. For the purposes of this literature review, various terminologies of "partnership working" have been identified and presented. A discussion on the factors encouraging and hindering partnership working will also follow.

3.5.1. Definitions of "working in partnership"

In general, the literature on children's services working in partnership has been vast and confusing, characterised as a "definitional chaos" (Ling 2000, p. 82). This is because there have been various attempts to define the concept of children's services "working in partnership" leading to a lack of consensus and eventually to greater confusion on what this concept entails (Anning et al 2006; Dyson et al 2009; Frost 2005; Ovretveit 1993). This has also been the case for Scotland. For example, it is suggested that "GIRFEC is a way for families to work in partnership with people who can support them, such as teachers, doctors and nurses" (Scottish Government n.d., n.p.). However, a clear definition of "working in partnership" has been missing from the policy documents, which the Scottish Government has been criticised for (Siraj-Blatchford and Siraj 2010).

Another reason causing confusion around the definition of “partnership working” has to do with the term being used in accordance/ instead of other terms, such as “collaboration and multiprofessional agency working” (Powell and Exworthy 2002, p. 13) as well as “co-ordination, co-operation, communication, joined-up thinking, inter-agency, multidisciplinary, partnership and joint planning” (Frost 2005, p. 12) or “synergy” (Sutton and Long 2014, p. 6). All these phrases have been used interchangeably; still, they each entail a unique meaning. Agencies using their own professional terminology and language has been also adding to the confusing nature of the term (Gasper 2010). This was also found to be problematic for Brown and White (2006, p. 2), who argued that a clear definition of the concept “may contribute to enhancing communication and understanding”. According to Fitzgerald and Kay (2008), however, attention should not be given to the terms used but to the underlying meaning of these terms, which is the overall concept of “bringing professionals together”.

In general, Hallett & Birchall (1992) have identified two approaches used in the literature in terms of defining children’s services “working in partnership”; according to the first approach, researchers use a common-sense understanding of the terms without paying too much attention to the exact meaning of their definitions while, according to the second approach, researchers propose their own definitions without, however, articulating the criterion/-a for their choice. To better understand the various terms used to explain partnership working in children’s services, the findings of some of key studies undertaken mostly since 2004 are chronologically presented.

Edwards (2004) explored the elements enabling multi-agency working for children’s services and discussed what multi-agency was *not* about. She clarified that simply the co-location of professionals, the absence of shared objectives and small projects working in isolation did not guarantee effective multi-agency. A key element for effective multi-agency activity is the participation of service-users along with professionals by tailoring the service around the needs of each family and individual.

In another review of literature, Warmington et al (2004) examined the studies on inter-agency collaboration of children’s services. In doing so, they explored the concepts of interagency, multi-agency and joined-up working. The common thread among the three concepts was the involvement of more than one agency. However, interagency activity constituted a planned and formal way of working whereas multiagency could result from the absence of proper interagency activity because it did not guarantee that agencies would work jointly. Joined-up activity, policy or thinking, on the other hand, did not limit itself to agency practices only but incorporated multiple policies, too. Owens (2010) who conducted a review exploring the key terms used to describe partnership working in the Children’s Services Committees in Ireland, also agreed with the definitions of these

terms. She also added, however, the concept of “integration” to describe the formal collaboration and coordination among services to better support children and families, placing the needs of the child at the centre of professionals’ work.

Frost (2005), on the other hand, in his review addressed the practical implications of multiprofessional and multiagency working. He argued that there were different levels of partnership working ranging from lack of partnership to co-operation, collaboration, co-ordination and finally integration of children’s services. Co-operation was described as the first step of the ladder whereas integration as the ultimate and final stage of partnership working. In co-operation, agencies worked together but maintained their independence whereas in collaboration, agencies worked more closely by planning together and addressing problems of duplications and overlaps. In co-ordination, agencies worked in a more structured way by planning and working towards common objectives. Finally, in integration of services, agencies functioned as one holistic organisation, which according to Frost (2005: 16), “it is this level that current child welfare policy in England finds itself”.

Similar views were also expressed by Axelsson and Axelsson (2006), who examined inter-organisational integration of public health in relation to welfare services, even though some terminologies they used were different to Frost’s (2005). They argued that the first level of partnership working was the coexistence of services where services worked in isolation. The following stage was cooperation where information was being shared among services either formally or informally, followed by coordination where services worked in a more coordinated approach and made decisions collectively. Finally, the last step of partnership working was integration where agencies worked more formally.

Percy-Smith (2006), on the other hand, conducted a review on the delivery of partnership frameworks and identified some commonalities among the various terms used to describe partnership working. These commonalities included: services working in a particular, new structure but maintaining their independence, working towards a shared aim, which could only be achieved collectively, and formality in the way services worked in their planning, for example. More importantly, Percy-Smith (2006) concluded that effective partnership required professionals’ key attributes, such as commitment and enthusiasm, so as to overcome organisational challenges. For this reason, Percy-Smith (2006, p. 321) explained that “while partnership working is widely assumed to be a good thing it can be difficult to put into practice successfully”.

The significant role of professionals in effective partnership working was also highlighted in the review of Horwarth and Morrison (2007), who explored the complexities of multiagency partnerships of children’s services. In doing so, they stressed that services

could fail to work in partnership due to professionals resisting organizational change. In addition, they concluded that effective partnership should emphasize: strategy, governance, systems and capacity, outputs and outcomes. As such, it constituted a “developmental process” and required sufficient time to occur (Horwarth and Morrison 2007, p. 371). Apart from examining the concepts of “co-operation”, “co-ordination” and “integration”, Horwarth and Morrison (2007) also used the terms of “communication” and “coalition” in partnership working. The former concept referred to services talking to each other whereas the latter to forming a joint structure “sacrificing some autonomy” (Horwarth and Morrison 2007, p. 56).

Gasper (2010) reviewed the concept of “partnership working” particularly in the field of the early years and stressed that a policy shift took place in the UK from 2000, which encouraged partnership working not only among services but among services and service-users, too, which was not the case before 2000. This shift aimed to improve the way services worked among them by encouraging professionals to also reflect on their own work as part of whole team.

In the Early Intervention Foundation report, Messenger and Molloy (2014) reviewed the literature on local partnerships of integrated, early intervention systems for all children aged from pre-birth to pre-school, focusing particularly on health. They used the term “integration” to represent the “bringing together” of various, early years’ systems in order to better support families. The passing of sufficient time was considered important for Messenger and Molloy (2014, p. 10) in enabling services to transfer from a basic level of “commitment to action” into the early, substantial and eventually maturity stage where lessons could be learned on the outcomes of the integrated, early intervention systems.

In their evidence review, Sutton and Long (2014) examined the international evidence on the practices of integrating overall health services, such as diagnosis and treatment procedures, with health and wellbeing services, such as public health, preventive services. In doing so, they discussed the terms “integration”, “collaboration” and “coordination” by exploring the etymology of these terms. For example, they explained that the word “integration” comes from the Latin “integer”, which referred to a whole, an entity created by combining parts so that they could work collaboratively (Sutton and Long 2014). The term “collaboration”, on the other hand, comes from the Latin “collaborare” used to describe “a joint effort of multiple individuals or work groups to accomplish a complex task or project” whereas “coordination” from the Latin “coordinatio” to represent multiple organisations working together entailing the element of relationship-building among individuals, though (Sutton and Long 2014, p. 6).

Octarra (2018) in her study, on the other hand, used the term “inter-agency” to explore the formal practices taking place in partnership working among children’s services in

Scotland. This was because the concept of “inter-agency” included the establishment of formal and informal working arrangements and relationships among professionals. Table 2. presents some of the key terms identified in the literature that describe partnership working of children’s services.

Table 2. Key terms of "working in partnership"

Terms	Meanings
Integration	Characterised by pooled budgets and shared objectives (Simkins and Garrick 2012; Townsley et al 2004).
	Different services function as one (Frost 2005; Percy-Smith 2006; Sutton and Long 2014); synonym to “co-ownership” where no differentiation exists among services (Axelsson and Axelsson 2006); organisations merge to create new joint identity (Horwarth and Morrison 2007).
	Integration characterised by integrating information and knowledge (Grek et al 2009).
	Merging different systems to create coherent services for families (Messenger and Molloy 2014); supporting children and families through formalised collaboration and coordination and by placing the child at the centre (Owens 2010).
Multi-agency	More than one agency working with a client but not necessarily jointly (Frost 2005; Owens 2010; Warmington et al 2004).
	“A responsive tying of protective factors around vulnerable children, young people and families while building their capacity to take control of their own lives” (Edwards 2004, p. 2).
Inter-agency	More than one agencies working together in a planned and formal way (Owens 2010; Warmington et al 2004).
	Working together for separate organisations (Frost 2005).
	Working arrangements among and between agencies including formal and informal relationships and actions including communication and information sharing (Octarra 2018).
	Working for one organisation in one setting sharing formal and informal information (Frost 2005).

Partnership	Partnership is “embodied in, among other things, the relationships that are developed among individuals within these inter-agency contexts” (Simkins and Garrick 2012, pp. 13-14).
	A bottom-up and more client-directed approach, where work with families is considered necessary to have their needs met (Gasper 2010).
	Partnerships focus on “participation and achievement in education and training, outcomes for care leavers, drug use, youth offending, and teenage pregnancy” (Dickson et al 2004, p. 7).
Coordination	Services work in a planned and systematic manner having shared and agreed goals, even though these might not be fully understood (Frost 2005).
	Shared commitment and coordinated decision-making (Axelsson and Axelsson 2006).
	More formalized joint working, but no sanctions for non-compliance (Horwarth and Morrison 2007).
	“The bringing of different elements of an organisation (or complex activity) into a relationship that will ensure effectiveness and harmony” (Sutton and Long 2014, p. 6).
Cooperation	Services work together but maintain their independence (Frost 2005).
	Formal and informal communication between services where the information to share is not planned (Axelsson and Axelsson 2006).
	Joint working on a case-by-case basis (Horwarth and Morrison 2007).
Collaboration	Services plan together having a common objective but issues of duplication and overlap exist (Frost 2005).
	Joint effort of multiple individuals to accomplish a complex task or project (Sutton and Long 2014).

This review has stressed the existence of various terminologies and definitions used to describe the way children’s services have been working in the UK and in Scotland in particular over the past two decades. For the purposes of the present study, the term

“partnership working” has been chosen and is used henceforth because this concept can be used to explain the working arrangements and relationships that take place among services but also among services and families (Gasper 2010; Simkins and Garrick 2012), which has been a key element within GIRFEC. Because GIRFEC has encouraged and introduced the development of multi-agency meetings, though, the concept of “multi-agency” will also be used as part of partnership working. Apart from the various concepts used to describe “partnership working”, the literature is quite extensive on the factors encouraging and preventing such activity, a literature review of which follows.

3.5.2. Facilitators and barriers of “working in partnership”

Literature on the facilitators and barriers of children’s services working in partnership among them and with families has been quite extensive. Evidence on partnership working particularly since 2004 has included mostly secondary studies and less primary ones. Most of the studies have been qualitative exploring professionals’ perceptions of the self-reported enablers and challenges of partnership working. As such, the processes rather than the outcomes of “doing” partnership working have been well-documented in the literature, particularly from the perspectives of service-providers. Additionally, some studies have examined multi-agency teams and some focused on single services and the way they worked in partnership with other organisations. In the case of health visiting, studies exploring how health visitors worked in partnership with other services and families have been largely scarce. Apart from few differences, the factors identified in the literature to promote partnership working have generally been the opposite of the factors hindering it.

3.5.2.1. Facilitators of “working in partnership”

For the purposes of the present thesis, evidence on the factors encouraging partnership working, as identified in the literature, have been grouped into the facilitators for i) services, ii) professionals, and iii) families.

- Facilitators for children’s services

In terms of children’s services, there has been consensus in the literature that greater communication and information sharing among services facilitated greater collaboration among services. For example, the study of Messenger and Molloy (2014), which examined local partnerships of integrated systems across health and Local Authorities, found that better communication could facilitate greater partnership working. This was also highlighted in the secondary studies of Frost (2005) and Oliver et al (2010) who discussed joined-up working particularly in relation to child welfare and the effectiveness of integrated working respectively. Sharing information through electronic data management systems was also discussed in the literature. Sutton and Long (2014) in

particular reviewed the international evidence on the mechanisms to integrate general health services and health and wellbeing services. They found that sharing electronic patient record system can enhance greater partnership working. Similar findings came up in the study of Gasper et al (2006), too. In this study, members of a multiprofessional team within a children's unit regarded that children's records should allow access to all professionals offering care to families, even though a small number of participants opposed to this. The study also found that greater contribution from children/young people and parents/carers should be included in children's records.

Other factors facilitating partnership working for children's services have included the co-location of professionals, as stressed in the studies of Husain et al (2016), Frost (2005) and Cameron and Lart (2003). Husain et al (2016) in particular collected the views of various stakeholders and service-users on the IF21M programme, a universal programme which was also available for vulnerable families and young mothers aged under 25. Study findings highlighted that co-location was seen by professionals as being a key success of system integration as it facilitated team working to offer seamless provision. Similarly, in their review, Cameron and Lart (2003) explored the factors promoting and obstacles hindering joint working at the NHS/social services interface and found that professionals sharing offices or being based in the same building increased the opportunity for communication between employees from different agencies and resulted in improved co-operation. On the other hand, different findings came up in the study of Olander et al (2019) who conducted interviews with health professionals and mothers to examine their perceptions of co-location of midwifery and health visiting. In their study, they found that for most participants co-location was beneficial but some mothers did not consider it essential.

In addition, other factors enhancing joined-up working for services has involved the establishment of relationships among professionals (Atkinson et al 2002; Atkinson et al 2007) and eventually trust (Messenger and Molloy 2014; Sutton and Long 2014). In addition, less duplication and bureaucracy were also considered key facilitators according to Messenger and Molloy (2014) and Gasper (2010). Similar findings came up from professionals in the study of Education, Children and Families Committee (2014) in Scotland, which explored staff views on the Integrated Children's Services. On the other hand, different findings came up in the study of Atkinson et al (2002), which explored the views of various professionals on their collaborations. This study found that partnership working has caused increased workload for professionals. Moreover, other facilitators have included the establishment of common and clear aims and objectives among services (Atkinson et al 2005; Atkinson et al 2007; Sloper 2004), skilled leadership and co-ordination of services (Atkinson et al 2005; Oliver et al 2010; Sutton and Long 2014)

and cost-effectiveness by sharing funding and resources instead of working in isolation (Atkinson et al 2002; Messenger and Molloy 2014).

- Facilitators for professionals

In the case of professionals, the key factors encouraging partnership working have been identified in the literature to be multi-agency training, clear roles and responsibilities as well as personal attributes. For example, various studies have stressed that joint training (Cameron and Lart 2003) and pre-existing experience of working in various services (Atkinson et al 2002) could enhance understanding among professionals (Sutton and Long 2014) and offer more opportunities for career development (Oliver et al 2010). This was considered feasible through “co-ordinated initial professional training” (Frost 2005, p. 30) as well as various Continuous Professional Development training opportunities (Husain et al 2016). Joint training was found to be particularly beneficial for professionals in the identification of domestic abuse, as found in the literature review of Akehurst (2015) who examined professionals’ approaches in identifying neglect. Similar findings also came up in the study of Yardley et al (2020), who critically reflected, among others, on inter-professional challenges for professionals in England.

However, Alexander et al (2018) came up with different findings. In their study, they collected surveys from various practitioners to examine whether attending training sessions would encourage joined-up working. Even though participants considered such opportunities useful, the outcomes of the training sessions were reported to not be everlasting. In any case, Oliver et al (2010) and Taylor and Daniel (2006) clarified that evidence on whether inter-agency training could be beneficial for effective partnership working has been extremely limited suggesting that more research would be required.

Another factor identified to enhance partnership working has been the establishment of clear roles, responsibilities and expectations among professionals (Oliver et al 2010; Sloper 2004; Sutton and Long 2014). Atkinson et al (2002) argued, however, that there were conflicting views in the literature on whether partnership working resulted in clearer or more blurred boundaries among practitioners.

Apart from training and professional roles, personal attributes and attitudes of practitioners in working with others have also been considered important in enhancing collaborative approaches. Developing enthusiasm and motivation (Frost 2005), commitment and willingness (Atkinson et al 2005; Stewart et al 2003) as well as respect (Cameron and Lart 2003) have all been identified in the literature to constitute key enablers of partnership working. As described by Frost (Frost 2005, p. 39), “working together does not mean doing away with difference-it can mean living with diversity”. Additionally, working collaboratively with others was also found to be a rewarding

(Atkinson et al 2007) and enjoyable (Oliver et al 2010) experience for professionals, even though it has been found to increase practitioners' workload (Atkinson et al 2002). Furthermore, the review of Akehurst (2015, p. 41) has highlighted the effectiveness of joined-up activity in the form of professionals delivering joint visits particularly to complex families as it could "help reduce the 'threat' of parental hostility".

- Facilitators for families

For families, the key facilitator enhancing partnership working has been the improvement of their lives and wellbeing. This has been found in both primary (Atkinson et al 2002; Atkinson et al 2007; Education Children and Families Committee 2014; Stradling, MacNeil and Berry 2009) and secondary (Gasper 2010; Oliver et al 2010) studies. For example, the two Highland Pathfinder projects (Stradling et al 2009) carried out in Scotland to test the implementation of GIRFEC guidance found that parents, children and young people felt more integrated into the planning process and more aware of when and why multi-agency activity was initiated. Similarly, the scoping review of Oliver et al (2010) stressed that the use of the Common Assessment Form by all practitioners working with families in England resulted in greater awareness of services for families and to better relationships between families and schools. According to Gasper (2010), families' needs could be more easily identifiable through partnership working, too.

Other facilitators for families, as reported by parents but mostly professionals in various studies, has been improved accessibility to children's services with less waiting times (Atkinson et al 2007; Education Children and Families Committee 2014; Messenger and Molloy 2014), greater responsiveness (Messenger and Molloy 2014; Oliver et al 2010) and greater availability (Oliver et al 2010) of children's services. More importantly, empowering families by allowing parents, children and young people to be heard was also found to enable greater partnership working (Gasper 2010). Similar findings with a particular focus on child-centeredness were highlighted in the review of Oliver et al (2010), according to whom there has been early evidence indicating that multi-agency models promoted greater child-centred practices.

Regarding information sharing and confidentiality in particular, Redwood et al (2018) in England collected the views of parents and professionals to examine and evaluate the development of a new, universal assessment tool named "My Family Profile" to be used by practitioners with families having babies and toddlers. Findings indicated that parents would feel more confident in their health practitioners if the tool became electronic, which they could have access to. This could reportedly enable them to overcome confidentiality and intrusiveness challenges.

Despite these positive outcomes on families' lives, there has been ambiguity as to whether these findings could be generalizable and whether there could be strong links between particular causes leading to positive outcomes. In other words, it can be debatable whether multi-agency schemes could have positive effects on families' lives, particularly when based mostly on individuals' self-reported satisfaction. As explained by Bromley and Cunningham-Burley (2010, p. 67), "to truly examine cause and effect is very complex and usually requires experimental methods and the accumulation of evidence from numerous different sources". In addition, various external factors, not-related to these multi-agency frameworks, can have a significant impact on the subjects' wellbeing meaning that there can be no particular "recipe" to follow that could lead to specific expected outcomes. Again, it needs to be clarified that collecting various individuals' views, rather than measuring the impact of multi-agency frameworks has been the key drive of this literature review.

3.5.2.2. Barriers of "working in partnership"

As with the facilitators, the factors identified in the literature to be hindering partnership working have been grouped into the barriers for i) services, ii) professionals, and iii) families.

- Barriers for children's services

In regards to the barriers for children's services, these have included the lack of sufficient workforce, such as health visitors and midwives (Atkinson et al 2005) and even administrative staff (Cameron and Lart 2003), resulting in negative feelings and excessive workloads for practitioners (Education Children and Families Committee 2014). This was also found in the study of Aquino et al (2016), which explored women's perceptions of maternity care in England offered collaboratively by health visitor and midwives. Other key barriers for services involved fiscal challenges, including the absence of a physical space and issues around sustainability (Atkinson et al 2005; Atkinson et al 2007) as well as the political climate including the constant change and introduction of legislation and policies (Cameron and Lart 2003; Messenger and Molloy 2014) and the level of detail in the agendas developed locally (Messenger and Molloy 2014).

Ongoing confidentiality challenges in regards to information sharing has also been identified as an additional significant barrier preventing effective partnership working in several studies. The main two challenges in regards to information sharing have been found to derive from i) uncertainty as to what information can be shared particularly in relation to parental consent, and ii) the different electronic systems used by services and accessibility restrictions. The review of Messenger and Molloy (2014), for example, has

found that confusion and anxiety existed among practitioners regarding what kind of information they could share. Similar findings came up in the study of Frost and Robinson (2007) who discussed the multi-disciplinary activity of children's services. In their study, they found that information sharing and record-keeping practices of social and health services created disagreement between the two services. Seeking parental consent was also identified to be problematic in the study of Husain et al (2016) as professionals were uncertain on the cases where they had to seek it.

Additionally, it has been found in various studies (Atkinson et al 2005; Cameron and Lart 2003; Education Children and Families Committee 2014) that each service was using its own data management system preventing accessibility to healthcare databases for non-healthcare workforce, such as early years' practitioners (Husain et al 2016). In the review of Messenger and Molloy (2014) in particular, it has been found that health visiting, doctors, midwives and children's centres have all had their own data system and did not communicate with each other. Similar views were expressed by practitioners in the qualitative study of Robinson and Cottrell (2005) in England; disagreement among services was found to refer to restrictions in accessing families' records due to medical confidentiality. This was also found to be concerning in the study of Hodgson (2009), according to which some health visitors were not aware of who the key mental health worker for the family was.

Another factor preventing partnership working for children's services has included the lack of consensus on the meaning of multi-agency terms used by children's services as concepts of "early intervention" (Messenger and Molloy 2014) and "integrated working" (Husain et al 2016) were found to be perceived differently by practitioners. Moreover, the geographical distance among professionals of various services and the absence of co-location has also been considered a barrier (Aquino et al 2016). However, mixed views have been identified in the literature regarding co-location. For example, findings from the study of Silverwood et al (2019) and Leadbetter et al (2007) in England found that "bringing professionals together" in the same geographical space could not guarantee effective communication among professionals.

Other key barriers for services referred to lack of leadership and thus coordination of children's services (Atkinson et al 2005; Brown and White 2006), the absence of clear aims and objectives for all services (Barnes et al 2017; Cameron and Lart 2003), organisation differences among services, such as education, health and the police (Davies and Ward 2012), the absence of a common system for needs assessment, thresholds and planning among services (Frost 2005; Oliver et al 2010; Rooke 2015).

- Barriers for professionals

In regards to professionals, the key barriers preventing partnership working referred to: i) the lack of clarity around professionals' roles and identities, ii) the absence of multi-agency training, iii) excessive workload. In the case of professionals' roles, it has been well-documented, for example, that confusion existed among practitioners due to unclear professional roles, responsibilities and blurred boundaries (Atkinson et al 2002; Barnes et al 2017; Brown and White 2006; Frost and Robinson 2007; Messenger and Molloy 2014; Oliver et al 2010; Schmied et al 2010). As a result, power imbalances among professionals could lead to tensions among them (Robinson and Cottrell 2005). In the study of Black (2013, p. 5) in England, it was found that despite the unclear distribution of professionals' roles, "there was a strong collective and individual commitment to a shared goal, that of caring for 'the child'".

Lack of multi-agency training was also identified to prevent professionals from working seamlessly (Gannon-Leary et al 2006; Husain et al 2016) and was found to be particularly problematic for the workers that had been liaising between health and social workers (Cameron and Lart 2003). Additionally, excessive workload and feelings of being over-burdened and stressed have also been considered to prevent joined working (Messenger and Molloy 2014; Oliver et al 2010). Atkinson et al (2007, p. 2), on the other hand, found that there was no consensus in the literature on whether professionals' workload has been increased or decreased when working jointly with others, even though "the evidence seemed to be weighted towards an increased workload".

Other barriers for professionals have included resistance to change their professional culture by adopting a more joined-up thinking (Atkinson et al 2002; Atkinson et al 2005), the existence of cultural differences among professionals (Brown and White 2006) and personal attributes, such as mistrust and lacking commitment (Cameron and Lart 2003; Davies and Ward 2012; Schmied et al 2010).

- Barriers for families

In the case of families, the key barrier in effective partnership working has been the lack of awareness of any changes in the way services worked among them. This came up as a finding in the study of Kaehne and Catherall (2013) in Wales, which explored the advantages of health and social care services working in partnership to improve outcomes for children with learning disabilities. The studies of Aquino et al (2018) and Olander et al (2019), which both examined the views of mothers on the collaboration of health visitors and midwives in England, found that communication among professionals was flawed and that improvements could be made on the consistency of information offered to them. Similarly, the study of Birmingham City Council (2016), which investigated the views of the public and early years' practitioners on a proposed integrated model, found that there was an agreement among them that information was

confusing on what a single system collectively provided by agencies entailed. Similar views were expressed by parents in the study of Hogg et al (2012) in Scotland, according to which parents showed their preference for greater information to be available online regarding health visiting.

Finally, another key barrier for parents was information sharing and parental consent, as found in the study of Husain et al (2016). In particular, study findings stressed that in the cases where parents gave their consent, they felt “exposed” to having their information shared among services. This eventually led them to refuse to engage with the universal, integrated model that aimed to bring together health visiting, midwifery and early years’ services.

Although the literature on the facilitators and barriers of partnership working has been quite extensive, it has been mostly based on the perceptions of service-providers, rather than service-users. Studies collecting and analysing the views and experiences of families on partnership working have been extremely limited, particularly in the post-GIRFEC era. The present study will address this research gap by collecting the views of parents and young children on the facilitators and barriers of post-GIRFEC partnership working. Collecting the views of parents and young children can also help to shed light to the outcomes of “doing” partnership working through service-users’ self-reports. Besides, service-user involvement in the research process can be significant because it might help “to building quality health services” (Smith et al 2006, p. 3). Moreover, health visitors’ perceptions of the facilitators and barriers of partnership working will also be collected and analysed for the present study because evidence on the way health visitors in particular have been working with other services has also been limited.

Disappointingly, studies collecting the views of early years’ children on health visiting and partnership working have been absent. Most studies conducted have explored the views of children and young people aged mostly 6 and above on receiving health and nursing care (see, for example, Fletcher et al 2011; Moore and Kirk 2010; Randall 2012; Randall et al 2008; Robinson 2010), social care (Aubrey and Dahl 2006; Whincup 2015) or particularly on child protection (Cossar et al 2011; Cossar et al 2014). Despite the child-centred nature of GIRFEC, no studies have been identified in the literature collecting the perspectives and experiences of pre-school aged children on health visiting and partnership working. Perhaps, this could be due to pre-school aged children being considered too young for meaningful participation and/or to the complexity of identifying an effective method to collect data on young children’s experiences. However, ignoring children’s views on matters directly affecting them is linked to more conservative ideologies that prevailed before 1990s tending to ignore their contribution. After the 1990s, the field of childhood studies in research has changed dramatically in terms of

finding and developing innovative ways of engaging children in the research process. In this research change, which is known as a New Sociology of Childhood (James and Prout 1997), the child is viewed as an active social actor instead of an adult-to-be within a state of “becoming” (Jenks 2005). In line with the new childhood studies’ developments and despite children’s young age, my study will attempt to collect data from young children aged from 3-5 and will attempt to address whether it would be feasible to incorporate young children’s experiences.

3.6. Conclusion

This Chapter has reviewed the literature on the health visiting service of Scotland in the context of GIRFEC. Because GIRFEC has been based on the three principles of proportionate or progressive universalism, early intervention and prevention, and partnership working, health visiting has been reviewed in relation to these three GIRFEC principles. In particular, the literature on health visitors’ assessments of families’ needs, early intervention practices of health visitors in the key elements of service delivery as well as partnership working, with a focus on health visiting, have been reviewed.

Reviewing the literature on health visitors’ decision-making thresholds of families’ needs helped to shed light to the multiple factors affecting their assessment outcomes. These factors mostly involved multiple thresholds, among which the use of standardized forms prevailed. This was distinctive of a direction towards greater standardisation processes in health visitors’ decision-making. However, health visitors and parents’ views on standardisation processes have been mixed. Some studies signify health visitors and/or parents’ preference for standardisation processes because they enable greater identification of needs and documentation of progress. Some, however, were found to resist their use because of their inefficiency in assisting health visitors with their assessments and/or due to the thresholds for extra service being too high. In any case, standardisation processes need to be viewed in conjunction with the various other factors affecting health visitors’ assessments. A dearth in the literature has been identified on the exploration of health visitors’ decision-making thresholds in Scotland post-GIRFEC, which will be addressed by the present study.

In regards to the key elements of health visiting service delivery, the views of service-providers have mostly been in alignment with those of service-users, as found in the literature. Positive attributes for both sides have included the establishment of relationships, service availability as well as health visitors’ personal qualities, such as listening skills, being caring, friendly and non-judgemental. What has been highlighted in this literature review is the consensus between health visitors and parents’ on the need for the establishment of collaborative relationships between professionals and parents through opportunities for equal participation and involvement from both sides. On the

other hand, both health visitors and parents agreed on the existence of service deficiencies caused by inadequate staff training and lack of sufficient information to families regarding the service and health visitors' role, particularly in safeguarding children. The views of health visitors, fathers and children on health visiting delivery have been largely absent in the literature on the matter; hence, they will be addressed in my study.

Health visiting has also been reviewed along with the concept of "working in partnership" to better comprehend the GIRFEC principles. Rather than aiming to come up with a particular definition of joined-up working, the various terms and definitions used in the literature to describe this concept have been critically presented. I have decided to use the term "partnership working" because it explains the interactions and relationships among services but also among services and families. The facilitators encouraging and the barriers hindering partnership working have also been examined and presented, explaining that these exist in the whole spectrum of service delivery from the organisational level to professionals' practices and finally to families' lives. Most studies, however, have collected and analysed service-providers' views on the processes of working collaboratively. The views of service-users on partnership working have been largely omitted and, as such, they will be included in the present thesis. In addition, in line with the new sociological paradigm on children's role within research, the present study will also examine the feasibility of collecting the views of young children on the services they receive.

Overall, the introduction of GIRFEC provides a unique and exciting opportunity for further exploration of the way it has affected health visiting in Scotland. Because GIRFEC has been developed relatively recently, it has been under-researched. Therefore, this study aims to critically explore how the relevant policy documents and guidance health visitors, parents and young children describe and negotiate the potential tensions of GIRFEC (Scottish Government 2020b, n.p.) approach in offering:

- "The right help
- At the right time
- From the right people"

To meet the aim of the study, the following research questions were explored in this thesis:

1. What are the thresholds between the provision of universal and targeted health visiting service?

2. In the context of early intervention and prevention, how is the balance between support and intrusion negotiated?
3. In the context of partnership working, what are the facilitators and barriers in the delivery of integrated services?
4. In the context of “child-centeredness”, what is the role of pre-school aged children? To what extent is it possible to obtain their views on their experiences of receiving health visiting services?

4. Research design and methodology

4.1. Introduction

This Chapter provides a detailed account of the research design of this thesis, including the development of the research aim and objectives, the theoretical underpinnings, the methodology and reflections on carrying out the study. The aim of this Chapter is to describe the rationale adopted and to justify the choices made on the research design of the present study. Research design involves the process from conceptualizing a research problem to developing research questions, the methodology, the collection, analysis and interpretation of data and the reporting on the findings (Bogdan and Taylor 1975; Creswell 2007). Initially, I will present the research aim and objectives of the present study. After this, I will discuss the research paradigm and the theoretical underpinnings of the present study, including the ontological, epistemological and philosophical perspectives. I will then present the rationale for the methodology adopted for the present study, which is a qualitative single-case study design, and critically discuss its different stages from recruitment strategies to data collection and analysis approaches. Finally, the ethical considerations of the study will follow. My own reflections will be discussed throughout the Chapter.

4.2. Research Aim and Questions

This study aims to critically explore how the relevant policy documents and guidance, health visitors, parents and young children describe and negotiate the potential tensions of the *Getting it Right for Every Child*¹⁶ (Scottish Government 2020b, n.p.) approach in offering:

- “The right help
- At the right time
- From the right people”

To meet the aim of the study, the following research questions were explored:

1. What are the thresholds between the provision of universal and targeted health visiting service?
2. In the context of early intervention and prevention, how is the balance between support and intrusion negotiated?
3. In the context of partnership working, what are the facilitators and barriers in the delivery of integrated services?

¹⁶ (GIRFEC hereafter)

4. In the context of “child-centeredness”, what is the role of pre-school aged children? To what extent is it possible to obtain their views on their experiences of receiving health visiting services?

4.3. Research paradigm and theoretical underpinnings

In social and health science research, theories underpin scientific paradigms (Scotland 2012), which highlights the intertwined relationship between theoretical frameworks and research paradigms. As Babbie (1998, p. 32) puts it, research paradigms aim to offer “ways of looking” while theoretical frameworks “shape and direct research efforts” by offering explanations.

The literature on research paradigms is greatly extensive, particularly in social and health science research. The concept of “research paradigm” refers to the way researchers think (Kuhn 1962), to researchers’ beliefs about the world (Guba and Lincoln 1994; Lather 1986), to worldviews that underpin research (Guba and Lincoln 1994), to “fundamental models or frames of reference” (Babbie, 1998, pp. 32-33), and to the researcher’s principles or viewpoints (Denzin and Lincoln 2000). Research paradigms are therefore significant in shaping the research design of a study because they combine ideologies, worldviews, viewpoints and mind-sets.

There are various examples of research paradigms in the social and health science research literature, such as positivism, post-positivism, critical theory, interpretivism, realism, relativism, structuralism, modernism, pragmatism, feminism. Every paradigm is based upon its own ontological and epistemological principles. This means that each paradigm is underpinned by different assumptions of the nature of the social world (ontology), the nature and origins of knowledge and how it can be acquired (epistemology), and how to report the findings (axiology) (Creswell 1994; Ormston, Spencer, Barnard and Snape 2013). Therefore, these ontological and epistemological underpinnings impact on the research approach and the methodology and methods chosen by the researcher (Scotland 2012).

For the purposes of the present thesis, it is imperative to clearly describe the research paradigm and the theoretical underpinnings of the study before further exploring the methodology and methods employed. This will help to provide clarity on my own viewpoints and the philosophical stance adopted in the thesis. In terms of the research paradigm, the constructivist research paradigm has been adopted, which is one of the main influential paradigms in the social and health science research field. In regards to the theoretical underpinnings, the work of Foucault (1977, 1979, 1982) on power, surveillance and resistance as well as Bronfenbrenner’s (1979, 1986, 1994) ecological systems theory have informed the research paradigm and design of the present study.

4.3.1. Constructivism

The principles and assumptions underpinning the constructivist research paradigm are a relativist ontology, a transactional and subjectivist epistemology, a naturalist methodology and a balanced axiology (Kivunja and Kuyini 2017). Ontologically, constructivism advocates that there are multiple realities, which are constructed by human beings, and they need to be interpreted to discover the underlying meaning (Denzin and Lincoln 2005). There are no universal or absolute truths because reality is considered relative and socially constructed (Searle 1995). The aim of this research paradigm is therefore understanding and structuring, rather than predicting (Guba and Lincoln 1994) enabling the researcher to better understand participants' actions by allowing them to tell their stories (Crabtree and Miller 1999; Lather 1992; Robottom and Hart 1993).

In constructivism, there is a transactional and subjectivist epistemology, which translate into knowledge not being absolute and findings not being generalizable (Guba and Lincoln 1994). As such, realities need to be interpreted and should be examined using the best "tools". The researcher and the research problem "are assumed to be interactively linked so that the "findings" are literally created as the investigation proceeds" (Guba and Lincoln 1994, p. 111).

Methodologically, constructivism promotes naturalist methodology. This means that hermeneutical (interpretive) and dialectic (discourse) qualitative methods are employed (Guba and Lincoln 1994). Various examples of methodologies are presented in the literature in this case, such as grounded theory, ethnography, phenomenology, action research, discourse analysis and feminist standpoint research. For the purposes of the present study and for reasons that will be explained later on, a case study research methodology has been employed. Finally, from an axiological point of view, constructivism depicts a balanced axiology. This means that the aim of the study is to present the findings of the research in a balanced way, which will reflect individuals' perspectives and "the values of the researcher" (Kivunja and Kuyini 2017, p. 34).

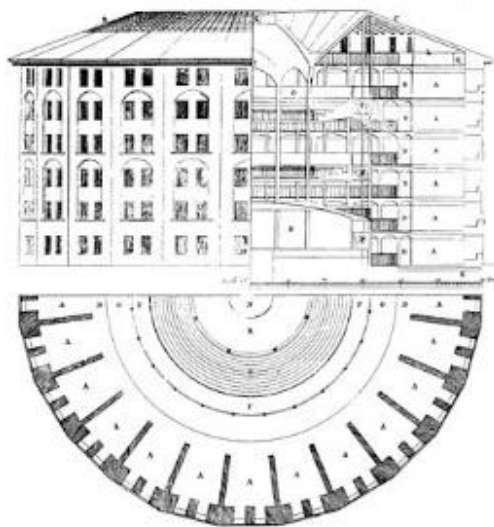
4.3.2. Foucault's theory of Power

The theoretical ideas and work of Foucault (1977, 1979, 1982) in relation to power are relevant to the present thesis and have therefore informed the research paradigm and design of the present study. It needs to be clarified that the present thesis has not employed Foucauldian Discourse Analysis or Foucauldian-inspired (or informed) Discourse Analysis because the study aim is not to explore networks of power through the investigation of discourse. However, Foucault's work on power, surveillance and resistance is greatly relevant to the GIRFEC policy approach of the Scottish context,

which is why the present study has been informed by his theoretical framework. This policy approach has introduced a number of changes impacting on professionals' everyday practices, such as adopting greater early identification and prevention strategies and collaborating with other services, which could constitute an approach for the state to acquire greater "power" and surveil citizens. In turn, citizens could be receptive of this policy or show resistance by declining services, such as health visiting.

Foucault's work was considered to be part of structuralism and post-modernism (Peters 1999). In 1975, Foucault published the "Surveiller et punir: Naissance de la prison" book, which was translated in various languages, including the English "Discipline and Punish: The Birth of the Prison" version (Foucault 1977). In his book, Foucault discussed the concept of Panopticon, which was initially introduced by Jeremy Bentham. Figure 3. represents an architectural drawing for Bentham's Panopticon prison.

Figure 3. Architectural drawing of Bentham's Panopticon prison



The image above is a 1791 design of the Panopticon prison by Jeremy and Samuel Bentham, drawn by the architect Willey Reveley. This drawing is reproduced as Plate II in 'Postscript, Part II' of Jeremy Bentham.¹⁷ Foucault used the concept of the Panopticon prison to explain the relationship of power, surveillance, law and normalization: the tower at the centre, which is covered with windows open to the peripheric building, is intended for the supervisor; the peripheric building, on the other hand, is extended all around the tower and consists of individual cells intended for the prisoners (Foucault 1977). The term "panopticon" derives from the Greek word *pan*, which means "all", and the word *opticon*, which means "the visual" (Briskin 1998). The idea of this Panopticon prison is that the tower "allows" for the supervisor to "view" and surveil all the prisoners; the "few" to supervise the "many". This concept is used by Foucault (1977, pp. 176-177) to

¹⁷ Reveley's original and other related drawings are in the Bentham Collection, UCL.

describe the context against which a network of relationships among supervisors and prisoners takes place; there is an “anonymous power” that “holds’ the whole together” and impacts on the behaviours of the supervisors and the supervised.

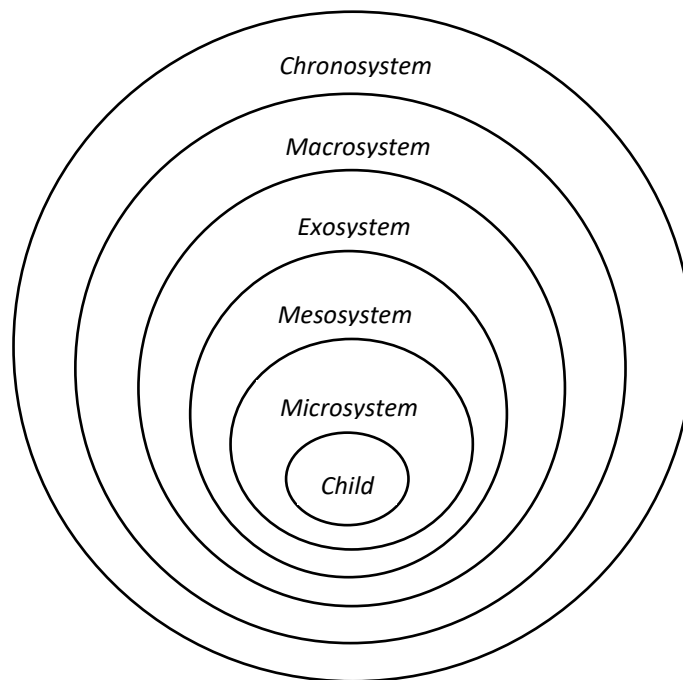
There are several similarities between Foucault’s theory and GIRFEC. This policy approach, which was enshrined by law¹⁸, aimed to lead to a re-organization of the Scottish children’s services system. Within this context, all professionals working with children and young people, including health visitors, have been encouraged to take on a number of particular steps to promote children’s wellbeing, including the offer of extra help, early intervention and prevention, and partnership working (Scottish Government 2020b). Such approaches could be perceived as a way for the state to surveil parents and decide on whether they follow the expert knowledge depicted in legislation (Smith 2000). This could lead the supervised to *internalize* feelings of being watched (Foucault 1977) meaning that the possibility of being punished for not adopting normalized behaviours could transform the soul of the prisoners. As Mathiesen (1997, p. 217) describes it, this transformation of the soul refers to “the creation of human beings who control themselves through self-control thus fitting neatly into a so-called democratic capitalist society.” On the other hand, citizens can show “resistance” towards the way they are being governed. GIRFEC therefore constitutes a fruitful research topic to explore whether families resist the GIRFEC framework or accept it as the norm.

4.3.3. *Bronfenbrenner’s Ecological Systems Theory*

Bronfenbrenner’s Ecological Systems Theory of Human Development (1979, 1986, 1994) has also helped to inform the present study because it provides a framework for comprehending the biological changes in a child’s development in relation to environmental factors. Childhood in this framework is considered a dynamic state where environmental factors are key for children’s development and wellbeing. As such, the present study examined such factors in relation to children’s wellbeing. Data ranging from children’s immediate (parents) to their remote environment (GIRFEC policy documents) were collected and analysed to explore the research questions of the study. Figure 4. represents the theoretical framework of Bronfenbrenner (1979).

¹⁸ See Children and Young People (Scotland) Act 2014.

Figure 4. The Ecological Systems Theory of Bronfenbrenner



The figure above represents Bronfenbrenner's Ecological Systems Theory and depicts the way the various environments/circles of a child's life are correlated and the way they affect children's development. More specifically, this theory places the individual child at the centre and recognises that children's developmental stages are interlinked with different environmental systems, which are: i) children's immediate environment consisting of the child's family, school or health services (microsystem), ii) a system of connections and relationships among the microsystem environments, such as between family and health services (mesosystem), iii) children's environments, in which children do not actively participate but can impact on their development, such as parents' work place (exosystem), and iv) children's remote environment consisting of their larger society including attitudes and ideologies of the culture, policies and legislation (macrosystem). Later on, another system/environment was added to this model acting as context of children's development, the chronosystem, referring to the "change or consistency over time not only in the characteristics of the person but also of the environment in which that person lives", such as life changes in the family structure (Bronfenbrenner 1994, p. 40).

Various immediate and remote environments, including the child's family, children's services (health, education), the wider political, economic and cultural context as well as the interplay of these affect a child's development, according to this theory (Bronfenbrenner 1986). The present study has been informed by this theoretical framework in the data sources chosen. For example, for the purposes of the research,

data were collected from young children (placed at the centre of the study), microsystem (parents and health visitors) and macrosystem (GIRFEC policy documents). Data collection from parents and health professionals also helped to explore mesosystem, by gaining an insight into the relationships and interactions between families and professionals.

4.4. Research methodology

Research paradigms are associated with and define the research methodology and methods employed in a study (Chilisa and Kawulich 2012). Research methodology refers to the research approaches and techniques in finding answers to the research questions of a study (Kumar 2019) whereas the methods refer to the various “tools” used by the researcher to conduct research (Mills 2014). Driven by the constructivist paradigm, the present study employed a qualitative single-case study, adopting an inductive approach as well as a descriptive and exploratory approach.

4.4.1. Qualitative single-case study design

A qualitative single-case study design has been employed for the purposes of the present thesis. The present study aims to capture the information contained in the relevant policy documents and guidance as well as the views and experiences of health visitors, parents and young children in relation to the GIRFEC principles underpinning health visiting. Considering that the current study aims to explore the perspectives of various individuals in regards to a particular phenomenon, it is in line with the fundamentals of qualitative research. Qualitative research seeks to uncover the views and perspectives (Ritchie, Lewis, Nicholls and Ormston 2013), human behaviours (Denzin and Lincoln 2011) and lived experiences, emotions and interactions (Strauss and Corbin 1998) of particular individuals and “social contexts” (Mack, Woodsong, MacQueen, Guest and Namey 2005, p. 1).

Moreover, data from various sources were collected and analysed for the present study, which is in line with the principles of case study methodology. The use of case studies for capturing complex and uncertain issues of social reality is quite common in health and social science research. This methodology allows for description and understanding of the phenomena from the participants’ perspectives (Ejimabo 2015) and is chosen when exploring how and why questions (Gerring 2004). Yin (2014) also agrees on this by adding that, apart from the use of how and why questions, the use of case studies in social research is preferred in cases where the researcher has little control over the phenomenon under examination and when the topic examined is contemporary within a real-life context. The key feature of this methodology is therefore the role of the *context* and its linkage with the investigation of the phenomenon under examination (Yin 2003,

Yin 2014). There are also pragmatic reasons for the use of case studies, such as time, money, and access to the fieldwork, which are also required to be taken into account by the investigator (Seawright and Gerring 2008). All these reasons also apply to the present study because it explores how GIRFEC translates into practice by collecting participants' views. Time limitations of a doctoral thesis also impacted my decision to employ such a methodology. Conducting a case study methodology has therefore been considered the most effective way for exploring the research questions of the project.

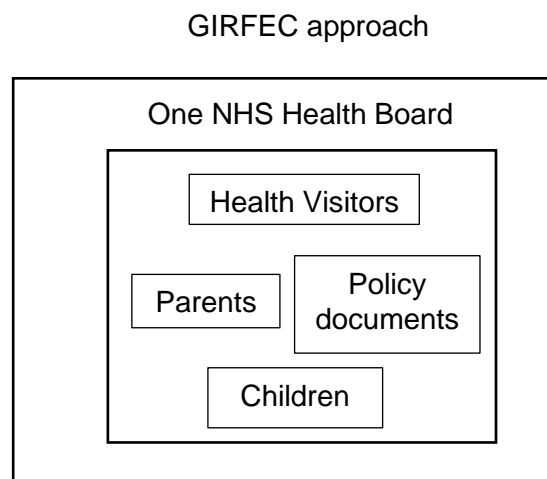
The case study methodology conducted is based on the work of Yin (2003) and Stake (2005). Despite their disagreement on the exact nature and definition of the case study design, they both agreed that this approach offers the opportunity for the researcher to in-depth explore and comprehend a particular case or multiple cases over a given time relying on several sources of information. In the literature, there seems to be a more or less agreement that a case study is an intensive investigation of a geographical area or a number of individuals (Cousin 2005; Zainal 2007) combining various data collection methods, for instance documents, surveys, interviews and observations (see, for example, Bennett 2004; Eisenhardt 1989; Mack et al 2005). The nature of the case study is such that various methods are used in collaboration with one another based on the principle that "the strengths of one method compensate for the weaknesses of another" (Bennett 2004, p. 48). The exact research methods employed for the present thesis are described elsewhere in this Chapter.

Case studies can be single-case, which allow for the examination of a particular case or phenomenon to be explored in-depth "as a stand-alone entity" (Paterson 2010, p. 2), or multiple cases, which allow for the examination of several cases (Gerring 2007). There is a consensus in the literature that the use of multiple cases in case study methodology may help the researcher(s) generate findings that can be generalized to a broader range of geographical areas or a greater number of individuals. However, some cases might be unique and thus cannot be easily compared to others or, in some cases, it may not be possible for the researcher(s) to explore the various cases extensively. In such instances, "the fewer cases there are, and the more intensively they are studied, the more a work merits the appellation "case study"" (Gerring 2007, p. 20). On the basis of the research questions, time, financial and human resources, gatekeeper pre-established connections and methods with which I felt comfortable employing, the present study has adopted a single-case or within-case design. This refers to the intensive exploration of the GIRFEC approach within health visiting in one particular NHS Scottish Health Board instead of collecting partial data from a greater number of settings, i.e. NHS Health Boards. In addition, the choice of one particular geographical region for the qualitative investigation of a particular topic or phenomenon has been quite common

in the health visiting research field in Scotland (see, for example, Doi et al 2017; Hogg et al 2012; King 2016, McAtamney 2011; Worth and Hogg 2000).

Because GIRFEC has been the key concept of my doctoral thesis, it was necessary to conduct my fieldwork in a Scottish NHS Health Board that had been implementing GIRFEC. After discussing the issue with the NHS Manager of Forth Valley, which has been partly funding my doctoral thesis, it became clear that the NHS Forth Valley was well advance in implementing GIRFEC. As such, this particular NHS Health Board was chosen for my fieldwork. Moreover, no studies examining GIRFEC and the health visiting practice have been conducted in this particular Scottish Health Board to the knowledge of the researcher, which was also seen as a promising setting to shed light to. Figure 5., which was adopted from Yin (2014), helps to clarify what the case study of the present thesis involves.

Figure 5. Single-case study representation of the doctoral study



There are multiple units of analysis in this model, including health visitors, parents, children and the relevant policy documents. Collecting the views of health visitors, parents and children on their experiences is vital, considering that the GIRFEC approach involves changes in the practices of health visitors to promote the wellbeing of children and better support families in Scotland. The exploration of the relevant policy documentation can also help to better understand the legal and policy landscape and if and how health visitors make sense of it. Data were separately collected and analysed from each unit of analysis.

There is extensive information in the literature on the specific steps researchers are to follow when conducting a single-case study design (see, for example, Eisenhardt 1989; George and Bennett 2005; Yin 2014). This procedure depends on the inductive or deductive orientation adopted by the researcher in every study, explored in the following part.

4.4.2. *Inductive approach*

The role of theory in case study methodology is significant because it can either emerge from the data (inductive approach) or it can already be existing and tested (deductive approach). In inductive research approach, theory is developed during the data collection, analysis and interpretation. In deductive research approach, on the other hand, a hypothesis derives from the existing theory and is being tested during the data collection, analysis and interpretation. Both research approaches require from the researcher to dive in, absorb and make sense of the data (Azungah 2018). The present study has adopted an inductive research orientation.

Employing a constructivist research paradigm inductively is quite common in the health visiting research field (see, for example, Appleton and King 1997; Appleton and King 2002). However, polarity has been identified in the literature on the role of theory in the case study methodology. On one hand, it is suggested in the literature that data are collected and analysed in a way similar to grounded theory, according to which there is no prior literature review nor theory in the research phenomenon studied (Glaser 1992; Strauss and Corbin 1998). This means that the way theory applies or does not apply to the phenomenon under study follows research. On the other hand, it is suggested that some theoretical preconceptions pre-exist and are necessary for the in-depth study of a research area (Eisenhardt 1989; Stake 2005; Yin 2003). The case study methodology employed in the present thesis has been informed by this latter approach. This is because it allows existing literature, theories¹⁹ and my own preconceived ideas to inform the research design discouraging me from acting as a tabula rasa within the research field. This approach therefore allowed me to have an open mind in collecting and analysing data and to eventually contextualise findings within the existing literature and theoretical frameworks.

4.4.3. *Descriptive and exploratory approach*

The current study has adopted a descriptive and an exploratory research approach. Descriptive approach is used to analyse and examine an individual, a population or a phenomenon by describing and clarifying characteristics, activities and relationships (Merriam 2009; Stake 1995; Yin 2014). The key difference between this approach and other research approaches, such as exploratory or explanatory reasoning, is that a “thick description” of interpretations of phenomena and situations are provided (Stake 2005, p. 102). This means that the description aims to incorporate all the details of the case examined to provide an understanding of the real world, which is also the case with the

¹⁹ Foucault’s theory of Power (1977, 1979) and Bronfenbrenner’s Ecological Systems Theory (1979), in particular.

GIRFEC policy approach of this study. In this approach, the development of the research aim and questions and the methodology takes place before data collection. However, a challenge identified in the literature on the use of descriptive approaches is that there is no “definite measure of how thick is thick enough” (Dawson 2010, p. 4).

Apart from the descriptive approach, an exploratory research approach has also been employed in the present study because it helps to explore a particular research problem in-depth. Exploratory research is considered the study of a research phenomenon which has not been studied thoroughly or at all in the past (Stebbins 2001; Streb 2012). It is also used in studies where the research problem is not clearly defined and offers explanations and greater understanding without providing final, definitive solutions to problems. Considering that the GIRFEC policy approach has been developed in the Scottish context relatively recently, an exploratory study can help to shed light to this phenomenon of limited exploration. Exploratory studies answer what and how questions (Yin 2014), which is also the case for the present study. A controversial characteristic of this approach lies on the emphasis it attributes to researchers’ experiential knowledge, which has been considered an advantage rather than a limitation by some (Streb 2012).

The next part of this Chapter focuses on the data collection methods chosen to address the research questions and the data analysis approach.

4.5. Implementation

The aim of this part is to explicitly describe the implementation process of the research design and methodology. It entails information on the research methods employed, the study setting, the recruitment process, the use of thematic analysis and triangulation in data analysis and the methodological limitations.

4.5.1. Research methods

According to the literature on case study methodology (Mack et al 2005; Stake 2005; Yin 2014), data are collected through various research methods, such as documents, interviews, archival records, observations, questionnaires and physical artefacts. Document review and interviews were the main data collection approaches of this study. More specifically, the present study used four main types of methods: document review, one-to-one interviews, group interviews (focus groups) and interviews using participatory techniques with young children. Each research method comes with its strengths and challenges and the choice of all of them was done under the justification of fully capturing the multi-dimensional nature of the research problem. The data collected and analysed from the research methods helped to explore each research question.

Being an outsider researcher (Corbin Dwyer and Buckle 2009), due to not having a health visiting background myself, was both beneficial and challenging in data collection.

It was beneficial because I acted as a newcomer and had the opportunity to gain an in-depth insight into the data. It was also challenging, though, because I eventually obtained a large number of data to be analysed.

4.5.1.1. *Document review*

Documents of every form have always played a significant role in health and social science research. In case study methodology, reviewing and analysing documents is considered one potential research method to be employed because it can be used in collaboration with other research methods. As such, it can help provide background and context information and verify findings. Document review is also a cost-effective and less time-consuming method comparing to other approaches as it involves a selection rather than a collection of data (Bowen 2009). Moreover, documents to be examined are in most cases easy to access because they are mostly available in the public domain (Merriam 1988) and can provide detailed information on facts, dates, individuals and events (Yin 2014) reducing “the impact of potential biases” (Bowen 2009, p. 28). Even though documents could range widely²⁰, Scottish Government policy documents and guidance were reviewed and analysed for the purposes of the present thesis. This helped to better comprehend the way GIRFEC was intended to translate at the ground-level. Additionally, they helped me correlate the findings of their analysis with the findings of health visitors, parents and children, and thus to fully explore the research questions.

While reviewing documents, I identified a number of GIRFEC and health visiting documents that have been published over the past years. These included policy briefings, NHS documents, reports, legislation, local guidance, the digital platform used by health professionals (MiDIS) and assessment forms, such as the GIRFEC National Practice Model and the Ages and Stages Questionnaires. Even though these documents were taken into account in the background information of the thesis, a more in-depth analysis of the Scottish Government documentation was required to provide a critical “lens” of the policy field and to help answer the research questions. Considering the extensive amount of documents, however, and the time limitations of conducting a doctoral study, analysing all of the relevant documents identified was not feasible. Besides, even though it is widely accepted that a wider selection of documents might be preferable in policy document analysis, the focus should be given to the quality rather than the quantity of the documents (Bowen 2009). For these reasons, it was decided that a limited number of policy documents but of great relevance and significance had to be selected for further analysis. I therefore employed a top-down, deductive reasoning on

²⁰ They could include, for example, charts, journals and other artefacts (Giacomini and Cook 2000), advertisements, letters, agendas, minutes of meetings, guidance documents, background papers, books, diaries and journals (Bowen 2009).

selecting the documents to be analysed, which led me to choose four particular Scottish Government policy documents and guidance for further analysis. These four sources were chosen on the basis of i) their content and relevance to the research aim and questions of the current study, ii) the time they were intended to be used by professionals, and ii) their target audience (nationally and locally). Table 3. contains information on the four documents.

Table 3. Policy documents and guidance analysed

Policy documents and guidance	Year of publication	Author	Target audience
A Guide to Getting it Right for Every Child ²¹	2012	The Scottish Government	All professionals working with children and adult services (national guidance)
Universal Health Visiting Pathway in Scotland: Pre-Birth to Pre-School ²² (the UP hereafter)	2015	The Scottish Government	Health visitors in Scotland (national guidance)
Core Standards for Health Visiting practice & Documentation ²³	2019	Placement NHS Health Board	Health visitors in the Placement NHS Health Board (local guidance)
	2018	Placement NHS Health Board	Health visitors in the Placement NHS Health Board (local guidance)

²¹ A Guide to Getting it right for every child (Scottish Government 2012)

²² Universal Health Visiting Pathway in Scotland: Pre-Birth to Pre-School (Scottish Government 2015)

²³ Core Standards for Health Visiting practice & Documentation (Placement NHS Health Board 2019)

Vulnerable Children Guidance ²⁴			
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The documents analysed are: i) the national GIRFEC guidance to be followed by *all* professionals working with children, young people and families (*A Guide to Getting it right for every child*), ii) the national health visiting guidance to be followed by health visitors only (the UP) and iii) the local health visiting guidance to be followed by health visitors particularly in the Health Board that this study was conducted in (*Core Standards for Health Visiting practice & Documentation* and the *Vulnerable Children Guidance*).

More specifically, considering that the present study aims to analyse GIRFEC through health visiting, it was considered necessary to select the most representative national documents in relation to GIRFEC and health visiting that were expected to guide health visitors' work at the time of data collection (from April 2018 until January 2019). *A Guide to Getting it right for every child* (Scottish Government 2012) constitutes the first nationally-wide GIRFEC document including information on all the key changes in service delivery as a result of GIRFEC introduction. As such, its analysis could have not been omitted. Similarly, the UP (Scottish Government 2015) was also chosen for policy document analysis because it constituted the most significant document for health visitors at a national level when collecting my data. Both the *Guide to Getting it right for every child* and the UP were publicly available.

Apart from selecting national policy documents, however, it was also necessary to select local guidance because fieldwork took place in a small, local NHS Health Board. While I was interviewing health visitors, I was made aware by many of them that there are a number of local documents developed to guide health visitors in that particular site. It became clear, though, that these local documents were not publicly available. I thus contacted the NHS Manager of the relevant Health Board to seek access to local guidance. The NHS Manager then issued two local health visiting documents of the particular site (*Core Standards for Health Visiting practice & Documentation* and the *Vulnerable Children Guidance*), which she considered significant for GIRFEC implementation and health visiting at the local level. This led me to include these two documents in the policy document analysis, too. During the writing up of the present thesis, the *Core Standards for Health Visiting practice & Documentation* (Placement NHS Health Board 2019) was revised (Placement NHS Health Board 2020), access to which was again provided by the NHS Manager. Despite this new document not being in use

²⁴ Vulnerable Children Guidance (Placement NHS Health Board 2018)

during the data collection period of the present study, its analysis helps to provide some useful insights on the “way forward” for GIRFEC local implementation.

Even though documents are usually analysed prior to conducting other research methods, such as interviews (Yanow 2010), in this study, the four Scottish Government documents were analysed prior, during and after the collection and analysis of the data of health visitors, parents and children. This enabled me to constantly reflect on the information contained in the documents and to correlate it with the data collected from participants. Reviewing the documents before commencing fieldwork was particularly useful in helping me develop the interview questions used with participants (O’Leary 2014).

4.5.1.2. *Interviews*

Twenty qualitative, one-to-one interviews were conducted with twenty health visitors who provided their services in the Scottish Health Board the study was conducted in. Interviews are considered a powerful tool in the research fieldwork and were used because they gave me the opportunity to delve into the interviewees’ narratives in a way that no other qualitative research method could. Qualitative interviews can help to collect individuals’ perspectives and experiences in relation to a particular phenomenon of concern (Lambert and Loiselle 2007) and to understand “*how* and *why* people perceive, reflect, role-take, interpret, and interact” (Adler and Adler 2012, p. 8). As such, interviews helped me explore and understand health visitors’ viewpoints on the current health visiting service of Scotland against the GIRFEC background. Face-to-face interviews in particular were employed because they helped me build rapport with the interviewees and enabled them to disclose information more freely comparing to phone interviews (Shuy 2003). The choice of the number of interviews was made on the basis of time.

The types of interviews used with the participants were semi-structured (or semi-standardized). This is because semi-structured interviews constitute a rather flexible method allowing for predetermined topics to be discussed as well as for unexpected responses to develop as a result of open-ended questions (Tod 2006). The interview template (Appendix 13) included open-ended questions to allow the interviewees to expand and provide responses as fully as possible. In line with Patton’s (2002) guidelines, the questions asked were about the interviewees’ experiences, views, feelings, expertise and sensory experience.

The twenty interviews with the health visitors took place in two phases. During the first phase, ten individual interviews were conducted with ten health visitors. Critical incident technique was used during the interviews to elicit their views on their service delivery. For example, during the interviews, I asked health visitors to recall and describe events

from their own experience of service provision by making questions, such as “can you recall and describe an event where...”. This approach helped me collect health visitors’ experiences of delivering health visiting and to understand their perceptions of the national and local GIRFEC guidance. The data from the first ten interviews were then analysed and helped me develop vignettes (hypothetical scenarios) to use in the focus groups with the parents, which followed. Vignettes are “short stories about hypothetical characters in specified circumstances” (Finch 1987, p. 105) and were used in the focus groups with parents because they can help elicit and compare respondents’ views and beliefs on a sensitive topic (Barter and Renold 1999). After the collection of parents’ views via focus groups, the second phase of the interviews with the health visitors followed; ten more face-to-face interviews with ten more health visitors took place.

4.5.1.3. *Focus groups*

Two focus groups were conducted with parents to elicit their views on the way they received health visiting in the post-GIRFEC era. This method is a semi-structured group interview on a particular topic, usually led by a coordinator (Cohen and Grabtree 2006). The core idea of focus groups lies on a set of predetermined questions, prepared by the coordinator, to lead a group discussion (Eliot and Associates 2005). According to Kirk and Miller (1986), focus groups consist of planning, observation, analysis, and reporting; planning plays a significant role in this research process, which is not the case in most qualitative research methods (Morgan 1997). Focus groups were chosen in this case because, in combination with other qualitative methods, they can offer a large amount of rich and robust information within a short period of time (Powell and Single 1996) and can lead to comparisons of participants’ experiences (Cohen and Grabtree 2006).

The parents/participants of each group already knew each other and had already developed relationships among them because they were all attending the same group from the beginning of the academic year. Therefore, the choice of focus groups was also made on the justification that the parents of each group would discuss topics more comfortably comparing to one-to-one interviews. However, the fact that parents were already familiar with each other might have influenced their responses and prevented them from freely expressing their views during the focus groups. This also made me reflect on the way my actual and perceived attributes –being a 30-year old, Greek, PhD student- might have affected participants’ responses and consequently the data findings, as also noted in the literature (Smithson 2000).

Vignettes (hypothetical scenarios), which were developed from the interviews with health visitors, were used in the focus groups to encourage parents to discuss their thoughts or potential reactions in different hypothetical scenarios regarding professionals’ practices.

Vignettes were used as a starting point for group discussion. Based on parents' responses, I then moved on to explore their experiences and perceptions in greater detail (see Appendix 15).

Each focus group consisted of approx. ten parents (fifteen parents in one focus group and five in the other). The parents of one focus group were receiving the minimum standard of health visiting support, deemed universal provision. The parents taking part in the second focus group, though, were receiving additional, prolonged services or additional support on occasional basis, such as parents dealing with mental health problems. Recruiting parents of different needs and level of support allowed for a variety of views to be expressed on the post-GIRFEC health visiting system.

4.5.1.4. Participatory methods with young children

Since the 1990s, the field of childhood studies in research has changed dramatically in terms of developing innovative ways of engaging children in the research process. This change in the research methods employed with children has influenced and has been influenced by the way we, adults, view children and childhood (Wyness 2015). As such, a number of innovative, participatory techniques for children have gradually started to thrive in the research field. These approaches can vary widely including: drawing/painting, child led tours, games (Lansdown 2017); video cameras and photographs (Cowie, Huser and Myers 2014); talking-mats (Murphy and Oliver 2013); vignettes, unfinished sentences and other visual stimuli (MacAuley 1996), to name but a few. These practices can be used with children and young people as prompts for discussion in combination with more traditional research methods, such as observations and interviews.

In line with the New Sociology of Childhood (James and Prout 1997), the present study aims to examine children's role within GIRFEC and the extent to which it would be possible to obtain their views on their experiences on the services they receive, with a focus on health visiting. This study therefore offers children the opportunity to be given a "voice" and describe the actions and attributes of the relevant professionals they come in contact with, what they like/expect from them, what they like/would like to change in their interactions with them and what the "ideal" health visitor/social worker/teacher would be for them. Giving children a "voice" in matters that affect them is also in line with Article 12 of the United Nations Convention on the Rights of the Child (UNICEF 1989).

Particular attention must be given to research conducted with young children because the methods used with them should be appropriate for the level of understanding and the abilities of the children. After careful consideration, I decided to use four different participatory methods in the interviews with children, including drawing techniques,

vignettes, unfinished sentences and postal boxes (see Appendix 17). The use of four different child-friendly approaches allowed for a variety of methods to be used in case a child lost his/her interest in one of the methods. The postal boxes, for example, were not eventually employed because it was the last method used and the children had already lost their interest by the time this prompt was used. Table 4. entails information on the participatory methods and a description of each one of them.

Table 4. Participatory methods used with children

Participatory methods employed in children’s interviews	Description
Drawing techniques	Children were encouraged to draw the relevant professionals they come in contact with and describe them. This was used as an introductory technique.
Vignettes	Discussion on what children would like/expect from health visitors and other professionals they might come in contact with, such as social worker, psychologist, teacher, in various hypothetical scenarios.
Unfinished sentences	Introducing a number of sentences on what children would like to maintain/change in their interactions with the professionals they come in contact with and on what the “ideal” health visitor/social worker/teacher was for them.
Postal box	Encouraging children to write a letter (or to tell me so that I can write the letter for them) on what they would like to maintain/change in their interactions with professionals. The letter was to be sent to their current health visitor, social worker and/or teacher.

Driven by the lack of research on collecting young children’s views on the services they receive, particularly health visiting, the present study collected young children’s views.

This experience enabled me to reflect on the extent it would be possible to collect their views on the services they receive, including health visiting. However, the data collected from the two children were not sufficient to be analysed. Children's responses were not well-articulated as they were limited to "yes"/"no" answers. This did not enable me to gain an in-depth understanding of their views and experiences. Due to the limited data collected from children, an in-depth analysis of their responses was not feasible and was not included in the present study. This experience has been valuable though in allowing me to reflect on the challenges of collecting young children's views on a topic.

Challenges in collecting young children's views in this study could be attributed to i) the very young age of children, and ii) the research methods employed. In regards to the young age of children, the inclusion criteria signified that children should be aged from three to five years old to take part in the study because their linguistic skills would have been developed during this time period. The children recruited though belonged to the lowest age range of the inclusion criteria as both were three-year-olds. The particular Aberlour Family Support service, through which I recruited children, was providing support to families of children aged from months up to three-year-olds at the time of the study. I therefore decided to recruit the older children receiving support from the service, even though it would be challenging for data collection and analysis. Perhaps, if the inclusion criteria ranged from four to five year old children, I would have been able to collect more articulate responses from children.

The brief responses collected from children also gave me the opportunity to reflect on the research methods I employed with them. The use of research methods that were more suitable for the age-range of the children recruited might have been more effective. Future research should take into account the ages of children and the development of research methods adjusted to their age. Overall, collecting children's views on a research topic could potentially be feasible with the use of age-appropriate research methods.

4.5.1.5. Observations of multi-agency meetings and interviews with professionals

Based on the principles of case study methodology that various research methods are employed for data collection (Yin 2003), the initial research design had included more research methods, which were eventually not conducted. Against the GIRFEC context, the initial research design aimed to also collect data on the way multi-agency meetings take place and on the views of professionals other than health visitors on GIRFEC. For this reason, two to three observations of multi-agency meetings and approx. five interviews with professionals other than health visitors (social workers, teachers, third

sector professionals, service managers) were also included in the initial methodology design²⁵.

More specifically, the initial research design included observations of approximately two to three Team Around the Child meetings (TACs hereafter), where various professionals along with parents and potentially the child meet up to discuss a child wellbeing concern. This could enable me to observe and take notes on how professionals collaborate (or not) at the frontline, how and what kind of information they share on children's wellbeing and families' role in these. In this way, I could meet with all the relevant professionals of the TACs and, after gaining their consent, I could conduct individual interviews with some of them (possibly after the meetings) to gather their views on GIRFEC and partnership working. Access to these multi-agency meetings, which take place either in the Health Centre or in the Nursery, would be accomplished through the health visitors I interviewed.

These observations and interviews were not eventually conducted for two main reasons. Firstly, the initial research design proved to be rather ambitious in the context of the time limitations of a doctoral study. Secondly, there were complications in gaining research access permission by the Social Services department of the Local Authority. More specifically, I did receive ethical approval from the University of Stirling and from Research & Development of the particular Health Board so as to observe multi-agency meetings and interview professionals other than health visitors. However, multi-agency meetings consist of professionals from various services, such as education, health, social work and potentially a third sector organisation. For this reason, I was also required to gain research access permission through different levels of the relevant Council (Social Services and Education Services) to observe these meetings and interview social workers and/or teachers. Even though I received approval from the Education Services, approval from Social Services was declined due to potential impact on operational practice and limited staff capacity. Even though research access request was not granted by both Council Services departments, this lack of agreement between the departments made me reflect on the way partnership working takes place in practice. For example, the decisions made individually by a service/department inevitably impacted on another service/department. Moreover, a lack of communication between the two departments was transparent as there was no system for effective communication between them.

²⁵ Participant Information Letters for Professionals other than health visitors (Appendix 3) and for Parents of multi-agency meetings (Appendix 4) as well as Consent forms for Professionals other than the health visitors (Appendix 6) were separately developed.

4.5.2. *Sample size*

The issue of how many participants are enough to adequately explore the research aim and questions of a study as well as the issue of saturation have always been integral and debatable in health and social science research. Even though there are various views in the literature as to the number of participants to be recruited in qualitative research (see, for example, Baker and Edwards 2012), no definitive answer nor “recipes” as to a certain number could be recommended for every study as this depends on a number of factors, such as time and financial constraints. For Mason (2010), qualitative samples should be large enough to ensure that all significant views have been brought to light but at the same time they should not be too large due to the fear of not being essential.

In line with previous qualitative studies on the matter and based on the timescale of a PhD programme, the sample size of the study was small. Four Scottish Government policy documents were reviewed and twenty health visitors, twenty parents and two pre-school aged children were recruited. These numbers were chosen on the basis of the theoretical underpinnings, the scope of the research aim and questions of the present study, geographical locality as well as time, budget, resources and practical limitations. In the case of pre-school aged children, the existing dearth in the literature on their views regarding the services they receive led me to examine whether it is even possible to obtain their views and experiences on the matter; hence, the small number of two pre-school aged children.

4.5.3. *Study setting and recruitment of participants*

All the data were collected from various settings of one Scottish Health Board. A number of participants, including health visitors, parents and young children, were recruited.

- Health visitors

Twenty health visitors were individually interviewed and all the interviews were carried out in the premises of the NHS Health Community Centres/Hospitals where they were employed in. The settings of the interviews were thus various covering ten different Health Centres/Hospitals in one Health Board. This allowed for the views of the health visitors of a wider geographical range to be collected (urban and rural, deprived and affluent). It also enabled health visitors to remain in their own work place (office, staff room or any other room), which they had already been acquainted with. Each interview lasted for approx. one hour and each professional received a “Thank you” card at the end of the interviews for their contribution.

Recruiting health visitors was accomplished through my personal links with the NHS Service Manager of the particular Health Board, after informing her about the current

study and my interest to recruit health visitors from the area. The Participant Information Letter for Health Visitors (Appendix 1) along with the Consent Form for Health Visitors (Appendix 5) were circulated by the Service Manager to health visitors via email. The health visitors who were interested in participating in the study directly contacted me via email. However, recruiting health visitors via their Manager, who acted as gatekeeper, made me reflect on whether participation in the study was indeed perceived as voluntary by health visitors and on whether their responses were affected by this. Table 5. presents the inclusion and exclusion criteria for the recruitment of health visitors.

Table 5. Inclusion and exclusion criteria for health visitors' recruitment

Inclusion criteria for the recruitment of the health visitors	Exclusion criteria for the recruitment of health visitors
Working in the Health Board the study was conducted in.	Adults having a severe cognitive impairment.
Providing universal or targeted health visiting services.	
Able to provide written informed consent to take part in the study.	

After the completion of all the interviews, each health visitor was sent a demographics questionnaire by email to complete (see Appendix 16) to gain greater background information. All the health visitors were white, British women and almost all were aged from 46-55 years old. In terms of health visitors' work experience, this varied widely. Most of them reported to have been employed as health visitors for the past 3-5 years and many for the past 11-20 years. Eventually, the health visitors recruited were a mixture of very experienced health visitors with experience of the Old Pathway (*A New Look at Hall4*²⁶) and newly qualified health visitors who were familiar with the New Pathway (UP²⁷).

- For parents

Two focus groups, consisting of twenty parents altogether, were also conducted. The parents recruited in the study deliberately varied on the level of support they required. This means that parents receiving the minimum standard of health visiting, that is universal service, and parents receiving additional services either occasionally or

²⁶ Scottish Government 2011
²⁷ Scottish Government 2015

indefinitely were recruited, which allowed for a variety of views to be expressed. One focus group with parents took place in the Baby, Toddler and Pre-school group within the Health Board, consisting of parents receiving universal or additional health visiting services. The second focus group, on the other hand, was carried out in the premises of the Aberlour Family Support service of the same Health Board and consisted of parents receiving additional service input due to complex or severe needs. To thank them for their contribution, all participating parents received a £10 gift voucher each and a “Thank you” card at the end of the focus groups (Appendix 10).

In terms of the focus group conducted in the Baby, Toddler and Pre-school group, it consisted of fifteen parents. This group offered a place for parents (mostly mothers) and their young children to meet on a regular basis so that their children could play and learn together. This focus group took place on the premises of the group, after coming to an agreement with the group Manager, who I initiated contact with through one of the health visitors I had interviewed. It should also be clarified that the young children of the parents participating in this focus group were not involved in the research project at all. During this focus group, a health visitor, whom I had not interviewed, was present; she was, however, limited to staying in one particular space area and was looking after the babies and toddlers of the parents while the discussion was taking place. This made me reflect on whether parents’ responses were affected by the health visitor’s presence in the room. Not all parents’ responses were positive towards health visiting, though.

The second group of parents consisted of five parents who were recruited through a third sector organisation of the area, the Aberlour Family Support service. This service helps families dealing with problems as well as children and young people having a disability or having suffered abuse and trauma. This was decided so as to collect the views of parents who also receive prolonged or occasional additional service input. This second focus group took place on the premises of the Aberlour service, after contacting and coming to an agreement with the service Manager. Two children of two of parents receiving support from the Aberlour service later took part in my study (see following section for children). Table 6. Presents the inclusion and exclusion criteria for parents’ recruitment.

Table 6. Inclusion and exclusion criteria for parents' recruitment

Inclusion criteria for the recruitment of parents	Exclusion criteria for the recruitment of parents
Receiving universal or additional health visiting services via a Baby, Toddler and Pre-school group in the Health Board.	Not acquiring sufficient level of English to participate in the focus group.

Receiving additional support for themselves and/or their children from the Aberlour Family Support service in the Health Board.	
Able to provide written informed consent to take part in the study.	

No demographic questionnaires were given to the parents participating in the study. On reflection, such information might have been valuable as it could help in data analysis and interpretation (Salkind 2010). For example, collecting information on parents' age or employment status might have helped to understand who participated in the focus groups and thus provide a richer context. It could also be advantageous in generalizing the sample to a larger population (Allen 2018).

- For children

Two three-year-old children, one boy and one girl, were interviewed using participatory techniques. The interviews with the children took place in the Aberlour premise and they were recruited through their parents who participated in one of the focus groups. Both the children and their families were receiving support from the Aberlour Family Support service due to dealing with complex problems. Children's assent (Appendix 9) as well as informed consent from the children's parents (Appendix 8) were sought for their participation. The parents of the pre-school aged children who participated in the study received a £10 voucher each, while the children received a sticker/stamp to thank them for their participation. Table 7. presents the inclusion and exclusion criteria for children's recruitment.

Table 7. Inclusion and exclusion criteria for children's recruitment

Inclusion criteria for the recruitment of children	Exclusion criteria for the recruitment of children
Aged from 3 to 5 years old.	Level of English insufficient to participate in the study.
Receiving support from the Aberlour Family Support service in the Health Board.	
Able to provide assent (verbally and in written), due to their young age, to take part in the study.	

4.5.4. *Data analysis*

The four Scottish Government documents as well as the data collected from the health visitors and parents were analysed separately and qualitatively with the use of thematic analysis. In the case of children, the data collected were eventually helpful in generating discussion and reflective thoughts in regards to the use of participatory approaches to elicit their views, rather than on children's responses. For the interviews and focus groups, a digital recorder was used in all stages; the audios were then anonymously transcribed and the data were analysed. All the data were saved and analysed in my University laptop with the use of the NVivo data analysis software. I have been the only one having access to my password-protected University laptop.

Various qualitative data analysis approaches are suggested in the literature, such as content analysis, narrative analysis, conversation analysis, ethnography, life stories, grounded theory and so on (Spencer, Ritchie, Ormston, O'Connor, and Barnard 2014). For the purposes of this study, thematic analysis was employed because it can be used to analyse various primary and secondary data (Clarke and Braun 2013), to interpret text in health services (Joffe 2012) and also constitutes a research tool for relatively novice researchers (Braun and Clarke 2012). Because the present study falls into all three categories, thematic analysis was used to provide an entry into the meanings of individuals' perspectives and documents.

Thematic analysis was employed in the present study based on the guidelines of Braun and Clarke (2006, 2012) and Boyatzis (1998). This is because the procedure of doing thematic analysis presented by these authors is clear, concise and thorough. Employing thematic analysis is not considered as a linear process but a rather reflexive one where the researcher moves around the various steps so as to better explore the research aim and questions of the study. In line with Braun and Clarke (2006, 2012) and Boyatzis (1998), the process I followed to thematically analyse the data consisted of a number of steps. Firstly, all the relevant documents and transcripts along with personal notes were collected, read and re-read. This stage allowed me to read the data several times in a reflective manner. I then identified some initial codes/common patterns, which are considered as "the building blocks of analysis" (Braun and Clarke 2012, p. 61). I then attempted to develop and establish connections among the codes; this helped me identify some initial themes among the various codes. The construction and development of the themes was followed, where I constantly reflected on the following questions: "Is this a theme (it could just be a code)?...Are there enough (meaningful) data to support this theme?" (Braun and Clarke 2012, p. 65). Finally, the last stage of thematic analysis included the writing up of the findings (Braun and Clarke 2006) and the establishment of rigour and validity regarding the findings of the study (Boyatzis 1998). Throughout all the

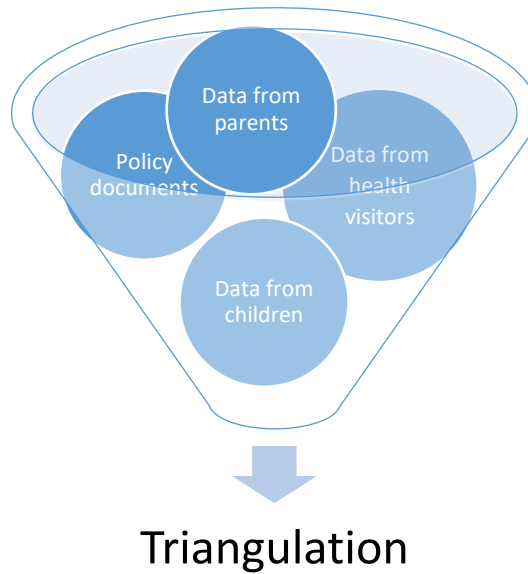
stages of the data analysis, I sought advice from my supervisors regarding the identification of the themes to establish greater rigour and validity.

Even though data analysis has led to the development of a descriptive and exploratory framework regarding the relationships of the themes, the relevant literature review has also been of great significance in thematic analysis. Combining study findings with the various themes that different researchers have come up with in the literature is in line with the principles inductive-oriented research and could also enable greater validity and reliability of the research findings. For example, this can enable the researcher to “confirm findings” (Strauss and Corbin 1998, p. 51) and therefore contribute to knowledge. Chapter 9 presents the study findings in conjunction with the relevant literature by exploring each research question separately.

4.5.5. Triangulation

Triangulation refers to the use of multiple i) methods, ii) researchers, iii) theories or iv) data sources in qualitative research for an in-depth understanding of a phenomenon (Denzin 1978; Patton 1999). For Denzin (1970), triangulation also refers to time and setting, too. The present study has employed triangulation of data sources because data from multiple sources, including policy documents, health visitors, parents and children, were collected and analysed to better comprehend GIRFEC through health visiting. Triangulation of data sources helps “to gain the most complete and detailed data possible” (Hall and Rist 1999, p. 296) and to establish credibility and validity (Eisner 1991; Yin 2014). Essentially, triangulation helps to capture different dimensions of the same phenomenon. According to Dubois and Gibbert (2010), the more the sources, the greater the validity attributed to the study. Figure 6. represents the way the data were triangulated in the study.

Figure 6. Data triangulation



The figure above represents the way the policy documents and the data collected from health visitors, parents and young children were analysed. The data from each source were analysed separately using thematic analysis based on the research questions. During the analysis, I was also open to identifying new ideas and themes that were not included in the research questions. The findings from each source are presented in Chapters 5, 6, 7 and 8. Chapter 9 integrates the findings from all the sources and correlates them with the relevant literature to explore each research question.

4.6. Limitations of research methodology

As in every study, this research entails methodological limitations. This study is of small-scale designed to fit the time constraints of a doctoral study and of obtaining ethical approvals. Additionally, the documents analysed were also limited and published at different timings. Three key limitations exist in case study methodology. Firstly, case study methodology brings up issues of generalization and representation of findings (Bennett 2004; Seawright and Gerring 2008). This is also the case for this study as it recruited a small number of participants of one particular Scottish Health Board. However, the study findings can constitute the basis for future research examining the delivery of GIRFEC through the health visiting service and can help to inform policy and practice.

Secondly, there is a lack of accuracy in estimating precise linkages between causes and their outcomes (Bennett 2004), even though there is disagreement on whether the aim of a case study is to represent causal relations (see, for example, Gerring 2004). It could also be that there may be unmeasured causes/variables leading to particular outcomes.

Despite this weakness, the use of case studies provides a primary baseline for developing linkages between relationships of cause-effect.

Another weakness is that case studies are considered too descriptive, almost as story-telling (Cronin 2014). However, this should not be considered as a limitation because the exploration of the research questions does require detailed descriptions in some studies. In the current project, for example, the findings were fruitful for the exploration of the research questions thanks to being descriptive.

Limitations also exist in the choice and use of the research methods. In regards to the research methods, the findings can never be “objective enough” because the researcher’s subjectivity may also influence these. The conceptual lenses through which the researcher examines the findings play a significant role in research (Allison and Zelikow 1999). In this case, triangulation of data sources can help to grasp a phenomenon through various angles and contribute to the objectivity of the findings as much as possible. In the case of the interviews with children in particular, the participatory techniques are not a panacea – they also come with their own challenges, just as every other research method. When using participatory methods with children and young people, the researcher would be required to adopt a reflexive approach on the effectiveness and the reasons why these were chosen to answer the particular research problem (Punch 2002). This is to ensure that the benefits of using participatory methods overcome the limitations.

The issue of lacking objectivity is also key in employing thematic analysis. One of the basic limitations of thematic analysis refers to the researcher being biased and, therefore, reflecting his/her biases into the research findings (Joffe 2012). In order to minimize this possibility in the present study, I took two key actions. Firstly, I conducted a literature review on the matter before and throughout the data analysis, which helped me interpret the data through a more objective lens. Secondly, the final constructed themes were reviewed by my supervisors so as to enable greater validity. More importantly, objectivity in interpreting findings cannot be fully accomplished because the researcher’s preconceptions cannot be completely vanished. However, the complete lack of objectivity is not necessarily a limitation. The researcher’s subjectivity could also prove useful in interpreting the data through a different, personal lens and hence contribute to research. As Clarke and Braun (2013, p. 5) put it, “...qualities such as subjectivity do not produce bias that undermines the research, but are essential to good qualitative research practice”.

4.7. Ethical considerations

Before commencing fieldwork, I followed all the relevant ethical procedures. I received NHS, Invasive or Clinical Research ethical approval from the University of Stirling (Appendix 18). I then received NHS ethical approval (Appendix 19) followed by Research & Development ethical approval in the particular Health Board the study was conducted in (Appendix 20). Taking into consideration the ethical issues in a study is much more than gaining ethical approvals, though. As Tisdall, Davis and Gallagher (2009) point out, ethics are related to a continuous, thoughtful reflection; ethics could be likened to the question of “how ethical could that be?” during every step of research. Therefore, throughout the research process, I have been continually reflecting on the ethical considerations of my research and actions. From my own reflection and discussion from supervision, the following potential ethical issues were identified:

4.7.1. Sensitive nature of research

Because of the nature of the study topic, sensitivity from the design of the study to the dissemination of the study findings is essential to prevent the arising of potential implications for the participants and has been taken into account. During the implementation of the research methods, it was anticipated that some parents or children might find the research topic distressing if, for example, they were asked to talk about their personal experiences of receiving extra support from professionals. In this case, I was prepared to suspend the interview until the participant was ready to continue, or to stop the interview if the participant did no longer wish to take part. In the case of the focus groups, a second facilitator was also present so as to prevent the arising of challenging situations due to the sensitive nature of the discussions. The second facilitator was another doctoral student with experience of conducting qualitative research. This also meant that in case a participant wished to leave the focus group due to becoming upset, I would keep on leading the group discussion whereas the second moderator would attempt to debrief the participant. I was also anticipating that in cases where participants in the focus group found some topics sensitive, one-to-one interviews with them could follow up to allow greater articulation and space for clarifications.

In terms of interviewing young children, I have extensive experience working with pre-school children and I have undertaken training using participatory techniques to elicit children's views. I am a qualified Early Years Teacher and I also acquired an MSc in Childhood Studies at the University of Edinburgh. As part of this course, I attended the “Listening to Children: Research and Consultation” module, which enabled me to develop my knowledge on ethical considerations when undertaking research with children (including very young children) as well as on approaches to research that have been tailored to children, such as use of puppets, drawing techniques etc.

If a child got visibly distressed during the interviews, I was prepared to try to fully debrief the child, discuss the possibility of pausing/stopping the research process and also inform the child's carer about the child's reaction after the end of interview. Moreover, I introduced the thumbs up and down technique between me and each child as a form of on-going non-verbal assent. The thumbs up movement indicated that the child was happy with the topic of whereas the thumbs down movement would indicate that the child would not like to continue. In the latter case, I was prepared to pause the research process and made sure the child understood what he/she had been asked, without using intrusive questions to elicit children's answers. If the child still refused to participate, the research process would terminate.

4.7.2. Anonymity and confidentiality

In order to ensure anonymity in the current study, all features that may have led to the identification of the participants were deleted from all the transcripts and from all the data used in the thesis. They will also be deleted from future publications, such as journal articles. A pseudonym was used for each participant and for the location of the study, which is known to me and my supervisors only.

Apart from anonymity, maintaining participant confidentiality, that is participants' data protection, is another essential part of every ethically-driven research project. In order to secure confidentiality in the current study, all the personal contact details of the participants involved, as in the consent forms, were accessed by me only and have been in line with the Data Protection Act 1998 and GDPR (2018) guidance; data collected by the participants have remained confidential at all times and have been securely scanned and stored in my University laptop; all the hard copies have been destroyed. In line with the University's principles, data will be held at the University of Stirling for a period of 10 years. Confidentiality of participants' contact details would only be breached in cases where safety concerns were raised, such as abuse or neglect (see following section).

4.7.3. Disclosure of information relating to the harm, neglect or abuse of participants

In the highly unlikely event where a child or a parent disclosed inappropriate information that was considered harmful to a child, such as abuse or neglect, I would stop the research process and would clearly and respectfully explain to the child or parent that the information would need to be shared with the relevant authorities. The participants, in this case, would be reassured that they would be dealt with professionalism and respect at all times. I would then seek consultation from my supervisors on the matter and for guidance from the Social Care and Health Department of the Council. The relevant child protection procedure would follow in this case and all the information I

would have already collected in relation to the particular child or parent would be passed on to the relevant statutory bodies when requested.

4.7.4. Gaining Consent

If researchers truly respect their participants, they have to inform them about every aspect of their research both verbally and non-verbally (Alderson 2005). Consent to take part in the study was sought from all the participants, including children (Appendices 5, 6, 7, 8, 9). A minimum of 48 hours was provided to all the participants between the issue of the Participation Information letters (Appendices 1, 2, 3, 4) and the Consent forms being signed, in line with the principles of the University of Stirling. Consent to take part in the study was taken on the day of and prior to the interview/focus group starting, when I asked in person whether the participant was still willing to take part. In the case of children, their assent was sought, instead of consent, due to their young age. All the participants had a further opportunity to ask questions and agree or decline to participate in the study.

Children's assent was sought both verbally and in written (Appendix 9) with the use of age-appropriate language and visual images so that the children could easily access the information about the research, ask questions and understand their involvement. However, informed assent was difficult to obtain due to the very young age of the children. In other words, it was challenging for me to ensure that the pre-school aged children could fully understand what the research involved and what they were assenting to. For this reason, informed consent was sought from the children's parents regarding their child's participation (Appendix 8). In order for a child to take part in the study, both the child's assent and their parents' written consent form were sought.

Although parents would be asked to provide written consent for their child's participation at the beginning of the interviews, consent should be also sought at every stage of research because it is an ongoing process (Tisdall, Davis and Gallagher 2009). Therefore, I carefully observed the children's body language and non-verbal communication to look for signals that indicated the child may wanted to stop (Cocks 2005). The use of the thumbs up and down technique was effective as a way to reflect on ongoing verbal assent. If a child appeared to be distressed during the participatory methods, I was prepared to discuss the possibility of pausing/stopping the research process.

4.8. Conclusion

This Chapter has presented the research aim and questions of the present study as well as the rationale for the methodology adopted. The constructivist research paradigm as well as Foucault's theory of Power (1977) and Bronfenbrenner's Ecological Systems Theory (1979) as the theoretical influences of the study were described and rationalised. The use of a qualitative single-case study was then described and justified as the research methodology of the study. In doing so, it was clarified that an inductive research approach has been adopted and that the aim of the methodology was to describe and explore the phenomenon under study. After this, the implementation stages of the research design were presented and justified. Multiple research methods, including policy documents, twenty individual interviews with health visitors, two focus groups with twenty parents in total and two individual interviews with two young children using child-friendly techniques were used. The rationale for the sample size, the study setting and the recruitment of participants was then presented. The data were analysed using thematic analysis (Boyatzis 1998; Braun and Clarke 2012) and the use of triangulation of data sources was employed to enable credibility and validity. Reflections on the methodological limitations then followed. Finally, the ethical considerations of the study were described.

The following Chapters will present the findings of data analysis. Chapter 5 presents the findings from the analysis of the policy documents, Chapters 6 and 7 from health visitors and Chapter 8 from parents.

5. Policy document analysis: GIRFEC changes and challenges

5.1. Introduction

The findings explored in this Chapter resulted from conducting thematic analysis (Braun and Clarke 2012) on the relevant Scottish Government policy documents and guidance in relation to *Getting it Right for Every Child*²⁸ (Scottish Government 2020b) and health visiting of Scotland. The four documents analysed are: *A Guide to Getting it Right for Every Child* (Scottish Government 2012), the *Universal Health Visiting Pathway in Scotland: Pre-Birth to Pre-School*²⁹ (Scottish Government 2015), the *Core Standards for Health Visiting practice & Documentation* (Placement NHS Health Board 2019) and the *Vulnerable Children Guidance* (Placement NHS Health Board 2018). The revised *Core Standards for Health Visiting practice & Documentation* (Placement NHS Health Board 2020) was also taken into account in the analysis. Justification on the choice of the documents is provided in Chapter 4.

The findings of this Chapter help to explore the research questions of the present study from the lens of the documents. Three broad themes, 'Towards a regulatory framework: Arising complications', 'Operationalizing GIRFEC: Missing the mechanisms' and 'Decision-making thresholds: Standardization vs. professional judgement' developed from the analysis of the documents, within which eight sub-themes developed. The theme 'Towards a regulatory framework: Arising complications' refers to challenges imposed by the state to families and health visitors due to the regulatory nature of health visiting post-GIRFEC. The theme 'Operationalizing GIRFEC: Missing the mechanisms' refers to the inadequate information identified in the documents on how professionals are to operationalize GIRFEC. Finally, the theme 'Decision-making thresholds: Standardization vs. professional judgement' refers to the tensions for professionals between employing standardized forms versus their professional judgement in deciding on the level of support families need. Table 8. presents the relevant themes and sub-themes in greater detail.

²⁸ (GIRFEC hereafter)

²⁹ (UP hereafter)

Table 8. Themes and sub-themes of policy document analysis

Themes	Sub-themes	Description
Towards a regulatory framework: Arising complications	<ul style="list-style-type: none"> • Universal nature of the service: Conceptual limitations 	<p>The universal and preventive nature of health visiting is in question because its provision does not necessarily lead to its receptiveness by families.</p>
	<ul style="list-style-type: none"> • The state vs. parents: Accountability issues 	<p>Accountability challenges develop in promoting children’s wellbeing and/or welfare for and between health visitors and parents due to the regulatory nature of health visiting after the Named Person service introduction.</p>
Operationalizing GIRFEC: Missing the mechanisms	<ul style="list-style-type: none"> • Information sharing: Guidance ambiguity 	<p>There is an operationalizing gap in the documents on the nature and the way information is to be shared among professionals.</p>
	<ul style="list-style-type: none"> • Multi-agency meetings: Coordination challenges 	<p>There is an operationalizing gap in the documents on the way health visitors are to coordinate multi-agency activity, by undertaking the Lead Professional role and managing the Child’s Plan.</p>
	<ul style="list-style-type: none"> • Children at the centre vs. children on the margin 	<p>There is an operationalizing gap, as identified in the documents, on the way professionals are expected to “do” child-centeredness, particularly for the very young children.</p>
Decision-making thresholds: Standardization	<ul style="list-style-type: none"> • Standardization: GIRFEC NPM and health visiting assessment forms 	<p>The information in the documents encouraging health visitors to use standardization forms to review, assess and evidence families’ needs so as to decide on the level of support they need.</p>
	<ul style="list-style-type: none"> • Health Boards guidance: Classification of families’ needs 	<p>The information in the health visiting documents encouraging health visitors to use particular Health Boards standards to categorize</p>

vs. professional judgement		families based on the level of support they require.
	<ul style="list-style-type: none"> Professional judgement: Health visitors as decision-makers 	The information in the health visiting documents enabling health visitors to use their own professional judgement in deciding on the level and nature of support families require.

5.2. Towards a regulatory framework: Arising complications

This theme explores the complications identified within the principles and recommendations of GIRFEC, as described in the relevant documents, resulting from the regulatory direction of the policy. These complications refer to the way health visiting was intended to be delivered to families and on the role of health visitors and parents post-GIRFEC. In the documents, greater state regulation and involvement in all families' lives is evident by encouraging greater monitoring practices to be employed by professionals, including health visitors. Within the health visiting service, for example, greater state regulation is evident in i) the suggested number and frequency of universal contacts between health visitors and families, and ii) the planned introduction of the Named Person service for professionals, including health visitors, and the use of the relevant language and terminology in the policy documents. These regulatory practices were introduced in line with the preventive nature of GIRFEC to reduce negative outcomes for families.

However, the analysis of the documents highlight a number of challenges arising within/from these practices. Firstly, the provision of health visiting raises questions on its universality and preventive nature because of the possibility that parents could decline the service. Secondly, the introduction of the Named Person service poses challenges to the professional identity of practitioners, including health visitors, by enabling them to acquire greater accountability for children's wellbeing and/or welfare than before. The Named Person development also creates tensions between professionals and parents by undermining parental autonomy. These complications have been explored as separate sub-themes below.

5.2.1. *Universal nature of the service: Conceptual limitations*

In terms of the suggested number and frequency of universal contacts between health visitors and families, the information contained in the documents recommends the provision of a minimum number of home visits to be delivered by health visitors to all families. This sub-theme describes the purported universal nature of health visiting

because the provision of the service does not necessarily lead to the receptiveness of the service by families. Even though the service is universally offered to all, parents who may not feel they need the service can decline it. As a result, the service is not universal and thus not preventive enough, despite its intentions.

The UP (Scottish Government 2015) and the *Core Standards for Health Visiting practice & Documentation* (Placement NHS Health Board 2019) provide detailed information on the number and purpose of universal home visits in particular. In a similar line, the revised *Core Standards for Health Visiting practice & Documentation* (Placement NHS Health Board 2020) provides even greater descriptions on what each universal home visit is expected to include.

“The Pathway presents a core home visiting programme to be offered to all families by Health Visitors as a minimum standard...The programme consists of 11 home visits to all families - 8 within the first year of life and 3 Child Health Reviews between 13 months and 4-5 years.” (Scottish Government 2015, p. 4)

What the documents suggest is that the provision of a greater number of contacts between families and health visitors, particularly during the first year of a child's life, can offer more opportunities to health visitors to assess families' needs. However, this direction towards greater regulation by offering a greater number of universal visits to all families may not necessarily lead to the receptiveness of the service by all families; service responsiveness fail to be addressed in the documents. Moreover, the issue of families declining the service and more importantly, the dichotomy between the voluntary and the compulsory nature of the service, are not taken into account within the documents. As a result, the preventive nature of the service is set in doubt. How can health visitors be able to identify any potential concerns and act preventatively for the families that decline the service? The analysis of the documents thus imply that for the service to be preventive enough, universal compulsory contacts between health visitors and parents would have to be provided. However, constituting health visiting mandatory for all, even though preventive, could lead parents develop negative perceptions towards the service by considering it intrusive of family life, as was the case with the Named Person scheme (see 5.2.2.). This raises questions on whether a service could be preventive enough, without being enforceable.

Moreover, the introduction of more contacts between health visitors and families during the first year of a baby's life sets in doubt the preventive nature of GIRFEC because it fails to take into account the offer of more intensive home visiting from the second year onwards in a child's life. According to the relevant policy guidance, three contacts only “...between 13 months and 4-5 years...” in a child's life are prescribed to be delivered to all families (The Scottish Government 2015, p. 4). Is the offer of three contacts during

four years a preventive enough approach to hinder any future negative incidents? In the documents, the potential difficulties and concerns that parents could have after the end of their child's first year and by the time the child enters school fail to be regarded. It is assumed that by the time all the first-year visits have been undertaken, the parents would know their health visitor quite well and presumably know they can contact them for potential concerns. Concerns are therefore raised over the preventive nature of the service for the children aged between two and 5 years old.

The recommendations outlined in the documents directly affect people's lives by having a material impact on individuals. The policy move towards universality and prevention, as described in the documents, attributes a more regulatory nature to health visiting, which does not concern families only but health visitors, too. The way the framework of the post-GIRFEC era is intended to be delivered by the service also affects health visitors' workload in terms of the number of families they are to work with and the frequency of the contacts they are to deliver. This can produce emotional and material distress for health visitors by adding up to their workload. Therefore, the preventive nature of GIRFEC and the support provided to health visitors for the delivery of their work need to be reviewed. This is to ensure that greater prevention approaches will be in place and that health visitors will be better supported with their heavy workload.

5.2.2. The state vs. parents: Accountability issues

The analysis of documents also highlights the issue of health visitors acquiring the role of the Named Person as another approach for the state to accomplish greater regulation in the post-GIRFEC-era. Even though the scheme does no longer exist, it is mentioned in the policy documents analysed as intended to be undertaken by health visitors, too. This is the reason why it has been further explored. In this sub-theme, I explore the challenges imposed for and between health visitors and parents in relation to their accountability for promoting children's wellbeing and/or welfare as a result of the greater regulatory approach of the service through the introduction of the Named Person service. In the case of health visitors, the introduction of the GIRFEC Named Person service signified the effort of the state to acquire greater accountability for promoting all children's wellbeing and/or welfare. This state accountability was intended to be "transferred" from the state to health visitors. In doing so, health visitors become the subjects of state accountability and undertake the burden of accountability. There is no information on providing for health visitors so that they can be better supported in undertaking this role nor on how parents could perceive health visitors' new attribute. In the case of parents, the state assumes that all children are potentially at risk; for this reason, the parents of children need to be closely observed and monitored by the state. Parents' role and skills

in successfully contributing to the promotion of their children's wellbeing is undermined within this policy direction.

In almost all the documents analysed, it is stressed that the health visitors are required to undertake the role of the Named Person for *all* the children in their caseload aged from pre-birth up to pre-school, after which teachers would undertake this role. This scheme, which was enshrined by law in the Children and Young People (Scotland) Act 2014³⁰, introduced the idea that health visitors would act as “a clear point of contact” for families of children aged from pre-birth to pre-school to seek advice and support from (Scottish Government 2020e, n.p.). This approach was intending to be effective i) for services by attributing responsibility and accountability for families' needs, and ii) for families by ensuring they are aware of their point of contact and where they could look for support. However, the scheme was not well-perceived by the public, which led to a number of campaigners bringing the scheme to the UK Supreme Court for breaching the right to privacy, as discussed in Chapter 2. This led eventually to its repeal, even though the scheme is still in action in the Scottish Local Authorities it had already been rolled out. Despite the recent repeal of the Named Person service by the Scottish Government (Scottish Government 2019a), the development and the way the service has been introduced to the public as in the policy documents helps to clarify the reasons why similar future schemes may also fail.

“The Getting it right approach includes a Named Person for every child, from birth (or sometimes before), until they reach 18. In most cases, the Named Person will not have to do anything more than they normally do in the course of their day-to-day work... This means that the child and their family have a point of contact who can work with them to sort out any further help, advice or support if they need it.” (Scottish Government 2012, p. 10)

“...Health Visitors exercising the function of a Named Person on behalf of their Health Board will be required to be available and responsive to parents to promote support and safeguard the wellbeing of children by providing information, advice, support and help to access other services.” (Scottish Government 2015, p. 4)

The introduction of the Named Person service is described in the documents to have been developed due to i) the lack of state accountability for children's wellbeing and/or welfare, and ii) the absence or the lack of knowledge of a service that parents can refer to when in need of support and advice. The Named Person service was introduced to allow for the state to act as an additional accountable parent through children's services so as to keep an eye on the children of *all* families.

³⁰ CYPA hereafter

Three key challenges arise from the development of the Named Person service as in the documents analysed. Firstly, there is lack of clarity in the documents on the particular duties of health visitors by undertaking the Named Person role. A material effect of this is for professionals undertaking this role, rather than children's agencies in the broader sense, to feel responsible and accountable for the wellbeing/welfare of their caseloads' children. In this case, the accountability burden of safeguarding and promoting children's wellbeing is being transferred from the abstract concept of the "state" to the more concrete concept of "professionals". In other words, the intention of the state to acquire greater accountability for children's wellbeing falls on health visitors; they are the subjects expected to deliver the service. The guidance fails to prepare health visitors for undertaking this service; there is no information on how health visitors can be better supported in undertaking this service nor on how they might be perceived by parents. These can lead to confusion over their role and duties as well as to parents developing negative perceptions towards health visitors.

Secondly, the issue that parents might not need support from a service, or even support at all, has been ignored in the policy documents. Thirdly, parents' responsibility for their children's wellbeing and/or welfare is being neglected. An effect of these is for parents to consider the scheme intrusive of their family life rather than supportive and thus not to make use of it. A reconsideration of the role of both parents and health visitors in relation to policies promoting children's wellbeing is therefore necessary. Perhaps, the policy focus should be given on effectively supporting health visitors in delivering their service.

The use of language and terminology in the documents analysed also underline the tendency for health visiting to acquire a rather regulatory, and even controlling, nature. In the UP (Scottish Government 2015), for example, the term "surveillance" is used seventeen times throughout the document, as part of the health visiting broader programme title, whereas the term "supervision" is used once in the *Core Standards for Health Visiting practice & Documentation* (Placement NHS Health Board 2019). Based on the information contained in the documents, the term "surveillance" is used for all families whereas the term "supervision" for child protection cases only. In both cases, the use of this terminology stresses the urge of the state to closely observe and monitor families via services so as to prevent future negative outcomes.

"Glossary of terms: Child Health Surveillance Programme" and "Child Health Surveillance Programme – Pre-School" (Scottish Government 2015, p. 63)

"STANDARD 13 – CP [referring to Child Protection] Supervision The Health Visitor must notify the Child Protection Team within 5 working..."
(Placement NHS Health Board 2019, p. 5)

The previous quotes imply that the post-GIRFEC guidance has developed to allow the state to keep a close eye on all families having children from pre-birth to pre-school age; this presupposes that all children are at risk and thus require monitoring. Not all families require to be closely observed, however. This policy development implies that parents' role in promoting their own children's wellbeing and/or welfare is minimized by the state. As a result, parents could develop negative perceptions towards the service and eventually reject it. This issue resurfaces the well-known tension of the provision of universal services in an effort to avoid stigmatizing particular minority groups and the objection/dissatisfaction of the parents not needing the service. Despite the recognition that state intervention programmes satisfying both ends may not be feasible, the challenges presented here imply that the relationship between the state and parents in regards to children's wellbeing/welfare needs to be rethought and re-examined in the policy documents for the sake of more positive perceptions to develop for parents. This was exemplified by the ultimate rejection and repeal of the Named Person service.

5.2.3. Theme summary

Policy document analysis has highlighted a number of challenges within GIRFEC. Firstly, GIRFEC was found not to be universal nor preventive enough, despite its intentions. This is because the service is voluntary and can therefore be declined by some families. The service also fails to be preventive enough particularly for the children aged from one until school-age as the contacts offered to the families in this case are only three. To accomplish greater universality and prevention, universal compulsory contacts between health visitors and parents, currently missing in the GIRFEC can would be challenging as it could lead parents develop negative perceptions towards the service, as was the case with the Named Person scheme.

Secondly, another GIRFEC challenge identified in the documents refers to the introduction of the Named Person scheme, which poses greater accountability to health visitors for safeguarding children and promoting their wellbeing. The scheme raises questions on whether health visitors are well-supported in undertaking this role. The compulsory nature of the scheme undermines parenting by assuming that all children are potentially at risk and need to be monitored, too. Moreover, the language and terminology used in the policy documents need to be reviewed so as to avoid leading parents develop negative perceptions of the service. These challenges highlight the need for policy reconsideration of the relationships between the state and parents.

5.3. Operationalizing GIRFEC: Missing the mechanisms

The changes introduced to the health visiting service in relation to partnership working and child-centeredness as a result of GIRFEC are also described in the documents. This theme reflects the existence of a distinctive gap between the objectives of GIRFEC and the processes for their achievements, as identified in the documents; there is a significant absence of information and lack of clarity in the documents on the way the GIRFEC changes are to be operationalised by health visitors in practice. In particular, all the documents analysed encourage particular changes to be made in health visiting, introduced by GIRFEC. These changes involve i) the sharing of information among services and professionals on families' needs, ii) multi-agency meetings with a key focus on the GIRFEC Lead Professional role and the GIRFEC Child's Plan, and iii) an urge for professionals to employ child-centred approaches. However, there is no description in the documents analysed on the *mechanisms* through which these GIRFEC changes are expected to be delivered by health visitors, which could create confusion among professionals at the ground-level. The term "mechanisms" refers to the absence of sufficient information in the documents on information-sharing practices, on coordinating multi-agency activity and on adopting child-centred approaches. The documents greatly focus on the *what* rather than on the *how* process of GIRFEC delivery. These gaps in operationalizing GIRFEC have been explored as separate sub-themes, the exploration of which follows.

5.3.1. Information sharing: Guidance ambiguity

In the context of GIRFEC, the documents analysed encourage professionals to share information among them on families' met/unmet needs. However, there is a lack of clarity on what kind of information is expected to be shared by professionals with/without parental consent and how. In this sub-theme, I describe the operationalizing gap within the analysed documents on i) the nature of the information to be shared, with a particular focus on parental role in it, and ii) professionals' record-keeping practices. Tensions and problems in effective partnership working among professionals and families could result from this.

There is a consensus among all the documents that information sharing is a key component of effective partnership working, both in light and in the absence of child protection concerns. For example, it is stated in *A Guide to Getting it right for every child* (Scottish Government 2012) that professionals are encouraged to reflect on five specific questions regarding families' needs when completing the relevant GIRFEC assessment forms, such as, the Wellbeing indicators in particular. Two of these questions include whether additional information and additional help by other parties are needed for

particular families. However, there is no clarity and consensus among the documents on the role of parental consent in professionals' information sharing practices.

“A common approach to gaining consent and to sharing information where appropriate...Respecting confidentiality and sharing information - Seeking agreement to share information that is relevant and proportionate...” (Scottish Government 2012, pp. 4-5)

“After following due process in the Act including seeking the views of the child and normally the parent, sharing of information to promote, support or safeguard a child's wellbeing with or by a child's Named Person service will be a duty even where there is a duty of confidentiality hence consent to share relevant and proportionate information in this context will not be required and if sought and refused could potentially damage the HV/parental relationship.” (Scottish Government 2015, p. 6)

“All Health Professionals, including those working with adults, must take cognisance of children being in the household; their potential vulnerability; and share any relevant information with Health Professionals and other relevant agencies in the best welfare interests of the child.” (Placement NHS Health Board 2018, p. 3)

The preceding quotes suggest that, even though information sharing practices among professionals are encouraged, there is no clarity on the nature of the information to be shared with/without parental consent. For example, in *A Guide to Getting it Right for Every Child* (Scottish Government 2012, pp. 4-5), it is stated that information to be shared needs to be “proportionate” and “relevant” but also encourages professionals to respect “confidentiality”, without specifying how to achieve both. Additionally, a key difference between the UP and the *Vulnerable Children Guidance* is evident in that seeking parental consent to share information depends on whether this information is about wellbeing or welfare matters. No definitions of the “wellbeing” and “welfare” terms are, however, provided in any of the documents. In particular, the UP (Scottish Government 2015) highlights that, due to CYPA 2014, health visitors as the Named Persons would have a duty to share any *wellbeing* matters about families among them even without parental consent. The *Vulnerable Children Guidance* (Placement NHS Health Board 2018, p. 3), on the other hand, explains that professionals could share information without parental consent “in the best welfare interests of the child” only.

As a result, this lack of clarity creates confusion and uncertainty on what is expected from professionals when sharing information. This could lead to tensions between parents and professionals if, for example, professionals do not seek parental consent in the cases where this is expected and vice versa. What is missing in the documents is greater clarity and consensus on professionals' information sharing practices to better support health visitors in delivering GIRFEC.

It needs to be clarified, though, that the Named Person scheme and the information sharing legalities attributed to it were eventually cancelled (Scottish Government 2019a), which means that health visitors can no longer share information on wellbeing matters without parental consent. It also needs to be clarified that the *Vulnerable Children Guidance* (Placement NHS Health Board 2018) constitutes a local GIRFEC guidance of the particular Health Board the study was conducted in. The Named Person scheme was never implemented in this Health Board and, as such, the information sharing practices within this Health Board had never been impacted by this scheme. This signifies the existence of variability and inconsistency on the way health visitors across the Scottish Health Boards had been sharing information before the Named Person repeal.

Additionally, some information is also provided in the documents on professionals' record-keeping practices. The *Core Standards for Health Visiting practice & Documentation* (Placement NHS Health Board 2019) and the *Vulnerable Children Guidance* (Placement NHS Health Board 2018) are the only documents containing information on the matter. It is explained in these that health visitors are required to keep "clear and accurate" records for every family and child they deliver their services to, which is suggested to be completed by health visitors in every home visit/review (Placement NHS Health Board 2019, p. 1). It becomes clear in the documents that particular health records, such as, children's weight and growth projectile charts, are to be kept both in paper and electronic form, whereas other forms, such as, demographic information of the families, notification visits and the relevant UP forms, are only to be kept in the health visiting electronic form, called MiDIS. The revised *Core Standards for Health Visiting practice & Documentation* (Placement NHS Health Board 2020) provide information on the new health visiting electronic platform, called MORSE, which is reported to function in a way similar to MiDIS and replace it. The *Vulnerable Children Guidance* (Placement NHS Health Board 2018) also entails information on caseload holders, responsible for keeping children's records particularly in multi-agency activity.

"The caseload holder must liaise with other professionals / agencies involved with the child / family e.g. GP, Substance Misuse Services, Community Psychiatric Nurse, Allied Health Professional, Social Work, Education Services and relevant others, ensuring that all appropriate services involved with the child / family are aware of identity of the agreed case holder." (Placement NHS Health Board 2018, p. 5)

"When a vulnerable family has been identified, the health professional who is the case load holder must retain the electronic child health records for all the children within the family." (Placement NHS Health Board 2018, p. 4)

The preceding quotes suggest that the role of caseload holders is key for keeping children's records. However, there is no information on the *number* of electronic systems used by children's services working with the same families, and the level of accessibility

to these. This means that there is a lack of clarity on how many electronic records there can be for one particular child/family receiving multi-agency activity. Information on whether other agencies and professionals working with the same families as the health visitors can access the health electronic records on MiDIS is also missing. This raises questions on whether electronic accessibility to records and electronic communication among services is permitted or forbidden due to accessibility restrictions. No information is provided in the documents on how the introduction of the new MORSE electronic platform could resolve such challenges either. Moreover, information on what the role of the caseload holders includes also fails to be taken into account, which prevents effective partnership working. In the case, for example, where several single-agency plans in the electronic platforms of various agencies are in place for one family, the GIRFEC aim to develop a seamless system of services appears to have failed. Therefore, the policy documents need to be reviewed and provide greater clarity on the way the records of children and families receiving multi-agency activity are documented, by whom and who can access them.

5.3.2. Multi-agency meetings: Coordination challenges

Apart from sharing information, it is also evident in the documents that professionals are encouraged to work in partnership particularly in the form of multi-agency meetings. However, substantial information on the way this is to be achieved is omitted. This sub-theme describes the operationalizing gap within the analysed documents on the way health visitors are to coordinate multi-agency activity, particularly in undertaking the role of the GIRFEC Lead Professional and in delivering the GIRFEC Child's Plan. The policy documents fail to describe how Lead Professionals are expected to coordinate multi-agency meetings. This could cause confusion among professionals of the pragmatic realities concerning these, such as, decisions made on the participants, the venue, invites etc. In addition, the way through which the Child's Plan is expected to be operationalised is also omitted in the documents, which could potentially lead professionals feel overburdened, puzzled or even incompetent.

The information contained in the documents on the Lead Professional role is blurred and unclear. For example, GIRFEC introduced the Lead Professional role for children and families requiring extra support to ensure effective coordination of multi-agency activity, including multi-agency meetings, is accomplished (Scottish Government 2020c). For the children aged from pre-birth until school age, this role was expected to be undertaken by health visitors acting as the Named Person (Scottish Government 2020c). However, no description of the way Lead Professionals were expected to perform their duties is provided in any of the documents analysed.

"When two or more agencies need to work together to help a child or young person and family, there will be a Lead Professional to co-ordinate that help...The Lead Professional: • acts as the main point of contact for children, young people, practitioners and family members, bringing help to them and minimising the need for them to tell their story several times" (Scottish Government 2012, p. 11)

The Lead Professional role is described in the documents to have developed to tackle coordination challenges of multi-agency meetings. Even though this role appears to be accompanied by additional workload, there is no information in the documents i) on the exact processes Lead Professionals are expected to take, and ii) on the availability of support to assist professionals undertake this role. Greater information on the operationalization of this role such as, the coordination and the administration of these meetings, minute-taking, the venue of meetings and invitation sending, would be essential in all the documents analysed, which is surprisingly missing.

Similarly, the analysed documents do explain that in the cases where extra, additional support is required for some families, an either single-agency or multi-agency Child's Plan would be initiated for families. According to the relevant guidance, this Child's Plan should include information on families' met and unmet needs, the views of the child/young person and the parents, the reasons for the Plan's initiation, information on what actions need to be taken by each party so that families' needs will be fully met and timescales and resources to be provided. It becomes clear that the Child's Plan is expected to be reviewed by individuals at every future meeting to reflect on whether the specified outcomes have been achieved; the Lead Professional is responsible for managing the Child's Plan (Scottish Government 2020c).

"In the Getting it right for every child approach, any child or young person who requires additional help should have a plan to address their needs and improve their wellbeing. This could be a single-agency plan but when two or more agencies are involved there will be a multi-agency Child's Plan..." (Scottish Government 2012, p. 21)

"The record must also contain a clear SMART single agency Action Plan (Form 4) and a copy of the multiagency plan if appropriate. The Action Plans must detail who is responsible for meeting the particular needs identified..." (Placement NHS Health Board 2019, p. 3)

Some key issues are evident in the preceding quotes. Firstly, adequate information on the way through which the Child's Plan is operationalised is missing. As a result, there could be confusion among professionals on Child's Plans, such as how this is initiated and who decides on the involvement of individuals. Information provided in the documents on the way the Child's Plan and multi-agency meetings are expected to be implemented by professionals would greatly benefit GIRFEC implementation. Secondly, in the case of families, the documents presuppose that parents and children are present

in these meetings and that their views are sought by professionals. Documents fail to consider the factors preventing families from attending these meetings and from having their voices “heard”. Information on the way families could be more involved in the Child’s Plan and multi-agency meetings, which is currently missing from the documents, would also be necessary for achieving partnership working. It would also be important to mention here that the Scottish Government eventually repealed the use Child’s Plan (Scottish Government 2019a) across Scotland; the Child’s Plan is, however, used in some Scottish Health Boards.

5.3.3. *Children at the centre vs. children on the margin*

A key principle of GIRFEC is to place children and young people at the heart of the decisions that affect them, which is why it encourages all professionals working with children to adopt child-centred approaches in their practices. In this sub-theme, I explore the operationalizing gap, as identified in the documents, on the way professionals are expected to “do” child-centeredness, particularly for very young children. This results in a distinctive tension on children being at the centre versus children being marginalised as identified between *A Guide for Getting it Right for Every Child* (Scottish Government 2012) and the health visiting documents. This implies that children’s role is minimized in the health visiting documents.

The concept of child-centeredness is evident and consistent throughout *A Guide to Getting it Right for Every Child* (Scottish Government 2012) as it is described as one of GIRFEC’s core components and one of its values and principles, too. *A Guide to Getting it Right for Every Child* (Scottish Government 2012) is the only document examined that greatly emphasizes the significant role of children, as a result of the GIRFEC introduction. The concept of child-centeredness within this document refers to the collection of children and young people’s views on decisions that affect them, to the documentation of their views and to actions taken by adults to ensure their views are being heard. The tools through which child-centeredness is intended to be accomplished are also provided in this document. For example, it is explained that the professionals undertaking the roles of the Named Person and the Lead Professional are expected to listen to and record children and young people’s views both in single-agency and multi-agency activity. The development of the National Practice model and the Child’s Plan, which constitute a number of assessment and recording GIRFEC tools to be used by professionals, contribute to child-centeredness because they allow and encourage children and young people’s views to be heard and documented. Children and young people’s role is therefore considered significant in the assessment and the planning of actions so as to have their needs met, according to this document.

“Putting the child at the centre - Children and young people should have their views listened to and they should be involved in decisions that affect them” (Scottish Government 2012, p. 5)

“Every plan [referring to the Child’s Plan], whether it is single- or multi-agency, should include and record: ...the views of the child or young person and their parents or carers...” (Scottish Government 2012, p. 21)

“It [referring to the National Practice Model] promotes the participation of children, young people and their families in gathering information and making decisions as central to assessing, planning and taking action” (Scottish Government 2012, p. 12)

“The parents/ carers must be fully involved in this process and their views clearly recorded.” (Placement NHS Health Board 2019, p. 2)

The preceding quotes suggest a direction towards maximizing children’s role where children are viewed by professionals as active recipients in decisions that affect them. However, this recommendation is only represented in *A Guide to Getting it Right for Every Child* (Scottish Government 2012); none of the other documents in relation to health visiting discusses child-centeredness. The analysis of the documents has brought up a number of limitations, though. Firstly, children’s role is minimized, rather than placed in the centre, within the health visiting documents. Secondly, there is no information in any of the documents on how child-centeredness translates into practice for very young children, who have not yet developed their linguistic skills. As a result, child-centeredness is not accomplished by all professionals, particularly health visitors, perhaps due to children’s very young age. This emphasizes the need for greater focus in the health visiting documents to be given on the role of children and on ways to place them in the centre of their work. Thirdly, child-centeredness in the documents simply refers to a number of practices to be employed by professionals, which misses out the need for professionals’ mind-set shift on the way they view children and young people. However, simply collecting and documenting children and young people’s views is not in line with the GIRFEC principles; a cultural shift on the way professionals view children and young people would be required, which could potentially be accomplished through greater training programmes for professionals.

5.3.4. Theme summary

A number of GIRFEC challenges were brought to light from policy document analysis in relation to professionals' partnership working and children's role, which are explored in this theme. These challenges can potentially prevent GIRFEC from being fully delivered.

GIRFEC aims to encourage greater partnership working among children's services by encouraging information sharing practices and by introducing the Lead Professional role and the Child's Plan. However, there is very limited information within the documents on the way GIRFEC is expected to be operationalized by professionals, including health visitors. The documents highlight a gap between GIRFEC purposes and the actions through which these are to be implemented. In terms of information-sharing, for example, there is a lack of clarity and consensus in the documents on the cases where parental consent is required, particularly in multi-agency activity. In the case of the Lead Professional, greater information on the coordination and administration of multi-agency meetings, such as minute-taking, venue-booking and invitation sending, would be essential to enable professionals to effectively deliver their role and responsibilities. Similarly, there is very limited information in the documents on the way the Child's Plan, multi-agency meetings and record-keeping practices (electronic and/or paper) are expected to be implemented, which would also encourage greater seamlessness. This lack of information creates barriers in effective partnership working and poses challenges to professionals by not sufficiently supporting them in delivering GIRFEC.

GIRFEC also aims to promote greater child-centeredness. However, a tension on the way children are represented in the documents is evident due to a gap between *A Guide for Getting it Right for Every Child* (Scottish Government 2012) and the health visiting documents. *A Guide to Getting it right for Every Child* (Scottish Government 2012) is the only document analysed that greatly emphasizes the significant role of children. Child-centeredness within this document refers to i) the collection of children and young people's views on decisions that affect them, ii) to the documentation of their views and iii) to actions taken by adults in ensuring their views are being heard. None of the health visiting documents, however, stresses the significance of child-centeredness. Perhaps, challenges in this link to the very young age of children, whom health visitors deliver their services to. More importantly, a cultural shift on the way professionals view children and young people would be required, which could potentially be accomplished through greater training programmes for professionals.

5.4. Decision-making thresholds: Standardization vs. professional judgement

The idea that additional support is to be provided to families who may need some extra help due to various difficulties in life is evident in all the documents. This theme describes the existence of a tension between standardization and professional judgement within the policy documents on the way health visitors are expected to gather information, reflect upon and decide on the level of support families require. Standardization refers to a number of assessment tools, including i) the GIRFEC National Practice Model (NPM), which consists of the SHANARRI (Wellbeing indicators), the My World Triangle and the Resilience Matrix, and ii) to the relevant health visiting assessment forms that are expected to be used by health visitors at appointed times³¹. Standardization also refers to the classification of families in particular categories on the basis of their met/unmet needs within health visiting by the Health Boards. On the other hand, health visitors' professional judgement refers to health visitors employing their own knowledge and expertise in assessing whether families may require extra support, as presented in the documents. Standardization and professional judgement have been explored as separate sub-themes, the exploration of which follows.

5.4.1. Standardization: GIRFEC NPM and health visiting assessment forms

This sub-theme explores the information within the documents on encouraging health visitors to use standardization approaches by using a number of forms to review, assess and evidence families' met/unmet needs and decide on the level of support families need. The standardization approaches in this case refer to the GIRFEC National Practice Model (NPM hereafter), as a result of GIRFEC introduction, and to the relevant health visiting forms that health visitors are encouraged to complete, such as the Ages and Stages Questionnaires (ASQs hereafter). This perhaps implies that professionals from services other than the health visiting service are also encouraged to use the assessment tools of their own service. However, these forms do not provide space for any individuality of children nor for professionals to report concerns/progress non-related to the standards of forms. There is also lack of information and clarity in the documents

³¹ Appendices 2, 3 and 4 of the UP (Scottish Government 2015) include information on a number of public health assessment forms that are suggested to be used by health visitors during the delivery of particular home visits. These "tools" are reported in the documents to include the Ages & Stages Questionnaire – ASQ:3, Parents Evaluation of Developmental Status (PEDS), the Parents Evaluation of Developmental Status: Developmental Milestones Questionnaire (PEDS:DM), the Ages & Stage Questionnaire: Social-Emotional (ASQ:SE 2), the Strengths & Difficulties Questionnaire (SDQ), The Sure Start Language Measure (SSLM) Modified Checklist for Autism in Toddlers (M-CHAT), the Childsmile Manual - 6-8 week assessment guidance, the use of 'other' Child Health Surveillance Programme – Pre-School (CHSP-PS) forms and the use of the EPDS/Whooley questions for maternal records.

on the way professionals are expected to use the NPM and/or the assessment tools of their service to make decisions on the level of support families require.

A move towards greater standardization is evident in the documents analysed, which is further boosted by the introduction of GIRFEC. The documents encourage professionals working with children and young people, including health visitors, to use a number of standardized assessment forms in the service delivery, such as the GIRFEC NPM or the health visiting ASQs. The full version of these forms were taken into account in the background information and literature review of the thesis; they were not, however, in-depth analysed for the purposes of policy document analysis due to time limitations and due to not being in line with the rationale of the document selection criteria.

The NPM refers to three assessment tools to assist all professionals working with children and young people develop shared decision-making thresholds and hence, greater partnership working, when assessing families' needs. The NPM consists of the SHANARRI wellbeing wheel, which is designed to be used with every child to assess his/her wellbeing, and the My World Triangle and Resilience Matrix for children requiring extra support. Along with children and parents' wellbeing represented in the NPM, the role of health visitors includes the identification of a range of issues in relation to children and parents' health and wellbeing, such as, finances, housing, parenting support, nutrition and weight represented in a number of other health visiting forms. The use of standardized forms aims to assist professionals in documenting children and parents' potential progress and concerns, which can be used as a reference for future reviews. The UP (Scottish Government 2015) and the revised *Core Standards for Health Visiting practice & Documentation* (Placement NHS Health Board 2020) in particular include a detailed description of all the assessment forms to be used in each home visit, including the NPM. It is clarified in the documents that the NPM is not intended to replace the existing assessment forms used in every service but introduces additional forms in an effort to achieve greater seamlessness and consistency among agencies on their decision-making practices of families' needs. In this sense, the NPM and the health visiting assessment forms are intended to exist in symbiosis.

"It is a way for all agencies and workers who support children, young people and their families to begin to develop a common language within a single framework...It [referring to the NPM] is not intended or designed to replace existing methodologies...it [referring to the NPM] can be used as a 'common tool' alongside and in conjunction with other processes and assessment tools." (Scottish Government 2012, p. 12)

"Assessment, analysis and Care Planning must be completed with the use of the GIRFEC National Practice Tool." (Placement NHS Health Board 2018, p. 5)

The preceding quotes suggest a direction towards greater standardization by encouraging professionals to use particular forms in assessing and evidencing children and families' met/unmet needs. The state expects that the development of tools for professionals will help them assess whether children work towards "doing well", "success" and "progress". "Success" according to the GIRFEC framework refers to families meeting the state expectations. Children and young people in *A Guide to Getting it Right for Every Child* (Scottish Government 2012, p. 7) in particular are presented as if they are required to be in a state of continuous "progress" to be able to succeed in life. It is also assumed that the visual representation of the NPM tools assists both professionals and families to more easily comprehend their content.

However, a set of specific standards that all children and young people in Scotland are required to meet could be viewed as a rather prescriptive approach. What the guidance fails to take into account is the role of professional judgement in this. *A Guide to Getting it Right for Every Child* (Scottish Government 2012) indicates that the documents present the expectations and standards that families should meet in relation to parents and children's wellbeing. The language used in the NPM in particular is rather detailed and prescribed. For example, in several parts throughout the text, there are phrases, such as, "We want all our childrento be...." and "...children and young people need to progress..." (Scottish Government 2012, p. 1). The current policy documents ignore the individuality of children and the role of parents in this framework. This approach assumes that all children are the same, go through similar developmental processes and acquire the same skills; success in this framework is similar to going through hoops so as to reach the highest level of success. As such, there is a sense in the documents that the forms are like tests, where failing to meet the minimum number of achievements constitutes families as not doing well enough. As a result, parents and children who do not meet the state standards of the assessment forms could develop feelings of having failed; children look like they have fallen behind with their development and parents that they have failed in their parenting. The need for greater individuality in the way professionals make assessments is therefore evident. This means that standardized forms to be used with children and families should leave space for professional judgements to also be documented and justified.

Moreover, another issue arising from adopting the GIRFEC and health visiting standardization approaches refers to the existence of seamlessness challenges in professionals' decision-making thresholds. There is confusion and lack of clarity in the documents on the way professionals are expected to use the NPM and/or their service assessment tools to decide on the level of support families require. For example, would children who do not meet one wellbeing indicator of the SHANARRI wheel be assessed

as needing extra support or as universal, standard support? Are professionals' decisions to provide extra support to families dependant on the number of unmet needs or on the nature of the unmet needs identified? There is also no information and clarity on the documents on the way professionals are expected to use the NPM in conjunction with their service assessment forms in the case of multi-agency activity in particular. As a result of these challenges, there can be confusion among professionals and services on the way they are expected to decide upon families' needs. The introduction of the NPM does constitute an approach leading to greater integration of services but greater information on how it can be used by professionals so as to decide on the support families require is also imperative. The use of the NPM in conjunction with other assessment forms of services also requires to be reviewed. This is to ensure there is no overlap and additional, unnecessary paperwork to be filled in.

5.4.2. Health Boards guidance: Classification of families' needs

This sub-theme describes that the health visiting documents encourage health visitors to *categorize* families depending on the level of support they require based on particular Health Boards standards. The assessments of family needs are expected to determine whether families are to receive the universal, minimum standard of service or additional support in the form of single-agency or multi-agency activity. Health visitors are expected to allocate families in two categories, the "core" or the "additional" Health Plan Indicator (HPI), in relation to the support they require. Once again, classification of families into the two categories underlines a policy preference for greater standardization approaches. This is because allocating families into particular categories is based on whether they meet or do not meet certain standards. As a result, challenges in relation to the absence of more personalized assessments is evident. Interestingly, the documents also underline a tension between centralized (national standards) and localized standardization (local adjustments) within health visiting on the way families are classified. This could lead to seamlessness challenges within health visiting and across children's services.

In contrast with *A Guide to Getting it Right for Every Child* (Scottish Government 2012), the health visiting documents encourage health visitors to assess families' needs and then classify these depending on the level of support they require. For example, in the UP (Scottish Government 2015), which is the national health visiting document at the time of writing, it is described that health visitors are encouraged to classify families as requiring no extra help or sustained, additional single-agency or multi-agency work for more than three months. The classification of families refers to either the "core" Health Plan Indicator (HPI) for families requiring the minimum standard of universal health

visiting support, or to the “additional” HPI for families requiring extra single-agency or multi-agency help for more than three months.

“The Pathway presents a core home visiting programme to be offered to all families by Health Visitors as a minimum standard.” (Scottish Government 2015, p. 4)

“An additional HPI [Health Plan Indicator] indicates that the child (and/or their carer) requires sustained (>3 months) additional input from professional services to help the child attain their health or development potential. Any services may be required such as additional HV support, parenting support, enhanced early learning and childcare, specialist medical input, etc.” (Scottish Government 2015, p. 5)

The preceding quotes describe the way through which families are expected to be allocated into the “core” HPI and into the “additional” HPI by health visitors. Distinguishing between the two HPIs is described to be linked with the *duration* of the additional services families may require/receive. The UP (Scottish Government 2015, p. 5) explains that in the cases where families require single-agency or multi-agency “sustained...additional input” for more than three months, they will be categorized as having “additional” HPI. However, challenges in relation to the classification standards are evident. This categorization of families depends solely on the duration during which families receive extra support, leaving no space for other, more personalized criteria, such as the nature of the concern/unmet need. As such, the categorization of families rather than the provision of individualized support becomes health visitors’ target. This implies that health visitors employing their professional judgement on classifying families is minimized, whereas a more prescribed and dehumanizing approach is promoted. Moreover, this classification is only encouraged in the health visiting documents. *A Guide to Getting it Right for Every Child* (Scottish Government 2012) does not provide any information on this, which raises questions on the way professionals other than health visitors decide on the level of support families require and on whether they categorize families or not. If each service develops its own categories of families’ needs, the existence of a fragmented rather than a seamless framework exists.

The analysis of the documents underline that standardization and seamlessness challenges are not evident among children’s services only but within the health visiting service, too. There are distinct differences between the national health visiting guidance, that is the UP (Scottish Government 2015), and the local health visiting documents (Placement NHS Health Board 2018; Placement NHS Health Board 2019). These differences refer to the way families are classified on the basis of the support they require. For example, in the case of the local guidance, that is, the *Core Standards for Health Visiting practice & Documentation* (Placement NHS Health Board 2019) and the *Vulnerable Children Guidance* (Placement NHS Health Board 2018), the “vulnerable”

HPI category is also introduced to refer to child welfare/protection concerns. This is also the case for the revised *Core Standards for Health Visiting practice & Documentation* (Placement NHS Health Board 2020).

“...the HPI allocated may be Core, Additional or Vulnerable (see separate guidance re: allocation of V indicator). The allocation of V is a local category only...Vulnerable children should be seen as per single agency plan, but at least 3 monthly...Additional children may be seen as per UP and their individual care plan dictates.” (Placement NHS Health Board 2019, pp. 3-4)

Along with the “core” and the “additional” HPI, the “vulnerable” categorisation is described to refer to families required to be seen at least every month. The “vulnerable” HPI is reported to be applied in the particular Health Board the study was conducted in. This means that other Scottish Health Boards do not use this categorisation. Perhaps, this flexibility among Health Boards results from the political context, which allows for each Health Board to develop its own localized adaptations, creating a gap between centralized and localized guidance. Health Boards employing their own localized categorization of families’ needs creates flexibility but also inconsistency among the Health Boards i) on the classification categories of families’ needs, and ii) more importantly, on the level of support provided to families. For example, do Health Boards that use the “additional” and “vulnerable” classifications offer a different level of support to families comparing to Health Boards using the “additional” category only? In other words, the way families are classified for meeting or not meeting their needs depends on the classification categories of each Health Board; this can therefore impact on the level of support provided to families depending on their geographical region. This could lead to fragmentation and transferability issues for families moving in between Health Boards. How can families classified as “vulnerable” in one Health Board be classified in another, which does not use the “vulnerable” category? The existence of this flexibility highlights the need for the development of a national and unified framework across the Scottish Health Boards to ensure greater consistency and seamlessness is achieved on the way health visitors classify families’ needs and on the level of support families receive.

Interestingly, another challenge in the case of offering either single-agency or multi-agency additional support to families refers to the absence of links with families’ socioeconomic context; children in this case are seen as separate from their socioeconomic context. For example, it is stated in the documents (Scottish Government 2015, p. 5) that in the case of families requiring extra support, “(ongoing) additional support” is to be provided to the families so as to “reduce health inequalities”, which implies that children’s potential health inequalities can be reduced through the health visiting service or partnership working. Health inequalities cannot, however, be reduced through children’s services because children’s services, irrespective of their universal or

targeted support provision, are not sufficient enough to tackle health inequalities. Health inequalities is a broad and complex issue, which is distinctively linked with the socioeconomic inequalities and the wider context. As such, professionals may struggle to meet families' needs and effectively support families because the actual root cause of health and socioeconomic inequalities is being distracted. The policy documents are directed towards the outcome, rather than the causes leading families to receive additional support, which signifies that GIRFEC comes in too late into families' lives. This underlines the need for policy focus to be directed towards interventions tackling inequalities and social injustice. This could help tackle the root causes of problems instead of applying stitches to the re-occurring challenges families face. The development of such interventions can, however, be challenging in light of the current austerity measures and the wider climate of financial cuts. This highlights that the functioning of children's services cannot be examined separately from the wider financial and political context of the state.

5.4.3. Professional judgement: Health visitors as decision-makers

Not all the analysed documents encourage professionals to employ standardized methods at all times when assessing families' needs. This sub-theme explores the information within the documents on enabling health visitors to use their own professional judgement in deciding on the level and nature of support that families require. This underlines health visitors' role of acting as decision-makers of families' needs. However, the way through which practitioners are to acquire professional expertise and whether this approach is effective, consistent and justifiable are excluded from the documents.

Even though the NPM, the relevant health visiting forms and the Health Boards guidance are expected to be used by health visitors in assessing families' needs, the role of health visitors' professional judgement is also emphasized in the UP (Scottish Government 2015). Apart from the UP, which uses the term "professional judgement" twenty times, none of the other documents contain any information on practitioners' professional judgement. This shows the significance for health visitors in particular to use their own professional judgement and expertise in assessing families' needs. According to this concept, health visitors' professional judgement should define their decision on the venue of the service delivery and on the use of other, more specialised assessment forms. For example, the use of particular assessment tools, such as the Domestic Abuse Risk Assessment Checklist, is described to be dependent on health visitors' judgement and expertise. It is expected thus that health visitors need to complete the GIRFEC SHANARRI, as part of the NPM, which contains broad areas affecting children's wellbeing. After completing this form, professionals are encouraged to use their own professional judgement on whether additional health visiting assessment forms in

relation to the unmet needs identified in the SHANARRI wheel need to also be completed. Health visitors act as the decision-makers of families' needs in this case.

"It is expected that in addition Health Visitors utilise all assessments and tools consistently at multiple points along the pathway according to judgement and need." (Scottish Government 2015, p. 5)

"Use of other questionnaires is a matter for Health Visitors' professional judgement however in general it is expected that use of other questionnaires will be uncommon." (Scottish Government 2015, p. 35)

"The pathway is based on the best available evidence which indicates that all visits should be undertaken by a Health Visitor in the home...Professional judgement should be used to assess where this [referring to the provision of home visits] is not appropriate, such as in cases / suspected cases of domestic abuse...This should also include parents who have a history of violence, substance misuse or concerns around mental health." (Scottish Government 2015, p. 5)

What the documents suggest is that the use of the NPM is to be employed with all families by health visitors, irrespective of families' needs. However, in the case of the health visiting documents, health visitors are expected to employ their own professional judgement on whether overall family-related concerns are raised. There are two key issues raised here. Firstly, a lot of emphasis is being attributed to the role of professional judgement in the health visiting documents only. This raises questions on whether this is also the case for the documents of services other than health visiting. Inconsistency on the way professionals from multiple services are expected to decide on the level of support families require can lead to inconsistency on the assessment outcomes and the level of support provided. Secondly, the role of intuitive processes in relation to professional judgement is also brought up here. Are opportunities for health visitors to document and justify their own intuitive indicators presented in all the standardized forms? In any case, the analysis of the guidance stresses the need for the role of professional judgement to be reviewed in the existing standardized forms.

5.4.4. *Theme summary*

Professionals are encouraged to provide either the minimum standard of service or, if needed, additional support to families in single-agency or multi-agency form. The analysed documents provide information on the thresholds based on which professionals, including health visitors, are expected to make decisions on the level of support families require. A tension between standardization and professional judgement is evident in the documents, which this theme explores.

Standardization in the documents is evident by encouraging health visitors to use the GIRFEC National Practice Model (NPM) as well as the relevant health visiting forms, such as the Ages & Stages Questionnaires (ASQs). The NPM in particular was introduced as a tool for all professionals working with children and young people, including health visitors, to promote greater joined-up activity between professionals. However, the forms are too ambitious and prescribed limiting professionals' ability to employ their knowledge and expertise on identifying and reporting concerns that are not included in the forms. Additionally, the use of the forms leave no space for recognizing children's individual differences.

Standardization is also evident in the health visiting documents by encouraging health visitors to classify families into particular categories on the basis of the level of support they require. Health visitors are expected to allocate families into the "core" Health Plan Indicator (HPI), for the families requiring universal, minimum support and into the "additional" HPI for the families requiring extra single-agency or multi-agency support for more than three months. In some Health Boards, the "vulnerable" HPI was also encouraged to be employed to classify families requiring to be seen at least every three months. The criterion to classify families into the "core" or the "additional/vulnerable" HPI lies on the duration of additional support families require. This, however leaves no space for other factors to be considered crucial in deciding that families may need extra help, such as the nature of the identified concern. It also raises concerns on the seamlessness within health visiting as there is inconsistency on the categories each Health Board employs.

On the other hand, health visitors' are also described in the documents to be the decision-makers of families' needs. This is because health visitors are depicted as the key means to decide on the venue of the service delivery (parents' houses or Health Centres/clinics) and on the use of additional, specialized health visiting assessment forms, depending on their assessment. This approach, even though individualized, hinders the development of consistency among professionals' assessment. As a result, challenges arise from this in health visitors documenting and justifying their concerns.

The decision-making challenges described in this theme highlight the need for the development of a common, universal framework among children's services and Health Boards. The development of such framework will need to allow for professionals i) to develop shared decision-making thresholds among them, and ii) to express and record their own intuitive concerns in the relevant forms.

6. Health visitors' findings: Challenges in operationalizing GIRFEC

6.1. Introduction

The findings presented in this Chapter describe the way the *Getting it Right for Every Child*³² (Scottish Government 2020b) principles were reported to be implemented at the ground-level through the eyes of the health visitors, highlighting the implementation challenges. Two broad themes, 'Overlooking health visitors: Facing pragmatic realities' and 'Working in partnership: Communication and inclusivity challenges', developed from the analysis of the data collected from health visitors. Within each of the two broad themes, five sub-themes emerged.

The first theme 'Overlooking health visitors: Facing pragmatic realities' describes health visitors' views on not being sufficiently supported to deliver the GIRFEC principles. As a result, health visitors had to reportedly deliver GIRFEC in variability so as to tackle pragmatic realities, such as workforce and workload challenges. The second theme 'Working in partnership: Communication and inclusivity challenges' refers to health visitors' views on the existence of communication and inclusivity limitations hindering partnership working among professionals and families. Table 9. presents the relevant themes and sub-themes in greater detail.

³² (GIRFEC hereafter)

Table 9. Themes and sub-themes of health visitors' findings (I)

Themes	Sub-themes	Description
Overlooking health visitors: Facing pragmatic realities	<ul style="list-style-type: none"> Lacking universality: Getting it Right for some children 	The reported variability in i) the families health visitors delivered their services to and ii) the frequency of the contacts between health visitors and families, questioning the universal and preventive nature of GIRFEC.
	<ul style="list-style-type: none"> Service venue: Expediency over quality assessments 	The issue of variability in the venue of service delivery as a result of health visitors choosing their expediency (families visiting the Health Centres) over quality assessments (health visitors visiting families' houses).
Working in partnership: Communication and inclusivity challenges	<ul style="list-style-type: none"> Information sharing: Guidance ambiguity and electronic systems restrictions 	The reported existence of communication challenges imposed by the lack of clarity in guidance on information sharing practices and by the electronic record-keeping systems restrictions.
	<ul style="list-style-type: none"> Multi-agency meetings: Missing "multi-agency jigsaw puzzles" 	Health visitors' perceptions that inclusivity challenges discouraged professionals and parents from attending the GIRFEC-introduced Team Around the Child multi-agency meetings (TACs), and thus prevented seamlessness.
	<ul style="list-style-type: none"> Children at the centre vs. children on the margin 	Health visitors' views that inclusivity challenges existed in employing child-centred approaches when delivering the service, emphasizing the tension between children being considered in the centre versus on the margin.

6.2. Overlooking health visitors: Facing pragmatic realities

Considering that the *Universal Health Visiting Pathway in Scotland: Pre-Birth to Pre-School*⁶³ “requires to be delivered in the context of the GIRFEC policy” (Scottish Government 2015, p. 3), health visitors were expected to promote the GIRFEC principles through health visiting. This theme reflects health visitors’ views on and experiences of not being sufficiently supported to deliver the GIRFEC principles. This was attributed to the lack of policy and state provision on the way practitioners’ workload and work would be affected by the GIRFEC introduction, such as by ensuring adequate staff capacity would be obtained. The potential for professionals to develop emotional and material distress resulting from this lack of policy and state provision also came up as a finding in Chapter 5 after analysing the policy documents. As a result, health visitors and ultimately families were negatively impacted upon as the service was reported to be delivered in variability. This was reportedly evident in the absence of a universal service and of quality assessments of families’ needs, which were examined as separate sub-themes.

6.2.1. Lacking universality: Getting it Right for some children

Health visitors provided a number of examples to describe how health visiting was delivered in the post-GIRFEC era. This sub-theme reflects their views that the reported lack of policy and state provision to better support professionals in delivering GIRFEC led them deliver the service in variability and take on the burden of acting as decision-makers on which families would receive the service and how often. This reportedly placed the universal and preventive nature of GIRFEC in doubt.

There was a consensus among health visitors that the lack of sufficient staff led them *prioritize* the service delivery to new and “additional/vulnerable” families-those requiring extra help- over the delivery of home visits to “core” families requiring no additional input.

HV6: “But at the moment, we are short-staffed. We went down to about 60 per cent capacity, at some stage last year, so we're very short-staffed in a lot of areas...so, realistically, we have to prioritise...the more vulnerable children, we would always prioritise...”

HV12: “...although unfortunately because of staffing...we have got to make that decision ourselves [referring to which families to visit]... It definitely, you know, we've got to prioritise. So basically, our new babies and our vulnerable children...is definitely our priorities...”

In contrast with the principles of GIRFEC and UP, these quotes highlight that the service was not considered preventive enough nor universal due to staff capacity issues. According to the study participants, this was because the service was selectively offered

³³ (UP hereafter)

to some families which were either new or assessed to be in need of extra support. The responses in this case imply that appointing sufficient staff does have the potential to enable GIRFEC to be fully delivered.

Apart from variability in the families receiving the service, variability was also identified in the frequency of the contacts between health visitors and families. Many health visitors, for instance, argued that they were unable to deliver all the home visits to each family as set out in UP due to shortage of staff. Ante-natal and pre-school visits in particular were reportedly not delivered at all. This was attributed to health visitors prioritising the home visits in between ante-natal and pre-school visits or even condensing two or more home visits into one as a more time-saving technique.

HV8: "...We have an ante-natal contact, which I would say...we're not doing entirely at the moment, because of staffing issues..."

HV9: "...In some cases these visits would potentially have to get condensed when we're under pressure like this. We can be on action plans which would say that you can condense your three and four-month visit, you know, in certain circumstances..."

HV11: "...and we'll combine the three- to four-month together; so that will be one contact rather than two, because there's no staff to do it..."

Health visitors' responses illustrate that families did not receive the prescribed amount of home visits, which sets in doubt the efficiency of the service to promote early identification and prevention practices. In other words, health visitors reporting to not frequently meet with families could prevent them from identifying concerns early and acting upon them on time, which is opposed to GIRFEC principles.

Service variability was associated with negative consequences for health visitors in particular. When discussing issues around their work ethic, feelings of underachieving, such as anxiety, unproductiveness, disappointment and frustration, were voiced by practitioners. This was a recurrent theme in participants' accounts, reported by almost all of the health visitors I spoke to.

HV9: "...I do worry a little bit about in terms of we've raised the expectation and I do worry a little bit in terms of how we can deliver on that at the moment...So it adds a lot on to you but because I feel, you know, we have raised expectation we give people...I give people a copy of what they can expect from the pathway and therefore how can you then say, oh, but actually on this occasion we can't deliver? So I find it a little bit hard to do with when you're developing the relationships with the families..."

HV12: "...So they [referring to parents] might phone up. They might complain. I want this assessment done...We can be sometimes their only point of contact, you know, and we want to build that relationship up because if they're ever worried about their child or

worried about their own health, or their relationship, we want to be the people, or one of them, you know, a point, they know they can contact. So sometimes we're actually making it worse..."

Providing the service selectively was thought to be a necessary but disruptive factor of the health visiting relationship. There was a sense that the lack of health visitors' involvement in families' lives and the constant change of the professionals delivering the service could hinder the establishment of relationships between parents and their health visitor. As a result, parents' help-seeking ability from their health visitor could be reduced. Failing to meet the expectations of parents and the guidance by being involved in their lives as set out in UP made health visitors develop negative feelings.

Even though almost all of the health visitors reported to deliver their services in variability, this was not the case for one participant. According to this practitioner, the service was universally delivered in the particular Health Centre she was employed in thanks to being fully staffed.

HV2: "...In this particular practice we are able to implement the pathway because we are fully staffed... whereas in the practice across the way one out of two health visitors is off sick so...and she can't do all of the work herself..."

This quote clearly identifies staff availability as the main factor enabling service delivery in this Centre but also as the main barrier preventing service delivery in other Health Centres.

6.2.2. Service venue: Expediency over quality assessments

During the interviews, health visitors also discussed the venue of the service delivery highlighting once again the matter of variability and its consequences. This sub-theme unpicks the issue of venue variability of service delivery emphasizing health visitors' reported choosing their expediency over quality assessments of families. According to the study practitioners, expediency assessments refer to delivering the service in Health Centres, which is not in line with UP (Scottish Government 2015). Quality assessments, on the other hand, were reported to refer to delivering home visits, as set out in UP.

Home visits, even though time-consuming, were described by practitioners as a more quality assessment strategy comparing to delivering drop-in baby clinics in the Health Centres. Despite this consensus, almost all of the health visitors reported that they relied partly or fully on drop-in baby clinics in the Health Centres due their own expediency. The quotes below are indicative of such concerns and practices:

HV18: "...That's the plan for the pathway, is that mainly it's home-visiting. And I get that as well, I think it's a good idea. It is just that that is more time-consuming, and it is definitely, if we could do it, it would

be a better quality contact, but we just haven't got the capacity to do that...It's sort of hit and miss really..."

HV8: "...And people are different in their own homes, than they would be in a clinic. It's very easy to come to a clinic and present yourself in a form. In your own home environment, you're gonna see more. And I think that, so that's why, ultimately, all visits should be in the home..."

HV19: "...what I'll maybe do is see them [referring to families] in the clinic at eight months, but to be honest with you, is that what the pathway says? No, it's not, but for manpower, it is a lot easier, quicker for me to have someone come to me and I can see more..."

Health visitors' quotes suggest that home visiting was the preferred way of delivering the service because it could help professionals "get a glimpse" of the family's environment and identify potential concerns. Home visiting was also described as a less intrusive method of assessing families' needs; it allowed for observations rather than the posing of questions. Despite this preference, health visitors agreed that they offered drop-in clinics instead of home visits for expediency reasons attributed to "...quickness...", space efficiency and space control. "...Quickness..." in the drop-in clinics was reported to refer to the opportunity for a greater number of families to be examined by one health visitor in a relatively small amount of time. Space efficiency reportedly referred to the existing resources, such as measuring scales, of the Health Centres, particularly in the delivery of the 27-month review. Home visiting, for example, would require from health visitors the cumbersome task of carrying the relevant resources to families' houses and hence more effort comparing to home visiting. Space control was reported to refer to limiting children's actions in drop-in clinics. This means that offering the service in parents' houses was perceived as potentially hindering professionals' work because children could be distracted and wander off.

Apart from practical reasons, other justifications were also proposed for health visitors' preference for delivering clinic visits. A few health visitors, for instance, explained that variability in the location of the service resulted from parents' preference and convenience or due to being in a transition period where health visitors were in the process of implementing the GIRFEC and UP principles via gradually delivering home visits.

HV19: "...However, if a parent feels that it's more convenient for them, and I don't think there's anything that they're trying to avoid...then again...I'm not going to force it down their throat, you know, it's...we're not meant to do that. We've got some parents that are in the middle of decorating, they're getting work done in their house and that, and they're like, there's no way you can come to my house just now. That's fair enough..."

HV20: "...The Health Visiting Pathway we're meant to do all home visits. I have recently just changed to a new practice so there's a couple of clinics that have already been set up in terms of assessments for some core families. The idea is that I'll move towards completely doing all home visits for all the contacts..."

HV3: "...Now a lot of our families miss the clinic because they used it as a bit of a social event to come and see each other and get out the house..."

The extracts in this case indicate that for some, the choice of the location of the service delivery was negotiated between health visitors and parents. This raises questions, however, as to what practices would be followed by health visitors in the cases where the two parties failed to reach to an agreement on the matter. Additionally, offering the service in a clinic setting was reported to be valuable by one participant because it offered opportunities for parents to participate in a support network. Drop-in clinics therefore served as social events where parents could meet up and socialise. This could imply the need to re-introduce the drop-in clinics, which are not encouraged in the post-GIRFEC era.

The participating practitioners also discussed the challenges in the provision of both drop-in clinics and home visits. In the case of drop-in sessions, challenges were identified on the nature of the service provision, implying that it constituted a one-size-fits-all approach. In the case of home visiting, challenges were identified in discussing topics of all nature in houses. A few participants in particular stressed that not all families might turn up in the Health Centre for the relevant reviews and that parents might be reluctant in discussing sensitive issues, such as domestic abuse incidents, in their houses.

HV16: "...On Friday when I called people in, not that...three of them didn't turn up, so that wasn't great, but I think I had four in the morning and four in the afternoon which I couldn't have done going out to see them..."

HV4: "...That's probably the one thing I don't like about the new pathway, because...I understand why they want home visiting, but I do sometimes think if you've got a mum maybe that you suspected domestic abuse, sometimes to have a reason to bring her to here and get her out of that home and then be a position to ask questions is quite crucial..."

Health visitors' extracts illustrate that the provision of drop-in baby clinics could not ensure all families' attendance, which proves to be problematic for the universality of the service. However, the issue brought up by health visitors in this case relates to the voluntary/compulsory nature of the service, rather than the venue of the service. Health visitors' responses highlight that, irrespective of whether the service is delivered in the Health Centres or in families' houses, parents have the choice to receive or decline the

service due to the voluntary nature of it. This implies that constituting the service compulsory for all families could have the potential to enable the universality of the service by ensuring the basic standard of contacts is provided to all families. However, constituting the service mandatory cannot guarantee that it will be well-received by parents. This issue also came up in the findings from the analysis of policy documents in Chapter 5.

6.2.3. *Theme summary*

This theme describes health visitors' perceptions that the policy did contain extensive information on the GIRFEC foundations aiming to support families but ignored the way GIRFEC introduction would impact on professionals' work. This neglect reportedly led to GIRFEC being delivered in variability with health visitors being left on their own to face pragmatic realities, including workforce and workload challenges. Service variability referred to i) the families receiving the service and the frequency of contacts between health visitors and families, and ii) the venue of the service delivery.

Service variability was eventually reported to lead to significant outcomes for health visitors and families. Firstly, the GIRFEC principles of universality and early intervention and prevention were not delivered through health visiting because the service was offered to some families only. In addition, health visitors' reported inability to meet parents' expectations in line with guidance led them develop negative feelings, such as underachievement and stress. Furthermore, the quality of the assessments of families' needs was negatively impacted by service venue variability. There was a shared understanding among health visitors that delivering the service in families' houses constituted a more quality assessment in comparison to delivering drop-in baby clinics in Health Centres. However, workforce and workload challenges were reported to have led health visitors to choose to deliver their services in the Health Centres in the form of drop-in baby clinics for practical reasons.

Health visitors' responses indicate that the recruitment of greater workforce is imperative to fully deliver the GIRFEC principles. This, however, would require a considerable amount of time and funding. Becoming a health visitor in the UK would normally require four years of studies on a full-time basis; three to become a qualified nurse or midwife and one to be qualified as a Specialist Community Public Health Nurse (Health Visitor) (Institute of Health Visiting n.d.). In addition, practitioners' responses highlighted that the Scottish health visiting service did not and cannot escape the austerity measures of the 21st century, which has involved cutting government spending for the health sector. In any case, there was a consensus in their responses that the policy requires to be reviewed so that it will include and incorporate ways for professionals to also be supported in delivering GIRFEC.

6.3. Working in partnership: Communication and inclusivity challenges

Health visitors discussed the way they worked in partnership with other professionals and families in the post-GIRFEC era. This theme reflects their views on the way partnership working was implemented at the ground-level, emphasizing the existence of communication and inclusivity challenges. GIRFEC delivery in regards to joined-up working and child-centeredness was therefore reported to be prevented by these limitations.

Health visitors reported that communication limitations existed due to i) lack of clarity in the guidance on the nature and the circumstances under which professionals could share information on families' needs without parental consent, and ii) restrictions imposed by the electronic record-keeping systems of services. According to health visitors, inclusivity challenges referred to issues preventing professionals, parents and children from working in partnership, which stresses the absence of seamlessness and child-centeredness. These communication and inclusivity issues were examined as separate sub-themes, the exploration of which follows.

6.3.1. Information sharing: Guidance ambiguity and electronic systems restrictions

During the interviews, practitioners talked about their information sharing practices focusing on what kind of information they shared among them, particularly in relation to parental consent, and how. Despite health visitors' consensus on the significance of information sharing, a key limitation identified referred to communication challenges because of the amount of information practitioners reportedly shared among them on families' needs. This sub-theme reflects health visitors' views that communication challenges imposed by the relevant guidance and the electronic record-keeping systems created problems in partnership working. These challenges also came up in the analysis of the policy documents examined in Chapter 5. It needs to be clarified that the Named Person scheme and the information sharing developments as in Children and Young People (Scotland) Act 2014 had not been implemented in the particular Health Board the study was conducted in, as explained by health visitors. As such, participants discussed information sharing practices taking place locally.

In regards to the relevant guidance, it was echoed in the interviews that professionals developed differing understandings and expectations on the *kind* of information that could be shared without parental consent. As explained by many health visitors, this was associated with the lack of clarity in the state guidance.

HV3: "...I think the biggest challenge is relevant information sharing because what is necessarily relevant to me isn't necessarily relevant to the voluntary sector. So it's about...information sharing is very challenging..."

HV20: "...But, again, that's [information relevant to the child] something that is not always, I think, straightforward..."

HV4: "...I think there's a...there is an expectation amongst agencies that we would just tell them everything and that's not really how we work. We've still got to respect families' rights of confidentiality. So I think there's that that's a bit dangerous..."

The previous extracts indicate that health visitors recognised that only "...relevant..." information could be shared among services without parental consent due to confidentiality reasons and parental rights to privacy. However, confusion was reported to exist among professionals across children's services on what kind of information was considered as such. This issue was also highlighted in the findings from policy document analysis presented in Chapter 5. For example, the issue of sharing information on parents' health history, such as maternal depression, was controversial. For some professionals, sharing information on parents' health history without first seeking parental consent was perceived as proportionate and relevant and in line with GIRFEC principles (Scottish Government 2012a), due to potentially impacting on families' children; for some, though, such information was not considered to meet the guidance thresholds on the matter and was argued that it should not be shared without parental consent. In addition, this reported controversy on the information shared/to be shared had the potential to be extended between professionals and parents too, because of professionals' potential uncertainty about the cases parental consent was to be sought.

Practitioners' responses suggest that greater clarification should be provided in the state guidance on what kind of information is considered acceptable to share among them without parental consent, particularly in the case of parents' history of health and wellbeing problems. However, greater clarifications in the guidance can be difficult to achieve and may not necessarily lead to the development of a shared understanding of the issue. The challenging nature of producing an information sharing Code of Practice of clear direction for professionals was also recognised by the Scottish Government³⁴. Instead of focusing on changes within the guidance only, however, focus should also be given to multi-agency training. This is because common training among, for example, health professionals, social workers and teachers, could potentially lead to a common understanding of the information to be shared and consequently to greater seamlessness.

³⁴ See, for example, the Scottish Government response on Supreme Court's judgement regarding information sharing challenges that had to be addressed on Parts 4 and 5 of Children and Young People (Scotland) Act 2014 (Scottish Government 2019c).

Apart from the guidance, challenges in communication and partnership working were also identified in the way services kept family records. Challenges in this case were associated with accessibility restrictions imposed by the electronic record-keeping systems of services. Findings from the policy document analysis in Chapter 5 also highlighted the lack of clarity within the documents on professionals' record-keeping practices. In the case of the health visiting system in particular, health visitors clarified that families' records for every child of their caseload were kept both in electronic form, using the MiDIS electronic platform, and in paper copies locked in cabinets within Health Centres. These records were reported to include information on families' met and unmet needs, on their HPI allocation³⁵, completed assessment forms and any other information regarding multi-agency activity and support provided. It was explained that GIRFEC introduction produced additional assessment forms to be completed and recorded, such as the GIRFEC National Practice Model (NPM hereafter) for all services. The introduction of the newly-introduced Ages & Stages Questionnaires (ASQs hereafter) was also discussed as being an additional set of forms used in health visiting.

Health visitors explained that each service, such as health visiting, education or social work, used its own electronic system for record-keeping purposes. Each electronic system was identified as working in isolation though, because it did not allow for professionals of other services to access records and share information electronically. Many participants, for example, supported the view that MiDIS could be accessed by health visitors only, but not from doctors, midwives or social workers.

HV6: "...GPs don't [have access to MiDIS], midwives don't...Social Work don't have access. But we can communicate to social work, and education, but not through MiDIS. So, yeah, it's not the best...And obviously, some of the hospital staff, like speech therapy, dietician, and they can see what you've been doing...But we can't really get into theirs, which is ridiculous..."

HV14: "...And then GPs use a system called EMIS...don't know what that stands for, but that's what GPs use. And then obviously the hospital uses a different system. And then midwives use another system called BADGER...And we can't access education or social work or Nurseries...and you've all got different systems for recording...So now we've all got the same paperwork which is meant to make it simpler, but actually I don't know if it does, because everyone does their own little thing with it..."

The previous extracts reflect the existence of communication challenges among professionals deriving from the electronic systems of services. This lack of effective

³⁵ Health visitors are responsible for allocating families into the "core" Health Plan Indicator (HPI hereafter) category, that is, families requiring no additional support, or into the "additional/vulnerable" HPI category, that is families requiring extra support, by the first six months in each baby's life (Scottish Government 2015).

communication among services was particularly evident in the reported completion and recording of the GIRFEC forms. Despite the aspiration that the introduction of the GIRFEC assessment forms would promote greater integration of services, these forms were reportedly completed and recorded individually rather than collectively by services. Health visitors' responses suggest that improvements in the way services share information and communicate with each other electronically regarding families' needs are needed. This could also prove effective and convenient for part-time staff by allowing them to view their colleagues' updates, be informed and contribute their own assessments. In this way, the multi-agency nature of GIRFEC could be fully promoted in the post-GIRFEC era. Interestingly, the role of parents on the way services share information electronically with each other was not discussed in the interviews. It was not clear from the data whether these electronic systems restrictions were, for example, attributed to parents' refusing to have their information shared.

Accessibility and communication limitations were not identified in the electronic systems of various services only but within the health visiting electronic system, too. A few health visitors, for instance, argued that the MiDIS electronic system, used by health visitors in the Scottish Health Boards, did not allow for families' records to be electronically transferred from a Health Board to another due to compatibility problems.

HV2: "...I can't send my MiDIS record to another health visitor if a family moves. The other Health Boards' computer software can't read it, so we have to print all the assessments off...and send them in paper form. But it would be much better from a communication point of view and from a family's continuity if...or the record could be the same as the pathway is..."

HV6: "...They [children's records] might not even be transferable on MiDIS, so they're coming in a big pile of papers..."

HV14: "...And that's [referring to MiDIS] probably going to stop and we're going to get a new system called MORSE and I know nothing about MORSE 'cause we've not...it's not happened yet..."

In the cases where young children moved in between Health Boards, the transferring of children's records from the MiDIS system of one Scottish Health Board to another was perceived as time-consuming and confusing by practitioners. Transferability problems in the health visiting electronic systems among the Scottish Health Boards were thus found to lead to communication problems within health visiting itself. These challenges could have been problematic for the effective communication and partnership working between health visiting and other services. The development of one universal electronic health visiting platform across Scotland could potentially help to overcome these transferability limitations. Health visitors clarified though that a new electronic system called MORSE would be introduced in 2020 and replace MiDIS, for which training would be provided. It

remains to be seen whether the use of the new electronic system will tackle the challenges reported in MiDIS and whether health visitors would be able to keep up with the new electronic format change.

6.3.2. Multi-agency meetings: Missing “multi-agency jigsaw puzzles”

Challenges in partnership working among professionals and parents were also identified in the multi-agency meetings of the post-GIRFEC era. In this sub-theme, I explore health visitors’ perceptions that existing inclusivity challenges for professionals and parents in the GIRFEC-introduced multi-agency meetings prevented partnership working. Self-imposed barriers, such as professionals’ resistance to change, and the absence of a parent-friendly environment were identified by practitioners as key factors discouraging individuals from attending the GIRFEC-introduced multi-agency meetings.

During the interviews, a number of multi-agency meetings were reported to take place in the post-GIRFEC era presented in the Table 10. below. The Team Around the Child meetings (TACs hereafter) have been explored in greater detail though, because they were reported to have developed as a result of the GIRFEC introduction in this particular Health Board. In other Scottish Health Boards, these meetings may be called differently, such as Team Around the Family or Meeting Around the Child. In these meetings, all professionals involved in a family’s life along with the parents were reported to meet up to discuss about wellbeing concerns and actions to be taken to tackle them. TACs were thus described as a voluntary approach preventing a wellbeing concern from escalating into a child protection case.

Table 10. Types of multi-agency meetings in Scotland

Types of multi-agency meetings
Team Around the Child meetings (TACs)
Child Protection Case Conferences
Core groups
Staged Intervention meetings
Professionals’ only meetings
Children’s Hearings
Looked After Child Review (LAC) meetings
Pre-birth Case Conference meetings
Referrals with voluntary services

One of the key GIRFEC principles is partnership working, which refers to the collaboration of families with all the services involved in their life. In the case of TACs, however, health visitors explained that some “multi-agency jigsaw puzzles” were missing from these meetings as some professionals were absent. According to some

practitioners, for instance, some professionals, such as the doctors, were not attending their families' TACs, as described in the quote below:

HV13: "...Sometimes people can't make the meeting, some professionals can't be there...The only thing about the TAC, you don't get any of the paediatricians going to the TAC meetings. You don't get any of the doctors going, they don't go to any. Sometimes I think that's...I know maybe they're short of time but sometimes you're thinking what's the paediatrician's saying but you don't know because you only get letters from them...you know, Team Around the Child is supposed to be everybody but they don't..."

This extract highlights the existence of caveats in joined-up activity because there was no reported system for professionals not attending TACs to be informed and exchange information with colleagues on families' needs. More importantly, this issue highlights the existence of underlying obstacles within professional cultures that reportedly hindered GIRFEC implementation. The changes introduced by GIRFEC did not solely refer to professionals' practices; they referred to a change in professional cultures on the way practitioners were expected to work among them. Professionals not prioritizing and not attending TACs signified their resistance to change their professional culture and to adopt a more collaborative stance. Eventually, what was highlighted in these responses was that simply introducing guidelines and policies was not sufficient enough to accomplish effective partnership working. Professionals undertaking multi-agency training, which was not mentioned by any of the health visitors, could have the potential to create a change in professional thinking and culture and lead to greater effective collaboration among services.

Another "jigsaw puzzle piece" that was reported to be missing from TACs referred to the physical presence of parents. Despite practitioners' recognition that a move towards greater seamlessness was identified in the post-GIRFEC era by inviting parents to TACs, TACs were described as an uncomfortable experience for parents. Some health visitors interviewed, for example, argued that parents were discouraged from attending TACs due to fear of being criticised on their parenting capacity by professionals.

HV15: "...I think sometimes, sort of, parental resistance type thing. But usually...'cause I understand it...especially the first, when it can be intimidating walking in a room and seeing all these professionals round a Table..."

HV2: "...The challenge is to the parent really, I think it's very difficult to go along to a meeting where everybody is talking about your child, so that must be quite hard...yes, I think the challenge is for the parent..."

HV20: "...The barriers to Team Around the Child are I've had a lot of parents feel really uncomfortable attending and it's just the fact

they're round a table, do you know, and it's...yes, very anxious. Not knowing what to expect I think... ”

These extracts reflect the assumption that inviting parents to TACs also meant they would attend them; the possibility of parents being negative or reluctant to attend these due to feeling intimidated or uncomfortable in the presence of various professionals was reported to be ignored. Effective provision to ensure a parent-friendly environment in TACs, which was reportedly missing, could have been achieved by preparing parents in advance. For example, informing parents in advance of the meetings on what will be discussed in the meeting could be a less intimidating approach and potentially encourage parents' attendance. Additionally, providing individualised support in these meetings which does not fall solely on child's wellbeing but on parents' wellbeing too, could also be promising in achieving greater participation from parents' perspective.

6.3.3. Children at the centre vs. children on the margin

Apart from professionals and parents, inclusivity problems were also identified in partnership working and the overall GIRFEC approach for children, too. Considering that GIRFEC encourages child-centeredness, health visitors were asked to discuss children's role within health visiting. In this sub-theme, I explore their accounts of the way they employed child-centred approaches when delivering the service, emphasizing the tension between children being considered in the centre versus on the margin. This tension was also stressed in the findings of policy document analysis, as presented in Chapter 5 of the thesis.

Participants' views were mixed on whether and how they “did” child-centeredness. Many health visitors, for example, argued that they did adopt child-centred approaches in their service delivery aiming to empower children, which is indicative in the quotations below:

HV9: “...it's making sure that their [children's] voice is heard in whatever way you can with that age group, if that makes sense...”

HV12: “...I think the child's views are getting documented now. We're asking, we're actually, as part of our assessment. We are in the SHANARRI, six weeks, we have got a section to write about the child's view...”

HV19: “...I mean, a wee baby can't turn around and say, oh, this is happening to me, but...if you're doing your job right, you should be able to see how that baby's reacting. So, they might not be able to verbalise it, but they can always show you it, always, no matter what age they are...”

HV1: “...I've been to meetings where the children have been invited: babies, toddlers, 4-year-olds...Yes, so the TAC meetings...And that's been LAC reviews, that's been Child Protection Case Conferences and TAC meetings...”

Child-centeredness was associated with various practices for health visitors, such as the gathering and documentation of children's views either verbally or via observing their behaviour during home visits and/or during multi-agency meetings. These practices were reported to result from GIRFEC development. In the case of very young children, whose verbal communication skills had not been fully developed, their young age was not considered to prevent professionals from identifying children's needs. This was because practitioners reported to observe and document babies and toddlers' behaviour and interactions with their parents and/or themselves. A significant issue that came up from data analysis was that listening to children's views only may not be representative of child-centeredness, though; taking actions to also meet their wishes may be indicative of child-centeredness, even though it was not reported by any of the health visitors.

Despite health visitors' reported move towards more child-centred approaches, the issue of children's minimised role in service delivery was also expressed during the interviews. More traditional and conservative views on children being passive recipients were found to constitute the key obstacles preventing professionals from adopting child-centeredness. For some health visitors, for instance, collecting children's views was reported not to take place even in the cases where children were old enough to talk because such practices were considered new and not yet fully embedded in their current professional culture.

HV12: "...We, we've not done that yet [collecting children's views]. We've not had, and I don't know if I ever will because the children are too young to understand. It's quite a comprehensive bit of work, isn't it?..."

HV13: "...Their role [referring to children]? They don't really have...they're too young to have a role. They're vulnerable, they're young..."

HV4: "...Sadly, I don't think the children have a big enough role...And we place too much emphasis on the families and I still think unfortunately we're not moving on from that massively...I'm...I am quite mindful that sometimes we don't always get an opportunity to speak to a child on their own, to hear what their views actually are. We make assumptions of what we know..."

These extracts indicate that children's active role was not perceived as significant nor imperative by all health visitors, which posed seamlessness and child-centeredness challenges. More importantly, these quotations highlight the existence of professionals' resistance in attributing greater role to children since eliciting their views was not perceived as meaningful for them. These marginalizing views may be reflective of health visitors' mind-set and the way they viewed children, though. Just as with the multi-agency nature of GIRFEC, child-centeredness also requires a mind-set change that may be

achieved through training. Professionals undertaking training so as to develop a more child-inclusive professional culture and develop a shared understanding of this may be promising in achieving greater partnership working and child-centeredness.

Another example of health visitors marginalising children's role due to their lack of training was identified in the case of TAC multi-agency meetings in particular. As explained by some health visitors, the practice of verbally eliciting the views of children whose linguistic skills have already been developed was indeed reported to take place in these meetings but it was reportedly employed by professionals other than health visitors, such as, social workers or nursery teachers.

HV11: "...Social Work do have forms, and schools do have forms, for the child to give their views, depending on their age and stage; but that's usually at school. In fact that they actually do it at nursery, they do have a form at nursery, but then they ask the child, and it's just really basic things; who's your friend, what do you like doing when you're at nursery..."

HV17: "...It tends to be social work that collect these views, or the foster carers, or the people responsible for the children..."

HV16: "...And I suppose I don't feel I've been trained to speak to children in a way that would let me find out their views as in...But getting verbal views from children of the ages that we work with I don't think I'm skilled enough to really do that and I don't think we've ever been given any training in that..."

Health visitors' responses in this case highlight that they felt unskilled or less responsible for eliciting older children's views in TACs, which was indicative of their lack of training. In order to tackle these barriers and promote child-centeredness, the need for greater training for health visitors on how to verbally elicit children's views was once again stressed.

6.3.4. *Theme summary*

This theme reflects health visitors' views that communication and inclusivity restrictions prevented professionals and families from working in partnership, as set out in GIRFEC. In regards to communication restrictions, challenges in information sharing practices, particularly in relation to the guidance and the electronic record-keeping systems of services, were reported to prevent the seamlessness of services. Even though health visitors were in agreement on the beneficial role of information sharing for assessing families' needs, confusion was evident in their responses on the nature and the circumstances under which information was to be shared without parental consent. Practitioners' responses implied that greater clarification on information sharing within the guidance could enable greater partnership working.

In the case of the electronic systems of services, accessibility restrictions and the absence of opportunities for services to electronically "communicate" with each other created communication problems among professionals of various services but also for health visitors across Scotland, too. Not allowing professionals to electronically view or comment on assessments on their record-keeping systems underlines the inefficiency of platforms and suggests the need for improvements in these to be made. In health visiting in particular, the development of one universal electronic health visiting platform used across all Scottish Health Boards could have the potential to tackle communication challenges, particularly for families being transferred in between Health Boards. Health visitors clarified, though, that a new electronic system called MORSE will be introduced in 2020.

In terms of inclusivity restrictions, it was reported that professionals and parents were discouraged from participating in the GIRFEC-introduced Team Around The Child multi-agency meetings (TACs) in particular. Professionals' resistance to change and adapt to GIRFEC principles was apparent in their reported absence from TACs. In the case of parents, being invited to TACs could not necessarily guarantee their attendance due to the intimidating nature of the meetings. Such challenges stressed the need for more parent-friendly practices to be adopted in delivering TACs, such as informing parents in advance on what will be discussed in the meetings.

In terms of children's inclusiveness, health visitors' views on employing child-centred approaches were mixed highlighting a tension between children being considered at the centre of professionals' work and being marginalised. For health visitors, child-centeredness referred to i) verbally eliciting and documenting the views of the older children, and ii) observing and documenting the interactions of babies and toddlers with their carers and/or professionals. What was indicative of health visitors' responses in relation to partnership working and child-centeredness was their reported lack of training

on these matters. GIRFEC is more than anything a change in professionals' mind-set towards greater partnership working and child-centeredness, rather than practices to employ. Considering that GIRFEC involves a number of different services and professional cultures, professionals are required to be trained i) in relation to what information can/cannot be shared without parental consent, ii) on how to employ child-centred approaches in real-life. This could potentially enable them to change their professional culture and move towards a common understanding of what effective partnership working includes.

7. Health visitors' findings: Health visitors and families through a relational lens

7.1. Introduction

This Chapter presents findings resulting from the analysis of health visitors' data on the relational practices between families and the health visiting service since the introduction of *Getting it Right for Every Child*³⁶ (Scottish Government 2020b). Two broad themes, 'Thresholds of support and intrusion' and 'Decision-making thresholds: Standardization vs. professional judgement' developed from the data collected by health visitors. The first theme explores the factors that were considered by health visitors to make the service supportive or intrusive. The second theme, on the other hand, describes health visitors' perspectives of the decision-making factors that helped them determine the level of support families required, emphasizing the tension between standardization and professional judgement. Five sub-themes developed within these two themes, which are presented in greater detail in Table 11. that follows.

Table 11. Themes and sub-themes of health visitors' findings (II)

Themes	Sub-themes	Description
Thresholds of support and intrusion	<ul style="list-style-type: none"> Intensive home visiting: Parenting experience 	The perspective that the provision of intensive home visiting, particularly in relation to the level of parenting experience, determined whether the service was supportive or intrusive.
	<ul style="list-style-type: none"> Wellbeing and child protection concerns: Actions with vs. on parents 	The perspective that particular regulatory practices employed in light of wellbeing and child protection concerns made the service supportive or intrusive.
Decision making thresholds: Standardization vs. professional judgement	<ul style="list-style-type: none"> Centralized standardization: GIRFEC NPM and health visiting assessment forms 	The view that health visitors used centralized standardization forms to assess and decide on the level of support families required.
	<ul style="list-style-type: none"> Localized standardization: Health Boards guidance 	The perspective that health visitors used localized health visiting standards, as prescribed by the Health Boards, to assess families' needs.
	<ul style="list-style-type: none"> Experiential knowledge 	The view that health visitors employed their experiential knowledge as part of their professional judgement to decide on the level of support families required.

³⁶ (GIRFEC hereafter)

7.2. Thresholds of support and intrusion

In this theme, I explore health visitors' accounts of the two key factors in the relationship between families and health visiting that determined whether the service was supportive or intrusive. These factors were i) the provision of intensive home visiting particularly in regards to the level of parenting experience, and ii) the collaborative or non-collaborative nature of the regulatory practices employed in light of wellbeing and child protection concerns. Health visitors used examples from their professional experience to illustrate their arguments. These two elements have been explored as separate sub-themes, the exploration of which follows.

7.2.1. *Intensive home visiting: Parenting experience*

The issue of intensive home visiting was discussed by health visitors in the interviews. Intensive home visiting was reported to translate into the delivery of a great number of home visits during a particular amount of time, even though the level and frequency of this intensity was not clearly defined by participants. This sub-theme reflects health visitors' views that the provision of intensive home visiting, particularly in relation to the level of parenting experience, determined whether the service was supportive or intrusive.

In the case of parents having limited parenting experience, such as first-time parents, the provision of intensive home visits was reported to be supportive. This was attributed to health visitors' having more opportunities to provide advice and guidance on parenting skills. On the other hand, offering intensive home visiting to parents of extensive parenting experience having, for example, two, or more children, was perceived as making the service unsupportive and even intrusive. This was echoed by almost all of the practitioners I interviewed.

HV1: "...Whereas, they [referring to families] depend on you a lot more in the earlier days...whereas later on if you're visiting all the time at home, you are almost a pain in the neck..."

HV11: "...think it's quite good for new families and to have that intense support. But for maybe baby number four, and the health visitor is coming out all the time, and they're a confident family, good supports around them, I think that can be a bit intrusive...And then personally, though I'm past the age of having kids [laughs] now, but if I was having a child just now, and being a health visitor, I wouldn't want it. And that's a big statement coming from a health visitor..."

HV3: "...so for parents who are experienced parents, [they] don't necessarily want us in the house that much. You know, if you're on child, three, four, five, you don't need a health visitor

necessarily out every week or every other month and that can prove a bit of a challenge...

What is emphasized in these extracts is the level of dependency families reportedly had with health visiting. Parents' help-seeking ability from their health visitors was described to be greater during the "...earlier days...", particularly for first-time parents, due to their limited level of parenting experience. Their reported preference for more intensive home visiting in these "...earlier days..." of a baby's life and less so later on *is* in line with GIRFEC and *Universal Health Visiting Pathway in Scotland: Pre-Birth to Pre-School*³⁷ (Scottish Government 2015), as discussed in the findings from policy document analysis in Chapter 5. Based on UP in particular, eight home visits are expected to be delivered to every family in Scotland during the first eight months of a baby's life. After this time period and by the time the child goes to school, three more home visits are expected to be delivered to the families, the UP suggests. In the case of inexperienced parents, no changes were therefore suggested by health visitors to be made on the number and frequency of home visits set out in UP.

On the other hand, health visitors' views were not in line with the principles of GIRFEC and UP for experienced parents. Even though GIRFEC and UP encourage the offer of intensive home visiting for all new parents, irrespective of their parenting experience, participants argued that this was unsupportive and even intrusive for experienced parents. One participant, for instance, described intensive home visiting to these parents as being "...almost a pain in the neck..." because of parents' already developed parenting confidence and skills. The service was therefore described as being universal but not appropriate for experienced parents. To make the service supportive for these parents, it was suggested that less intensive home visiting would be required for them during the first year of the baby's life. This poses challenges in regards to the preventive nature of the service, though. If health visitors considered that intensive home visiting should be offered to first-time parents only, how could potential concerns be identified and tackled early for experienced parents, too?

7.2.2. Wellbeing and child protection concerns: Actions with vs. on parents

Another factor that was perceived to determine whether the service was supportive or intrusive referred to the way professionals and parents worked with each other both in light of wellbeing and child protection concerns. This sub-theme reflects health visitors' views that particular regulatory practices employed in light of wellbeing and child protection concerns made the service intrusive or supportive depending on whether they encouraged collaboration between parents and professionals. Wellbeing concerns

³⁷ (UP hereafter)

reportedly referred to issues on the holistic aspects of the being of the child whereas child protection concerns to signs of risks or harm whereas. For health visitors, the statutory regulation practices in light of child protection concerns were reported to make the service intrusive because of actions taken *on* parents minimizing their role. In the case of wellbeing concerns, some of the statutory regulation practices made the service supportive and some intrusive on the basis of whether professionals worked collaboratively *with* parents or took actions *on* them respectively.

Health visitors explained that the identification of either child protection or wellbeing concerns in a family led to the initiation of particular practices or procedures by professionals. In the case of child protection concerns, health visitors explained that the service was mostly intrusive for families having had either social work involvement or child protection history. They argued that there was a correlation between the intrusiveness of the service and the statutory regulatory practices employed, specifically due to the information sharing practices among services. In particular, they discussed their duty of care to safeguard children by sharing their child protection concerns with other services and professionals. *All* health visitors explained that in the exceptional circumstances where child protection concerns were identified within a family, they reportedly escalated their concerns and initiated multi-agency activity *without* first seeking parental consent. However, some professionals found such regulatory practices problematic, which is indicative in the quotes below:

HV8: "...[In light of child protection concerns] you're not asking for consent, it's not like a, I'd like to refer you onto this, would that be helpful. This is very clearly saying where you are...but as I said, child protection, you're not asking consent, but it's good practice to have that conversation, that's your plan..."

HV1: "...Obviously we have to respect a right to private family life and parental wishes and I think we should, where possible, you know, even when there's child protection [concerns], ask parents or ask for a form parents for that information to be shared. I think that's common decency for anybody..."

Health visitors considered that parental rights to privacy were superseded by children's safety in child protection cases. This was in line with the national (the UP³⁸) and local guidance (*Vulnerable Children Guidance*³⁹), as also highlighted in the analysis of the policy documents presented in Chapter 5. The issues raised here are twofold. Firstly, health visitors reported that, in such exceptional circumstances, the relevant guidelines did not allow professionals to inform parents on their intentions to act upon and share their concerns with other professionals and services. Their responses imply, however,

³⁸ Scottish Government 2015

³⁹ Placement NHS Health Board 2018

that improvements in the guidance could be made by allowing professionals to inform parents on the matter because "...it's good practice..." to let the parents know. Secondly, the issue of informing parents on the matter also sheds light to their overall role in child protection cases and questions whether they are given the opportunity to have a say and be listened to in such cases. These practices reportedly signified the existence of a system which minimized parents' role by allowing professionals to intervene into families' lives and share information acting "behind their back", instead of intending to collaboratively work with them. Health visitors' responses suggest that for the service to be supportive in child protection cases, greater collaboration between professionals and parents was reportedly required by informing parents on their intentions.

In the case of wellbeing concerns, health visitors explained that the regulatory practices employed in relation to information sharing made the service supportive because they enabled them to collaboratively work with parents. For example, when health visitors were uncertain about the existence of a wellbeing concern in a family, they sought more information on families' met/unmet needs from other services and professionals *after* gaining parental consent. Collecting more evidence was reported to impact on their decision on the level of support the family required. The collaborative nature in this case lied on professionals' practice to seek parental consent before seeking any further information. This practice was reported to be employed by *all* health visitors interviewed and reportedly made the service supportive.

HV13: "...I would usually, if I was in a house and I was worried about someone that I wanted to clarify something, I would say to the mum, is it okay if I give the Nursery a phone just to see what they think?..."

HV17: "...And, I find a lot of the time, they'll [referring to parents] say, yeah could you do that [talk to the Nursery to collect more information in terms of the child's behaviour]?..."

HV10: "...Yeah, I think just a key thing...that the parents are involved all the way along so that it's not any sharing of information, or support is not seen as something being done or coming from the outside..."

HV8: "...So it is very much making sure that, you know, we [professionals] shouldn't be having conversations about children without the mum being aware of it. And I think we need to be very mindful of that..."

The preceding quotes illustrate that for wellbeing matters, parental permission to contact other services working with the families, such as the Nursery, was sought. This practice of seeking and sharing family information *after* gaining parental permission encouraged the development of collaborative relationships between services and parents and is in

line with the local guidance, as explained in Chapter 5. However, questions are raised on the information sharing practices health visitors followed when parents did not consent to their information being shared.

However, some regulatory practices employed with parents in light of wellbeing concerns were reported to make the service intrusive because of the absence of collaborative relationships between parents and professionals. These regulatory approaches involved minimising parents' role. Some health visitors stressed that, even in the absence of child protection concerns, parents were enforced to comply with professionals' recommendations. The extracts below are indicative of such perceptions:

HV5: "...Then again if you felt at that point...it wasn't getting [anywhere]...and you think, oh, the child's really not engaging, then you would have to explain all that as well saying, well, actually we've explained this, this is not getting any better. You're refusing to go. So it then may become a child protection issue at that point as well..."

HV8: "...Sometimes they [professionals] use it [Team Around the Child meetings] as a way of a, if you don't come to this and do this, we're going to go to child protection...And the social workers are saying, right if you come along, if you agree to this meeting, if you agree to the actions of this meeting, we will keep it to here. If that's not happening, we will then escalate it. So that's not always the most conducive environment to make changes..."

Health visitors' extracts suggest that the current system was reported to create a hostile environment for parents of child wellbeing concerns, too. In the cases where wellbeing concerns were identified and parents were not willing to comply with professionals' suggestions, intervention was intended for them in an almost threatening and punitive way. Parents' non-compliance would lead to the escalation of the case into a child protection case. As a result, an ineffective system towards parents reportedly existed even in child wellbeing concerns. Participants' responses highlight the need for improvements to be made so that the service would be more supportive in light of wellbeing concerns. This could be achieved by reviewing and focusing on the collaborative work between services and parents. Even though GIRFEC introduction does provide opportunities for parents and children's views to be documented in the relevant GIRFEC forms, such as in Child's Plan, questions are raised on whether actions were taken to provide individualized support to parents. Parents should be given the opportunity to have their views heard and documented but also acted upon so as to receive individualized and family-centred support.

7.2.3. Theme summary

According to health visitors, the key factors that determined whether the service was supportive or intrusive were: i) the level of intensive home visiting provided to families, particularly in relation to parenting experience, and ii) the level of concern potentially identified within families by practitioners.

Intensive home visiting, which referred to the provision of a great number of home visits during a particular time, was reported to be supportive for inexperienced parents but not for experienced ones. Inexperienced parents were described those being parents for the first time whereas experienced parents on their second, third child and so on. This was because health visitors saw themselves as providing guidance and advice on babies' development, which was reported to not be useful for competent parents. Health visitors agreed with the universal nature of GIRFEC and UP. Nevertheless, they suggested that intensive home visiting should be provided to first-time parents only, for the service to be supportive. This, however, brings up challenges on the preventive nature of GIRFEC for the experienced parents.

Another criterion to determine the supportiveness or intrusiveness of the service was in relation to the regulatory practices that reportedly took place between parents and professionals in light of wellbeing and child protection concerns. It was explained by participating professionals that non-collaborative regulatory practices took place in light of child protection concerns, which reportedly made the service intrusive. These regulatory practices were reported to be less empowering for parents. For example, when child protection concerns were identified, professionals escalated their concerns. In line with the national and local guidance, health visitors did not inform parents of their intentions to escalate their concerns, which minimized parents' role. On the other hand, the regulatory information sharing practices in the identification of child wellbeing concerns were reported to be supportive because they encouraged seeking parental consent to seek further information from other services. Interestingly, some regulatory practices were described as limiting parental role even in light of wellbeing concerns, which reportedly made the service intrusive. In such cases, health visitors' responses highlighted that parents had to comply with professionals' recommendations or else the case would escalate into a child protection one. Support from services was hence described to be delivered in an either-or situation where parents' views and role was minimised. Health visitors' responses implied that greater collaborative practices between professionals and parents need to be required in light of wellbeing and child protection concerns for the service to be supportive.

7.3. Decision-making thresholds: Standardization vs. professional judgement

One of the fundamentals of GIRFEC and UP is the opportunity for services and professionals to provide additional help to families that need it (Scottish Government 2020b). This theme explores health visitors' accounts of the existence of a tension between standardization and professional judgement on the decision-making thresholds employed to assess families' met/unmet needs and decide on the level of support they required. These decision-making thresholds were: i) the centralized standardization assessments including the GIRFEC-introduced forms but also the relevant health visiting forms, ii) the localized Health Boards standards, and iii) health visitors' intuitive skills. These elements have been explored as separate sub-themes and follow.

7.3.1. Centralized standardization: GIRFEC NPM and health visiting assessment forms

In this sub-theme, I explore health visitors' perspectives that they used a number of centralized standardization assessment forms to assess and decide on the level of support families required. These national standardization forms were reported to include i) the GIRFEC National Practice Model (NPM hereafter), resulting from GIRFEC introduction, and ii) the relevant health visiting assessment forms, such as the Ages and Stages Questionnaires (ASQs hereafter). This also came up in Chapter 5 on policy document analysis.

All the health visitors reported that they completed the GIRFEC and the health visiting assessment forms during the service delivery to assess families' needs. Even though various forms were reportedly used depending on the nature of the home visit, a move towards greater standardization in their assessments was evident. In regards to GIRFEC forms, participants discussed the use of the NPM, which was reported to refer to the SHANARRI wellbeing wheel for all children of their caseload and to the My World Triangle (MWT hereafter) for children requiring extra support. Some health visitors also talked about the Resilience Matrix for families requiring extra help too, as part of the NPM. Despite health visitors' consensus that these forms added more workload to them, they were supportive of their use. For example, some health visitors explained that the use of the MWT in particular assisted them in identifying and reflecting on families' unmet needs.

HV9: "...so if we've identified a sort of unmet need or I wasn't sure, I was thinking, this family potentially needs a wee bit more here or there's something, you know, need a bit more support with whatever, what you would do is you would use a My World Triangle so you would do an additional assessment..."

HV16: "...I would say that's true [referring to "grey" areas] and that's where the assessments come in very useful because if you were doing like a My World Triangle assessment it makes it clear to you, well, actually this is the bit that I need to be doing or actually all of these child's needs are met and I don't need to be visiting anymore..."

HV2: "...for a lot of the newer health visitors...it's very specific and, you know, this is when you go, this is what you talk about, and these are the leaflets that you provide to the family, so it's a...I think if you're new to health visiting it's very clear what it is that you achieve and every family therefore gets the same..."

The GIRFEC-introduced MWT was reported to be useful for health visitors' decision-making processes, particularly when they were uncertain on whether families required extra help or not. Rather than being an assessment form per se, the MWT was reported to constitute a tool which helped professionals bring together all the information known about a family's needs and reflect on it. In the cases of multi-agency activity, the use of MWT would be reportedly required to be used in collaboration with all the professionals working with the family. This shows that the introduction of MWT assisted multi-agency activity by encouraging the exchange of information among professionals and the collective assessment of needs. This was also highlighted in Chapter 5, presenting the findings of policy documents analysis. Moreover, the use of the NPM was described as useful particularly for health visitors who were new to the profession because it could reportedly provide clarity and assist them in reflecting on wellbeing areas where they would not have thought of by themselves, if it had not been for these forms. This underlines that there was a relationship between the use of the NPM and the working experience of health visitors, implying that the newly experienced professionals might be more inclined to use these GIRFEC tools in their assessments.

Along with the GIRFEC NPM, health visitors explained that they used a number of other health visiting forms for their assessments depending on the nature of the reviews delivered. In doing so, many health visitors argued that the use of both the NPM and the health visiting forms provided opportunities for them to document families' met and/or unmet needs, such as children's achievements, rather than developmental delays or concerns only.

HV10: "...So for example, in the past with the old pathway we would often have a lot of assessments that we would have done in our head but we might not have evidenced that on paper. So we tended to probably operate in a way that we more wrote about problems rather than talked about all the positive things...And I think also it's really important to talk about all the positive things that parents are doing 'cause if it's just seen as kind of negative then the parents disengage..."

HV14: "...And they might be really...like, the parent might be really pleased that the child can kick a football and climb up, but they've maybe not thought about...so it helps you to pinpoint areas that the parents can concentrate on..."

The preceding quotes raise three key issues. Firstly, it was reported that the use of these official records provided opportunities for the justification of practitioners' decision-making outcomes, which was missing in the pre-GIRFEC era. Secondly, the use of these forms gave credibility to the service and health visitors' role. Health visitors were seen as health experts, similar to nurses, for example, and the service was considered more credible and professional. Thirdly, both the achievements and the areas for improvement were required to be presented in these forms, rather than the areas for improvement only, which was not reported to be the case before the development of the GIRFEC framework. This provided opportunities for parents to identify the accomplishments of their children too, rather than their lack of strengths only, which could have been perceived as judgemental. However, an assumption is evident in these responses; that parents would be receptive of the use of these forms in service delivery. Questions are raised in this case on what other assessment approaches could be in place in the cases where parents were not receptive of the use of such forms.

Apart from the opportunity to evidence children's milestones, the use of the GIRFEC and UP forms was also considered positive due to encouraging the development and establishment of relationships between families and their health visitor. Emphasis on the way these standardized forms in particular were used, rather than these forms per se, was reported to encourage the relationship-building between health visitors and families. Many health visitors clarified, for example, that the GIRFEC and UP forms were completed with parents/carers through discussion between parents and themselves during the home visits.

HV8: "... And it's not, I don't walk in the house and go, tick, tick, tick, tick. And to do that properly, you do it by building a relationship. A one off, cold visit, asking you all that, it's like, I don't know who you are, and you're defensive...But it [the ASQ] doesn't take away from your underlying knowledge, and your clinical assessment...You know, it's like anything else, it's [the ASQ] a tool to support your assessment, not a tool to replace it..."

HV14: "... 'Cause obviously you want to be doing it [completing the MWT] with the parent because what's...what you think might be a problem, the parent might not think's a problem. So you've got try and, you know, marry it up in that respect..."

These extracts illustrate that the completion of the GIRFEC and health visiting forms was accomplished i) by sending these forms to families in advance of the home visits so as to give parents the opportunity to reflect on the forms' questions, and ii) through

conversation between parents and health visitors during home visits. These practices were considered positive by health visitors because they were seen as tools leading to the completion of assessments collaboratively by the two parties. More importantly, the use of these forms was reported to be particularly crucial in the case where concerns on children's wellbeing were identified by practitioners because they helped in establishing a common set of standards between parents and themselves. In other words, the use of these forms was reported to help health visitors communicate their potential concerns to parents regarding children's wellbeing by developing a common threshold of the need for extra support. Based on health visitors' responses, it was unclear, however, whether parents were given the opportunity for their views to be expressed and documented on any of these assessment forms. Questions are also raised here on whether there was a system in place in the cases of disagreement between health visitors and parents over the assessment outcome.

On the other hand, the use of GIRFEC and UP forms was not considered by all the health visitors as an effective approach due to their standardized nature. For some of the health visitors interviewed, for example, these forms were described as too prescriptive and as a tick-boxing exercise, as also found in the analysis of the policy documents in Chapter 5.

HV4: "...So what I'm particularly finding, especially the one year review is...one year review is now...the expectations are quite high for these children, so if a child doesn't walk by one, then they fail their whole gross motor. And that's not necessarily the case. You know, your professional judgement would say, yeah they're not walking, but they're doing this, this and this. So I would have no concerns about that. However when you look at the form it looks like they've failed. And I think that's the difference. And I think families are struggling with that..."

HV16: "...So I would say there's probably quite a few instances where they [referring to parents] think, hmm, why are you asking me that..."

Health visitors' accounts indicate that the use of GIRFEC and UP forms undermined and was opposed to health visitors' professional judgement, instead of encouraging it. This is because the criteria presented on these forms were reported to be too hard to reach for some children and left no space for children's individualization. Their development was based on the assumption that all children needed to meet the same, particular criteria to "achieve wellbeing". This was perceived as dehumanizing the human nature by attempting to shape children's behaviour in a way that would best meet the accepted behavioural standards of the state. In this sense, assessment forms were seen as tests, where failing to meet one or more of these standards was perceived as a failure. Parents might therefore have been resistant to comply with the desired state level of standards,

due to interfering with their own personal standards and parenting style. The health visiting relationship between health visitors and parents was therefore seen as being negatively impacted by the use of these forms.

Moreover, health visitors' responses highlighted that some of the questions included in these forms might have not been seen by parents as directly linked to their children's wellbeing and as intrusive of family life. Greater information would be useful here, though, on whether professionals discussed with parents what the purpose of all the questions were in advance of the forms' completion. For example, it was reported by the participants interviewed that issues in relation to finances or past health problems of parents could affect children's wellbeing but it was unclear from the interviews whether that was explained to the parents, too.

7.3.2. Localized standardization: Health Boards guidance

Apart from using centralized assessment forms, localized guidance was also reported to determine health visitors' decisions on the level of support families required. This sub-theme describes health visitors' invocation of the localized health visiting standards in assessing and deciding on the level of support families required, as prescribed by the Health Boards. In contrast with the centralized standards, which were national, the localized standards referred to the local guidance of each Health Board. This finding also came up from the analysis of the policy documents as discussed in Chapter 5 of this thesis.

Even though both GIRFEC and UP encourage the provision of additional support to families requiring it, health visitors reported that greater direction was given in health visiting on how to decide upon the level of support families needed. For example, health visitors explained that they were also required to classify families into standardized categories on the basis of their met/unmet needs. In other words, there was a consensus among health visitors that the assessment of families' needs would determine their allocation into the "core" or the "additional/vulnerable" Health Plan Indicator (HPI hereafter), which would reportedly take place by the first six months of each baby's life. All of the health visitors interviewed explained that a "core" HPI allocation indicated that the family required to receive the basic, minimum standard of support and reviews, as suggested in the UP. On the other hand, allocating families an "additional/vulnerable" HPI would suggest that additional help and reviews to the UP would have to be provided to the family due to unmet needs. I use the "additional/vulnerable" term in this case to describe the families in need of extra support varying in the level of their needs because the "vulnerable" HPI category was reportedly only used in some Health Boards, as will be further explored later on. There was a shared sense of understanding among

participants that changing a family's HPI from "core" to "additional/vulnerable" and vice versa was feasible. Many health visitors explained, for example, that their relevant Health Board prescribed localized standards which reportedly determined health visitors' decisions on whether families would be allocated into the "core" or the "additional/vulnerable" HPI.

HV13: "...but if they've got more than two unmet needs then they go into an additional programme..."

HV10: "...The "additional" criteria is supposed to be if there are two unmet needs and if we are going to do extra work with the family for longer than three months..."

HV5: "...Where I worked before in Durban [referring to another Health Board, we only had core and additional but here in Fargo they have vulnerable, as well. So children at risk or on the child protection register are then classed as vulnerable...Then coming here that is still the way that they're working so you can see from work in different health board areas it is a little bit different..."

The current localized guidelines of the particular Health Board the study was conducted in were reported to refer to i) the number of unmet needs identified in a family and ii) the duration of the provision of extra support to the family. This was partly in contrast with the findings of the analysis of the policy documents, as presented in Chapter 5, which highlighted that families' categorization was to be accomplished on the basis of the duration of the provision of extra help only. In particular, the identification of only one unmet need in a family and the provision of extra support for less than three months were reported by health visitors to encourage the classification of this family into the "core" HPI programme. On the other hand, the identification of two or more unmet needs in a family and the provision of targeted help for more than three months would indicate the family's HPI allocation as "additional/vulnerable". The Health Boards' guidance was therefore used as a directive tool aiding health visitors' in their decision-making practices and eventually to the HPI classification of families.

However, there are two key emerging issues here, which signify the existence of fragmentation challenges within health visiting and across children's services. Firstly, participants' responses indicated that each Health Board was using its own thresholds, that is classification categories for families' needs. This means that there was a reported differentiation and inconsistency among Health Boards on the criteria for meeting families' needs. This in turn could lead to differentiation at the level of support offered to families among the Health Boards. Does the classification of families into the "vulnerable" HPI, which is reportedly in use in some Health Boards only, mean that more intensive, individualized support would be required to these families comparing to the classification of "additional" HPI? The differences in the localized decision-making thresholds created

barriers in multi-agency activity. Secondly, questions are raised on whether services other than the health visiting, such as social work or education, also employed similar decision-making thresholds and/or classification of families. If each service developed each one, either national or localized, thresholds to decide upon the level of support families needed, no seamlessness among services would be achieved nor would good enough support to families be provided. These issues were also highlighted in Chapter 5 resulting from the analysis of the policy documents.

Although many health visitors highlighted the significance of Health Boards thresholds in their decision-making practices, not all of them reported to use them. A few health visitors, for instance, argued that the allocation of families' needs based on the number of their unmet needs was ineffective. The quote below is indicative of this view:

HV5: "...So say, for example, like a mum that's got postnatal depression...because there's only one health need for that family then they don't actually fit that additional criteria, they should be core. So they should only be getting the core visiting pathway but then if you've got a mum with postnatal depression, we know all the evidence behind the postnatal depression that they need a lot of input, they need the early intervention, there's all this to...for that bond and interaction...and if they've only got one issue then they should be down as core rather than down as additional..."

The preceding quote highlights that Health Boards criteria were considered problematic because decisions on whether families needed extra support depended on the number of their unmet needs, rather than the nature of these. For example, it was argued that the identification of only one unmet need in a family, such as maternal post-natal depression, might have been severe enough for the family to require additional support and hence be allocated as "additional/vulnerable", instead of "core". This, however, was reported to not be in line with the relevant localized guidelines. As a result, the support provided to families was not good enough because it did not effectively help them meet their potential unmet needs nor provide the individualized support they needed. These views stress the significance of developing a unified framework among Scottish Health Boards that will adopt more personalised criteria and allow families to receive extra support based of the nature of their unmet needs, rather than the number of these. Once again, similarities between this issue and the findings of policy document analysis explored in Chapter 5 are evident.

7.3.3. Experiential knowledge

Another factor acting as a decision-making threshold for health visitors was reported to be their intuitive skills. In this sub-theme, I explore participants' views of employing their own experiential knowledge, which reportedly constituted an element of their professional judgement, so as to decide on the level of support families required. Chapter

5 also discussed the role of professional judgement in decision-making but not of experiential knowledge.

In regards to experiential knowledge, it was mentioned by many health visitors that they employed their intuitive feelings to decide whether families required extra support, particularly in the cases where they were in doubt. Participants used the terms "...gut feeling...", "...uneasy feeling..." or "...gut instinct..." to describe their impression of families' needs when or after delivering a home visit.

HV2: "...but I think if they're...if you've got a...if there's a gut feeling then there'll be an issue..."

HV3: "...There are other times that I've been out to houses that I just get a very uneasy feeling when I'm in the house and I don't necessarily know why I've got that feeling but I've learnt to trust it because it's usually right..."

HV5: "...So my gut instinct was saying, I really want to visit this family. I really want to visit them. I really want to do something, but the mum and dad had done everything that was needed to be done at that point in time. They'd attended all the health appointments. We'd managed to get them [children] to nursery. They'd done everything so there was really nothing else for me to do..."

Practitioners provided examples of incidents, where they were inclined to allocate a family into the "additional/vulnerable" HPI category without conscious reasoning for doing so. They rather characterised their decision as a hunch which acted as an element of judgement and led them reflect on families' needs. In one case in particular, the attribute of experiential knowledge was considered so impulsive by one health visitor that led her deliver additional home visits to the family, even though no unmet needs were identified. Considering the significant role of experiential knowledge in health visitors' decision-making practices, greater exploration of the way it builds up could provide insights into whether and how developing experiential knowledge could be taught and on its role in assessment forms.

Interestingly, a correlation was identified between health visitors' development of experiential knowledge in their decision-making practices and their working experience. Unlike training programmes, experiential knowledge seems to develop through practice and experience. Almost all of the health visitors who reported to rely on their experiential knowledge in assessing families' needs were experienced professionals (with more than ten years of working experience) in the health visiting field. In only two cases, the role of experiential knowledge was reported to be considered key by two participants of either mid-level (with less than five years of working experience) or low-level experience (with less than three years of working experience). For the low-level experienced participant though, it was explained that she had been employed as a social worker for more than

a decade prior to working in the health visiting sector. Participants' responses suggest that experiential knowledge was indeed a good enough factor to be incorporated in the formal assessment forms, which is currently missing from GIRFEC NPM and the health visiting forms. Future directions in assessments of families' needs should also provide opportunities for health visitors to report their own intuitive concerns and also encourage the collaboration of professionals of mixed experience, such as through consultation meetings.

7.3.4. *Theme summary*

Health visitors explained that they provided the minimum standard of service to all families but also additional support to some families, when needed. During the interviews, they discussed their decision-making thresholds on assessing families' unmet/met needs and how they decided on their level of support required. Their responses highlighted the existence of a tension between standardization and professional judgement, which this theme explores. Three key decision-making thresholds were evident in health visitors' responses, which refer to: i) the centralized GIRFEC National Practice Model and the health visiting standardization assessment forms, ii) the localized Health Boards standards, and iii) health visitors' experiential knowledge.

Health visitors' decision-making thresholds emphasized that the GIRFEC introduction has impacted on these practices but also helped to shed light to some of the challenges in the service. In terms of the national standardized assessment forms, their responses highlighted the need to keep on using them in families' assessments due to their effectiveness. The use of these forms was considered effective by many health visitors because it assisted them in their multi-agency assessments, it encouraged the documentation of children's developmental stages and/or achievements and the relationship-building between health visitors and parents. The view that these forms were not particularly useful due to their prescriptive and dehumanizing nature was also expressed by some participants. Overall, the need for greater opportunities for more individualization of children within the forms were highlighted.

In terms of the localized standards, the reported localized differentiation on the decision-making thresholds among Health Boards created inconsistency and hence seamlessness problems within health visiting and among children's services. Additionally, localized standards were considered too rigid with too much emphasis given to the number of the unmet needs, rather than to their nature. This system reportedly failed to provide individualized support and effectively support families posing the preventive nature of GIRFEC in doubt. Health visitors' responses stressed the need for the development of a universal framework among Scottish Health Boards that will adopt more personalised criteria.

Finally, health visitors also reported to employ their experiential knowledge in their assessments, which highlights the need for the relevant assessment forms to develop opportunities for health visitors to evidence their own intuitive concerns in them.

8. Parents' findings: Perspectives and experiences of receiving GIRFEC through the health visiting service

8.1. Introduction

In this Chapter, the findings of the qualitative analysis of the data collected by the parents participating in the two focus groups are presented. These findings describe parents' views on the way the *Getting it Right for Every Child*⁴⁰ (Scottish Government 2020b) principles were implemented at the ground-level through the health visiting service, highlighting the challenges of this implementation. Three broad themes, 'Receiving the health visiting service: Expectations vs. Reality', 'Working in partnership: Communication and inclusivity challenges' and 'Meeting parents' needs: Balancing parental autonomy and regulation' developed from the data collected by parents, within which eight sub-themes developed.

The first theme 'Receiving the health visiting service: Expectations vs. Reality' describes parents' views of an existing gap between their expectations and reality in regards to receiving health visiting in the post-GIRFEC era. Parents' responses indicate that the service was not delivered as suggested in the *Universal Health Visiting Pathway in Scotland: Pre-Birth to Pre-School*⁴¹ (Scottish Government 2015) and the GIRFEC guidelines but rather in variability. The second theme 'Working in partnership: Communication and inclusivity challenges' explores parents' views of the challenges that hindered seamless collaboration of children's services and families in the post-GIRFEC era, highlighting the existence of communication and inclusivity problems. The third theme 'Meeting parents' needs: Balancing parental autonomy and regulation' examines parents' views that, for their needs to be fully met, greater parental autonomy as well as regulatory practices were required for all families; however, greater regulatory practices but less autonomy were needed for parents of child protection concerns. Table 11. presents the relevant themes and sub-themes in greater detail.

⁴⁰ (GIRFEC hereafter)

⁴¹ (UP hereafter)

Table 12. Themes and sub-themes of parents' findings

Themes	Sub-themes	Description
Receiving the health visiting service: Expectations vs. Reality	<ul style="list-style-type: none"> Lacking universality: Getting it Right for some children 	The perception that the health visiting service was not universal nor preventive enough due to being delivered in variability.
	<ul style="list-style-type: none"> Unsatisfactory relationships: Health visiting substitutes 	The perception that service variability created unsatisfactory relationships between parents and health visitors leading parents to seek support from other services, or else health visiting substitutes, to have their needs met.
Working in partnership: Communication and inclusivity challenges	<ul style="list-style-type: none"> Multi-agency meetings: Coordination challenges 	The view that communication challenges existed in the GIRFEC-introduced multi-agency meetings imposed by the lack of clear coordination.
	<ul style="list-style-type: none"> Children on the margin 	The view that professionals, including health visitors, did not employ child-centred approaches in their practices, highlighting the existence of inclusivity and seamlessness problems.
Meeting parents' needs: Balancing parental autonomy and regulation	<ul style="list-style-type: none"> Regulation: In need of more, universal home visits 	Parents' perceptions that they preferred greater regulation in the post-GIRFEC era by being offered more frequent and a greater number of home visits.
	<ul style="list-style-type: none"> Parental autonomy: Health visiting outside the home 	Parents' views that they preferred greater parental autonomy in the post-GIRFEC era by being offered opportunities to receive the service outside the home environment, such as in parents' groups and Health Centres.
	<ul style="list-style-type: none"> Decision-making thresholds: Standardization over professional judgement 	The view that parents preferred greater regulation by health visitors through the use of standardized assessment forms, which needed however to be less prescribed.
	<ul style="list-style-type: none"> Child protection concerns: Actions on parents 	The view that, in light of child protection concerns, the statutory regulation practices should minimize parents' autonomy by allowing services to share their concerns and

8.2. Receiving the health visiting service: Expectations vs. Reality

During the focus groups, parents discussed their own experiences and perspectives of the way the GIRFEC principles were implemented through the delivery of health visiting. It needs to be clarified that, during the focus group discussions, none of the participating parents specifically mentioned GIRFEC nor the UP in particular; however, there was a shared understanding in both focus groups that a particular number of home visits was expected to be offered to all families at appointed times. As such, parents discussed the particular times health visitors were expected to visit them. This theme explores parents' views of an existing gap between their expectations and reality in regards to receiving health visiting in the post-GIRFEC era. Parents' responses indicate that the service was not delivered in line with the UP and the GIRFEC guidelines but rather in variability.

This service variability, which signified a service being under strain, was reported to have led to two main negative outcomes for parents and their relationships with health visitors. Firstly, the service was reportedly not universal nor preventive enough, despite the intended universal nature of GIRFEC and UP. Secondly, service variability was reported to have led parents develop mixed feelings about the service; feelings of being left behind or feelings of being a burden. In any case, this variability was reported to negatively impact on the health visiting relationship between parents and health visitors, by reducing parents' help-seeking ability from the health visiting service. Instead of looking for help from health visiting, parents reported to refer to other forms of support, acting as health visiting substitutes. These two main reported outcomes of service variability have been explored as separate sub-themes, the exploration of which follows.

8.2.1. Lacking universality: Getting it Right for some children

This sub-theme describes parents' views that the health visiting service was not universal nor preventive enough due to being delivered in variability. This finding also came up from policy document analysis in Chapter 5 and health visitors' findings in Chapter 6. As will be further explored in the discussion Chapter 9 though, the reasons for this differed among the data sources. Variability was identified by parents in both the service delivery and the information provided to them on what the service entailed. In the case of health visitors though, variability was reported to take place in the families receiving the service and the frequency of the contacts offered, as explained in Chapter 6.

Parents described various forms in the way health visiting was delivered and experienced. For example, many parents stated that there was variability in receiving

particular developmental reviews for their children at appointed times. The following quotes are indicative of this:

Mother 15: “We had a health visitor when he [referring to her son] was a baby and then she went off sick and we’ve never had a health visitor since, so I’ve only had a few visits, maybe two or three and then nothing at all...”

Mother 2: “We never...we had...honestly, I had her [health visitor] coming out like four times...”

Mother 4: “...Sometimes you...oh, sorry, I forgot my scales this time, I forgot my height chart this time and it’s like...she [referring to health visitor] says as she was coming out to weigh him [referring to son], and she went, oh, I forgot it, I’m sorry.”

Mother 6: “...and it [referring to assessment form] should be given to you with enough time to practise those things. Sometimes they’re not, sometimes they come out quite late, but because they’re [referring to health visitors] under pressure...”

The previous extracts make evident the inconsistency between parents’ expectations and the delivery of the service. Parents’ expectations included the delivery of particular developmental reviews at particular times in their child’s developmental stages as set out in the UP as well as receiving the relevant assessment forms in advance of the reviews. However, the service delivery was found to be disrupted by staff-related factors, such as, sickness and the absence of key equipment needed for home assessments. This indicates i) the existence of a service that was under strain, ii) the lack of staff capacity to appropriately deliver the service to *all* families as in UP, and iii) challenges in implementing early intervention strategies both in time and in identification of needs. All these three elements were also highlighted in health visitors’ findings explored in Chapter 6 and stress the existence of a system that was not in line with GIRFEC principles due to staff capacity problems.

Apart from variability in service delivery, variability was also reported to be experienced in the provision of information to parents regarding the service. Parents’ responses highlight the issue of inconsistent, insufficient or complete lack of information provided on what the service was and where it was delivered, particularly in the case of parents’ groups. Even though all the parents of both focus groups reported to have had received home visits by health visitors, none of the participants of the second focus group conducted in Site 1⁴² reported to have had received the service in the setting of a parents’ group. The parents of the focus group conducted in Site 2⁴³ only reported they regularly

⁴² The focus group of Site 1 was conducted at a third sector organisation which provides a range of services to young children and their families in Central Scotland.

⁴³ The focus group of Site 2 was conducted at a parents’ group taking place weekly at a Community Centre in Central Scotland.

received the service in the parents' group where interviews for this study were carried out.

Mother 6: "Yeah, we've only agreed I think to have Karina [the health visitor] come out [to parents' group]."

Mother 9: It's quite rare, isn't it, for somebody...

Mother 11: No, I think you're right, I think sometimes they [other parents] don't know..."

Mother 15: "...But I was told by another health visitor that if you're in a group, they are seeing families in a group, they [health visitors] wouldn't be doing any home visits. You know what I mean though. I'm happy to involve if I would know..."

These quotes suggest that receiving information about the service being delivered in parents' groups proved to be either lacking or inconsistent, as parents' responses indicate that they were informed on the matter via word of mouth. For one parent in particular, the provision of the service in parents' groups was considered as a substitute service for home visiting, something that was not reported by any of the other parents. This signifies the existence of a system lacking to effectively provide opportunities for universality and prevention by informing parents on the provision of the service; potentially leading them to perceive the service as neither supportive nor universal. For the service to be supportive, universal and preventive, greater and consistent information would be reportedly required to be offered to families on what the service was and how to access it.

Similar views in relation to receiving a variable and non-universal service were identified in the information provided to parents regarding the role and practices of health visitors, too. Some parents, for instance, stated that they were given insufficient and inaccurate information on the way families were assigned to their health visitor and on what their children's developmental reviews consisted of.

Mother 2: "...Because most of us are the same practice [Council], we do tend to have, depending what the kid's name is, it [being assigned a health visitor] goes by alphabetical order."

Mother 2: "They [health visitors] just appear."

Mother 4: They appear. After your midwife stops coming then the health visitors start coming.

Mother 5: They just come to your door and chap on your door. Hi, I'm the health visitor, come to see your baby."

The preceding quotes indicate that receiving the service "just happened" and was taken for granted as families reported to have been assigned to their health visitor on the sole basis of the relevant Council arrangements, irrespective of families' needs. Challenges were identified by parents in the provision of information regarding the process of service

delivery and on the developmental reviews in advance of the first home visit. This lack of a system providing sufficient and accurate information to all families i) set the universality, preventive nature and supportiveness of the service in doubt, and ii) could have led to a misunderstanding on health visitors' role, and potentially to perceiving the service as intrusive.

8.2.2. Unsatisfactory relationships: Health visiting substitutes

Service variability was also reported to negatively impact on the relationships between health visitors and parents. This sub-theme reflects parents' responses that service variability has created unsatisfactory relationships between health visitors and parents leading parents to seek support from other services, or else health visiting substitutes, to have their needs met. This issue also came up in the findings of the analysis of health visitors' responses in Chapter 6, where health visitors reported to be in fear that service variability would negatively impact on their relationship with families.

Even though the parents of both focus groups clarified that they were in need of support –either more or less occasionally- for their young children or themselves, the analysis of their responses highlighted the existence of mixed feelings between the parents of the two focus groups towards the service. The parents of one group reportedly developed feelings of abandonment whereas the parents of the second feelings of being a burden. Many parents participating in the focus group of Site 1⁴⁴ expressed the view, for example, that variability in service delivery, such as the lack of receiving home visits at appointed times in line with UP, resulted in feelings of abandonment and being forgotten by professionals, despite their need to receive support from them.

Mother 13: *“I had to chase them [referring to the health visitors] up...”*

Mother 1: *“...Instead of coming out to keep checking on you and that...”*

Mother 5: *They just leave you.*

Mother 1: *Yes.*

Mother 5: *You just get left.”*

Parents' responses in this case highlight that, on one hand, they required support, which the service could not meet, and that, on the other hand, they reportedly chased up and initiated contact with health visitors. Health visitors' practice of initiating contact with parents and delivering home visits at appointed times was perceived as important by participants, even though reportedly missing. The disruption of this basic function was

⁴⁴ The focus group of Site 1 was conducted at a third sector organisation which provides a range of services to young children and their families in Central Scotland.

found to lead to the disruption of the health visiting relationship between parents and health visitors, undermining parents' sense of these professionals as dependable.

Variability in the delivery of health visiting was found to not lead to feelings of abandonment for all the participating parents, though. Many parents of the focus group of Site 2⁴⁵, expressed feeling a burden to health visitors' workload by adding extra work to their already heavy schedule. There were some parents in this case who even suggested that service variability was necessary to "...take the pressure off..." these professionals. This means that, for these parents, not being offered the service at appointed times was necessary so as to prevent health practitioners from acquiring extra workload.

Mother 9: "...I think if it's your third child and you've like...you think that you've got mummyhood absolutely nailed, you shouldn't really have to have somebody if you don't need...because maybe you're taking up a resource that a first time mother might want or need..."

Mother 8: "...I kind of felt again I was taking the pressure off a wee bit that I could say to them [referring to health visitors], I'm in the surgery anyway, do you want to see her [referring to daughter] while I'm in? And that meant they weren't having to set aside time to come out to the house to do it then."

Mother 7: "I think I thought maybe there'll be a six month [review] or something, but then I wouldn't want to bother them [referring to health visitors] by phoning them up and asking for another visit round about then."

The extracts in this case indicate that the participants perceived health professionals as being under pressure and their workload as heavy. This reportedly led them i) not want to "...bother the health visitors..." in fear of being a burden to their workload, ii) receive the service in variability, that is, in the Health Centre rather than in the families' houses, or iii) not to receive the service at all in fear of using the support that other families might needed the most. This could be translated into parental willingness to adjust to professionals' suitability and adapt their behaviour to accommodate professionals' needs.

Inconsistency in the reported feelings between the parents of the two focus groups towards health visitors was evident, which could be attributed to the level of support the two groups of families required. The parents of the focus group of Site 1 reportedly were in need of extra, targeted support varying in the level of their needs; hence, they were receiving support from the third sector organization the focus group was conducted in. The parents of this focus group expressed feelings of abandonment by the service. On

⁴⁵ The focus group of Site 2 was conducted at a parents' group taking place weekly at a Community Centre in Central Scotland.

the other hand, the parents of the focus group of Site 2 were reported to be in need of the minimum standard of health visiting support and expressed feelings of being a burden to the service. The data collected from parents indicate that those who did not require extra support expressed greater understanding and sympathy for health visitors comparing to those in need of extra help. Parents in this sense put health visitors' work over their own needs exactly because they were not in need of additional help. On the contrary, the parents who reportedly needed support the most were less sympathetic towards health visitors and tended to criticize them for their "inability" to meet their needs. This implies that greater health visiting support needed to be directed towards families that were mostly in need.

More importantly, service variability was found to impact on the relationships between parents and health visitors in terms of parents' help-seeking ability from health visitors. Parents reported to look for alternatives of support to have their needs met due to the variable service. For example, many participants claimed to look for support in the Family Centre or from other parents of the parents' group they reported to attend whereas one parent reported to look for relevant information on the Internet.

NK: "Let's say that you have a child...a baby up to the age of five and you have concerns about the child's well-being and you're not sure what to do, who do you contact?"

Mother 4: Here [referring to the Family Centre].

Mother 5: Here.

Mother 1: Here.

Mother 2: Here.

Father 2: Here."

Mother 4: "...So here [Family Centre] is the best place than you've got your health visitor. Because as I keep saying this is your health visitor because they are so much more involved, they see Orlando [referring to son] five days a week and the last time a proper health visitor seen Orlando was over a year ago..."

Mother 11: "...we've [referring to the parents of the parents' group] got a group on WhatsApp, we've got questions of, oh, I've just put the wee one in a sleeping bag and it's really big, what did you do with the extra bit, and folk were like, oh, we just tucked it back..."

Mother 9: "...and then you have to wait quite a long time 'til you see somebody again, or Google it, I suppose."

These quotes reveal that not delivering the service in line with the UP, by not providing, for example, developmental reviews in families' houses at appointed times, created uncertainty about what parents could or could not expect from health practitioners. It was also reported to reduce parents' reliability on the health visiting system as well as parents' help-seeking ability from health visitors. Parents sought for alternative sources,

for substitutes of the health visiting service, so as to receive support and help and have their needs met.

8.2.3. Theme summary

Inconsistency between parents' expectations in receiving health visiting and service delivery in real-life was evident in the analysis of parents' responses, which was found to be the outcome of the service being under pressure. This inconsistency translated into service variability in i) particular developmental reviews not taking place at appointed times, and ii) in the provision of inaccurate and inconsistent information to families regarding the location, the process of service delivery as well as health visitors' role.

Parents' responses indicated that the UP and GIRFEC guidelines to reach out to each and every child were not implemented through the health visiting service. This was because the provision of the service was reported to be limited and narrow rather than universal and preventive. For the service to be universal and preventive, it was explained by participants that it needed to be delivered as set out in UP. Despite the austerity challenges of the 21st century, this required a greater number of health visitors to be recruited to relieve health visitors from their heavy workload. In addition, greater information regarding the service was reportedly required to be offered to all families.

Along with problems in the universal and preventive nature of the service, this theme also examines parents' views on the level of supportiveness they received from health visiting. Despite parents of both focus groups reporting that they recognised the importance of the service, service variability was found to have a different impact on the perceptions of parents between the two groups. For example, for most parents of the focus group of Site 1 conducted in a Family Centre, service variability translated into a feeling of being left alone by health visitors. For most parents of the focus group of Site 2 conducted in a parents' group, though, it led parents consider the service as being under pressure and resulted in parents' developing feelings of being a burden to health visitors' work responsibilities.

Irrespective of parents' feelings towards the service, service variability was reported to reduce parents' help-seeking ability from health visitors and led them to look elsewhere to have their needs met, such as, in Family Centres, parents' groups or the Internet. For the service to be supportive for parents, parents' help-seeking ability was required to alter by building relationships with health visitors. Greater involvement of health visitors in families' lives by providing the service in line with the relevant guidance could achieve greater relationship-building between parents and health visitors. These findings once again suggest that the recruitment and engagement of a greater number of workforce was imperative.

8.3. Working in partnership: Communication and inclusivity challenges

Parents also discussed the way joined-up activity took place in the post-GIRFEC era. This theme describes their views of the challenges hindering partnership working, highlighting the existence of communication and inclusivity problems. Communication challenges were reported to exist in conducting the GIRFEC-introduced multi-agency meetings due to lacking clear coordination. Findings from policy document analysis in Chapter 5 of this thesis also highlighted problems in the coordination of such meetings, having developed as a result of GIRFEC introduction. Parents also explained that inclusivity challenges existed in professionals' practices of not adopting child-centred approaches excluding, therefore, children. These limitations have been explored as separate sub-themes, which follow.

8.3.1. Multi-agency meetings: Coordinating challenges

During the focus groups, views were expressed on the way multi-agency meetings took place for parents and professionals in the post-GIRFEC era. Although I intended to explore the way the GIRFEC-introduced Team Around the Child multi-agency meetings (TACs hereafter) took place and were perceived by parents as a central feature of GIRFEC, it was only two parents in particular who reported to have had experience of attending TACs. One of the two clarified though, that this was from a work capacity as she was a police officer and was unable or unwilling to comment on the matter in greater detail. As a result, the data from one parent who expressed her own personal experiences of attending TACs were analysed and discussed in this sub-theme. Considering the significant role of TACs in understanding how partnership working was conducted after GIRFEC introduction, I felt that the data, even though limited and based on one parent only, were worth reporting on for the in-depth exploration of GIRFEC. This sub-theme therefore discusses one parent's responses on the challenges encountered in TACs, emphasizing issues in regards to coordination and, as a result, communication among professionals. The parent's responses imply that, even though a direction towards greater partnership working was evident, the multi-agency nature of GIRFEC was not fully implemented. However, as only one parent was able or willing to comment on such processes, the resulting discussion was very limited and, in line with qualitative research, cannot make claims for generalizability.

The participant clarified that, in light of concerns, TACs were initiated and consisted of parents and all the professionals supporting the family aiming to review, identify and plan actions to tackle any potential unmet needs. A move towards a less fragmented multi-agency framework was evident in the parent's responses:

Mother 5: "...and it's been since I had social work involvement because me and Martin had a fight. Obviously the police

got involved, the social work got involved and then obviously there was a Team Around the Child meeting...

This extract illustrates that multi-agency activity in the post-GIRFEC era was evident in the so-called TACs. These meetings were found to allow for various professionals involved in a family's life, such as health visitor, social worker, Family Centre staff members, *along with* the parent(s) of the family to meet up and discuss the relevant concern(s). In contrast with meetings where professionals only meet and discuss a family's concern, the parent in this case was also given the opportunity to attend these multi-agency meetings and contribute to the discussion, which highlighted the existence of seamlessness. However, whether the parent's views were being heard, documented and acted upon as well as the extent to which the parent had a say in the outcome of the meeting were not clear from her responses. Another issue in relation to the effectiveness of TACs also came up from this. It was reported from the parent that a TAC was arranged after a fight between her and her partner occurred. In this case, perhaps TACs took place too late stressing that the nature of these meetings may not have been preventive enough. This also implies that the universal framework of the state might have not been effective enough to enable professionals to identify concerns in families, even before parents had a fight. The issue that GIRFEC intervention is not preventive enough due to coming in too late in families' lives instead of dealing with the root causes of the problems was also stressed in health visitors' findings presented in Chapter 7 of the thesis. To overcome such challenges, greater policy direction needs to focus on the preventive nature of children's services universal framework.

Despite the reported move towards greater partnership working through the delivery of multi-agency TACs, problems hindering seamlessness were presented by the parent. It was highlighted, for instance, by the same participant that there was a "...lack of communication..." among services, as outlined in the quotations below:

Mother 5: "I think there's a lack of communication...when it comes to like it's only now that the social worker's in my life, that they are like putting their foot down and everybody is running to them whereas before when it was just me nobody listened. But now that the social worker is saying this needs done and this needs done now, the health visitors and such and such and they..."

Mother 5: "They [family centre of Site 1] arrange that [TACs]. The family centre arranged everything. They put it together, they messaged everybody and got all the dates, everybody's diaries together. Really they should have probably been my health visitor or something doing that."

In these extracts, multi-agency communication was described as being associated with coordination of services. The absence of effective coordination of multi-agency activity reportedly led to communication problems among services and thus to seamlessness

issues. As explained by the parent, better coordination of children's services had been recently accomplished by the family's social worker. It was, however, unclear whether this transition to better coordination was the result of GIRFEC introduction. According to the participant, the practice of assigning one particular service responsible for coordinating multi-agency activity was considered significant for effective partnership working. However, there was a reported inconsistency and confusion on the role and responsibilities of each service in regards to coordination. For example, even though the responsibility for coordinating multi-agency activity was reported to fall on the social worker, it was explained that the practicalities of organizing TACs, such as the venue, invites etc., were undertaken by a third sector organization. In this case, coordination of the overall multi-agency activity and coordination of TACs were reported to be conducted by two separate services, that is social work and a third sector organization, respectively. This could be particularly problematic for families receiving multi-agency support but not from a third sector organization, in which case there would be greater confusion among the services on whose responsibility organizing TACs would be. Such issues in regards to confusion over professionals' responsibility for coordinating multi-agency activity and the pragmatic realities concerning TACs were also discussed in the policy documents analysis in Chapter 5 of the thesis. The participant's responses stress the need for greater clarity to be attributed to the role and responsibilities of each service in partnership working, particularly in regards to coordination, so as to achieve greater seamlessness. It needs to be clarified, though, that this sub-theme was developed based on the analysis of the limited data of one particular parent-participant.

8.3.2. Children on the margin

A key tenet of GIRFEC is that professionals should have the child at the heart of their work. In this sub-theme, I describe parents' views on the marginalised role attributed to children by professionals, including health visitors, in the post-GIRFEC era, highlighting the existence of inclusivity problems. As a result, the GIRFEC principles of child-centeredness and partnership working were reportedly not implemented. As examined in the findings of policy document analysis in Chapter 5, children's marginalised role was also evident in the health visiting documents. Similar findings on the absence of child-centeredness were also presented by some health visitors in Chapter 6, too.

It was concluded from parents' accounts that health visitors did not sufficiently adopt a child-centred approach, where children were seen as experts of their own lives. This was reported to have negatively impacted on parents' perceptions towards the level of supportiveness of professionals and services. In the cases where children could verbally communicate their needs, some parents in particular discussed the need for their children's voices to be directly sought by their health visitor or other health professionals,

such as doctors, during their interactions. Only one participant described an incident where a professional, such as, a doctor, directly talked to the participant's child to seek the child's views.

Mother 4: "...And Jordan [the health visitor] came out and it was basically the new health visitor seen him once and it was like so how is Orlando [referring to son], oh he is standing there so why not ask Orlando? He is nearly three so speak to him. And see what he thinks instead of asking me. It's like you are here to support him so..."

Mother 5: "...He [referring to doctor] was so good with James [referring to son], he was talking to James, he wasn't talking to me, he was talking to James. Now when they [old Health Centre] were speaking they were always very much speaking to you and I never...every time I took him there."

These extracts reveal that professionals' practice of collecting children's views rarely occurred but was considered to be a greatly valuable and positive approach for parents. One parent in particular described an incident where the health visitor did not directly make questions to the child of the family about his health and wellbeing, but to his mother, even though the child had already developed his linguistic skills. This was perceived to be an ineffective and even rude practice. However, professionals' practice, including health visitors, of not interacting with older children so as to verbally collect their views could come as a result of health visitors' lacking in confidence or training to do so. More importantly, it could reflect professionals' mind-set on the way they viewed children themselves. Parents' responses indicate that greater training for professionals, through Continuing Professional Development programmes, for example, could enable them to adopt more child-centred practices and change their mind-set, and perhaps professional culture, on the way they viewed children. This could potentially achieve greater child-centeredness and partnership working.

It should be mentioned here that the parents of Site 2 in particular consisted of parents having children aged less than one year old, in which case children were unable to verbally communicate their needs and as such be given voice. Challenges on how professionals can "do" child-centeredness for babies and toddlers were also highlighted in the findings of policy document analysis in Chapter 5. For the cases where the children were very young, parents reported that *they* were their children's advocates and represented their very young children's views. However, due to their children's young age, they were unable to share their personal experiences on whether health visitors attempted to elicit children's views. Professionals relying on parents' accounts to report on their children's behaviour raises questions though on the level of parents' representativeness of their children's wellbeing, particularly in child protection cases, as

well as on the alternative state intervention methods that could be employed to collect data on babies' wellbeing.

8.3.3. *Theme summary*

Parents discussed the obstacles preventing the provision of seamless services to families in the post-GIRFEC era. These obstacles were found to include i) the lack of clear coordination and eventually communication among children's services, particularly during multi-agency meetings, and ii) the lack of adopting child-centred approaches, as part of partnership working.

In regards to the GIRFEC-introduced Team Around the Child multi-agency meetings (TACs), one parent only reported or was willing to report her own experiences from attending these meetings. The data collected and analysed on the exploration of TACs were therefore limited but significant for exploring the research aim of the study. A move towards greater partnership working was reported to be evident in the parent's responses. TACs, for example, reportedly allowed the parent to attend these and work with all professionals involved in their life, in light of concerns. However, ineffective communication was reported to take place among agencies, stemming from the lack of clarity on the specific roles and duties of each professional, particularly in relation to coordination of multi-agency activity and TACs. Such challenges identified by the parent in partnership working mirrored the insufficient state provisions to meet families' needs. Assigning the coordination of multi-agency activity to one particular agency or professional was valued by the parent. However, the development of a system of greater clarity on the role and duties of each service, particularly in regards to coordination of TACs, was reported to be missing but needed. This was perceived as significant for the development of a more supportive and seamless framework.

Along with problems in multi-agency meetings, issues in professionals delivering child-centeredness were also brought up during the focus groups. As a result of these, the GIRFEC principles of child-centeredness were reported to not be implemented. According to parents, children were found to be "lost in adults' world" because of the absence of a framework where professionals would be able collect their views on their experiences. Health visitors' practice of verbally collecting the views of very young children may constitute a challenging task considering that children of this age may have not yet fully developed their linguistic skills. Parents' accounts reveal, however, that professionals omitted to collect the views of children who were old enough to verbally communicate their needs. Instead, professionals were described as relying on the accounts of the children's parents even in the cases where children were of pre-school age. Perhaps this issue links with professionals' lacking training skills in eliciting young children's views, which implies the need for professionals to undertake relevant training. This could lead to a mind-set change and potentially a professional culture shift by familiarizing themselves with child-centred approaches.

8.4. Meeting parents' needs: Balancing parental autonomy and regulation

Parents also talked about what they found supportive and what required to be changed in the health visiting service of the post-GIRFEC era so as to better have their needs met. This theme explores their views on the oxymoron that, for their needs to be fully met, greater regulatory practices as well as greater parental autonomy were required for all families; however, greater regulatory practices but less autonomy were required for parents of child protection concerns.

In regards to regulatory practices, parents reported to need more frequent and a greater number of universal home visits at appointed times and the use of standardized assessment forms of wider-scope. In terms of parental autonomy, parents explained that they found opportunities to receive the service outside their home environment also very supportive. For example, parents reported to greatly value the provision of the service in parents' group and in Health Centres, which is currently missing in the post-GIRFEC era.

When it came to child protection concerns, however, parents showed their preference for a system that promoted regulatory practices *to* parents, rather than *with* parents; hence, minimizing parents' role and autonomy. This highlights their preference for a less collaborative relationship between parents and professionals in such cases. Their views in this case were in line with the GIRFEC principles, which encourage information to be shared among services without seeking parental consent nor informing parents in advance. Parents' preferences in relation to greater statutory regulation and parental autonomy have been explored as separate sub-themes, which follow.

8.4.1. Regulation: In need of more, universal home visits

In this sub-theme, I describe parents' perceptions that they valued the provision of home visits and preferred greater state regulation in the post-GIRFEC era and being offered more frequent and a greater number of home visits. In particular, there was a consensus among the parents of the two groups that receiving the service in their houses at appointed times was particularly beneficial, as described in the following quotes:

Mother 8: “...so for people that maybe aren't willing to phone or feel embarrassed to phone or don't have the confidence to phone if they think of...is that...does that mean that I'm not a good mum if I'm having to ask a question, knowing that someone'll be out at those points, give them an opportunity...”

Mother 14: “...how do you keep an eye on the vulnerable children if the health visitors and services aren't going to their households to see it...how do you intervene, how do you know what's happening to those children overall...”

The previous quotes suggest that the provision of home visits could promote equality by offering the same service to all. In this way, stigmatization of the families seeking help would be avoided. Offering health visiting in families' houses was also reported to constitute an early intervention and prevention practice by allowing for the identification of concerns, including child protection concerns. Findings from the analysis of health visitors' data presented in Chapter 7 also highlighted health visitors' preference for delivering home visiting due to constituting quality assessments, even though they explained they delivered drop-in clinics for expediency reasons. However, the underlying assumption that all families would be receptive of the home visits offered at appointed times is evident in parents' quotes. Even though the offer of support in the form of home visiting might be considered by parents to promote universality, the voluntary/compulsory nature of the service is not taken into account. Findings from policy document analysis presented in Chapter 5 also bring up this issue.

The need for greater state regulation was raised by *all* parents of both focus groups emphasizing that the more contacts offered by health visitors to parents in their houses, the more valuable and supportive the service.

Mother 11: "...I think four [home] visits after six months isn't very many, it's not...until they start school sort of..."

Mother 5: ".....Like I say, they [referring to health visitors] were going four weeks when James [referring to son] was only a baby without even seeing a health visitor...So, they [health visitors] need to be more supportive...from what I was telling them was going on in my head, they shouldn't have been leaving me for that long. They should have been coming out and checking up, and saying..."

Mother 1: Every week or something."

The previous extracts highlight that there was a demand for more home visits to be offered to all families in comparison to the number of visits the families had reported to be receiving. For the families requiring additional support from services, the need to be offered even more home visits comparing to families not requiring extra help was also expressed by parents. As described in Chapter 5, this is in line with the policy documents which encourage the provision of a number of universal visits to all families but there is also scope for additional visits to be delivered if needed.

A number of justifications were presented by parents on the reasons why a greater number and more frequent home visits was needed for all families. Some parents argued that receiving the service more frequently could lead health practitioners to form a more holistic assessment on families' needs and identify potential concerns early. Some parents also stressed that, during the first few months of a child's life, several changes in children's development take place, which parents require information, guidance and

reassurance for. One of the parents questioned the absence of a 6-month review in particular.

Mother 9: "Imagine if something happened to the baby and everybody was like, oh well, why didn't you catch it, so it goes both ways, I suppose."

Mother 7: "...but now it's like it goes from four to eight months, and there's going to be a lot of things that will come up then with the starting weaning, I think I thought maybe there'll be a six month or something...."

Mother 6: "...I think it would be more reassuring if there were a few more visits around that time.

Mother 8: It's an important time."

Mother 6: "...and sometimes you'll forget things that you were going to ask, you might have a list of things that you want to ask and maybe not get through them all or forget to ask anything, because you've had to wait such a long period of time between visits, sometimes you'll have forgotten what you were concerned about."

The parents in this case explained that the greater provision of home visits was perceived as supportive and effective both in assessing families' needs and in providing greater reassurance to them, particularly during the first months of their baby's life. This reportedly allowed for the delivery of more effective assessments to take place, which the delivery of one-off, "slice" visits could not offer. It was also considered significant for parents in seeking information and asking questions, which they might forget when sporadically receiving the service. Findings from the analysis of policy documents in Chapter 5 also highlighted the need for the provision of more intensive home visiting but from the second year onwards in a child's life. The analysis of health visitors' data discussed in Chapter 7, on the other hand, highlighted health visitors' preference for intensive home visiting to be provided during the first year of a baby's life for first-time parents only, rather than to all parents.

8.4.2. Parental autonomy: Health visiting outside the home

There was a consensus among parents that it would be preferable for the health visiting service to be delivered outside families' houses, too. This sub-theme describes parents' views that they preferred greater parental autonomy in the post-GIRFEC era by being offered opportunities to receive the service outside the home environment. Findings of the analysis of health visitors' views discussed in chapter 6 also stressed health visitors' preference for offering the service in Health Centres due to practical reasons rather than constituting quality assessments. Many parents expressed the view that receiving the service in drop-in clinics in the Health Centres and in parents' groups was perceived as

supportive and effective. In the case of the drop-in clinics, parents suggested that they should be re-introduced as they are currently missing in the post-GIRFEC era.

- Mother 6: "I think the only other thing that everyone I know wanted to be back was the drop in clinics...and it's [drop-in clinic] something social as well..."*
- Mother 1: "...I think there should be a health visitor drop in like where parents, if they're concerned about their child, you should be able to be sent here."*
- Mother 11: "And then you're taking it [the concern/disagreement with the health visitor] on whether you've got a support network, whether you could root we'd like to say oh, have you noticed anything about that, because they've [referring to health visitors] said this, and getting feedback from here, but if you were all secluded and didn't maybe attend stuff like that [parents' groups]..."*

Parental responses highlighted the need for i) greater opportunities to receive the service in parents' groups, and ii) the re-introduction of drop-in clinics in the Health Centres in the post-GIRFEC era. Participants agreed that by receiving the service in places outside the home, they were offered opportunities to develop a support network by meeting up and developing relationships with other parents. In other words, participating in a support network would provide opportunities for parents to socialize, support one another, discuss any child-related or parenthood issues and share concerns. This also came up from the analysis of health visitors' data explored in Chapter 6.

Apart from opportunities for support networking, parents also showed their preference for receiving the service outside their home environment due to their level of availability and responsiveness comparing to home visiting. This issue was brought up by many parents I talked with and was also perceived as greatly valuable and supportive.

- Mother 6: "...coz I think they [referring to parents] felt that the drop-in clinic was really impulsive. To be able to have somebody that you can just go to with...you think this is silly questions...And Karina [the health visitor] is a massive draw to this [parents'] group...because she comes here almost every week..."*
- Mother 11: "And then all those questions come up [in parents' groups], when you're sitting there and you're doing something, you're like, there's this wee mark, oh, can you [referring to the health visitor] just have a look at that for me, and you're there and you can do it instantly, and it's...but just having that instantness."*
- Mother 5: "And things got done (referring to a particular health visitor)."*

The preceding quotes illustrate parents' views that the provision of the service in parents' groups and Health Centres encouraged them to regularly meet the health visitor, have the opportunity to ask any questions and have their babies' health examined. The two attributes of availability and responsiveness were reported to be key in the delivery of the service outside the home environment. Service availability reportedly referred to parents' perceptions of the service being easily accessible and approachable and constituting a "door's always open" service by being offered on a weekly basis to all families, for example. Service responsiveness was reported to refer i) to the willingness of health visitors to take actions to meet parents' needs, such as by providing advice and recommendations, but also ii) to the "...instantness..." through which actions were taken. The attribute of "quickness" was also highlighted by health visitors in Chapter 6 as an advantage of offering the service in Health Centres.

However, the parents attending the parents' group in particular also discussed the existence of challenges in relation to receiving the service there, as presented below:

Mother 14: "...I mean I drive here and whatever and pay to come to this but there would be mums who couldn't drive here. Just for the five of us that could move to come here..."

Mother 11: "But sometimes it's hard, I think, for a new mum to come to a group sometimes, just getting that initial...get them into the group at the start..."

Mother 11: "...quite a lot of groups like this would be perceived as cliquy."

Mother 9: It's really not."

These quotes highlight the practical and personal challenges parents may face in joining parents' groups and receiving the service there. As parents explained, joining a parents' group might be challenging due to the location of the group, including transportation limitations or might even be perceived as "...cliquy...", that is, offered to exclusive parents. Considering the challenges that parents reported to face in joining such groups, questions are raised on the efficiency of the currently employed post-GIRFEC statutory approaches aiming to overcome these by encouraging parents' initiation into such groups.

8.4.3. Decision-making thresholds: Standardization over professional judgement

Parents also discussed the way health visitors assessed their needs and decided on the level of support they required. In this sub-theme, I explore parents' reported preference for regulatory practices in their interactions with health visitors, particularly in the use of assessment forms, which reportedly needed, however, to be less prescribed for the service to be supportive. The tension between standardisation and professional

judgement was also explored in Chapters 5 and 7, which presented the findings of the policy document analysis and health visitors' responses respectively.

The benefits of using standardized assessment forms were reported by many parents to be associated with opportunities for documentation of children's progress and/or delays in their development and wellbeing. This was also reported by health visitors, as discussed in their findings on Chapter 7. The extracts below are indicative of this:

Mother 9: "...but it's more just because I think for her, when she [referring to daughter] grows up, she's going to ask me like when did I do this, when did I do that, and then it'll be like, oh, here you go. [laughs] That's when you did it, so it's...as long as you know you're doing okay, I think that's..."

Mother 4: "...but she [referring to the health visitor] didn't even mark it down, she wrote it down on a scrap bit of paper and never put it into his [referring to son] book. I was like, how did that...why take his height and his weight and put it on a scrap of paper that's just going to get tipped off the Table and into the bin probably."

Mother 7: "...when I was pregnant we were always seeing a different practitioner, a different pregnant appointment with someone else. They'd all feel my belly but differently, say something different and you're saying well actually what's going on. At one point they told me the baby could be breech but then the next time it was like well, no. I think there's no system..."

The key issues raised from parents' responses are threefold here. Firstly, documentation in the form of standardized tools was reported to lead to the strengthening of relationships among the family members by sharing children's developmental progress or difficulties. Secondly, the use of these official forms was found to provide reassurance and credibility to parents in terms of their parenting skills. Thirdly, the use of such forms was also considered beneficial in the delivery of health visiting thanks to enabling consistency of the assessment outcomes of families' needs, which the absence of such forms could not provide. Omitting to use such forms was negatively perceived by parents as it reflected a lack of faith in the whole health visiting system and health visitors and also disrupted the establishment of relationships between parents and professionals.

Even though the use of standardized tools was positively perceived by many parents, some key limitations were also identified. For instance, the narrow-scope of the standardized assessment forms was described as problematic in assessing families' needs, based on some parents. The need for an assessment form of a wider scope, allowing for information for both the child and parent's health and wellbeing to be documented, was raised by parents.

Mother 5: "...But I feel from a health visitor's point of view, what you were saying earlier on, the assessment, like an assessment sheet or something, I feel that that would be beneficial but like it would need to be like a wide scope. It can't just be like...so...but not for the child, for the adult because I think parental well-being is so...it's not much more...it's not more than children because your children's needs...but see if you're not well...

Mother 4: Aye. In the right frame of mind.

Mother 5: ...in the head, you can't be the best parent for your child."

The previous extracts show that parents did consider the use of official assessment forms as supportive in identifying families' needs. However, their responses stress that opportunities to incorporate information on parental health and wellbeing in these forms would be perceived as even more supportive. Considering that the GIRFEC Wellbeing wheel, or else the SHANARRI wheel, consists of eight general wellbeing "domains" referring to the wellbeing of the child and the parent (Scottish Government 2020f), parents' responses indicate that they were not familiar with or completely understood this GIRFEC form.

Despite the apparent agreement that the use of official documentation by health visitors was preferred and considered effective in identifying and meeting families' needs, there were few parents stressing the challenge for children to meet particular criteria prescribed in these forms. In particular, some of the developmental milestones in the standardized forms which were expected to be met by the children were considered demanding by few parents. Employing more personalised assessments for the identification of families' needs, such as, via discussions between health visitors and parents, were reported to be preferable by these participants.

Mother 2: "You ken the amount of times that I had someone say to me, she should be sitting up by herself. Well, I'm trying. Oh because, she's just too lazy to do it. She was 11 months old and two years later she started crawling. And now you look at her and you'd never think she was that wean. But then that's just because how she was.

Mother 1: You actually came to me and said, I'm worried because Julie was walking and I told you the same, every child is different, completely different.

Mother 2: I thought that was a bad thing."

Mother 5: "...how are you, are you still thinking that this? How's your baby?...Do you know what I mean? It's just sometimes it's just a case of sitting and talking to somebody. It's fine."

Parents' accounts indicate that they were inclined to show resistance to the use of standardized assessment forms and perceived the provision of a more relational approach as more supportive comparing to the completion of assessment forms during

contacts. This was because the provision of a professional to talk to and raise concerns was considered more significant than filling in forms. Parents reported to consider the standardized assessment forms as statutory checklists enforcing particular desirable behaviours for children and diminishing those considered as undesirable. Findings from policy document analysis and health visitors' responses also stressed this issue discussed in Chapters 5 and 7 respectively. More importantly, the use of these forms was reported to lead parents to i) feelings of anxiety and fear of being judged for their parenting capacity when not meeting the desirable criteria of the forms, and ii) being under pressure to ensure their children would meet the standardized criteria of the forms. Pressure being put on parents was evident in their accounts of making comparisons between their child's and other children's behaviour of the same age as theirs so as to identify whether there were any delays in their children's developments. However, the use of these forms might have been irrelevant to parents' practice of comparing their children's behaviours to others as this practice could occur even without the use of these. Meeting the standards of assessments forms raises questions as to where the defining line between parenting style actions and child wellbeing or child protection concerns is and how it can be defined. Additionally, questions are also raised as to whether or not opportunities for parents to discuss on the matter with their health visitors were presented and, most importantly, whether they were given the opportunity to express their point of view on the matter either orally or in written.

8.4.4. Child protection concerns: Actions on parents

This sub-theme reflects parents' views that, in light of child protection concerns, the statutory regulation practices employed should minimize parents' autonomy by allowing services to share their concerns among them and intervene, without first seeking parental consent. Parents were therefore in support of actions taken *on* parents rather than along *with* parents in light of child protection concerns. Greater regulation and less parental autonomy was therefore suggested by parents when professionals identified child protection concerns.

All parents agreed that the identification of child protection concerns by professionals, including health visitors, must equal to the sharing of their concerns with other agencies, such as social workers, for which no parental consent would be required. Professionals' duty of care to safeguard children came over parental consent in this case. Perhaps, however, the fact that there were no objections to this unanimous view by parents stemmed from their potential fear of being negatively perceived by the rest of the parents in the group.

- Mother 7: "I can see why the mum would be annoyed about it, but I thought the health visitor's done the right thing [in sharing concerns], because the important thing is the child."*
- Mother 14: "...But I think with sharing information, if we don't watch our children, I guess they [social workers] do..."*
- Mother 1: "Why should she [the mother of the story] consent [in terms of the health visitor contacting the Social Work department after finding traces of drugs in the family's house]?...To give her the heads up if she's doing drugs?"*

The previous extracts suggest that parents prioritized health visitors' duty of care to protect and care for children comparing to parental rights to privacy; parental consent and approval to share information was considered unnecessary. The participants reported to value these regulatory provisions because they promoted children's safety. On the contrary, seeking parental consent was not preferred in such cases because it was considered a practice that would prepare the parents of the family on what was coming, and potentially lead them to deny the concern. Parents' responses are in line with the policy documents analysed for the purposes of this thesis and the GIRFEC principles, according to which parents will not be made aware of the nature of information shared among services "in exceptional circumstances, such as where there is a concern for a child's safety" (Scottish Government 2020d, n.p.). A challenge identified in this case, however, was on whether professionals could easily distinguish between a child protection concern and wellbeing concern within a family. In line with the guidance, in the first case parental consent would be not necessary whereas in the second case it would not. This could potentially lead professionals to confusion on the cases where parental consent must be and must not be sought. The potential for confusion among professionals and tensions between parents and health visitors on the shared information also came up in the findings from policy document analysis in Chapter 5 and health visitor's findings in Chapter 6, as a result of the unclear guidance.

Although none of the participants claimed that parental consent should be sought in light of child protection concerns, the view that parents should be informed on professionals' intentions to escalate their concerns was also expressed. This also came up as a finding in the analysis of health visitors' data in Chapter 7. One parent, for example, described a past experience she had and explained that not being informed on the initiation of multi-agency activity on time negatively impacted on her.

- Mother 4: "And I'd taken him [referring to son] up to see Dr Baird...because he had sickness and diarrhoea...But he had a red mark on his leg here, and they said to me at the hospital, how did he get this mark? I went, really, I don't know, I don't even ken why I'm here. They phoned the Social Services on me...because he had a red mark on his leg...I said, it could have been anything because he was*

really active, he used to kick everything...So why put me through this? Then all this anxiety and all the rest of it, to go on social works and for a little small red mark.”

This extract indicates that professionals not informing the participant on their decisions to take on statutory intervention practices was reported to cause parental anxiety and stress. The parent also reported that, after this incident, she was very alert and attempted to immediately report any health and wellbeing accidents of her child, such as injuries, to all the professionals involved in the family's life. Such practices were not therefore preferred. On the other hand, professionals' practice of informing and justifying to parents the reasons why child protection concerns were raised was described as necessary and as an example of good practice. More importantly, what was highlighted in this response was the issue that, even though parental consent was reported that it must not be sought when child protection concerns were identified, parents should still be informed on professionals' intentions to escalate their concerns. Although this practice is not in line with GIRFEC, it was reported to reflect greater collaborative intentions from the services' side and could also help to establish the ground for greater future partnership working between parents and professionals.

Parental consent was also discussed in relation to receiving multi-agency support, particularly in relation to multi-agency meetings. What was concluded from parents' responses was that, even though their consent was being sought so as to have their information shared, this was only superficially accomplished. For instance, some parents shared their own personal experiences of receiving multi-agency support by services. In doing so, they explained that their consent was being sought in written before attending multi-agency meetings to allow for information to be shared among services.

NK: “But how do you feel about information being shared about your child's wellbeing like among different professionals like let's say between the services, the social worker or someone else without you knowing about that?”

Mother 4: They do it all anyway. You have to sign and tick things to give your permission.

Father 2: Your permission.

NK: Oh, okay. So they ask for your consent.

Father 2: Aye.”

Parents' responses highlight that, in the cases where multi-agency support was provided to families, they claimed to “...have to sign...” the relevant consent forms. In any case, parents' responses set in doubt the level of parental autonomy as they were practically not being given an alternative in case they did not wish to consent. What was presented as a choice to parents essentially was not, which emphasized the power dynamic between services and parents' role. The fact that none of the parents reported to have

had refused to sign the relevant consent forms reflects the existence of a system legitimizing such compulsory approaches to gaining parents' views on the matter; such practices may be assisted through parental resistance towards such practices. The need for policy review on the way parental consent is sought and accomplished becomes imperative so as to enable greater supportiveness.

8.4.5. Theme summary

A paradoxical demand for a combination of greater regulation, or else state supervision, and greater parental autonomy in various forms was expressed by parents for the service to be more supportive. In the case of child protection concerns, however, a demand for greater regulation but less parental autonomy was perceived as the preferred practice by parents.

In terms of greater regulation practices, parents reported to prefer the delivery of more frequent and a greater number of universal home visits at appointed times. Parents described this practice as promoting the lack of stigmatization of families as well as the early identification of concerns by professionals. Offering additional home visits also reported to constitute a more preventive approach that would enable health visitors to form more holistic assessments on families' met/unmet needs. It was also explained that they offered valuable opportunities for themselves to receive information, advice and reassurance. Parents' responses therefore suggest that changes in health visiting, and therefore GIRFEC, needed to be introduced for the service to be more supportive by offering a greater in number and more frequent, home visits to all families.

Moreover, for the service to be more supportive, parents expressed their preference for greater parental autonomy. This referred to receiving the service outside the home environment, such as in parents' groups and Health Centres. This was reported to maximise opportunities for parents to establish a support network with other parents and to access a service of greater availability and responsiveness. These responses thus suggest that changes in the service should be made by encouraging greater opportunities to receive the service in parents' groups as well as by re-introducing drop-in clinics in Health Centres, which are currently missing in the post-GIRFEC era.

However, the changes suggested by parents for greater autonomy require greater workforce and resources. This means that for parents' needs to be fully met, a great number of staff and resources is needed. Against the context of austerity measures, however, the service not only has been inefficiently supported but even eviscerated. Efforts to initiate the GIRFEC policy in a time of financial restrictions without the necessary resources and staff capacity have been doomed to fail.

Parents also showed their preference for greater, regulative practices by being receptive of the use of assessment forms in the service delivery. Parents clarified, however, the need for less prescribed content within the forms. Providing opportunities for evidence and ensuring credibility and consistency in the assessment outcomes were reported by parents to be the benefits of using such forms. On the other hand, some of the limitations of using these were reported to involve parental anxiety and struggles for their children to meet the demanding criteria of the forms.

In the case of child protection concerns, parents reported that greater regulation practices and less parental autonomy would be required for the service to be more supportive. Greater regulation practices in this case referred to actions taken *to* parents rather working collaboratively with them. Parents' views are in line with the current GIRFEC changes, which allow services to share their concerns for a family without first seeking parental consent or informing them. Such practices, however, do not encourage the development of collaborative relationships between parents and professionals. More importantly, parents reported that their consent was sought in the cases of receiving multi-agency support to allow the sharing of information among services. However, parental consent was reported to be superficially rather than substantially sought as parents explained that they "...have to sign..." the forms. This stresses the need for the policy to re-examine the relationship between statutory provision and parents' role in child protection cases.

9. Discussion, Conclusion and Implications

9.1. Introduction

This study aimed to critically explore how the relevant Scottish Government documentation, health visitors, parents and young children describe and negotiate the potential tensions of the *Getting it Right for Every Child* (Scottish Government 2020b, n.p.) approach in offering:

- “The right help
- At the right time
- From the right people”

The previous Chapters 5, 6, 7 and 8 presented the research findings. This Chapter is organised around each research question, reflecting on the findings and the relevant literature in the context of *Getting it Right for Every Child*⁴⁶. In doing so, I will also reflect on the theoretical framework of the study and the way it applies to the Scottish context. Study limitations as well as recommendations for policy, practice and research are also described.

⁴⁶ (GIRFEC hereafter)

9.2. Research aim

This study has found that the health visiting service did not always offer the right help, at the right time, from the right professionals in NHS Forth Valley. As such, the GIRFEC framework was not implemented in line with the relevant policy documents, despite its intentions. Even though it was found that both health visitors and parents appreciated the health visiting practice, challenges in its design were found to prevent GIRFEC from being fully delivered in practice leading health visitors and parents to perceive the service as unsupportive. For example, the framework failed to include any information on the practicalities of delivering the GIRFEC principles, such as staff capacity, caseloads and staff training. In addition, some key aspects of the GIRFEC principles in relation to decision-making thresholds on needs assessments, record-keeping practices as well as the role of parental consent were unclear and 'blurred' within GIRFEC. As a result, professionals, including health visitors, were left ill-prepared and ill-equipped to fully meet policy expectations and deliver GIRFEC. For this reason, it would be imperative for the GIRFEC practicalities and some of its core foundations of partnership working and early intervention and prevention to be re-examined so as to be successfully delivered. However, it needs to be clarified that the study findings only represent one small area of Scotland and cannot be generalized across the country.

9.3. Research question 1

What are the thresholds between the provision of universal and targeted health visiting service?

Findings from all the data sources indicated that health visitors made decisions on families' needs and the level of support they required on the basis of: i) the use of centralised standardized assessment forms, ii) the local standards set by Health Boards, and iii) their experiential knowledge. More importantly, the common thread was the use of centralised standardized assessment forms, particularly the newly-introduced GIRFEC forms. Parents commented on the centralised assessment forms only implying that they perhaps were not familiar, aware or wanted to report on any of the other two decision-making criteria.

9.3.1. Centralised assessment forms

Findings indicated that health visitors made decisions on the level of support families required by using centralised assessment forms, which referred to the health visiting forms and the newly-introduced GIRFEC National Practice Model (NPM hereafter). This signified the symbiosis of multiple assessment forms in service delivery and underlined a move towards greater standardisation. Study findings highlighted that the use of such forms was considered to be important and preferred for various reasons, stressing the

need for their continuation in needs assessments. However, there were a number of challenges in their use, which had to be addressed and tackled. These included i) the overly prescriptive nature of the forms, and ii) the potential for intervening with parenting styles. Because these health visiting and GIRFEC-introduced forms have been developed nationally, this finding is significant in shaping professionals' work practice across Scotland.

Many health visitors spoke of the overall benefits in the use of centralised forms. Opportunities to document progress as well as delays or concerns regarding the health and wellbeing of children and/or parents were found to be provided when using these tools. Similar findings on the effectiveness of the use of assessment forms were also identified in other studies. For example, Sim et al (2013) found that the universal 30-month assessment was effective in helping health visitors identify language and social/emotional concerns of children. Similarly, the studies of Thompson et al (2013) and Williams (1997) found that standardized forms were indeed used by health visitors in their assessments and may have helped them with their professional judgement. Opportunities to document the assessment process were also identified to be useful when using the Lothian Child Concern Model in particular, according to the study of Hogg et al (2012). On the other hand, the study of McGlone et al (2016) came up with different findings as professionals struggled to reach to assessment outcomes using standardized forms –the Whooley questions, in particular- because they did not know how to use the information collected to decide on families' needs.

In addition, findings from health visitors stressed that these forms could offer opportunities to professionals to justify their choices, attributed greater credibility to the health visiting profession and encouraged the establishment of relationships between families and health visitors by initiating discussion. Similar findings were reported by Astbury, Shepherd and Cheyne (2016) who explored the processes that encouraged shared decision-making between health visitors and parents. Parents also reported to perceive these forms as significant due to encouraging the development of relationships between parents and their children, rather than professionals and parents. The forms reportedly allowed parents to share their children's developmental progress or potential difficulties with their children in the future. Another advantage of the standard forms, as found in health visitors' data, was that they enabled the establishment of a common set of thresholds between parents and health professionals. The data from parents also identified benefits in their use by attributing greater reassurance and credibility on their parenting skills and greater consistency to the assessment outcomes, too.

The challenges the use of these forms imposed were also evident in the study findings. For example, a key limitation of the forms identified in all the data sources referred to

their overly prescriptive nature. The policy document analysis, for example, indicated that children were described as being in a state of constantly requiring to progress, which was evident in the terminology used (“...doing well...”, “...success...”). More importantly, findings from the analysis of all the data sources highlighted that these forms left no space for children’s individuality. Children were viewed as being all the same having particular developmental stages they had to tick in the forms so as to “succeed”. As a result, the participating parents claimed that because the standards of the forms were too demanding, they developed feelings of anxiety and of being judged when not meeting all the criteria. Similar findings also came up in the study of Mitcheson and Cowley (2003), who found that possible distress can be caused to parents as a result of the use of the pre-determined questions of the Health Needs Assessment Tool (HNAT) in particular. In a similar line, Hogg et al (2012) stressed the need for the thresholds of the Lothian Child Concern Model to be less hard to reach.

The forms indirectly enforced children to reach the standards established and considered by the state as “ideal”, which could also interfere with the parenting style of parents. This was indicative of the controlling nature of the forms, where not being able to meet the prescribed standards translated into failure. The theoretical ideas of Foucault, which informed the present study, can help to better understand the relationship between the state and parents through this process of needs assessments. According to Foucault’s theory of Power (1977, 1979, 1982), the government attempts to lead the public to normalization of behaviours while those unable to follow the statutory directions are deemed to be “punished”. Under this theoretical prism, assessment forms can be of a controlling and disempowering nature because they constitute a set of statutory tools to use so as to assess whether families are in line with state expectations or derail from them, in which case greater statutory intervention would be provided. Similar findings came up in the studies of Appleton and Cowley (2004) and of Kendall (1993), who found that the use of assessment forms disempowered parents by limiting their participation in their interactions with health visitors and inhibited professional judgement. As described by Cowley and Houston (2003) who explored the impact of the use of the Health Needs Assessment Tool (HNAT) on ethnic communities in Great Britain, the use of these forms could be particularly problematic for families of various ethnic backgrounds and raises questions on whether parenting standards can holistically apply to all. Sorkhabi (2005), on the other hand, argued in her review that actions need to be taken to protect children, irrespective of their cultural background.

Some participating health visitors explained that, rather than focusing on the use of the forms per se, emphasis should be on the way these forms were completed by introducing a conversation-style assessment. Similar views were echoed in in the study of Houston

and Cowley (2002), which found that such forms –the so-called Field of Words assessment, in particular- were an empowering tool because they were expected to be completed by health visitors along with parents. Completing the forms collaboratively with parents could allow the transfer of power and control from health visitors to parents. In this sense, assessment forms can help professionals with their assessments instead of replacing “their ability to do their job” (Houston and Cowley 2002, p. 647).

Interestingly, the use of assessment forms was also identified as significant by some parents of this study, who stressed that *not* using these forms was perceived as a disadvantage because it reportedly signified their lack of faith in health visiting and prevented them from establishing relationships with their health visitors. While parents showed reported to value the use of such forms, they highlighted their preference for the development of less prescriptive and “...wider-scope...” forms, which will allow for information on the wellbeing of both the parent and the child to be documented. Considering that the GIRFEC SHANARRI wheel entails information on eight broad wellbeing “domains”, instead of posing particular questions, parents’ responses may signify that they were not aware or not familiar with this wider-scope form. Further research would be therefore useful in regards to parents’ views of the GIRFEC SHANARRI wheel, in particular.

9.3.2. *Health Boards standards*

In line with the principles of proportionate or progressive universalism (Institute of Health Equity 2020; Marmot 2010), findings from the analysis of policy documents and health visitors’ responses highlighted that health visitors also made decisions on families’ needs on the basis of the Scottish Health Boards standards, highlighting once again the encouragement of standardisation in decision-making. These Health Board thresholds were found to be pre-existing and to not have developed as a result of GIRFEC introduction. More importantly, study findings highlighted the existence of a gap between centralised and localized Health Boards’ standards, which was problematic for two main reasons. Firstly, because, according to the study findings, this gap created inconsistency and seamlessness challenges in decision-making within health visiting and across children’s services. Secondly, because these standards were found to be ineffective particularly for families requiring extra help as, according to the findings, they did not constitute an early identification and prevention approach. Even though these findings on the challenges imposed by Health Boards standards only reflect the data from a single case study of one small geographical area of Scotland, they may be applicable to other Health Boards that may also implement their own local standards. As such, this gap between centralised and local standards may exist in other Health Boards and may therefore pose challenges in GIRFEC implementation throughout the country.

In the case of health visiting, study findings highlighted that the Scottish Health Boards standards led to inconsistency on i) the categories health visitors classified families into based on the level of support they were assessed to require, and ii) the way health visitors assessed families' needs. In regards to the health visiting categories, findings from policy document analysis indicated that health visitors were expected to allocate families into the "core" or the "additional/vulnerable" Health Plan Indicator (HPI, hereafter) for families requiring the minimum standard of health visiting or extra, targeted support respectively. However, it was evident in the local documents analysed that the health visitors of the geographical area studied were also expected to employ the "vulnerable" HPI. This inconsistency on the HPI categories among Health Boards could create communication and transferability problems particularly for families moving from this Health Board to another, according to findings. Similar discrepancies between national and local aims in regards to family policies were also reported in the literature (Cairney and St Denny 2020; Cairney, St Denny and Matthews 2016) highlighting the existence of a UK system, where a national strategic agenda does exist, without interfering too much locally. Moreover, the labels used to describe the HPI categories used for families, such as "additional" or "vulnerable", could be stigmatizing for them. Interestingly, none of the participating parents reported to have been aware of or willing to share their own HPI allocation.

Inconsistency was also identified in health visitors' decision-making thresholds resulting from the Scottish Health Boards standards. As described in *Universal Health Visiting Pathway in Scotland: Pre-Birth to Pre-School*⁴⁷ (Scottish Government 2015), decisions on which category each family would be allocated into would depend on the *duration* of the additional support families would receive; families receiving single-agency or multi-agency additional, sustained support for more than three months, would be required to be allocated into the "additional" HPI. However, the analysis of health visitors' data highlighted that such decisions were made on the basis of both the *duration* of the provision of extra support to the family and the *number* of unmet needs identified in a family. This reportedly meant that the identification of two or more unmet needs in a family would instantly lead to the allocation of the family into the "additional/vulnerable" HPI, which was not identified in any of the policy documents analysed. This could imply that perhaps health visitors' perceptions reflected localized guidance, which was not included in the policy document analysis documentation of the present thesis. Such study findings indicate that shared decision-making thresholds among Health Boards, even

⁴⁷ UP hereafter

though missing, were needed to promote greater consistency and seamlessness within health visiting.

Apart from health visiting, lacking shared decision-making thresholds also came up from study findings in the case of children's services. For example, *A Guide to Getting it Right for Every Child* (Scottish Government 2012), which was intended for all professionals working with children and families, did not contain any information at all on the allocation of families into the "core" or the "additional/vulnerable" HPI. This was only reported in the health visiting documents implying that services other than health visiting, such as social care or education, could potentially be employing different categories and/or different decision-making thresholds (other than duration or number of unmet needs). Health Boards standards were thus not found to be problematic for health visiting only but for the effective partnership working among services. If each service developed its own decision-making thresholds and family classifications, effective partnership working, which is one of GIRFEC foundations, could never be achieved.

More importantly, Health Boards standards were found to be ineffective in helping health visitors identify the families in need of extra support. For example, study findings indicated that families might have not always received the support they eventually needed due to being allocated into a category that was not representative of their met/unmet needs. This was found to be the case because thresholds were based on the duration of support provided to families or the number of unmet needs rather than the *nature* of these, calling the preventive principles of health visiting into question. Another significant issue that came out from policy document analysis findings in particular was that health visiting was not preventive enough because it emphasised solely on the level of universal or targeted support so as to meet families' needs. In doing so, it ignored the root causes of problems, such as socioeconomic inequalities, injustice and poverty. For this reason, GIRFEC and similar policy initiatives may always be doomed to fail because, in spite of their "preventive" nature, they come into families' lives too late. Such findings underline the need for policy focus to be directed to the development of interventions aiming to tackle root challenges families face. In contrast with GIRFEC, such interventions could have the potential to be truly preventive and meet families' needs. Similar views have also been documented in the policy briefing of Cairney et al (2016), according to whom there is a government direction in the UK for targeted parenting programmes rather than extensive economic redistribution, which should have been the focus of governments.

9.3.3. *Experiential knowledge*

According to findings from the analysis of policy documents and health visitors' data, health visitors were found to conceptualise decision-making thresholds differently

depending on their experiential knowledge. Experiential knowledge referred to professionals' taking actions without conscious reasoning. Similar views were also echoed by health visitors in the literature. For example, in the study of Appleton (1994), health visitors talked about making use of their experiential knowledge in identifying vulnerable families. Similar views were identified in the study of Appleton and King (1997), too, who found that many nurses made use of their experiential knowledge when assessing families' needs but they were been forced to hide it.

According to study findings, health visitors' experiential knowledge was attributed to their working experience. This is because employing experiential knowledge in decision-making was expressed by more experienced participants who had worked for more than ten years in the field. These findings suggest that i) collaboration of professionals of mixed experience could potentially lead less experienced ones to develop their experiential knowledge and encourage the development of shared decision-making criteria, and ii) opportunities for professionals to document and justify their own intuitive indicators should be offered in the standardized forms.

9.4. Research question 2

In the context of early intervention and prevention, how is the balance between support and intrusion negotiated?

Information was identified and analysed in all the data sources on what factors were considered to be supportive, unsupportive and even intrusive within health visiting since the GIRFEC introduction. These were found to exist in three main areas of the service including: i) the frequency and number of home visits between health professionals and families, ii) the venue of the service delivery, and iii) the parental role in absence and in light of child protection concerns.

9.4.1. Frequency and number of home visits

In regards to the supportiveness of the service, study findings highlighted the existence of a distinctive gap between what the policy documents prescribed and what health visitors and parents reported to offer and receive respectively due to pragmatic challenges. Findings from policy document analysis stressed that more home visits to all families, particularly in the first year of a baby's life, were introduced in the GIRFEC era to constitute an early identification and prevention approach and to better support families. Despite this policy move though, findings from the analysis of both health visitors and parents' data highlighted that the service was not universal, preventive, nor supportive enough due to not being delivered in line with UP and GIRFEC.

Service variability was identified in participants' responses in regards to the families receiving the service and the frequency of home visits. This was found to be associated with health visitors not having been supported enough themselves by the state and within policy on how to deliver GIRFEC which resulted in the service being under strain. Such policy initiations "could work in theory" but require workforce that is effectively prepared and supported, as also highlighted by Cowley et al (2015, p. 15). In particular, Cowley et al (2015) conducted a scoping study and a narrative review and found that the new health visiting framework in England was rather aspirational because it required full staff capacity to be implemented. Study findings indicated that a key consequence of lacking staff was that health visitors were not involved in families' lives as expected and eventually led parents to seek support, when needed, from other services. This finding confirms findings of other studies indicating that greater attention should have been paid within policy on the way GIRFEC could be practically delivered at the ground-level. For example, according to the study of Adams and Craig (2007), health visitors' caseloads had been increasing over the past years, which prevented them from being available to all families. According to health visitors' findings, this lack of staff capacity led health visitors prioritise their services to families being assessed as requiring extra support or to first-time mothers. Delivering the service to those mostly in need due to lacking time

was also found in the study of Appleton and Cowley (2008), who explored the basic principles underpinning the health visiting assessment process in England. Such findings were also confirmed by mothers receiving the service in the study of Russell and Drennan (2007) arguing that the delivery of universal home visits was gradually disappearing.

Study findings stressed the need for the service to be delivered in line with the UP and GIRFEC, which would require sufficient workforce. Considering that a number of studies conducted in the UK have highlighted the significance of recruiting additional health visiting staff to effectively provide a quality service (Cowley, Dowling and Caan 2009; Cowley et al 2015), it is concerning that health visiting was found in this study findings to remain patchy, underdeveloped and left to face the same workforce challenges. Some studies, however, found that health visitors were not sufficiently supported to deliver their service due to lack of training, rather than staff capacity. The studies of Cummings and Whittaker (2016) and Cowley et al (2013), for example, found that health visitors were unable to appropriately deliver the service as prescribed due to lacking sufficient education and training skills.

For the service to be supportive, universal and preventive, findings from parents' data and policy document analysis indicated that a greater number and more frequent home visits were required to be delivered to all families. Findings from other studies (Brook and Salmon 2017) found that parents also welcomed the increase in their routine home visits. For the participating parents, this was found to be needed for all families having children from pre-birth to pre-school, irrespective of their parenting experience, so that they could be better supported. A number of justifications were provided on this including greater reassurance to first-time parents in particular and more frequent opportunities to ask advice and seek info from professionals. The duration and intensity of home visiting were also found to be significant in the literature due to mostly improving parenting and encouraging the early identification of risks through universal health visiting provision (Elkan et al 2001; Macleod and Nelson 2000) but particularly through targeted interventions for vulnerable families (Kirkpatrick et al 2007; McIntosh and Shute 2006; Olds et al 2002; Puura et al 2005; Stevens-Simons et al 2001). The need for the provision of more home visits was also stressed in the findings of policy document analysis but for the children aged from two to pre-school in particular because the home visits set out in the documents to be delivered during this time period were only three. This limited amount of visits was found to be problematic as it was based on the assumption that parents would reach out to their health visitors during this time period, if needed support, but ignored that parents may be unaware or feel reluctant to seek help.

For health visitors, on the other hand, different views were expressed in relation to the intensity of home visiting during the first year of a baby's life. According to findings from the analysis of their responses, intensive home visiting during the "...earlier days..." was supportive but required for inexperienced parents only because these parents were considered to need help with their parenting skills. Offering intensive home visiting to experienced parents in the first year of their child's life was perceived intrusive by almost all the health visitors I interviewed. This means that, for health visitors, changes needed to be made on the prescribed number and frequency of home visits as in GIRFEC and UP for experienced parents; less home visits would be required for them during the first year of their baby's life, even though this places the preventive nature of the service in doubt.

Overall, for the service to be supportive, universal and preventive, findings highlighted that i) health visitors needed to be better supported in delivering GIRFEC through the recruitment of more staff, for example, and ii) more intensive home visiting needed to be offered to all families, including children aged from two to preschool. Even though the findings on the intensity of home visiting reflect the limitations of GIRFEC at a national level, the findings on staff shortages may reflect the problems of GIRFEC implementation at a local, rather than national, level. In other words, problems in regards to staff capacity may not necessarily be representative of larger populations and other Health Boards. Nevertheless, these findings can still be used to inform national policy and practice.

9.4.2. Venue of service delivery

Data analysed in regards to the venue of the service delivery were also fruitful for the exploration of the supportiveness of the service. Within the policy documents, a move towards home visiting is evident. It is clarified in the UP, for example, that the service is encouraged to be offered to families' houses, unless potential concerns existed, in which case a different venue could be used. However, a gap between policy and practice was also evident in this case. Study findings stressed that i) health visitors did not deliver the service in families' houses, as set out in the policy documents, due to pragmatic realities, and ii) both health visitors and parents indicated their preference for a mixture of service delivery venues including families' houses and venues outside the home environment, such as in Health Centres and/or parents' groups.

While the UP is home-visiting based, health visitors' findings indicated that they were rarely able to deliver a fully home-based service due to staff constraints. As such, the service was reportedly delivered fully or partly in Health Centres for expediency reasons due to being a time-saving approach. Once again, this finding stresses the need for changes to be made in the health visiting framework, such as by recruiting additional

workforce, so that health visitors could be better supported in delivering domiciliary health visiting.

Study findings indicated health visitors and parents' preference for a combination of service delivery both in the home environment and in places outside of it, for different reasons in each case. Similar findings were reported in the studies of Donetto and Maben (2014) and Donetto et al (2013), which both explored parents' views of their experiences of receiving health visiting and concluded that both features should be available. In the case of home visits, health visitors highlighted that these were effective because they facilitated a more quality assessment compared to drop-in baby clinics in Health Centres and allowed professionals to identify risks early by observing behaviours, rather than asking questions which could be intrusive. This was also supported by parents, who argued that the provision of health visiting in families' houses encouraged early identification of concerns by professionals, adding that it also promoted greater equality and universality and reduced stigmatization for families seeking support. Findings from other studies which explored health visitors' views of health visiting (King 2016; Pettit 2008) also indicated their preference for visiting families' houses due to assisting them in assessing families' needs by observing the house environment. Similar views were also expressed by both health visitors and parents in the study of Worth and Hogg (2000), who found that home visits helped to build the health visitor-parent relationship. Home visits also offered opportunities for more personalised support to be offered to each family instead of a one-size-fits-all approach, which was reportedly the case in drop-in baby clinics.

In the case of delivering the service outside the home environment, study findings were also indicative of health visitors and parents' preference for greater parental autonomy by providing the service in Health Centres and parents' groups. Offering the service in Health Centres, even though not encouraged in the post-GIRFEC-era, was described by health visitors as a time-saving practice due to its "...quickness...", space efficiency and space control. It was also considered preferable because it offered opportunities for parents to develop support networks by socialising with other parents as well as opportunities for discussions over sensitive topics, such as domestic abuse. This last issue of "opening up" about potential risks or concerns is not in line with findings of other studies, though. Evidence from other studies (Chalmers and Luker 1991; Dixon et al 2005; Worth and Hogg 2000) found that it was more likely for parents to discuss such issues in relation to domestic violence, histories of abuse or mental health issues with their health visitor in their home environment.

Being offered opportunities for support networking as well as the issue of saving time in the case of Health Centres and parents' group were also found to be beneficial for

parents, too. Other studies (Donetto and Maben 2014; Russell and Drennan 2007) also found that parents valued opportunities for socialising and collective receipt of support through group activities outside the home environment when receiving the service. In addition, participating parents added that service delivery in such venues was supportive due to their level of availability, by being easily accessible and approachable, and their level of responsiveness in meeting families' needs. Their responses also indicated that the need for state provision would be necessary so that families could overcome practical and personal challenges in attending parents' groups or drop-in clinics, such as location and transportation problems and the possibility for new members to think of these groups as "...cliquey...".

Overall, for the service to be more supportive, findings from data analysis suggest i) the need for health visitors to be better supported in delivering home visits, ii) greater opportunities offered for parents across Scotland to receive the service in parents' groups, and iii) the need for the drop-in baby clinics, which are missing in the post-GIRFEC era, to be nationally re-introduced. The findings on health visiting to be offered in parents' groups and drop-in baby clinics echoed national challenges and changes needed in implementing GIRFEC. On the other hand, the findings on health visitors not delivering the service in families' houses, as in the national and local documents, may only reflect the staff capacity challenges of applying GIRFEC at a local level, which could also inform national policy and practice.

9.4.3. Parental role in light of concerns

The analysis of all the data highlighted that service intrusiveness was particularly evident in light of child protection concerns but also in wellbeing concerns. Intrusiveness was found to be associated with minimising parental role and the absence of collaborative relationships between parents and professionals. Similarly, greater collaborative practices employed between parents and professionals were found to make the service supportive. Even though the terms "wellbeing" and "child protection concerns" were not specifically defined in any of the data sources, it was implied that wellbeing concerns referred to any concerns on the holistic being of the child that did not pose an immediate threat to their wellbeing. Child protection concerns, on the other hand, were identified to refer to issues related to adversity and risk (Scottish Government 2012) and matters of abuse or neglect for health visitors and parents. Study findings indicated that changes needed to be made on the way state intervened nationally into families' lives in light of both child protection and wellbeing concerns to make the service supportive through the establishment of more collaborative relationships between professionals and parents in such cases.

In the case of child protection concerns, findings from health visitors' responses highlighted that this system was ineffective and problematic for parents because it allowed professionals to act "behind parents' back" and take actions *on* them rather than work with them. The absence of collaborative relationships between professionals and parents in child welfare cases also came up as a finding in the study of Kirkpatrick et al (2007, p. 42) stressing that vulnerable mothers felt that "if you didn't do as you were told" you might risk losing your baby. This was found to be evident in the information sharing practices encouraged within policy documents. As described in GIRFEC, the policy documents and by health visitors, in light of child protection concerns, professionals, including health visitors, were encouraged to escalate their concerns to other services without first seeking parental consent nor informing parents (Placement NHS Health Board 2018; Scottish Government 2020d).

However, according to findings from some health visitors, "...it's good practice..." to inform parents on the escalation of concerns, which was reportedly not in line with the guidelines, as it could potentially lead to more collaborative relationships between the two parties. Perhaps, informing parents in advance on professionals' intentions to escalate their concerns could constitute a more collaborative approach and mediate between the rights of the state to protect children from risk, in line with Article 19 of United Nations Convention on the Rights of the Child⁴⁸ (UNICEF 1989), and to respect the rights and duties of parents, in line with Article 5 of UNCRC (UNICEF 1989). Similar findings came up in the study of Chalmers (1994), according to which it was vital to directly bring up and discuss any welfare concerns identified, which the parent might have been avoiding. Interestingly, participating parents expressed a different viewpoint. Almost all of them were in support of such statutory practices minimizing parental role in child protection cases; one parent only argued that parents should be informed on professionals' intentions so as to avoid causing parental anxiety in cases where the concerns were not of child protection nature.

Interestingly, the absence of collaborative practices between parents and professionals was also identified when multi-agency activity was in place due to wellbeing concerns. Study findings highlighted that collaborative practices were only superficially employed between professionals and parents in light of wellbeing concerns. For example, policy document analysis concluded that, in light of wellbeing concerns, professionals were encouraged to collect evidence from other services, such as the Nursery, to develop more holistic assessments on children's and parents' wellbeing *after* gaining parental consent. *All* participating health visitors agreed on following these policy guidelines on

⁴⁸ UNCRC hereafter

this by seeking parental consent in such cases. However, findings from parents' responses called this "voluntary" nature of being sought their consent into question. Their responses highlighted that even in the cases where parental consent was sought this was only superficially accomplished as they reported to "...have to sign..." consent forms. There is also no information in the documents on what practices professionals would be expected to follow in the cases where parents did not consent to this. The study of Kellett and Apps (2009) found, for example, that information should be offered in a particular manner to non-cooperative parents that would encourage their trust and permission because it was challenging to gain their consent. The need for the policy to re-examine the meaning of consent and the way through which consent is sought was thus highlighted in these findings. As explained in Chapter 2, the tension between professionals sharing information to promote the wellbeing of children and young people, on one hand, and respecting the private and family life⁴⁹, on the other, could be addressed through parental consent. Besides, "health visiting is about balancing contradictions" (Pound 2013, p. 520).

Moreover, in the cases where multi-agency activity was initiated for wellbeing concerns, the regulatory practices were also found to not be of collaborative nature because parents were indirectly obliged to follow professionals' recommendations, according to health visitors' findings. Just as with the identification of child protection concerns, state interventions were found to take place *on* parents rather than *with* them, even in light of wellbeing concerns. Similar views were also echoed by the Institute of Health Visiting (2020b, p. 15), which found that working "with and not for, or to, people" should take place at all times in health visiting. These findings highlighted the existence of a system that left parents with no choice and forced them to comply with professionals' recommendations without focusing on their needs and the provision of individualised support. Perhaps, this is what Scott (1998, p. 90) referred to when distinguishing "support for parents" from "support for parenting"; even though both concepts were described to be interconnected, focus on supporting parents, rather than focusing solely on their parenting skills, has been ignored in the policy context. Several other studies concluded that parents appreciate it when their views are being listened to by providing very detailed accounts (Cowley et al 2004; Donetto et al 2013; Kendall 1993). Such findings stress the need for the health visiting service to encourage health visitors to use practices of greater collaborative nature in their interactions with parents and allow parents to have a greater role in these. In line with Bronfenbrenner's ecological systems theory (1979, 1986), though, which has informed the present study, the wellbeing of the child is impacted upon

⁴⁹ See, for example, Article 7 and 8 of the EU Charter of Fundamental Rights (European Commission 2000) and Article 8 of the European Convention of Human Rights (European Court on Human Rights 1948).

its immediate environment, such as parents, and distant environment, such as health visitors and the policy context. This means that for the health and wellbeing of a child to be promoted, the health and wellbeing of the individuals in the overall environment of the child need to be encouraged, too. The need to therefore provide individualised support to parents becomes of high priority.

The key issue identified in these study findings was the surveilling role of the state with the possibility of health visiting interfering with the parenting style of parents in light of child protection concerns. This could negatively impact on the relationships between health visitors and parents. Once again, the relationship of families and the state can be examined through the lens of the theory of Power of Foucault (1977, 1979) based on which health visiting can be seen as a system that encourages the surveillance of parents and reinforces particular norms for all families. Similar views of health visitors “policing” families were documented in other studies, mostly in light of child protection concerns. For example, Peckover (2002) found that there are tensions and complex relationships between mothers and health visitors in light of welfare concerns, which should be taken into account in policy and practice. Similar views were expressed by Abbott and Sapsford (1990, p. 144), who argued that mothers who are assessed as “inadequate” are eventually involved in intervention programmes so that they will become “good enough” mothers, even though some of them can show resistance in multiple ways. In the absence of concerns, though, the study of Machen (1996) found that the service was considered supportive rather than surveilling for first-time mothers, particularly when the service was parent-centred. In order to keep up with policy changes, though, greater and more recent primary studies are required to further explore the views of the “surveilling” role of health visitors, which have been strikingly absent particularly since 2000.

Overall, study findings indicate that for the service to be supportive in cases of child protection and wellbeing concerns, changes should be made. Firstly, findings from health visitors’ data stressed that greater collaborative practices between parents and professionals would be required in child protection, such as by informing parents on professionals’ intentions to share concerns. Such views were not in line with parents’ findings though, almost all of whom were in support of the current GIRFEC child protection practices on marginalising parents’ role. Secondly, findings from health visitors and parents’ responses also concluded that greater collaborative practices in the case of child wellbeing concerns should also be encouraged by empowering parents and reviewing the nature of parental consent.

9.5. Research question 3

In the context of partnership working, what are the facilitators and barriers in the delivery of integrated services?

All the data analysed highlighted the existence of various factors, in some instances encouraging but mostly preventing partnership working among children's services and families in the post-GIRFEC era. These facilitators and barriers were identified in information sharing practices, which involved guidance and electronic systems, and in multi-agency meetings, including coordination and professionals' attendance. Findings of each of these areas were examined separately, as follows.

9.5.1. Information sharing: Guidance ambiguity and electronic systems restrictions

The issue of information sharing practices was mostly evident in the findings of the analysis of policy documents and health visitors' data. The key facilitator promoting seamlessness of services in this case was associated with the encouragement of information sharing among professionals in the post-GIRFEC era in all cases. A consensus was apparent among participants on the significance of sharing information for the early identification of risks. However, this was found to have been limited by various factors that involved the policy guidelines. Two key barriers to effective partnership working were the lack of clarity on i) the kind of information that was expected to be shared among professionals, and ii) the record-keeping practices of services. According to the findings, these limitations derived from unclear national and local guidance and, as such, was problematic both at the national and local level.

A substantial barrier found to prevent partnership working was identified within GIRFEC and referred to the lack of clarity and absence of information on the "relevance" and "proportionality" of the information that could be shared. Study findings stressed that an operationalizing gap was thus created on the way professionals, including health visitors, could implement the policy guidelines. Health visitors explained that different understandings and expectations developed among professionals due to this guidance ambiguity, which could eventually lead to tensions among professionals and between professionals and parents. Challenges in developing an information sharing Code of Practice for professionals working with children and families were also highlighted by the Scottish Government⁵⁰, directing the focus into multi-agency training.

The challenge of finding a balance between confidentiality and the need for information sharing has also been documented in the literature (Atkinson et al 2007; Frost 2005) and, according to this study findings, it still remains to be addressed. For example, the

⁵⁰ See, for example, the Scottish Government response on Supreme Court's judgement regarding information sharing challenges that had to be addressed on Parts 4 and 5 of Children and Young People (Scotland) Act 2014 (Scottish Government 2019c).

review of Atkinson et al (2007) examining the different models of multi-agency activity concluded that confidentiality issues can prevent effective partnership working by inhibiting professionals from sharing information. This finding was also stressed in the review of Frost (2005), who examined the challenges of joined-up working, particularly in relation to child welfare. In his review, he concluded that issues around confidentiality and information sharing across children's services remained problematic and still remain to be solved.

Apart from the nature of information, lack of clarity was also evident in the case of record-keeping practices across services and within health visiting. For example, the GIRFEC NPM was developed to enable greater seamlessness of services by encouraging the use of the same "tools" by all professionals working with children. However, no information is provided in the national nor local documents on the way children's documentation were expected to be recorded by services, particularly for families receiving multi-agency support. Health visitors' responses shed greater light to this barrier by explaining that each service was using its own electronic system declining access to professionals of other services and preventing "clear channels of communication" (Atkinson et al 2007, p. 44). This signified the existence of a fragmented framework of various electronic systems working in isolation. As a result, accessibility and eventually communication challenges were reportedly posed, because services could not share information on families' needs among them nor communicate electronically. Not sharing information due to confidentiality and accessibility restrictions in record-keeping systems for professionals among children's services were also found to create conflicts among children's services in the qualitative study Robinson and Cottrell (2005) who investigated joined-up working in the four UK countries.

Such communication challenges were not only found to occur among the electronic systems of children's services but also in the MiDIS health visiting electronic system used across Scotland. . Despite data being collected by one small local geographical area of Scotland, they provided insights into the way health visitors electronically communicated and shared information with each other across Health Boards, which helps inform national policy and practice. Each Health Board was reportedly using its own MiDIS system, which caused inconsistency problems across all Health Boards. It remains to be seen whether the introduction of the new MORSE health visiting platform in 2020 might be more promising (Placement NHS Health Board 2018). Evidence (Baines, Wilson and Walsh 2010; Peckover, White and Hall 2008) suggests that the development of effective electronic platforms among Local Authorities and their partners can enable information sharing, even though some practitioners might not be receptive of using electronic platforms.

Overall, study findings indicated that changes needed to be made within the relevant national and local guidance to enable effective partnership working. This could be achieved by providing greater information and clarity on i) the kind of information professionals are to share among them with/without parental consent, and ii) the way professionals are to keep records of families and communicate electronically among them in cases of multi-agency activity. The need for the development of one universal electronic health visiting platform to be used across Scotland was also clear.

9.5.2. Multi-agency meetings: Coordination challenges and missing “multi-agency jigsaw puzzles”

Study findings highlighted a move towards greater partnership working through the introduction of the GIRFEC-introduced Team Around the Child multi-agency meetings (TACs, hereafter), which allowed parents’ attendance. Study findings stressed, however, that barriers were identified in multi-agency meetings, which prevented the seamlessness of children’s services. These challenges were found to exist due to missing the mechanics of coordinating activity due to unclear national and local guidance and because not all professionals and parents attended these meetings.

The relevant guidance was found to lack information on the way professionals were expected to “do” multi-agency activity, by including information on arranging the venue, inviting individuals, sending out invitations etc. The information in the documents was mostly focused on *what* GIRFEC entailed rather than *how* to “do” multi-agency. This lack of clarity was also conveyed by the only parent in this study who reported to have participated in TACs and who indicated that they greatly valued the coordination of multi-agency activity by one particular service. Parents valuing effective coordination of services and health visitors acting as a point of contact to other services was also a key finding in the study of Donetto et al (2013) who examined health visitors’ experiences of the health visiting service in England. However, as only one parent recounted such experiences, caution is required in reaching any conclusions. Lacking effective coordination was also identified as a key barrier in effective partnership working for a number of studies. The existence of coordination challenges in partnership working was also identified in the literature review of Sloper (2004) who examined the facilitators and barriers of coordinated multi-agency services. To enable greater partnership working, greater clarity needs to be provided in the relevant guidance and policy on how professionals are expected to work collaboratively and to the role and responsibilities of each service, particularly in regards to coordination.

Moreover, findings from the analysis of health visitors and parents’ responses indicated that TACs were introduced post-GIRFEC allowing the attendance of parents and all the

professionals involved in the family's life when concerns were identified. A key attribute of these meetings was the opportunities offered to parents to actively participate in the meetings, encouraging greater partnership working. Findings from the analysis of health visitors' responses stressed, however, that some professionals and parents were reportedly not attending TACs. In the case of professionals, for example, it was identified in health visitors' responses that not all professionals were present in TACs because they did not prioritize these meetings. This was indicative of professionals' resistance to change their professional culture.

Study findings suggest that, greater multi-agency activity could be achieved through joint training to enable professionals to change their mind-set and develop common decision-making standards. This was also highlighted in the review of Frost (2005) explaining that multi-agency professional training undertaken both at the initial training and post-qualifying training could eradicate fragmentation of services. Similar findings were also stressed in the study of Long et al (2006) who examined the key challenges in health professionals' education in England. In their study, the need for multi-agency pre-qualifying and post-qualifying training was considered significant in blending single-agency and multi-agency learning. White and Featherstone (2005) described this eloquently by stating that greater communication is not sufficient to achieve seamlessness; a change in the mind-set and professional cultures is required for this via encouraging professionals to be open to scrutiny and challenge. This signified the importance of motivation within professionals in *wanting* to participate in multi-agency activity, "rather than being directed to engage in it" (Atkinson et al 2002, p. v).

Health visitors' narratives of TACs conveyed a picture of an uncomfortable and intimidating experience for parents, which in effect, prevented them from attending the meetings. As highlighted in the study findings, the factors discouraging their attendance were not taken into account within the policy. The need for the establishment of more parent-friendly environment in TACs was highlighted in the findings by encouraging, for example, parents to be informed on what will be discussed in advance of the meeting and by providing individualised support to them. In this case, links with Bronfenbrenner's ecological systems theory (1979, 1986) can also be made in regards to TACs. This theoretical framework, which has informed the current study, helps to understand the role of GIRFEC, and TACs in particular, for children's wellbeing. This is because GIRFEC, which constitutes part of children's remote environment, encourages all professionals involved in the family's life along with parents, who are part of children's more intimate environment, to work collaboratively so as to improve children's wellbeing. TACs can thus constitute a solid example of Bronfenbrenner's theory at the ground-level.

Recurring themes in the literature, which did not however come up in the present study, on constituting additional barriers to multi-agency activity included i) the lack of developing common aims (Atkinson et al 2007), ii) effective planning with particular protocols (Atkinson et al 2007), iii) challenges around funding (Atkinson et al 2002; Brown and White 2006), and iii) developing new “professionals identities” (Frost and Robinson 2007, p. 198).

9.6. Research question 4

In the context of “child-centeredness”, what is the role of pre-school aged children? To what extent is it possible to obtain their views on their experiences of receiving health visiting services?

Unfortunately, the data collected from parents and children were not sufficient to help explore this research question. The key findings in regards to child-centeredness came from the analysis of findings of the policy documents and health visitors’ responses. According to these findings, the child-centred principles of GIRFEC were not fully or not at all employed through health visiting, leading to seamless challenges and lack of child-centeredness.

There are three main challenges identified in data analysis on the reasons why child-centeredness has not been achieved in the post-GIRFEC era. Firstly, findings from policy document analysis indicated that child-centeredness was not encouraged in all the documents analysed. A significant gap on the way children were viewed was identified between *A Guide to Getting it Right for Every Child* (Scottish Government 2012) and all the health visiting documents analysed. For example, in *A Guide to Getting it Right for Every Child* (Scottish Government 2012), child-centeredness includes the collection and documentation of children and young people’s views on matters affecting them as well as the encouragement of actions to be taken by professionals to meet their needs. This was also aided by the introduction of the GIRFEC NPM which included space for children’s views to be documented, as explained in *A Guide to Getting it Right for Every Child* (Scottish Government 2012). However, none of the health visiting documents includes information on the way health visitors could “do” child-centeredness in their practice. This might have been associated with the very young age of children health visitors delivered their services to, leading to the second key challenge on the matter.

Secondly, the very young age of children was found in policy document analysis to constitute another factor preventing the inclusion of children in professionals’ work. This issue also came up in eliciting the views of young children participating in this study. Within *A Guide to Getting it Right for Every Child* (Scottish Government 2012), for example, no information is included on how professionals would be expected to adopt child-centred approaches for babies and toddlers. For some health visitors, children’s

very young age was not perceived to be problematic though because, as explained by them, gathering children's "views" could also result from observing their interactions with family members or professionals. Perhaps, this relates to Pascal and Bertram's (2009, p. 255) of "listening" to children, explaining that this practice refers to all communication cues which are "not limited to the spoken word".

Thirdly, findings from health visitors' and parents' responses underlined that more traditional and conventional views on children's role were adopted by some of them. Children's role was reportedly considered marginalised, even in the cases where children were old enough to talk. This was also reported to take place in the TAC multi-agency meetings, where some health visitors reported to feel unskilled, unconfident or less responsible in eliciting the views of children; professionals other than health visitors, such as social workers, were reported to undertake this role in TACs.

What was concluded from the analysis of the data was that child-centeredness is more than the implementation of particular practices involving children and young people. More than anything, child-centeredness refers to a change in the mind-set and professional cultures. For this reason, the need for professionals, including health visitors, to undertake relevant training in relation to children's role, through Continuing Professional Development programmes, for example, was identified in the findings to be more than imperative. This could potentially lead to greater child-centeredness and multi-agency activity. Similar findings were echoed in the study of Appleton et al (2013), according to which health visitors required further training as they did not pay much attention to the babies' behaviour when delivering home visits.

Finally, in line with Article 12 of the UN Convention on the Rights of the Child (UNICEF 1989) on respecting the views of the child, the research design and methodology of this study has included space for young children to express their own views on health visiting and the overall services they received. As explained in Chapter 4, the data collected from the two young children were very limited and their responses were not articulated enough, which made me reflect on the research methods employed and the challenges entailed. Methodological challenges in eliciting children's views, particularly of those under the age of six, were also highlighted in the literature including, for example, the difference between "having a child perspective and taking the child's perspective" (Nilsson et al 2013, p. 1). After this experience, it was concluded that it would be potentially feasible to elicit young children's views on their experiences with the use of research methods suitable for the age-range of the children recruited.

9.7. Study limitations

The study entails limitations which could have affected the validity of the findings. Even though NHS Forth Valley was chosen as a representative case of implementing GIRFEC through health visiting in Scotland, the study findings cannot be generalized across all Health Boards and populations. NHS Forth Valley constitutes one small local area and the findings are expected to have represented local variations. Practice experiences may differ in other sites so the conclusions are provisional. Perhaps, this issue of representation could have been overcome by recruiting participants from more than one Health Boards. However, this was beyond the scope of the present research as this was conducted within the time limitations of a doctoral study and in the context of the time challenges of obtaining all the relevant ethical approvals. In any case, it is the researcher's hope that the study findings, even though collected from one particular Scottish geographical site, will be meaningful to health visitors and professionals working in similar contexts. Another limitation referred to the presence of a health visitor in the focus group with the parents at the Aberlour Family Support service, which might have influenced parents' responses. Moreover, the fathers volunteering to take part in the study were only two, even though the views of both mothers and fathers were intended to be collected. Finally, another limitation refers to lacking demographic data of the parents who participated in the study focus groups. This information could have been collected through demographic questionnaires distributed to parents at the end of the focus groups and might have been useful in data analysis. Despite the limitations, the study can contribute to future policy, practice and research.

9.8. Recommendations for policy, practice and research

Following the findings of this study, implications for future policy, practice and research have been identified, which could impact on health visiting and the wellbeing of children and parents.

9.8.1. Recommendations for policy and practice

In regards to future policy and practice, a number of recommendations are provided below:

- Study findings stress the need for health visitors to be better supported in the delivery of the GIRFEC approach through the recruitment of additional staff and through opportunities for further training particularly on multi-agency activity and child-centeredness, such as via Continuing Professional Development programmes. In line with these findings, Health Boards across Scotland need to evaluate the levels of staff capacity and training on multi-agency activity and child-centeredness at local level. This is to assess whether the study findings derived from one Scottish Health Board, as presented in this doctoral thesis, are

also found in other localities. In this case, appropriate measures need to be adopted at a local level in relation to staff capacity and training to encourage the full implementation of GIRFEC.

- The study found that a combination of receiving the service in the home environment and outside of it is required. It was found that drop-in baby clinics at Health Centres need to be reintroduced in the post-GIRFEC era and that focus should also be given to the service delivery in parents' groups. In the case of home visiting, more intensive home visits for all families having children from pre-birth to pre-school was required so that parents will feel better supported. Considering that these findings derived from one geographical area, it needs to be assessed whether these findings are also representative of other Health Boards. In this case, changes would be required in the service delivery venue and intensity across Scotland. These changes would include the health visiting being offered in drop-in baby clinics and parents' groups along with families' houses while intensity of home visiting would include the provision of more frequent home visits for all children aged from pre-birth to pre-school.
- Greater and clearer information is imperative within the policy documents, national and local guidance on the way professionals are expected to use the GIRFEC National Practice Model to reach to conclusions on the level of support families require. Similarly, greater information is required on the nature of information to be shared among them with and without parental consent. Greater clarity is also required on the way pragmatic realities of coordinating multi-agency activity, such as arranging the venue, and the role of coordination in particular. This could provide greater direction on the way GIRFEC is intended to be delivered at the ground-level.
- Greater emphasis should be attributed to the development and continuation of collaborative relationships between families and health visitors at a national level. In particular, where there are either wellbeing or child protection concerns. Parents need to be informed of professionals' intentions to escalate their concerns and emphasis should be given to the provision of individualised support to them. As such, the need for the development of more parent-friendly environment in the provision of multi-agency activity is also needed.
- The need for the development of a system that will provide clear, accurate and efficient information to parents on the role and responsibilities of health visitors and on what the service entails constituted another study finding. It would be necessary, though, to evaluate whether this finding refers to changes required at the local or at the national level. It is imperative for Health Boards to assess whether the information offered to families in other Health Boards is also unclear,

inaccurate and inefficient. In this case, the national system of informing parents on the health visiting service and its components needs to be reviewed and improved.

- Study findings highlighted that common decision-making thresholds among Health Boards would be required to ensure there is a common understanding on the cases where extra help needs to be offered. Single-agency training within health visiting and multi-agency training across children's services can be effective in this. In doing so, the Health Boards thresholds need to be re-examined so that they will be solely focused on the nature of any potential unmet need identified, rather than the number of these or the duration of the support needed. This could ensure that families being in need receive the support they deserve. It would be necessary for Health Boards to examine whether these challenges are also identified as such in other Health Boards, in which case changes would be also required in these Health Boards.
- The role of experiential knowledge in decision-making needs to be reviewed. In particular, the collaboration of health visitors of mixed experience is encouraged as this could enable the newly-qualified professionals to develop their experiential knowledge skills. In addition, standardized forms are required to allow opportunities for professionals to document and justify their own experiential knowledge indicators that may be not be offered in the forms.
- The record-keeping practices of services need to be re-examined. The development of one universal electronic health visiting platform used across Scotland would be required to tackle fragmentation issues within health visiting.
- Future policies should focus on the development of intervention programmes aiming to tackle root causes of problems, such as poverty, inequality and injustice. This could encourage the early identification and prevention of concerns.

9.8.2. Recommendations for research

A number of recommendations for further research with potential implications for health visiting and families have also been identified. These are summarised below:

- The number of professionals and parents taking part in this study is relatively small. Further studies are required to collect the views of a greater number of health visitors and parents, potentially from various Health Boards, regarding health visiting and the concept of multi-agency activity, particularly in relation to TACs.

- Considering that GIRFEC involves all children's services, further research is required to collect the views of professionals other than health visitors on the way they perceive and employ partnership working.
- Future research should be directed in the research methods employed with young children to reflect on whether it would be feasible to collect their views on the services they receive.

9.9. Conclusion

GIRFEC has been a significant and innovative policy in Scotland aiming to improve the wellbeing and welfare of all children and young people through children's services, including health visiting. Both health visitors and parents valued the health visiting service. However, this study has found that, despite its intentions and aims, the policy was not fully implemented at the ground level because it faced a great number of challenges in its transition from theory to practice. As such, the service was not considered supportive enough by neither health visitors nor parents. Two main flaws were identified in its design, which ultimately affected the quality of the service and signified that GIRFEC has always been doomed to fail. Firstly, the policy was found to be designed in a way that focused solely on supporting families rather than professionals. This was found to result in health visitors not being well-prepared to deliver their service in line with the GIRFEC principles. For example, this study has found that health visitors were unable to fulfil their role due to staff capacity problems, unmanageable caseloads and lack of training around multi-agency activity and child-centeredness. Secondly, the findings highlighted that some of the core foundations of the services were not taken into account in the policy design mitigating against integration of services. These core foundations included matters, such as decision-making thresholds on needs assessments, record-keeping practices as well as the relationships of professionals and parents in light of child protection and wellbeing concerns. For GIRFEC and similar, future policies to be successful, the role of families but also the role of professionals and the pre-existing foundations of services need to be taken into account more thoroughly. This could ensure that all children and young people in Scotland can have the best possible start in life.

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Appendices

Appendix 1 - Participant Information Letter for Health Visitors

Appendix 2 - Participant Information Letter for Parents

Appendix 3 – Participant Information Letter for Professionals

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Appendix 5 - Consent form for Health Visitors

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Appendix 13 - Interview Protocol for Health Visitors

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Appendix 15 - Template for Focus Groups with Parents

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Appendix 20 - R&D Ethical Approval



Participant Information Letter for Health Visitors

Research project: "An exploration of the *Getting it Right for Every Child* policy approach: Finding the balance among its tensions"

Who am I?

Hello, my name is Nikoletta Komvoki and I am a PhD student at the Centre for Child Wellbeing and Protection of the University of Stirling. I am originally from Greece and I am here to learn more about Scotland's children's services and whether they are delivered in an integrated and seamless manner.



What is my research about?

My research aims to explore the views and experiences of professionals (mostly Health Visitors), parents and pre-school age children on the potential tensions created for the Scottish health visiting service as a result of the new policy initiatives (the *Getting it Right for Every Child* policy approach, or else *GIRFEC*).

How will the research be done?

In order to collect the perspectives and experiences of professionals, parents and pre-school age children on the current Scottish health visiting service and the tensions arising from it, various methods will be used. These methods include: document analysis, individual interviews with professionals, focus groups with parents, participatory methods with pre-school age children and observations of Team Around the Child (TAC) meetings. So as to collect your views, in particular, individual interviews will be used for the Health Visitors working in the Forth Valley area.

Why have I been invited to take part?

You have been invited to participate in this study because you are a Health Visitor providing services to pre-school age children and your views are of utmost importance to my study. This study offers you the opportunity to discuss your experiences regarding the new legislation on the services you offer to families. Through my study, therefore, the policymakers can be informed about the views of Health Visitors, which could lead to amendments in the service so as to better meet your needs in the future.

What is expected of me if I take part in the study?

Should you decide to take part in the study, you will be asked to participate in an individual interview. During the interview, the questions will be about your views on the practices you are required to follow when intervening in a family, on your personal experiences of providing your services as well as on information sharing and the overall 'bringing together' of professionals so as to promote children's wellbeing. The interviews are expected to last for approximately 60 minutes and can take place at the Clackmannanshire Community Health Care Centre or a University of Stirling site. I will personally carry out the interviews and will take notes throughout them. The interviews will also be tape recorded to make sure all of your answers are captured in the interview.

Do I have to take part?

Participation in this research is voluntary. If you choose to take part you can drop out of the research at any time and withdraw the information you have provided up until the point of analysis when all information has been anonymised and it will not be possible to identify you or your information. Each participant will be given a minimum of 48 hours between the issue of the Participant Information letter and the signing of the consent form to consider whether he/she would like to participate in the study.

Is the information I give confidential?

Yes. All the information to be collected and used for the purposes of my study and my PhD thesis will remain confidential and will be anonymized. Confidentiality shall only be breached where the interviewer believes that something you have told them places you or others at serious risk. In this instance, they are obliged to pass this information on to the relevant persons. All the data collected by you will be in line with the provisions of the Data Protection Act 1998. Electronic data shall be securely stored in a locked office, with hard copies held in a locked filing cabinet. Data will be held at the University of Stirling for a period of 10 years. Should this data be later used in publications, such as journal articles, no personal information will be identified. Any information that might identify you, will be removed from all reporting.

How will my information be used?

Should you decide to take part in the research interview, the data provided by you will be recorded, transcribed and then anonymised. Audio recordings will then be destroyed. The data collected by you will then be analysed and published in my PhD thesis. Your personal details will remain anonymized at all times.

Will I be informed of the results of the study?

Yes. The findings of my study will be used for the purposes of my PhD thesis, which will be completed in 2019. You can then be sent a summary of the main findings (unless you indicate otherwise).

Thank you

Your contribution in my study is of great importance as it will enable you to be 'heard' and have your say regarding the children's services of Scotland and how they can improve children's wellbeing.

If, after reading the leaflet, there are still questions or areas you would wish to discuss further, please feel free to contact me at Nikoletta.komvoki@stir.ac.uk. If you would like to speak to or raise concerns with someone independent of the study, please contact Professor Jayne Donaldson, Dean of the Faculty of Health Sciences & Sport at jayne.donaldson@stir.ac.uk.

Thank you for your time and attention.

Appendix 2 – Participant Information Letter for Parents

Appendix 2 Date: 10/09/17 Version number: 1.0

NICR 16/17 – Paper No.81



Participant Information Letter for Parents

Research project: "An exploration of the *Getting it Right for Every Child* policy approach: Finding the balance among its tensions"

Who am I?

Hello, my name is Nikoletta Komvoki and I am a PhD student at the Centre for Child Wellbeing and Protection of the University of Stirling. I am originally from Greece and I am here to learn more about Scotland's children's services and whether they are delivered in an integrated and seamless manner.



What is my research about?

My research aims to explore the views and experiences of professionals (mostly Health Visitors), parents and pre-school age children on the potential tensions created for the Scottish health visiting service as a result of the new policy initiatives (the *Getting it Right for Every Child* policy approach, or else GIRFEC).

How will the research be done?

In order to collect the perspectives and experiences of professionals, parents and pre-school age children on the current Scottish health visiting service and the tensions arising from it, various methods will be used. These methods include: document analysis, individual interviews with professionals, focus groups with parents, participatory methods with pre-school age children and observations of Team Around the Child (TAC) meetings. So as to collect your views, in particular, focus groups will be used for parents receiving children's services in the Forth Valley area of Scotland. In the case of the pre-school age children, creative methods, such as drawing, hypothetical scenarios, use of unfinished sentences and postal boxes will be used to collect their views on the services they receive. The Protective Vulnerable Groups (PVG) scheme clearance has already been obtained by the researcher.

Why have I been invited to take part?

You have been invited to participate in this study because you are a parent of a pre-school age child and your views are of utmost importance to my study. This study offers you the opportunity to discuss your experiences regarding the new legislation on the services you receive or do not receive. Through my study, therefore, the policymakers can be informed about the views of parents, which could lead to amendments in the service so as to better meet your needs in the future.

What is expected of me if I take part in the study?

Should you decide to take part in the study, you will be asked to participate in a focus group, that is a group discussion with other parents having a child of a pre-school age. For the focus group, the topics to be discussed will be about the children's services you receive, on your personal experiences of receiving health visiting services as well as on information sharing and the overall 'bringing together' of professionals so as to promote children's wellbeing. The focus groups normally last for approximately 60-90 minutes and can take place at the parents' group or a University of Stirling site. I will personally carry out the focus group and will take notes. A £10 gift voucher will be given to you at the end of the focus group by way of thanking you for your time and commitment to the study. If you have to travel to take part in the focus group, your travel expenses will be reimbursed.

Do I have to take part?

Participation in this research is voluntary. If you choose to take part you can drop out of the research at any time and withdraw the information you have provided up until the point of analysis when all information has been anonymised and it will not be possible to identify you or your information. Each participant, including children, will be given a minimum of 48 hours between the issue of the Participant Information letter and the signing of the consent form to consider whether he/she would like to participate in the study. Moreover, your decision to take part or not in the study will have absolutely no impact on the services you receive. Although the study is not expected to cause distress to participants, sensitive issues might be discussed during the focus groups (e.g. having had a negative experience with HVs). In the unlikely event of the discussion leading you to visible distress, I will stop the focus group or terminate it completely. Moreover, an information leaflet with contact details of family support bodies, such as the Aberlour Early Years Outreach service, will be provided to all parents in advance.

Does my child have to take part?

With your child's and your permission, your child may be asked to take part in the study. After gaining consent from both your child and you, your child will be asked to participate in the following research methods, which will take place under the form of games: drawing techniques, discussion on hypothetical scenarios, use of unfinished sentences and postal boxes. Your child's participation will help in collecting pre-school age children's views on the services they receive and the professionals they come in contact with. These participatory methods can last from 30-60 minutes and can take place at the parents' group or at your place of convenience. Your child can withdraw from the research process any time if he/she wishes to do so. All his/her personal details will remain confidential and anonymized. A £10 gift voucher will be given to you, for your child's contribution, at the end of these child-friendly methods by way of thanking your child for his/her time and commitment to the study. If you have to travel for your child to take part in the child-friendly methods, your travel expenses will be reimbursed.

Is the information I give confidential?

Yes, all the information to be collected and used for the purposes of my study and my PhD thesis will remain confidential and will be anonymized. Confidentiality shall only be breached where the interviewer believes that something you have told them places you or others at serious risk. In this instance, they are obliged to pass this information on to the relevant persons. All the data

collected by you will be in line with the provisions of the Data Protection Act 1998. Electronic data shall be securely stored in a locked office, with hard copies held in a locked filing cabinet. Data will be held at the University of Stirling for a period of 10 years. Should this data be later used in publications, such as journal articles, no personal information will be presented. Any information that might identify you, will be removed from all reporting.

How will my information be used?

Should you decide to take part in the research study, the data provided by you from the focus group as well as from your child (if asked to take part) will be recorded, transcribed and then anonymised. Audio recordings will then be destroyed. The data collected by you and your child will then be analysed and published in my PhD thesis. Your personal details will remain anonymized at all times.

Thank you

Your contribution in my study is of great importance as it will enable you to be 'heard' and have your say regarding the children's services of Scotland and how they can improve children's wellbeing.

If, after reading the leaflet, there are still questions or areas you would wish to discuss further, please feel free to contact me at Nikoletta.komvoki@stir.ac.uk. If you would like to speak to or raise concerns with someone independent of the study, please contact Professor Jayne Donaldson, Dean of the Faculty of Health Sciences & Sport at jayne.donaldson@stir.ac.uk.

Thank you for your time and attention.

Appendix 3 – Participant Information Letter for Professionals

Appendix 3 Date: 10/09/17 Version number: 1.0

NICR 16/17 – Paper No.81

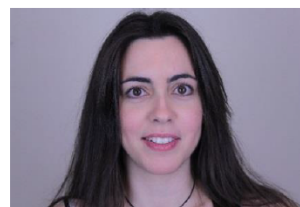


Participant Information Letter for Professionals

Research project: "An exploration of the Getting it Right for Every Child policy approach: Finding the balance among its tensions"

Who am I?

Hello, my name is Nikoletta Komvoki and I am a PhD student at the Centre for Child Wellbeing and Protection of the University of Stirling. I am originally from Greece and I am here to learn more about Scotland's children's services and whether they are delivered in an integrated and seamless manner.



What is my research about?

My research aims to explore the views and experiences of professionals (mostly Health Visitors), parents and pre-school age children on the potential tensions created for the Scottish health visiting service as a result of the new policy initiatives (the Getting it Right for Every Child policy approach, or else GIRFEC).

How will the research be done?

In order to collect the perspectives and experiences of professionals, parents and pre-school age children on the current Scottish health visiting service and the tensions arising from it, various methods will be used. These methods include: document analysis, individual interviews with professionals, focus groups with parents, participatory methods with pre-school age children and observations of Team Around the Child (TAC) meetings. So as to collect your views, in particular, you will take part in a TAC meeting, which I will observe so as to capture the way all professionals interact, collaborate and share information with each other.

Why have I been invited to take part?

You are invited to participate in this study because you are a professional participating in Team Around the Child meetings of pre-school age children and your views are of utmost importance to my study. I hope to observe this meeting to explore how professionals interact with each other and with carers for the child's benefit. Through my study, therefore, the policymakers can be informed about the practices of multi-disciplinary teams, which could lead to amendments in the service so as to better meet your needs in the future.

What is expected of me if I take part in the study?

Should you decide to take part in the study, you will be asked to participate in a TAC meeting of the nursery/school you have been assigned, as you would normally do. I will be present in the meeting and observe the way all professionals interact, work and share information with each other. During the observation of the TAC meeting, I will take notes, which you can view at the end of the observation.

Do I have to take part?

Participation in this research is voluntary. If you choose to take part you can drop out of the research at any time and withdraw the information you have provided up until the point of analysis when all information has been anonymised and it will not be possible to identify you or your information. Each participant will be given a minimum of 48 hours between the issue of the Participant Information letter and the signing of the consent form to consider whether he/she would like to participate in the study. If you are not comfortable with my presence before or during the observation of the TAC meeting, please let the Head Teacher or me know so that I will not join this meeting.

Is the information I give confidential?

Yes. All the information to be collected and used for the purposes of my study and my PhD thesis will remain confidential and will be anonymized. Confidentiality shall only be breached where the interviewer believes that something you have told them places you or others at serious risk. In this instance, they are obliged to pass this information on to the relevant persons. All the data collected by you will be in line with the provisions of the Data Protection Act 1998. Electronic data shall be securely stored in a locked office, with hard copies held in a locked filing cabinet. Data will be held at the University of Stirling for a period of 10 years. Should this data be later used in publications, such as journal articles, no personal information will be identified. Any information that might identify you, will be removed from all reporting.

How will my information be used?

Should you decide to take part in the research observation, the data provided by you will be recorded, transcribed and then anonymised. Audio recordings will then be destroyed. The data collected by you will then be analysed and published in my PhD thesis. Your personal details will remain anonymized at all times.

Will I be informed of the results of the study?

Yes. The findings of my study will be used for the purposes of my PhD thesis, which will be completed in 2019. You can then be sent a summary of the main findings (unless you indicate otherwise).

Thank you

Your contribution in my study is of great importance as it will enable you to be 'heard' and have your say regarding the children's services of Scotland and how they can improve children's wellbeing. If, after reading the leaflet, there are still questions or areas you would wish to discuss further, please feel free to contact me at Nikoletta.komvoki@stir.ac.uk. If you would like to speak to or raise concerns with someone independent of the study, please contact Professor Jayne Donaldson, Dean of the Faculty of Health Sciences & Sport at jayne.donaldson@stir.ac.uk. Thank you for your time and attention.

Appendix 4 – Participant Information Letter for Parents of TAC meetings

Appendix 4 Date: 10/09/17 Version number: 1.0

NICR 16/17 – Paper No.81

UNIVERSITY of
STIRLING



Participant Information Letter for Parents of TAC meetings

Research project: "An exploration of the *Getting it Right for Every Child* policy approach: Finding the balance among its tensions"

Who am I?

Hello, my name is Nikoletta Komvoki and I am a PhD student at the Centre for Child Wellbeing and Protection of the University of Stirling. I am originally from Greece and I am here to learn more about Scotland's children's services and whether they are delivered in an integrated and seamless manner.



What is my research about?

My research aims to explore the views and experiences of professionals (mostly Health Visitors), parents and pre-school age children on the potential tensions created for the Scottish health visiting service as a result of the new policy initiatives (the *Getting it Right for Every Child* policy approach, or else GIRFEC).

How will the research be done?

In order to collect the perspectives and experiences of professionals, parents and pre-school age children on the current Scottish health visiting service and the tensions arising from it, various methods will be used. These methods include: document analysis, individual interviews with professionals, focus groups with parents, participatory methods with pre-school age children and observations of Team Around the Child (TAC) meetings. So as to collect your views, in particular, you will take part in a TAC meeting, which I will observe so as to capture the way all professionals interact, collaborate and share information with each other.

Why have I been invited to take part?

You are invited to participate in this study because you are a parent of a pre-school age child attending a TAC meeting and your views are of utmost importance to my study. I hope to observe this meeting to explore how professionals interact with each other and with carers for the child's benefit. Through my study, therefore, the policymakers can be informed about the practices of multi-disciplinary teams, which could lead to amendments in the services so as to better meet your needs in the future.

What is expected of me if I take part in the study?

Should you decide to take part in the study, you will be asked to participate in a TAC meeting of the nursery/school you have been assigned, as you would normally do. I will be present in the meeting and observe the way all professionals interact, work and share information with each other. During the observation of the TAC meeting, I will take notes, which you can view at the end of the observation. A £10 gift voucher will be given to you at the end of the observation by way of thanking you for your time and commitment to the study.

Do I have to take part?

Participation in this research is voluntary. If you choose to take part you can drop out of the research at any time and withdraw the information you have provided up until the point of analysis when all information has been anonymised and it will not be possible to identify you or your information. Each participant will be given a minimum of 48 hours between the issue of the Participant Information letter and the signing of the consent form to consider whether he/she would like to participate in the study. If you are not comfortable with my presence before or during the observation of the TAC meeting, please let the Head Teacher or me know so that I will not join this meeting.

Is the information I give confidential?

Yes. All the information to be collected and used for the purposes of my study and my PhD thesis will remain confidential and will be anonymized. Confidentiality shall only be breached where the interviewer believes that something you have told them places you or others at serious risk. In this instance, they are obliged to pass this information on to the relevant persons. All the data collected by you will be in line with the provisions of the Data Protection Act 1998. Electronic data shall be securely stored in a locked office, with hard copies held in a locked filing cabinet. Data will be held at the University of Stirling for a period of 10 years. Should this data be later used in publications, such as journal articles, no personal information will be identified. Any information that might identify you, will be removed from all reporting.

How will my information be used?

Should you decide to take part in the research observation, the data provided by you will be recorded, transcribed and then anonymised. Audio recordings will then be destroyed. The data collected by you will then be analysed and published in my PhD thesis. Your personal details will remain anonymized at all times.

Will I be informed of the results of the study?

Yes. The findings of my study will be used for the purposes of my PhD thesis, which will be completed in 2019. You can then be sent a summary of the main findings (unless you indicate otherwise).

Thank you

Your contribution in my study is of great importance as it will enable you to be 'heard' and have your say regarding the children's services of Scotland and how they can improve children's wellbeing.

If, after reading the leaflet, there are still questions or areas you would wish to discuss further, please feel free to contact me at Nikoletta.komvoki@stir.ac.uk. If you would like to speak to or

raise concerns with someone independent of the study, please contact Professor Jayne Donaldson, Dean of the Faculty of Health Sciences & Sport at jayne.donaldson@stir.ac.uk.

Thank you for your time and attention.

Appendix 5 – Consent form for Health Visitors

Appendix 5 Date: 10/09/17 Version number: 1.0 NICR 16/17 – Paper No.81



Consent form for Health Visitors

Research project: "An exploration of the *Getting it Right for Every Child* policy approach: Finding the balance among its tensions"

Please initial box

I confirm that I have read the Participant Information Sheet and I have had the opportunity to ask the researcher any questions.

I understand that my participation is voluntary and that I am free to withdraw from the study at any time, including at any point during the interview, without giving a reason.

I understand that what I say will be treated confidentially and that I will not be identified in any transcription of the interview or future publications of the study findings.

I agree to the interview being recorded and then transcribed.

I understand that, if I have any concerns regarding the way in which the research is conducted, I can contact Professor Jayne Donaldson, Dean of the Faculty of Health Sciences & Sport, at jayne.donaldson@stir.ac.uk.

I agree to take part in the study:

Name:

Signature: Date:

For further information, please contact Nikoletta Komvoki.

Email: Nikoletta.komvoki@stir.ac.uk

Appendix 6 – Consent form for Professionals

Appendix 6 Date: 10/09/17 Version number: 1.0 NICR 16/17 – Paper No.81



Consent form for Professionals

Research project: "An exploration of the *Getting it Right for Every Child* policy approach: Finding the balance among its tensions"

Please initial
box

I confirm that I have read the Participant Information Sheet and I have had the opportunity to ask the researcher any questions.

I understand that my participation is voluntary and that I am free to withdraw from the study at any time, including at any point during the observation and/or interview, without giving a reason.

I understand that what I say will be treated confidentially and that I will not be identified in any transcription of the observation or future publications of the study findings.

I agree to the observation being recorded and then transcribed.

I understand that, if I have any concerns regarding the way in which the research is conducted, I can contact Professor Jayne Donaldson, Dean of the Faculty of Health Sciences & Sport, at jayne.donaldson@stir.ac.uk.

I agree to take part in the study:

Name:.....

Signature:

Date:.....

For further information, please contact Nikoletta Komvoki.

Email: Nikoletta.komvoki@stir.ac.uk

Appendix 7 – Consent form for Parents

Appendix 7 Date: 10/09/17 Version number: 1.0 NICR 16/17 – Paper No.81



Consent form for Parents

Research project: "An exploration of the Getting it Right for Every Child policy approach: Finding the balance among its tensions"

Please initial
box

I confirm that I have read the Participant Information Sheet and I have had the opportunity to ask the researcher any questions.

I understand that my participation is voluntary and that I am free to withdraw from the study at any time, including at any point during the focus group/observation of the TAC meeting, without giving a reason.

I understand that what I say will be treated confidentially and that I will not be identified in any of the transcriptions of the focus group, observation or any of the future publications of the study findings. Confidentiality shall only be breached where the interviewer believes that something you have told them places you or others at serious risk. In this instance they are obliged to pass this information on to the relevant person.

I agree to the focus group or observation of the TAC meeting being recorded and then transcribed.

I understand that, if I have any concerns regarding the way in which the research is conducted, I can contact Professor Jayne Donaldson, Dean of the Faculty of Health Sciences & Sport, at jayne.donaldson@stir.ac.uk.

I agree to take part in the study:

Name:.....

Signature: Date:.....

For further information, please contact Nikoletta Komvoki.

Email: Nikoletta.komvoki@stir.ac.uk

Appendix 8 – Consent form for Parents for their Child's Participation

Appendix 8 Date: 10/09/17 Version number: 1.0 NICR 16/17 – Paper No.81



Consent form for parents for their child's participation

Research project: "An exploration of the *Getting it Right for Every Child* policy approach: Finding the balance among its tensions"

I confirm that I have read the Participant Information Sheet and I have had the opportunity to ask the researcher any questions.

I consent to my child taking part in the study and give Nikoletta, who has achieved The Protective Vulnerable Groups (PVG) scheme clearance, permission to play and talk with him or her.

Name:.....

Signature: Date:.....

For further information, please contact Nikoletta Komvoki

Email: Nikoletta.komvoki@stir.ac.uk

In case there are any concerns regarding the way in which the research is conducted, please contact Professor Jayne Donaldson, Dean of the Faculty of Health Sciences & Sport, at jayne.donaldson@stir.ac.uk.

Appendix 9 – Assent form for Children

Appendix 9 Date: 10/09/17 Version number: 1.0 NICR 16/17 – Paper No.81



Assent form for children

Reply to invitation to take part in a project about families in Scotland

Would you like to play and talk to Nikoletta?

Yes No



Is it ok for Nikoletta to record our talk?

Yes No

Nikoletta
Nikoletta.komvoki@stir.ac.uk

Would you like someone with you when we play and talk?

Yes No

My name.....

Date.....

'Thank you' leaflet

Thank you very much for participating in my study regarding the exploration of the views and experiences of professionals (mostly Health Visitors), parents and pre-school age children on the potential tensions created for the Scottish health visiting service as a result of the new policy initiatives (the Getting it Right for Every Child policy approach, or else GIRFEC). Your contribution to this important research is very much appreciated and is invaluable for helping the delivery of the Scottish health visiting service in the future.

Below you can find information on family support services, in case they are needed:

Service	Who is it for?	Contact details
Forth Valley Family Support Service	For Scottish Families affected by alcohol and drugs.	Tel: 08080 10 10 11 Email: fvfamilies@sfad.org.uk Website: fvfamilies.org.uk
Stirling Family Support	For individuals and families affected by a loved one's alcohol or drug misuse.	Tel: 01786 470797 Address: 36 St John Street, Stirling, FK8 1EA Website: www.s4f.org.uk
Contact A Family	For families with children who have any disability or rare disorder; it provides a helpline, support groups and information.	Tel: 0131 659 2930 Website: www.cafamily.org.uk
Aberlour Early Years Outreach	Provision of parenting support to families with children under the age of four.	Tel: (01324) 503494 Address: Laurieston Campus, Bog Road, Falkirk FK2 9PB
Counselling Directory	For those in distress seeking help.	Website: www.counsellingdirectory.org.uk
HandsOnScotland	For those seeking information on how to respond to children and young people's challenging behaviour and promote positive mental wellbeing.	Email: handson@nhs.net Website: www.handsonscotland.co.uk
Child Law Advise	For child abuse concerns over a child.	Tel: 999 (police) Tel: 0808 800 5000 (NSPCC)
Central Scotland Rape Crisis & Sexual Abuse Centre (Forth Valley)	For rape, sexual assault and child sexual abuse. The service is available for women, men and young people over the age of 13.	Tel: 01786 471771 Address: 1 Glebe Avenue, Stirling Email: info@rapecrisiscentralscotland.co.uk



Leaflet for parents and children

Title of research project: "An exploration of the Getting it Right for Every Child policy approach: Finding the balance among its tensions"

This study will seek your views, and potentially your child's, on the potential tensions created from the Scottish health visiting service as a result of the new policy initiatives (Getting it Right for Every Child). In the study, you will be asked to take part in a focus group consisting of approximately 10 parents regarding the current health visiting services you receive. The focus group will last for approximately 60-90 minutes and will take place either at the parents' group or at a University of Stirling site.

Moreover, your child may also be asked to take part in the study by participating in the following research methods, which will take place under the form of games: drawing techniques, discussion on hypothetical scenarios, use of unfinished sentences and postal boxes. Your child's participation will help in collecting pre-school age children's views on the services they receive and the professionals they come in contact with. These participatory methods can last from 30-60 minutes and can take place at the parents' group. Both you and your child will be reimbursed a £10 gift voucher each for your contribution. If you have to travel to take part in the focus group and/or the child-friendly methods to be used with your child, your travel expenses will be reimbursed.

If you are interested in taking part, please email me at Nikoletta.komvoki@stir.ac.uk.

Thank you,
Nikoletta
PhD Researcher
The Centre for Child Wellbeing and Protection
University of Stirling



Leaflet for parents

Title of research project: "An exploration of the Getting it Right for Every Child policy approach: Finding the balance among its tensions"

This study will seek your views on the potential tensions created from the Scottish health visiting service as a result of the new policy initiatives (Getting it Right for Every Child). In the study, you will be asked to take part in a focus group consisting of approximately 10 parents regarding the current health visiting services you receive. The focus group will last for approximately 60-90 minutes and will take place either at the parents' group or at a University of Stirling site.

Moreover, you will be reimbursed a £10 gift voucher for your contribution. If you have to travel to take part in the focus group, your travel expenses will be reimbursed.

If you are interested in taking part, please email me at Nikoletta.komvoki@stir.ac.uk.

Thank you,
Nikoletta
PhD Researcher
The Centre for Child Wellbeing and Protection
University of Stirling

Appendix 13 – Interview Protocol for Health Visitors

Appendix 13 Date: 10/09/17 Version number: 1.0 NICR 16/17 – Paper No. 81

Interview protocol to be used with the Health Visitors

-Can you recall and describe an event where you assessed

- you had to intervene in a family by offering additional, targeted support
- you considered a family situation as a 'grey area' where you were unsure about the services the family would require, and
- that no additional intervention was required in a family

-What are your views on the health visiting service of Scotland as in the Old Pathway in comparison to the New Pathway?

-Would you describe the current health visiting service of Scotland as 'intrusive' or as 'supportive', by whom, and why?

-Can you recall and describe a home visit experience you had in the past, which was considered by parents

- Statutory help?
- 'Intrusive'?
- A 'neutral' case between the previous two?

-What are your views on the effectiveness of the overall 'bringing together' of professionals to promote pre-schoolers' wellbeing?

-What are your views on the Team Around the Child (TAC) meetings? Do they work and, if so, for whom and under what circumstances?

-In what other cases do you interact with other professionals, apart from the TAC meetings, and why?

-What are your views on information sharing among professionals so as to promote pre-schoolers' wellbeing?

Appendix 14 – Interview Protocol for Professionals other than Health Visitors

Appendix 14 Date: 10/09/17 Version number: 1.0 NICR 16/17 - Paper No.81

Interview protocol to be used with professionals other than the Health Visitors

-Can you recall and describe an event where you assessed

- you had to intervene in a family by offering additional, targeted support
- you considered a family situation as a 'grey area' where you were unsure about the services the family would require, and
- that no additional intervention was required in a family

-What are your views on the effectiveness of the overall 'bringing together' of professionals to promote pre-schoolers' wellbeing?

-What are your views on the Team Around the Child (TAC) meetings? Do they work and, if so, for whom and under what circumstances?

-In what other cases do you interact with other professionals, apart from the TAC meetings, and why?

-What are your views on information sharing among professionals so as to promote pre-schoolers' wellbeing?

Appendix 15 – Template for Focus Groups with Parents

Appendix 15 Date: 10/09/17 Version number: 1.0 NICR 16/17 – Paper No. 81

Template for focus groups with the parents

-What do you think of the new health visiting service of Scotland comparing to the old one? Would you describe it as 'intrusive' or as 'supportive', and why?

-Can you recall and describe a home visit experience you had in the past, which was considered by you as

- Statutory help?
- 'Intrusive'?
- A 'neutral' case between the previous two?

-Use of vignettes/hypothetical scenarios on Health Visitors' actions during home visits and how parents would respond to them.

-Use of vignettes/hypothetical scenarios regarding incidents where parents view information sharing as necessary and incidents where parents think of information sharing as a breach of privacy.

-What are your views on information sharing among professionals to promote pre-schoolers' wellbeing?

-What are your views of professionals working together to promote children's wellbeing?

Appendix 16 – Demographic Questionnaire for Health Visitors

Appendix 16 Date: 06/12/19

Health Visitors' Demographic Questions

Title of research project: "An exploration of the Getting it Right for Every
Child policy approach: Finding the balance among its tensions"

Question 1: What is your age?

- 25 or under 46-55
- 26-35 56 or older
- 36-45

Question 2: What is your gender?

- Female
- Male
- Prefer not to say

Question 3: What is your nationality?

- British

Other (please specify):

Question 4: What is the highest level of education you have completed that is of
relevance to your current position or occupation??

- College Doctoral degree
- Bachelor's degree
- Master's degree

Other (please specify):

Question 5: How long have you worked in this position for?

- Less than 2 years
- 3-5 years
- 6-10 years
- 11-20 years
- More than 21 years

Question 6: How long have you worked in this Health Centre/Hospital for?

- Less than 2 years
- 3-5 years
- 6-10 years
- 11-20 years
- More than 21 years

Question 7: Which one of the following best describes your role in the Health Centre/Hospital?

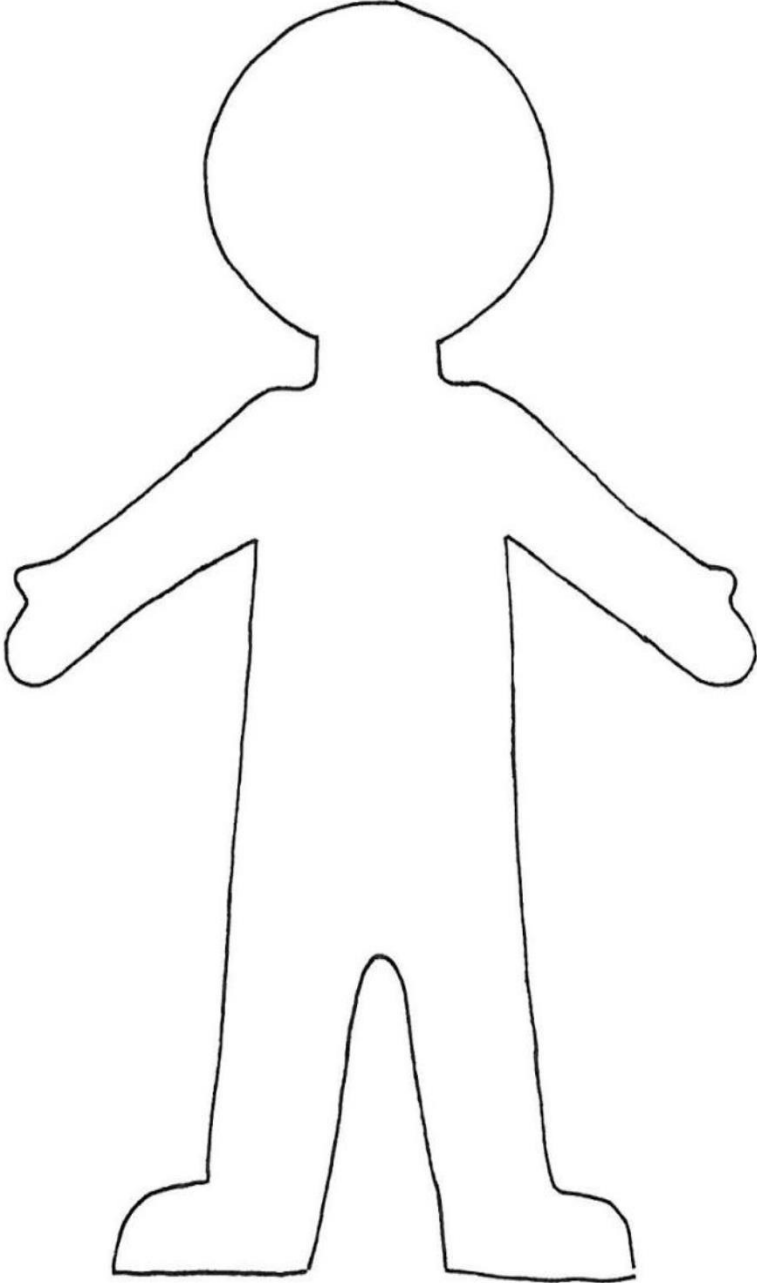
- Student
- Trained professional
- Health Visitor specialist
- Team Manager

Other (please specify):

Appendix 17 – Interview Materials for Young Children

Appendix 17 – Materials used with young children

Name: _____



Unfinished sentences for children

Name: _____

Date: _____

Introduction

-What do you like doing when you come here?

-Who do you work/play with when you come here?

-Are there any grown-ups/professionals you talk to when you come here?

-What do you like doing with the grown-ups when you come here?

-Do you have any other grown-ups/professionals that come to your house or the Nursery to work with you?

-Do you maybe know what a Health Visitor/Social Worker/Nursery Teacher is and what they do?

Unfinished questions

When I meet my Health Visitor, I feel _____.

When I meet my Social Worker, I feel _____.

When I meet my Nursery Teacher, I feel _____.

The things I do with my Health Visitor are _____.

The things I do with my Social Worker are _____.

The things I do with my Nursery Teacher are _____.

I feel _____ with the things I do/say with my Health Visitor.

I feel _____ with the things I do/say with my Social Worker.

I feel _____ with the things I do/say with my Nursery Teacher.

If I could change something in the things I do/say with my Health Visitor, that would be _____.

If I could change something in the things I do/say with my Social Worker, that would be _____.

If I could change something in the things I do/say with my Nursery Teacher, that would be _____.

Vignettes/Hypothetical scenarios for children

Name: _____

Date: _____

Scenario A:

There is a family with a mum, a dad and two children, Jessica and Thomas. Jessica is 7 years old and Thomas is at your age. At times, there are some grown-ups/professionals, such as a Health Visitor and a Social Worker, to help Jessica and Thomas. When these grown-ups visit Jessica and Thomas' house, they talk about Jessica and Thomas' School/Nursery and the things they do every day. What do you think about that?

Questions: Should these grown-ups visit the family or not, and why? If so, how often should these grown-ups visit the family you think? Do you think these grown-ups should talk with Jessica and Thomas or should they talk with Jessica and Thomas' parents only?

Scenario B:

In the previous scenario, all the grown-ups that help Jessica and Thomas' family meet with the parents of Jessica and Thomas and talk about how things could be better for the family. What do you think about that? Do you like the idea of all the grown-ups meeting and working together or do you think each one of them should work individually with the family?

JE/SF

11 October 2017

Ms Nicole Komvoki
94/5 South Bridge
Edinburgh
EH1 1HN



NHS, Invasive or Clinical Research (NICR)
Committee

Room G10
Pathfoot Building
University of Stirling
Stirling FK9 4LA

Tel: +44 (0) 1786 467390
Email: nicr@stir.ac.uk

Dear Nicole

**An exploration of the Getting It Right For Every Child policy approach: Finding the balance among its tension
NICR 16/17 – Paper No.81**

Thank you for your email of 9 October 2017, including the following attachments:

- Cover letter;
- Revised IRAS V2;
- PIS: Health Visitors; Parents; Professionals; Parents of TAC Meetings V2;
- Consent Form: Health Visitors; Professionals; Parents; Parents for Child's Participation V2;
- Assent Form for Children;
- 'Thank You' leaflet;
- Leaflet for Parents & Children;
- Interview Protocol: Health Visitors; Professionals (non-HVs);
- Focus Group Template.

I am happy to approve your study under Chair's Action for the NICR Committee and authorise its submission to NHS Research Ethics Committee.

May I remind you of the need to inform NICR (nicr@stir.ac.uk) prior to making any amendments to this protocol, or any changes to the duration of the project and provide notification of study completion. A site file of all documents related to the research should be maintained throughout the life of the project, and kept up to date at all times. The site file template can be found on the NICR webpage at:

<http://www.stir.ac.uk/research/integritygovernanceethics/researchethics/formsandguidance/>

Please bear in mind that your study could be audited for adherence to research governance and research ethics protocols.

NICR 16/17 – Paper No.81
Please quote this number on all correspondence

Yours sincerely

A handwritten signature in blue ink, appearing to read 'J. Evans'.

Dr Josie Evans
(Depute Chair)



Health Research Authority

South Central - Oxford B Research Ethics Committee

Whitefriars
Level 3, Block B
Lewin's Mead
Bristol
BS1 2NT

Telephone: 0207 104 8253

15 December 2017

Miss Nikoletta Komvoki
Collin Bell Building (Room 3S5)
University of Stirling
Stirling
FK9 4LA

Dear Miss Komvoki

Study title:	"An exploration of the Getting it Right for Every Child (GIRFEC) policy approach: Finding the balance among its tensions"
REC reference:	17/SC/0640
Protocol number:	81
IRAS project ID:	232568

Thank you for your letter of 14th December 2017, responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of

the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA Approval (England)/ NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" above).

Approved documents

The documents reviewed and approved by the Committee are:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering letter on headed paper [Cover letter]	1.0	14 December 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		06 November 2017
Interview schedules or topic guides for participants [Parents]	1.0	10 September 2017
Interview schedules or topic guides for participants [Health Visitors]	1.0	10 September 2017
Interview schedules or topic guides for participants [Other Professionals]	1.0	10 September 2017
Interview schedules or topic guides for participants [Focus Group Parents]	1.0	10 September 2017
IRAS Application Form [IRAS_Form_10112017]		10 November 2017
IRAS Checklist XML [Checklist_14122017]		14 December 2017
Letter from sponsor		06 November 2017
Letters of invitation to participant [Thank you leaflet]	1.0	10 September 2017
Letters of invitation to participant [Appendix 11-Leaflet for parents and children]	1.1	13 December 2017
Letters of invitation to participant [Appendix 12-Leaflet for parents]	1.1	13 December 2017
Participant consent form [Assent for Children]	1.0	10 September 2017
Participant consent form [Children]	1.0	10 September 2017
Participant consent form [Appendix 5-Consent form for Health Visitors]	1.1	13 December 2017
Participant consent form [Appendix 6-Consent form for Professionals]	1.1	13 December 2017
Participant consent form [Appendix 7-Consent form for Parents]	1.1	13 December 2017
Participant consent form [Appendix 8-Consent form for parents for their child's participation]	1.1	13 December 2017
Participant information sheet (PIS) [Appendix 1-Participant Information letter for Health Visitors]	1.1	13 December 2017
Participant information sheet (PIS) [Appendix 2-Participant Information Letter for Parents]	1.1	13 December 2017
Participant information sheet (PIS) [Appendix 3-Participant Information Letter for Professionals]	1.1	13 December 2017
Participant information sheet (PIS) [Appendix 4-Participant Information Letter for Parents of TAC meetings]	1.1	13 December 2017
Research protocol or project proposal	1.0	10 September 2017
Summary CV for Chief Investigator (CI)		09 November 2017
Summary CV for student		09 November 2017
Summary CV for supervisor (student research) [MF CV]		08 November 2017
Summary CV for supervisor (student research) [HC]		31 October 2017

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance>

We are pleased to welcome researchers and R & D staff at our RES Committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

17/SC/0640

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

Pp 

Mr Chris Foy
Chair

Email: nrescommittee.southcentral-oxfordb@nhs.net

Enclosures: *“After ethical review – guidance for researchers”*

Copy to: *Ms Joy Taylor*
Dr Rosemary Wilson, Research & Development Office

NHS Forth Valley

Carseview House
Castle Business Park
Stirling
FK9 4SW

Telephone:
Fax:



Ms Nikoletta Komvoki
94/5 South Bridge
Edinburgh
EH1 1HN

Date 23 March 2018
Your Ref
Our Ref

Direct Line: 01324214690
Email: FV-UHB.RandD-depart@nhs.net
R&D ref: FV1067

Dear Ms Komvoki

Study title: "An exploration of the Getting it Right for Every Child (GIRFEC) policy approach: Finding the balance among its tensions"
REC reference: 17/SC/0640

Following the favourable opinion from the South Central - Oxford B Research Ethics Committee on 15 December 2017, I am pleased to confirm that I formally gave Management Approval to the study above on 23 March 2018.

This approval is subject to the following conditions:

- Provision of a suitable Letter of Access for you to carry out the study within NHS Forth Valley

This approval is granted subject to your compliance with the following:

1. Any amendments to the protocol or research team must have Ethics Committee and R&D approval (as well as approval from any other relevant regulatory organisation) before they can be implemented. Please ensure that the R&D Office and (where appropriate) NRS are informed of any amendments as soon as you become aware of them.
2. You and any local Principal Investigator are responsible for ensuring that all members of the research team have the appropriate experience and training, including GCP training if required.
3. If someone working within NHS Forth Valley is recruiting participants, those figures **MUST** be recorded on the EDGE research management system. If you have not used EDGE before, you should already have been offered training on the system. If recruitment is all being handled outside Forth Valley, you will be contacted monthly for the latest recruitment figures.
3. All those involved in the project will be required to work within accepted guidelines of health and safety and data protection principles, any other relevant statutory legislation, UK Policy Framework for Health and Social Care Research and IHC-GCP guidelines. A copy of the Framework can be accessed at: <http://www.nhsresearchscotland.org.uk/uploads/tinymce/uk-policy-framework-health-social-care-research%20v1.1.pdf>



Chairman: Alex Linkston CBE
Chief Executive: Cathie Cowan

*Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW*

www.nhsforthvalley.com Facebook.com/nhsforthvalley @nhsforthvalley

and ICH-GCP guidelines may be found at <http://www.ich.org/LOB/media/MEDIA482.pdf>

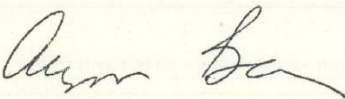
4. As custodian of the information collected during this project you are responsible for ensuring the security of all personal information collected in line with NHS Scotland IT security policies, until the destruction of this data.

5. You or the local Principal Investigator will be required to provide the following reports and information during the course of your study:

- A progress report **annually**
- Report on SAEs and SUSARs if your study is a Clinical Trial of an Investigational Medicinal Product
- Any information required for the purpose of internal or external audit and monitoring
- Copies of any external monitoring reports
- Notification of the end of recruitment and the end of the study
- A copy of the final report, when available.
- Copies of or full citations for any publications or abstracts

The appropriate forms will be provided to you by the Research and Development office when they are needed. Other information may be required from time to time.

Yours sincerely

Pp 

MR. ANDREW MURRAY
Medical Director

CC: