Supporting EU Migrant Families with Parent and Infant Relationships for Positive and Mental Health

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ABSTRACT

Recent evidence demonstrates the significance of factors in early pregnancy and in the first weeks and months of baby’s life on the neurological development which provides the blueprint for a baby’s future health. Secure attachment impacts on developmental issues including: labelling; development of the sense of ‘self’ and understanding broader social actions. These factors provide insight into why poor parental relationships can be a significant factor in good parenting (Fearon 2014). Good parenting reduces risk of children experiencing poor behavioural outcomes. Early parenting experiences are critical in the development of the child’s emotional regulatory system. A significant proportion of adult mental health problems are thought to have their origins in early childhood. The provision of timely maternal mental health support to EU migrant families, including interventions by Health Visitors can make a difference, not only to the families but also to the wider community. This project focuses on the contribution of Health Visitor support through the use of Visual Infant Cue Cards during the early transition to parenthood and as a contributor to enhance early neurological development.
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INTRODUCTION

This report considers the Health Visiting role as a factor in enhancing positive infant/parental attachment in European Union migrant families who experience poor health outcomes relating to health inequalities (IOM 2009, EU level consultation on Migration “Better Health for All”). Supportive action is provided by Health Visitors using Visual Infant Cue cards during contacts with mother/father/parent during the infant’s first year of life. The intended outcome is that Visual Infant Cue Cards will contribute to a reduction in mental health issues between parent and infant resulting from relationships and attachment issues. The project sits well with The Transition to Parenthood and the Early Weeks Maternal Mental Health Framework (2014). Together these frameworks facilitate the role of those working in implementing pathways to positively impact on children, families and communities.

A research study by Potenza & Rutherford (2014) in neuroscience and developmental psychology has shown that interactions and experiences with caregivers in the first months of a child’s life determine whether the child’s developing brain structure will provide a strong or a weak foundation for their future health, wellbeing, psychological and social development. Within the United Kingdom (UK) the remit of the Health Visiting Service is to promote positive infant mental health and to assess infant social and emotional development. The origins of this work based project stemmed from the author’s personal and professional interest in the developing parent and infant relationships and the awareness that speaking to parents about attachment i.e. the parent - infant relationship can be difficult. Anecdotally, such difficulties are exaggerated when working with Black and Minority Ethnic (BME) families. The ability of the Health Visitor to communicate, respond and facilitate the developing parent and infant interaction is vital.

The role of the Health Visitor is one of conveying knowledge and ideas with others to create shared understanding. The visual infant cue cards that the author has developed aim to be a positive verbal and non-verbal communication tool to build rapport and empathy with regard to the parent infant relationship. The application of the visual infant cue cards in practice takes into consideration and gives space for parent’s feelings as well as offering the opportunity for clarity to their understanding. The visual infant cue cards highlight the Health Visitor’s importance in communicating in a clear, confident, positive and professional manner.
REVIEW OF LITERATURE

INFANT MENTAL HEALTH AND ATTACHMENT

The aim of the literature search was to identify existing research relating to the exploration of early attachment and Health Visitor support in EU-migrant populations. The search was undertaken within nursing, psychological and social and other healthcare journals and databases. The literature search resulted in a mixed response. Keynaert et al (2013) argue that on arrival EU-migrants are comparatively healthy yet depending on the policies and practices may experience discrimination and drop in their socio-economic status. Ingold (2014) study on EU migrant populations discussed cultural barriers to health and disempowerment of women. The study identified access to healthcare provision as a significant issue impacting on the delivery of care to this population. A population based survey of mothers giving birth over a two week period in England in 2009 revealed that compared to White women born in the UK, BME women born outside the UK booked for antenatal care later, had poorer information provision and were less likely to be treated with respect by staff (Redshaw and Heikkila 2010).

The literature search revealed no existing findings directly relating to EU-migrants and Health Visiting support or to Health Visitors supporting infant parent relationships in UK. McLeish (2013) studied the impact of perinatal care including quality of care and access within ethnic, vulnerable groups. There have been some attempts to develop Health Visiting screening tools to enable discussions about parent infant attachment, but the background and philosophy of these is diagnostic and less pragmatic. Studies by Puckering et al. (2011) and Milford and Oates (2009) have developed screening tools for assessing perinatal mental health and as a by-product, these tools have produced information regarding the parent and infant relationships in the wider population.

The principle of attachment between mother and child is of paramount importance as a foundation for successful communication and emotional and social development. Findings from the field of neurochemistry (Fonagy 2001), established that emotional experiences in infancy and early childhood have a measurable effect on how individuals develop as human beings. The major effect is around future expectations and how individuals are set in their relationships with other people. This is supported
and well documented by Bowlby (1988), Fonagy (2001), Gerhardt (2005), Sunderland (2006), Allen (2011), and Zeedyk (2013). There are currently political concerns indicating EU-migrants negatively affect the NHS by adding extra financial burden (Home Office 2015). This sets negative connotations in relation to EU-migrants nationally and locally. This is a challenge for the planning and delivery of national and local healthcare services. This project is based on the principles of a universal NHS derived from the NHS constitution values and principles (2013). This is re-iterated within the Early Years Document (2014) core principles that universal services are essential for primary prevention, early identification of need and early intervention. Universal services lead to early support and harm reduction (DH 2014).

Health visitors (Nursing and Midwifery Council 2004) are well placed to address these issues and deliver the universal Healthy Child Programme (DH 2009). The critical period for gaining secure attachment begins during the ante-natal period where early intervention for attachment strategies can be implemented. The Healthy Child Programme (2009) emphasises the mental health and wellbeing strategy within its objectives, aiming to reduce occurrence of poor mental health throughout the childhood. Use of Visual Cue cards can facilitate Health Visitors in identifying potential maternal mental health issues.

HEALTH INEQUALITIES

The Early Years High Impact Area documents (2014) describe areas such as Transition to Parenthood and the Early Weeks and Maternal Mental Health (Perinatal Depression) where Health Visitors have a significant impact on health and wellbeing and improving outcomes for children, families and communities. Certain core principles have been identified for each of the high impact areas including: the importance of universal services for primary prevention, early identification and early intervention to reduce health inequalities.

The Marmot Review (2010) reported on health inequalities in England post 2010 and considered multifaceted social components in ethnic group’s health. The report stimulated the author’s consideration of cultural diversity. The author’s own experience of growing up in Finland, along with the implications of barriers to health interventions due to policies or the lack of policies and health interventions became more evident.
Bradford District’s demographic data demonstrates the vast ranging diversity of the area’s population. EU- migrants in Bradford parallels the notably large non-UK born population at 15% (Yorkshire Migration 2014) This is much higher than the average for Yorkshire and Humber region. A key factor for the study is the birth rate in Bradford, which continues to be the highest among all areas of Yorkshire and Humber. The proportion of births to mothers who were themselves born outside the UK is also the highest, reaching almost one third of all new births in 2012 compared to the average of 19% across Yorkshire and Humber. These demographics impact widely on the delivery of Health Visiting Services. Professionals need to constantly reflect on ways in which to effectively deliver services to all families (Yorkshire Migration, 2014).

WIDER DETERMINANTS AND THE NHS

The NHS Five Year Forward View was published on 23 October 2014 and sets out a vision for the future of the NHS. The project’s philosophy stems from the NHS Five Year Plan; in the provision of a pragmatic intervention for the Health Visiting service to support the EU migrant families; to review the evidence to support the initiation of conversation starters in the targeted group and to examine the process.

Although EU-Migrants are not a homogenous group they do share characteristics such as issues of poverty, deprivation and exclusion (Jayaweera 2010). Such factors contribute to barriers in accessing and using the health services including Health Visiting and Mental Health Services (Ingold, 2014). There is some evidence Phillipmore 2011) of barriers to health and social care arising from restricted entitlements for vulnerable EU-migrants. The NHS has opportunities to work towards eliminating discrimination and reducing inequalities in care. The NHS Constitution (2013) states clear values and principles about equality and fairness. The Equality Act 2010 reinforces many of these values. In order to influence future policy development further studies are required in which consideration is given to BME and migrant groups. The key is in what ways do practitioners facilitate a change with regard to the current negative impact of health inequalities and how do they facilitate positive change in the health inequalities identified as affecting these groups?

The following discussion explores Mental Health and wellbeing policies. The previous coalition government’s concept of the Big Society (2010) described a shift towards individuals taking more control over their lives and building more adept
communities. This is particularly pertinent to mental health issues. Good mental health and resilience are fundamental to: physical health, educational attainment, access to training and work and ability to reach full potential (Marmot 2010). The Government’s white paper ‘No Health without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Age’ (2011) aspires to decisions that are taken locally and will provide greater flexibility for individuals. The Mental Health strategy implementation framework guidance (DOH 2012) retains the mental agenda as a high priority affecting all health and wellbeing policies. In summary, the Government’s policy and strategy states the importance of good mental health and supporting those with mental health problems to recover. Mental health and well-being is integral to Health Visiting practice, with its focus on enabling early intervention support for families, mothers and infants. The impacts of mental health issues are well recognised.

The implementation of Visual infant cue cards links to the Care Quality Commissioning group (2013) report on high staff engagement and empowerment. Staff engagement is vital in delivering high quality care to public. Visual infant Cue cards illustrate and explain the behavioural cues commonly seen in infants. Visual infant Cue cards are a pragmatic and innovative tool to facilitate Health Visitors in having discussions with parents and caregivers about infant cues and relationships.
AIMS AND OBJECTIVES

This aim of this project was twofold: Development of a toolkit, visual aid to facilitate the Health Visitor in exploration of parent and infant relationship and to explore Health Visitor views on Conversations Starters Visual Infant Cue cards when Promoting secure attachment in EU Migrant. The theme of the project is supported by the national: 1001 Critical Days report (2013) which states the importance that every baby receiving insightful and responsive care from their main caregivers in the first years of life. Despite much good practice in health care there is considerable evidence that EU –migrant communities experience health inequalities and poor health outcomes (Ingold 2014). Problems in the perinatal phase within the infant and parental relationships can cause increased maternal/parental anxieties, depression and other mental health illnesses. Mothers and fathers play the most important part in raising children. The Longitudinal Millennium Cohort Study (2000) suggests that parents who combine high levels of parental warmth with high levels of supervision are more likely to have children at age five who are confident, autonomous and empathetic.

Infants are unable to regulate their emotions or the impact of overstimulation (Marrone 2014). Infants learn to regulate their emotions through repeated experiences with main caregivers. The infant’s experience is of being ‘rescued and saved’ or not (Bowlby 1988). Primary carers who are attuned to their infants produce children with secure attachment which improves a child’s life chances including educational attainment, resilience and self-confidence (Field 2010; Marmot 2010). Through positive interactions, with his or her main carers the baby learns that people can be relied upon to respond to their needs i.e. responsive parenting. This is known to lead to multiple positive outcomes for the child Bowlby (1969, 1988), Fonagy (2001) and Allen (2011). Visual infant cue cards support professionals to facilitate parental understanding of the importance of responsive parenting enabling carers to develop a stronger bond with their infant. This promoting healthy child development both socially and emotionally. The utilisation of visual infant cue cards supports the Gillam & Sirwardena (2013) report on high staff engagement and empowerment as being vital in delivering high quality care to the public through commissioning.
A wide range of research provides evidence demonstrating that the period between conception and the age of 2 years is a crucial phase of human development. Health Visitors promote secure attachment and consistent relationships with parents or caregivers. Sound parent and infant relationships is the key to successful social development and resilience (Fonagy, 2014). Effective parenting will help infants develop emotional regulation, enhancing neurological development consistent with the ability to develop positive relationships in later life. In adverse environments with poor parental support infants will potentially have lifelong social and wellbeing impairments and will be susceptible to abuse and neglect (Wave Report 2012). Visual Infant Cue Cards can be used to facilitate the understanding by parents of behavioural cues commonly seen in infants.

LOCAL CONTEXT

Participation was required from a range of colleagues, parents and partners to ensure the project’s effectiveness and validity. The following summary outlines in brief those the author has worked alongside: The Health Visiting Working Group; The Clinical Leads for Health Visiting who are responsible for the process of documenting Health Visiting Standards for Practice; The Head of Service who agreed the use of new tool kits; the Library Resource Department to aid literature searching and links to the Research and Development Team; The NHS trust Communications Team to facilitate the sharing of the project across the organisation; the availability and contact points with local EU Migrant Families, including cooperation with employers of these parents; Public Health colleagues in the Local Authority to obtain data on demographics etc.; a printing company to produce the visual infant cue cards and material relating to these.

A Health Visiting Working Group was established to consider evidence and resources for communicating effectively with EU- migrant parents regarding positive infant/parental attachment. Local EU-migrant community groups were contacted for their views and involvement in the development of the Visual Infant and Parent Cue Cards Toolkit.

EU MIGRANTS COMMUNITY

The local community was contacted through a collaborative project with an independent company’s Occupational Health Department (Morrisons PLC). The
The project was supported by a bilingual (Slovakian) Community Nursery Nurse from the BDCT NHS interested in reducing health inequalities in EU-migrant community and supportive of the Visual Infant Cue Cards. The session was planned as a ‘Wellbeing session’. The session was held at the company’s ‘Salad Factory’ with the provision of a stall with information promoting infant parent relationships. The stall was accessible to staff over an afternoon and evening, with over 150 attendees, many of whom were ‘fathers’. Over 100 people indicated an interest in the visual infant cue cards with many fathers showing specific interest in brain development and the neuroscience relating to secure attachment.

PROJECT APPROACH METHODOLOGY

This project is a pilot study. Qualitative methodology gives an interpretation, understanding of people’s thoughts and experiences (Stewart 2007). Focus groups can guide the development of nursing intervention (Jayasekara 2012) in this case the piloting of visual infant cue cards in Health Visiting Practice. Health Visitor involvement will engage practitioners directly with the project. It was anticipated that group processes may help the Health Visitor’s to explain their perceptions about the effectiveness of Visual infant cue cards as conversation starters when discussing parent and infant relationship with EU migrants. A discussion within with Maternal Mental Health Working Group was conducted to gain information, views and input, into the design and content of the pilot visual cue cards. A qualitative approach was used to undertake the project to inform and develop the data collection. The BDCT Research & Development team and Mary Seacole steering group were consulted for ethical guidance. The R&D team determined that full approval was not required as the project was identified to be a service evaluation rather than a designated research project. The project approval was referred to BDCT NHS audit department and approval was gained in December 2014. The transcripts and focus groups notes were stored safely. All other parties that were provided access to the information maintained confidentiality.

Focus groups were conducted following the pilot of visual cue cards in order to gain information about the application and fit of the cards to the situation. The focus groups were audio taped and transcribed. The transcribed text was analysed by thematic content analysis. The method is an inductive process whereby analysis is
used to identify, code and categorise important meanings and themes from the focus 
groups (Stewart & Shamdasani, 2015). The analysis established and highlighted the 
condensed parts of narrative text whilst preserving the central meaning. The process 
provided opportunities for fresh reflection about the data. Codes were reread and 
compared to ensure credibility (Robson 2011). The sub themes were created to 
interpret the dominating themes of Health Visitor’s feelings regarding Visual Cue 
cards. This process generated increased knowledge about the contribution of the 
visual infant cue cards; knowledge of services to support clinical practice within 
BDCT; a wider understanding of how to carry out community link work; a greater 
a wareness of the needs of culturally diverse populations; increased awareness of 
communication skills in working with diverse communities.

Purposive sampling was used. The study consisted of a cross district selection of 5 
Health Visiting team members. Group of A (n=9) and Group B (n=8) Health Visitors 
in each focus group. The focus groups presented rich narrative for the author to 
analyse. The author asked questions related to the following themes:

- Health Visitor Understanding of the concepts and meaning of parent and 
  infant relationship.
- How the cards were used as a tool to promote parent and infant relationship 
  and mental health.
- Challenges using the cards when promoting attachment and parent and 
  infant relationship.
- Contributions of the tool cards in parent–infant relationship.
- Practice implications and recommendations.

**LIMITATIONS**

Focus groups can have high credibility and validity but are susceptible to researcher 
manipulation and bias (Hislop 2015). The open ended nature of responses can make 
summarisation and interpretation difficult.

The group facilitator role is a complex one. The author is a novice in managing focus 
groups and undertook additional training on group dynamics with an experienced 
colleague prior to facilitating the group (Gerrish and Lacey 2010) and also formal 
training by Oxford University Nuffield Health Sciences department.
FINDINGS

Focus groups generated substantiation of Health Visitors views on the Visual Cue Cards tool in discussing Parent and Infant relationship. This generated further insight about ways of implement change, specifically implementing innovative attachment tool. The author gained a deeper knowledge and understanding of local services supporting clinical practice; a wider understanding of community development work.

THEMES TRANSITIONS TO PARENTHOOD

The themes that prevailed were parent’s transitions to parenthood, including: influences that affect the parent and infant relationship; building on relationships; infant observation and drawing on HV practice interventions, particularly communication. Health Visitor’s explored the cultural and social systems whilst being aware of support mechanisms these systems bring to infants and parents. The inter-relational and trans generational concepts of attachment behaviours in parent and infant relationships are complex. There appears to be a need to clarify the concept and interpretations of secure attachment, attachment behaviour in social contexts. Health Visitors were able to label some influences that inhibit the maternal representations such as stress, domestic abuse and violence. Health Visitors’ responses largely link concepts to behavioural and psychotherapeutic frameworks of attachment. Health Visitors appear not to fully consider all microsystem, mesosystem i.e. family relationships in supporting infant –parent relationship and infant mental health. Understanding of parent and infant relationship was largely defined through the Health Visitor intervention and interaction. At times, whilst defining parent and infant relationship Health Visitors demonstrated hesitation and ambiguity.

“Just kind of observing what the responses are between them. Just an assessment really. I think—comes to my mind”. HV P4 “A positive one when you see it going well as well I think it because it’s like that isn’t it” (FGAP7).

("FGAP") "reciprocal because when I am talking to the mum about the baby that she might think is just a baby and it’s really quite difficult to get your head into the thought of what does your baby think and feel...observing a baby as a person that's separate to you”.

This Health Visitor refers to infant awareness and infant identification of regulatory function. This reflects the complexity of the concept of parent and infant relationship.
The statement recognises the importance of infant observation and building relationships as key components of infant mental health.

Health Visitors working in more affluent areas and whom had less experience of working with migrant families defined the concept of parent and infant relationship through the dyad mother and baby. Health Visitors excluded dad as absent but simultaneously described key component that attributes to parent and infant relationship such as this HV states

FGBP2 “just loving relationship between mother and a baby and for mum responding to the cues that will obviously help them through-right through to being teenagers”.

This HV is interpreting the concepts of parent and infant relationship through the microsystem of the immediate family the dyad mother and baby, the Health Visitor identifies the parent-infant interaction and its consequences through the influences of time.

The parent–infant relationship was considered by some Health Visitor’s through professional standards and other Health Visitor attributes such … FGAP1”that we all as Health Visitor’s are keen to be aware and were perceptive I think picking up when things are not quite right…and when things go wrong early on then it’s important we are able to acknowledge it see that and provide support”. These comments link perceptiveness of parent-infant relationship to Health Visitor attributes and collective role and rationale of Health Visiting as a profession.

When the researcher followed on and asked what parent and infant relationship means to Health Visitor the results are interesting. FGBP3 “It means mothers—it doesn’t often need fathers to me.” FGBP5 “we don’t get to see them so it means mothers”. FGP P7 “I also think if I think there’s a positive parent/child relationship it means more work.”

FG A P4 “a positive one when you see it going well as well I think because it’s like that, isn’t it?”

These snippets link the parent–infant relationship back to the assessment .Health Visitor’s are speaking on building on moments of connections between infant and mother but fail to validate the role of father and or the other parent or recognising the importance of other maternal relationships.
FGA P5 “I think it’s very important that it is mum and baby.. we do see a lot where it may well be grandma that is doing the caring. Which is not going to help that mother and baby bonding and attachment and development of that reciprocal relationship”.

FG AP6 “I think it’s isolation in some regards. Because while some have got an interfering grandparent some of them have no one. They’re completely on their own.”

FGA P5 “In some families its very good amount of support so its quite individualistic really...they have friendship groups whereas sometimes I think British families are quite isolated because its nuclear families”.

BUILDING RELATIONSHIPS AND INFANT OBSERVATION

Building relationships is how Health Visitor’s explored the support, bonding and reflects on and reviewed parental capacity to reflect. It demonstrates some knowledge of neurological and physiological impacts of brain development. The theme reviews knowledge and understanding of attachment. Infant observation explores infant’s co-regulation of emotions with their main caregiver. Infant observation elicits the observation of baby’s sleep/wake states and analyses the interaction.

Health Visitor’s describing the use of Conversations starters FGBP 3: “I’d be saying ‘skin to skin’ about being responsive and caring. People don’t always get what it is so that one is not a bad picture is it”.

The Health Visitor was reflecting on her own interaction with parent and also parent–infant interaction. She is drawing on parallels with assessment and Health Visitor toolbox.

FGBP2 links ‘baby watching’ and identifying cues…”we need something that brings all those because breastfeeding, brain development, relationships, feeding your baby, responsive feeding, crying are interlinked.”

FGAP3 “…it’s interesting to hear what she says about baby, whether she is speaking positively about baby or nonchalantly because that’s a big clue.”

FGAP4 “…it’s almost like sometimes a parent does not understand that the baby is not an extension of themselves. The baby is purposeful and pointing that out to them: ‘look the baby did that’.

The above comments present the Health Visitor as able to identify infant cue states, interaction with parents and an awareness of the infant being separate, with
regulatory function. These Health Visitors appear to draw on building relationships and using Conversation starter’s visual cue cards as a tool to identify infant observations with mothers.

**DRAWING ON PARALLELS**

Health Visitor’s reflect and explore on how the application of the cards supports early interaction with infant development. This theme captures the Health Visitor’s role in conveying attentive skills for parent, encouraging the initiatives and receiving the initiatives. Health Visitors are discussing the pragmatism and challenges of the application of the cards. The following group of Health Visitor’s like to use cards collectively in a group setting many preferring the antenatal contact. These Health Visitors feelings align with Department of Health policies of integrated care and early interventions within the transition to parenthood.

**FG B P3** “I’d definitely —yeah ante-natal, definitely all visits”.

FG BP4 “I can imagine at an ante-natal group it would be useful to pass these around, talk a little bit about brain development and acknowledging things that people already know.”

**FGB P3** “when I used to run ante-natal groups we used to show ‘social baby’ DVD and this is similar to this, you’ve pictures and cues whole 1 hour session on that. I would tailor it to individual family.”

**FGB P5** “I like Marion’s idea of using them in group setting. I think that would be really good ante-natal group.

**FG B P9** “..and actually a group where people actually talk and what people have said is what sticks in my mind rather than what I’ve read.”

In the following extracts Health Visitors’ are emerging thoughts around which category of what card and which specific card to use during contacts.

**FGB P3** “So I think for me I would need to be clear about what the cards were saying and about so I suppose it’s getting to know your way around the cards as well because you wouldn’t want to go through them all.”

**FGAP7** “..So I’ve been able to use ‘ready to relate’ cue card and say actually look this is why. And that’s been really interesting as because mums thought ‘oh’. It’s like lights have been switched on”.

**FGA P 2** “I think in the time to change section I’ve used that quite a lot to tell parents that to try to talk around how baby feels when it might be in bouncy chair or settee for hours and they tell you the baby’s been crying a lot.”
HV’s describing the challenges when discussing parent and infant relationship with a tool FGA P2 “we’ve got people who can’t write read or write. Often we have people who have stopped schooling at 10 or 11. That’s really challenging. You’ve got no idea how much are they getting.”

FG A P5 “I think for EU families that would be really crucial as they wont trust us and have the same interpreter go would make the difference.”

FG B P6 “..you tell them things antenatally and you’re like yeah yeah and rose- tinted glasses and it’s all gonna be great when the baby’s here. I won’t need to know that about crying because my baby won’t cry.”

This view identifies the infant regulatory function of crying and the expectations of parenthood. The Health Visitor is drawing on parallels from her own relationship with parent and the relationship between parent and infant.

FG A P2 “...we’re using language that’s quite new to us like ‘mind mindedness’, which you would then break down so it can be interpreted... so if you’re talking about brain development then you’re having to break down a level that actually might stop meaning very much to you as a practitioner.”

FG A P4 “I think it’s isolation in some regards. Because, while some have got an interfering grandparent some of them have no one. They’re completely on their own.”

FG A P6 “In some families it’s very good amount of support so it’s quite individualistic really...they have friendship groups whereas sometimes I think British families are quite isolated because it’s nuclear families”.

Health Visitors’ discussing the contributions of the Visual infant cards in practice. The conversations Visual infant cue cards help Health Visitor to prepare for transitions to parenthood. Specific interventions such as Visual Infant Cue Cards appear to give opportunities for parents to discuss their feelings.

FGA P2 “I have used them and I do feel that they are really helpful because you can pick out-If I was going to go through all of them I would need probably a couple of visits”... “I tend to pick just things I need to tackle with mum or I want to point out positive things to her that’s she doing.”

This Health Visitor demonstrates understanding using the cards as toolkit and facilitating a ‘strength- based’ approach to parenting. HV continues to say “you can see them flourishing with positive feedback like that when you tell something positive” Health Visitor presents an understanding of parent-Health Visitor interaction and explores
bonding in a sensitive and reflective way, promoting building relationships and
drawing on parallel processes.

FG A P1 “..my favourite bit is the ‘ready to relate’ bit, about how it would affect baby’s brain and the
fact that the child needs the parents for their security and their comfort and love.

HV describes using the cards as a toolkit promoting the infant regulatory function,
contingent responses and early brain development. Health Visitor draws parallels on
transitions to parenthood and her own role as practitioner as she continues to say:
“...and that goes beyond just when they’re crying. That’s what I would say in relation to that one with
crying”.

Visual Infant Cue Cards have the potential to reduce communication problems with
a parent whose verbal English skills are limited. NHS Constitution (2013) has
expressed its commitment to provide equitable service to all service users. The
growth in heterogeneity of language is a global issue (Heikkila et al., 2010).

FGA P4 “…it was just lost a lot of emotion, she was trying to ..I could see it non-verbally, but some
detail in the conversation was definitely lost therefore, as it was very complex for her.”

Health Visitor contemplated their own values and beliefs in relation to their HV role
and social context of these parallel processes.

FG A P4 “..walking into house with my mentor and being mortified that there was nothing in the
house…going in and that child had nothing and coming out and thinking ‘oh god’ that can’t be right”..
DISCUSSION

Communication is a pivotal interaction process between a Health Visitor and a parent. Interpretation of language is crucial to the communication process and the therapeutic relationship. There are wider anticipated outcomes within the Health Visiting service, as it progresses with the development of the nationally developed perinatal and infant mental health agenda. The Visual Infant Cue Cards project facilitates an innovative, evidence based toolkit that was piloted by Health Visitors with EU- Migrants. This presented challenges in working with interpreters. At times the interpreters were not acting as conduits of communication but actively getting involved in communication and at times leading conversations instead of Health Visitors hence impacting on quality of rapport with mother. Hadziabic et al (2010) presented similar findings highlighting interpreter’s lack of proficiency in language and organisational routines. Health Visitors raised the problem of inconsistency and training of interpreters. Health Visitors felt that if a different interpreter was present at each contact then this impacted on the Health Visitors ability to discuss attachment and parent infant relationships. Health Visitors demonstrated compassion, paralleling the relationship information from the toolkit. They were therefore not only assessing the relationship, but also eliciting information about the emotional bond between parent and baby.

The Visual infant cue cards project promotes an open, honest and inclusive culture in accordance with the NHS constitution (2013) values, attitudes and principles. The project promotes an environment that values, respects and promotes equality and diversity. BDCFT’s organisational Values (2014) of Respect, Openness, Improvement, Excellence and Together are highlighted in the project. The challenge was implementation to test out proposed changes via pilot Visual Cards before the changes are fully implemented (NHS, 2013). The development of the pilot study of Visual infant cue cards demonstrates the delivery skills and techniques necessary to support the organisation in achieving QIPP (Quality, Innovation, Productivity, and Prevention) objectives.

The role of the lead was to be an innovative change agent to her peers, a role which the lead embraced actively. The lead, whilst having had experience of participating in
a change process as a team member in previous roles, had not previously taken on a specific leadership role of change or nursing innovation therefore this presented unique challenges. The policies and drivers, which were used to facilitate the application of the pilot study, were explored after the Maternal Mental Health Working Group Team collaborated with a cross section of the district’s Health Visitors in identifying health needs gap in service delivery; however this in itself was not a major issue as there is a difference between the ability to recognise the need for an innovation and the public health need to actually implement that change (Hayes, 2002). On reflection, a criticism of this process is that, while a large amount of time, effort and consideration went into the development of the Visual infant cue Cards comparatively less time went into the parental involvement and collaboration despite parents being identified as the main stakeholders. It is the responsibility of the project holder of the change process to decide how to relate to stakeholders and sometimes it is necessary to give more attention to one group over another; however no group should be overlooked (Hayes, 2002).

In future the Health Visitors leading health innovation and undertaking health projects, need to robustly plan, identify and discuss with local community groups what care or interventions they need or want to improve their infant’s and families wellbeing. There is a need for greater investment in Health Visiting innovation from the grassroots, including more time and financial investment from the managerial and commissioning side who carry a the responsibility to their local population. The Health Visiting service needs to respond to changing demographics locally and nationally and to assure the quality and improvement of Health Visiting services for the future. The Government, the Department of Health and other service agencies, national nursing bodies and the funders of research and higher education institutions all have a part to play in reducing health inequalities.

Health visiting itself is a large and essential profession and its contribution to reducing health inequalities and promoting parent and infant relationship for improved perinatal mental health is positive, but it must be evidence-based. The author’s work and findings adds to the evidence of studies of EU migrant population’s health and wellbeing with parent and infant relationships and attachment. Continued Implementation will enable individualised, accessible care for
the local community of EU migrants. The potential universal implementation of visual cue cards within health visiting practice will raise the value placed on the issues of secure attachment; meaningfulness of parent–infant relationships and the behaviours of practitioners and parents, which will result in maximising health and wellbeing outcomes for children and families.
RECOMMENDATIONS

It is recommended further studies are undertaken into the Visual Infant Cue cards to validate them as a tool for Health Visiting practice. There needs to be more effort made on role of father’s. Health Visitors need to be proactive and give consideration to more innovative ways of reaching fathers; fathers are central to the wellbeing of infants and mothers. The profession needs be in tune with current themes and interests and consider addressing infant wellbeing through not only the dyad mother and baby but also through family relationships and dynamics.

During the focus groups, at times the space was used to explore other influences affecting infants and families through the different systems. It was apparent that most HV’s wanted to discuss their work as a whole and appeared to enjoy the collective space and time together. The author felt Health Visitors collectively presented the need to reflect on work and difficult themes. Wider benefits of the project are as follows: potential reduction in mental health issues linked to infant and parent relationships SCIE (2011), NICE (2007); increased collaboration and multi-disciplinary working within NHS trust and local authority, voluntary sector and private sector.
REFERENCES

Allen, G. (2011) Early Intervention: the next steps. Available from:
Children and Adolescents. UK: Springer.

Big Society (2010) Available from:
business-big-society_0.pdf [accessed 8 October 2014].

Born in Bradford (2014) Available from:
http://www.bradfordresearch.nhs.uk/research-teams/maternal-and-child-health-
research-team/maternal-and-child-health-current-research [accessed 8 October
2014].


Care Quality Commissioning Group (2013) Essential standards of Quality and
Safety. Available from:

CQC Report (2015) Available from:
http://www.cqc.org.uk/sites/default/files/cqc_equality_objectives_2015-
2017_20150304.pdf [accessed 22 October 2014].

Health Care Professionals Managers. Available from:
http://www.nhsemployers.org/SiteCollectionDocuments/Managing_change_in_the_N
HS_developing_change_management_skills_aw_030309.pdf (accessed 8.4.13).

1001 Critical days Manifesto (2013) Available from:
http://www.1001criticaldays.co.uk/the_manifesto [accessed 4 October 2014].
DH High Impact Policies (2014) Transition to Parenthood and Early weeks. Available from:


Early years Document (2014) Available from:

Early Years High Impact Area (2014) Available from:

Equality Act (2010) Available from:


Hadziabdic, E. Heikkila, K. Albin, B. Hjelm, K (2011) problems and Consequences in the use of Professional Interpreters: Qualitative Analysis of Incidents from Primary Health Care Nursing Inquiry 18 (3) 253-261


Ingold, K (2014) Needs Assessment Bradford District’s Central and Eastern European Communities City of Bradford Public Health Department


Keygnaert, I Guieu, A Ooms, G Vettenburg, N Temmerman, M Roelens, K Sexual and Reproductive Health of Migrants: Does the EU care? Health Policy 114 215-225


Phillimore, J (2011) Approaches to health provision in the age of supervidersity: Accessing the NHS in Britain’s most diverse city Critical Social Policy 31:5


APPENDICES

APPENDIX 1 – CUE CARDS

Attached separately as PDF

APPENDIX 2 - ETHICS /RESEARCH AND DEVELOPMENT CONSENT

Hi Hille

I am pleased to confirm that the application for the Service Evaluation ‘Supporting EU Migrant Families with Parent and Infant relationships for positive mental health’ was accepted on the 3rd of December 2014 by the Clinical Audit Department of Bradford District Care Trust.

The project was registered and its ID number is S.E.14/15-049

Kind regards

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Focus Group

Times:

7 min Welcome, Introductions and Ground rules

5 min Brief background

5 min Around the room transition Question: When you hear term ‘parent and infant relationship’ what does this mean to you?

35 min Key themes: Observational Infant Cues, Attachment, Mental health, Reflectiveness, Empathy, Emotional regulation

Prompts to key questions:

Tell me about when you discussed parent and infant relationship with migrant parent? Give some concrete examples

What contributes to positive parent and infant relationship?

Are there circumstances in which you feel that these cards are maybe helpful in your work?

Tell me about the some challenges you experience when discussing parent and infant relationship using the cards?

How do you think cards can be developed further?

Conclusion and Ending around the room question:

10 min What do you take from today’s focus group to enhance your practice when discussing parent and infant relationship with EU migrant parent?

Thanks for time and Participation. Lunch will follow.