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From 'public health' to 'safeguarding children': British health visiting in policy, practice and research.

Abstract

Established in the nineteenth century as part of public health work British health visiting has maintained it's unique role in providing universal services to families with young children. Recent policy developments in both safeguarding children and public health have created new opportunities and challenges including an expansion of the safeguarding children gaze and requirements to target services within a framework of universality and with reduced resources. The location and visibility of health visiting in the academy and practice worlds contribute to shaping how the profession is understood providing additional challenges and strengths within an evolving policy context.

Introduction.

Improving health and welfare services and outcomes for children and young people has been a focus for several policy and practice reforms in the United Kingdom over recent years. The previous Labour government introduced an ambitious programme to improve children's services through modernisation, integration and early intervention (Chief Secretary to the Treasury 2003; HM Government 2009); they also mainstreamed policy rhetoric concerned with 'safeguarding children' (Parton 2006) and focused attention towards children's public health and particularly the early years as a means to enhance health outcomes for current and future generations (Association of Public Health Observatories, 2007; Blair *and others*., 2003; Department of Health 2004a). Central to the delivery of these

ambitious agendas is the 'children's workforce', a term that suggests coherence but also blurs occupational and professional boundaries. The plans of the new Coalition government towards children's policy are yet to be fully realised, and although inevitably re-shaped due to budgetary constraints it is anticipated that safeguarding children and public health will remain key issues (HM Government 2010a).

Whilst these policy developments have had wide ranging impact upon many agencies concerned with the health and welfare of children and young people the focus of this particular paper is British health visiting, a long established state sponsored profession with roots in public health nursing and which provides a universal service to families with young children (Elkan and others 2000a). Recent public policy reforms indicate a greater role for health visiting in both public health and safeguarding children, creating a climate of both opportunity and challenge for the profession. These developments include the provision of a targeted service underpinned by universalism, integration within the 'children's workforce', and extensive piloting of models of intensive home visiting to 'high risk' families based upon work undertaken in the USA (HM Government 2006; Olds *and others*., 2002) although there are concerns about the capacity of the health visiting workforce to deliver these policy agendas (Audit Commission 2010; Family and Parenting Institute 2007). Alongside these developments lies a legacy of professional uncertainty arising from lay, professional and governmental confusions about the health visiting role, an uncertainty that appears deeply entrenched within the professional meta-narrative.

At this introductory stage a reflexive turn is required to locate the author as an academic with a professional background in health visiting, and a particular interest in

developing an analytical perspective on professional practice as it cuts across both child safeguarding and public health agendas (see author 2009). This paper aims to examine British health visiting which has an important role within these policy developments but is often less visible in debates than other professional groups such as social work. This reflects wider ambiguities about how health visiting is understood and conceptualised which are examined within this paper. The discussion commences with an overview of the history of health visiting as it emerged and developed in relation to public health.

British Health Visiting and Public Health: History and Context

Emerging at a time of social upheaval and change British health visiting developed amidst early notions of public health work. Responding to concerns about urban poverty and insanitary living conditions, the early health visitors, known as 'Lady Sanitary Inspectors' developed a home visiting role concerned with improving the health of mothers and young children. Whilst portrayed as response to need, this also reflected a wider struggle for occupational roles for women as attempts to engage with more public spheres of public health work such as factory inspection were unsuccessful (Lloyd 1986; Davies 1988). Thus early health visiting was orientated towards the private spheres of home and motherhood, laying the foundations for future professional practice. As Davies (1988, p58) has argued these occupational struggles ".... confirmed health visiting as women's work and helped to set the parameters in which public health work in the community was to develop". There were also governmental concerns about the population's health and fitness for imperial endeavours and this triggered an expansion of state interest in maternal and infant welfare. This coincided with the interests of an available occupational group and by 1914 led to the establishment of health visiting as a state sponsored profession (Dingwall 1977).

This historical narrative which constructs health visiting as a response to 19th century public health problems has been far reaching in shaping contemporary professional identity (Burke 1990; Craig & Smith 1998). A more critical reading has drawn attention to how health visiting became established as a form of gendered state regulation focusing upon mothering. Central to this is how the relationship between health visitors and mothers developed, with the former being constructed as 'mothers friend'. As Davies (1988) has argued this promoted an informality about such contact, and served to disguise the actual nature of state intervention being undertaken, which involves the surveillance of mothers (Dingwall 1977; Dingwall and Robinson 1990).

Whilst the historical origins of health visiting have generated much debate, there has been less interest in tracing it's development during the twentieth century. This was a period of expanded state responsibility for health and welfare provision and afforded important opportunities for professional groups such as health visiting. During this period health visiting was incorporated into the nursing profession and maintained state sponsorship although uncertainties about its role and purpose continued. It's tenacity may be due to professional organisation and trade union affiliation while developments such as training and pay may have contributed to the attractiveness of health visiting as a professional route for nurses who wished to access higher education (Rolls 1992).

The NHS was established in 1948 although health visiting remained under the remit of local authority public health departments until 1974. By this time there was a marked shift of emphasis in public health which, influenced by bio-medicine, was becoming more oriented

towards individual, therapeutic and behavioural change approaches and health visiting was absorbed into the clinical and organisational framework of the NHS, which was providing more comprehensive maternity, paediatric and community services and health education programmes designed to improve maternal and child health. Over the years efforts to expand the health promotion remit to work with the adult and older population (Department of Health 1992; HM Government 1999) as well as alterations to the child health surveillance programme which adopted an evidence-based approach to ensure contacts and interventions were clinically effective (Hall and others 2009) challenged the overall pattern of service delivery to families with young children. Throughout these changes health visiting continued as a universal service to families with young children, delivered through home visiting.

The rediscovery of 'public health' from the 1980's onwards drew attention towards health inequalities and the socio-environmental context (Ashton and Seymour 1988) and provided further opportunities for professional development. Health visitors, always hailed as 'frontline workers', were in a key position to raise concerns about the numerous vulnerabilities facing women and children and, whilst only occasionally achieving political voice, the profession maintained its engagement with key public health issues, often developing specialist roles in areas such as homelessness or traveller health. Whilst notions of public health provide an important foundation for the professional construction of health visiting (Burke 1990; Craig and Smith 1998) there have been considerable challenges in developing this role (Smith 2004; Mackenzie 2008; De La Cuesta 1993). Writing in the 1990's for example De La Cuesta (1993, p665-666) found that despite a '.... move away from the traditional individualistic mode of practice .... to a collectivist or community oriented approach which regards health visiting as enabling and supporting social change' this was far from the modus operandi for many health visitors. More recently and drawing upon

experience of implementing public health policy in Scotland Mackenzie (2008 p. 1035) found '….a lack of shared understanding amongst staff of what public health meant either conceptually or in practice'. Challenges facing health visitors in developing their public health role include the need to establish role clarity, good leadership and links with wider public health networks (Smith 2004).

Public health policy concerned with tackling health inequalities required services to be targeted to those with highest need and this inevitably created challenges to the underpinning universality of health visiting provision (Elkan and others 2000a). The 'principles of health visiting' do include the search for health needs (Cowley & Frost 2006) and this supported drives to undertake health needs assessment at individual and population levels (Twinn and others 1990; Blackburn 1996). Attempts to encourage health visitors to target their practice to meet the needs of vulnerable children and families gained momentum during the early 1990s with the development of structured needs assessments tools. These largely emphasise risk factors for vulnerability and critics have pointed to their inappropriateness in the context of health visiting practice because they restrict professional judgement and the development of professional client relationships (Appleton 1997; Cowley and others 2004). Moreover, drawing upon experiences from the Scottish Starting Well project, Mackenzie (2008, p. 1035) suggests that 'the process of identifying vulnerability is not one that HVs feel comfortable with nor necessarily have the skills to put into action'. Recent findings from this project found that despite the use of standardised practice tools to support a targeted approach, health visitors missed families who subsequently had demonstrably higher needs (Wright and others 2009). It was also found that an anticipated reduction in contacts did not take place as the development of 'relationships with families resulted in an increase in issues identified' (Mackenzie 2008, p 1032-1033).

Targeting services through universal provision is embedded within the reforms in children's services and public health introduced by the Labour government (Blair and others 2003; Chief Secretary to the Treasury 2003). These aimed to tackle health inequalities and poor outcomes particularly in the early years and led to a raft of measures concerned with early identification and intervention focused upon issues such as childhood obesity, emotional health, and accidents and wider concerns such as children living with domestic violence, parental mental health and substance misuse (Blair and others 2003; Department of Health 2008; Department for Children, Schools and Families 2008). Health visitors have a long history of working with children and families who are vulnerable and have additional needs or risk factors (Appleton 1994) and were well placed to respond to the safeguarding children agenda which is discussed further in the following section.

Safeguarding Children - Health Visiting in Recent Policy.

The policy reforms designed to safeguard children and young people heralded a more comprehensive approach to the welfare and safety of all children (Department of Health 2004a; Chief Secretary to the Treasury 2003; Parton 2006). Although the history and origins of these reforms have diverse roots (Parton 2006; Williams 2004) they are particularly salient for health visitors, not only because they are well placed to deliver but also because they reflect longstanding professional concerns about promoting and protecting the health and welfare of young children and families through early intervention and tackling disadvantage (Department of Health 2004b).

Health visitors' frequently work with families where children are vulnerable and where there are 'risk' factors such as domestic abuse, substance misuse and mental health

issues (Crisp & Lister 2004; Appleton 1994) drawing upon professional intuition to recognize when children are vulnerable or in need of protection (Ling & Luker 2000; Appleton 1994). In relation to nursing more generally the need to develop '….better skills in identifying and supporting vulnerable children and families across the workforce with confidence in taking steps to safeguard children at risk' has been highlighted (DoH 2004a, p.6). This is particularly important for health visitors who as part of a policy referred to as 'progressive universalism' are now required to provide tailored services that meets the needs of all service users whilst at the same time ensuring children and young people with additional needs or risk factors receive extra or specialist services (Department of Health 2007; 2008). In other words,

> *'….those with high risk and low protective factors receive more intensive support and those with lower levels of need receive a lighter touch appropriate to their needs' (Department of Health 2007, p. 18).*

Progressive universalism poses particular challenges for health visitors who are expected to undertake a supportive role as 'mother's friend' whilst also involved in identification, surveillance and early intervention of a wider set of vulnerabilities facing children and young people that expand the scope of their gaze beyond more traditional health and developmental concerns (Department of Health 2008, pp. 11-12; author 2009). This requires health visitors to engage in a complex filtering of cases in order to identify and assess clients with additional needs or risk factors (author 2009). That this is being implemented at a time of staff shortages is particularly concerning as it requires health visitors to make assessments based upon limited professional client contact thus undermining

one of the cornerstones of professional practice which is largely relationship-based (Cowley 1995; De La Cuesta 1994).

The safeguarding children reforms have been critiqued because they increase the scope of state surveillance in the lives of children and young people through early identification, improved inter-agency working and greater information sharing. Some critical commentators have argued that this has led to a new era of 'net widening' which may achieve little to secure real protection for children and young people at highest risk of significant harm (see for example Munro 2007; Parton 2006). As Munro (2007) has argued

> *'The UK policy on prevention in child welfare includes a praiseworthy commitment to tackling the social injustice experienced by those children born into adverse circumstances that restrict their opportunities for achieving their potential in life. However, by opting for secondary instead of primary prevention it rests on a number of risky assumptions: that professionals can accurately predict which children will be problematic, that they can intervene effectively, using coercion if necessary, to change the course of children's development, and that there will be adequate resources to meet the needs identified through screening. It fails to consider what harm may be caused by the process of surveillance of families and by labelling children as future problems' (Munro 2007, p 53).*

Although not writing specifically about health visiting the issues raised by Munro (2007) reflect some of the challenges created by the expansive safeguarding children agenda, particularly the policy on progressive universalism.

Another dimension of the safeguarding children agenda of relevance to health visiting is the role played by public and media scrutiny when cases have tragic outcomes. Over the years in the UK child death inquiry reports have played an important role in shaping public perceptions and informing policy within the child welfare arena. However despite the high incidence of child deaths occurring to children under 5 years old and the stated universality of health visiting, the profession has largely avoided scrutiny or critique within this arena, with attention and blame being largely directed towards social care organisations and practice. This occurred following the death of 17 month old Baby Peter in 2007 although the subsequent review of child protection arrangements in England did draw attention towards the safeguarding role in health visiting (Laming 2009; Care Quality Commission 2009a).

> *Health visitors play a key role in child protection, particularly for very young children who are unable to raise the alarm when suffering from abuse or neglect. ….In this context, the role of health visitors as a universal service seeing all children in their home environment with the potential to develop strong relationships with families is crucially important. A robust health visiting service delivered by highly trained skilled professionals who are alert to potentially vulnerable children can save lives (Laming 2009, s 5.21, p. 57-8).*

The publication of the Laming Report (2009) was followed by a flurry of activity to reform the safeguarding children system. The health visiting contribution to safeguarding and protecting children is clearly stated in subsequent policy documents including the revised Working Together guidance (HM Government 2010b) and the Action On Health Visiting

Programme (Department of Health and others 2009). Whilst this suggests that the health visiting role in relation to safeguarding children is clearly recognised and established at least at the level of governmental rhetoric tensions remain in understanding how the various demands upon the role impact upon service delivery at practice level.

Health Visiting in the 21st Century

The above discussion has focused upon recent policy developments which are impacting upon British health visiting. Whilst offering new opportunities for the profession they have also provided additional challenges. Health visiting, although 'well placed' straddles both the public/private domain (Mayall1993) and health and social care, and whilst it has an established professional role within safeguarding and child protection work, it is also driven by a myriad of other public health concerns. These multiple demands on health visiting come at a time of resource shortages, an issue identified in the Audit Commission report about the health of under-5s

> *'Our fieldwork identified that safeguarding is a high priority for health visitors and that, in some cases, it was considered that limited capacity made it difficult for them to discharge their wider health responsibilities. All participants in our fieldwork reported problems with the recruitment and retention of health visitors' (Audit Commission 2010, p. 23).*

It is estimated that health visitor workforce numbers have declined by 13% since 2004 (Audit Commission 2010, p 25). Whilst some of the retention and recruitment difficulties are

due to the ageing workforce, they have been heightened by policy initiatives such as the Family Nurse Partnership which employs many health visitors (Cowley and others 2009; Care Quality Commission 2009b; Audit Commission 2010). Consumer groups have expressed concern about the impact of falling numbers on service delivery (Family and Parenting Institute 2007; Russell 2008) and there have been governmental pledges to strengthen the health visiting service (HM Government 2010a, p 19; Department of Health and others 2009). There are also tensions about the professional role and identity of health visiting. Policy reforms to develop an integrated children's workforce have blurred professional boundaries and created a climate of uncertainty, whilst modernisation plans have emphasised the need to enhance skills and leadership within the health visiting workforce (Department of Health and others 2009). Professional identity has been further eroded through alterations to the professional register which saw health visiting lose its status as a discrete entry and be renamed as a specialist branch of nursing albeit related to community public health.

This section has reviewed recent policy reforms in the areas of public health and safeguarding children which suggest a key role for health visiting. They also create particular challenges due to the expansion of the safeguarding children gaze and the requirement to target service provision within a universal framework. However despite these policy opportunities there remain uncertainties about the health visiting role and its location and visibility in academic and practice worlds which are discussed in the following section.

The Location of Health Visiting in Practice and Research.

The nature of health visiting work which bounded by space and gender cross into the private domain of home and family renders it partly invisible (Mayall 1993; Edwards 1998). It is largely undertaken by women workers and mediated through mothers who have themselves until recently been largely invisible within policy discourses. The spatial dimensions of everyday health visiting practice also contribute to this invisibility. These are multiple and include clients' homes, health centres, community settings, offices and meeting rooms; spaces which are obscured from public view and often within the private domain. Understanding the 'location' of health visiting has been further muddied by numerous spatial and organisational reconfigurations. These have seen health visitors *located* in for example community clinics, health centres, GP surgeries and Children's Centres, but also *co-located* with professionals from other agencies such as social workers, nursery nurses etc (White and Featherstone 2005). These changes in how and where health visitors are located, organisationally and geographically, reflect wider policy developments, but also contribute to a wider sense of spatial dislocation, mobility and uncertainty.

Emergent scholarship in social work has examined the mobilities involved in protecting children and the spatial context of home visiting (Ferguson 2008; 2009). In contrast studies of the 'home visit' in health visiting have largely focused upon aspects of the professional client relationship, such as initiating contact, and assessing client's needs (see for example Cowley 1995; Chalmers 1991) with little attention being paid to more mundane elements such as the spatial, organisational and temporal aspects of home visiting. Indeed very few studies have attempted to explore the everyday work of health visiting and for many people outside the profession this remains a hidden and elusive world. There are of course challenges to opening up occupational worlds in order to observe everyday working practices, although ethnographic research offers opportunities for this form of scholarly

endeavour (Hall and White 2005; Street 1992). Such studies however are resource intensive and require funding as well as an 'a priori' interest in the professional and institutional practices being investigated.

The absence of such scrutiny of health visiting through scholarship may reflect a wider epistemological dislocation. Whilst studies examining professional practice have been undertaken by researchers with a health visiting background, there has not been a coherent programme of research about health visiting. This reflects a wider issue about knowledge generation and research into health visiting, which caught between various disciplines such as nursing, medicine and social work, has struggled to establish itself as a discrete discipline underpinned by a scholarly body of work. This does however leave real difficulties in understanding the knowledge base of health visiting. Health visiting has its roots in nursing, and yet unlike other nursing specialities is removed spatially and philosophically from nursing knowledge and practice. The profession has a definitive focus upon 'health' although as Robinson (1992) has observed this is an abstract concept and may itself further contribute to professional uncertainty, particularly as it is a diverse and socially constructed concept (Blaxter 2004). The ambiguous and contested knowledge and practice may reflect the complexities and contradictions inherent within the historical and contemporary narratives of health visiting. Public health is a good example as this is itself a contested and multifarious discipline heavily but not exclusively informed by medical discourses.

There have been various attempts to develop a theoretical or conceptual basis for health visiting. Bryans et al (2009 p. 564) for example argue that 'the continuing absence of a comprehensive and integrated conceptual basis for practice has a negative impact on the

profession's ability to respond to current challenges'. They have proposed a framework to conceptualise health visiting practice based upon the ecological, 'person-in-context' framework developed by Bronfenbrenner (1979), which is widely used in social care frameworks (Bryans and others 2009). In a qualitative study examining mother's perceptions of health visiting, Plews and others (2005) found that the provision of social support enhanced the wellbeing of clients and contributed to their ability to cope. They argue that the theory of social support provides one means for describing and explaining the benefits of health visiting for clients.

An important driver for health visiting research has been the need to demonstrate evidence based practice which is orientated towards effectiveness of interventions and outcomes. The nature of health visiting work with children and families creates very real difficulties for attributing outcomes to health visiting involvement (Elkan and others 2000b) and judging practice within these parameters has probably obscured the wider professional contribution to many areas of health and social care. Nevertheless a preoccupation with professional certainty has been a constant thread in the history of health visiting (Robinson 1985; Robinson 1992) and has shaped a great deal of theorising and writing about the profession. In contrast and given the influence of postmodern ideas in scholarhip about health and welfare (see for example Fox 1994; Cheek & Rudge 1994; Parton 1991) it is notable that health visiting has not been theorised through the lens of postmodernity. This may reflect the location and relationship of health visiting to the academy or indeed may be a more pragmatic concern with professional survival.

Conclusion

This paper has examined the location of health visiting in contemporary policy discourses concerned with public health and safeguarding children. Tracing its' history through public health work with children and families provides a lens to understand professional identity and orientation. That this now coincides with an expansive safeguarding children agenda has provided additional opportunities for health visiting development although one not without challenges. These include the requirement to undertake a progressive universal approach to service provision which incorporates a broad concept of risk and requires early intervention. Alongside these very real policy challenges are a number of issues stemming from the ways in which health visiting is understood and represented to others in the academic, policy and practice worlds. Whilst the gendered nature of health visiting work contributes to it's invisibility it also has a relatively weak position within the academy and has struggled to establish a coherent knowledge base.

Despite the lack of a meta-narrative for health visiting, it is important to acknowledge its enduring nature. Indeed although uncertainty about the future of health visiting has been an ongoing feature of the professional narrative it has a remained a key and universal service within the British welfare state. This may because health visiting always meets a central policy objective whether that is concerned with child protection, early intervention or public health. Indeed the lack of certainty or meta-narrative about health visiting may itself be a strength, enabling the profession to adapt itself in response to policy and practice developments. Thus as this paper has illustrated it is important to both celebrate and critique the survival of health visiting which is ever-present, often invisible and probably threatened by future policy and budgetary reforms in the UK.

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