

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

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This study examines the location of British health visiting in contemporary policy discourses concerned with public health and safeguarding children. It argues that professional identity and orientation can be understood through health visiting's long history of public health work with children and families, which has included an engagement with protecting children. The expansive safeguarding children agenda, which includes the requirement to undertake a progressive universal approach to service provision and which incorporates a broad concept of risk and requires early intervention, has created tensions, particularly given current workforce constraints. The location and visibility of British health visiting in the academic and practice worlds also shape how the profession is understood. © 2011 The Author(s). Children & Society © 2011 National Children's Bureau and Blackwell Publishing Limited.

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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 UK 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, 2004). Central to the delivery of these ambitious agendas is the 'children's workforce', a term that not only suggests coherence but also blurs occupational and professional boundaries. Although the plans of the new Coalition government towards children's policy are yet to be fully realised, safeguarding children and public health will continue as key themes (HM Government, 2010a).

Although 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 study is British health visiting, a long established state-sponsored profession with roots in public health and now a specialist branch of nursing providing universal services to families with young children (Elkan and others, 2000a). Recent initiatives that particularly impact upon health visiting policy include the introduction of a standardised Healthy Child

Programme, which incorporates a progressive universal stance to service provision (Department of Health, 2009), 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). Amidst concerns about the capacity of the workforce to deliver these policy agendas (Audit Commission, 2010; Family and Parenting Institute, 2007), the government have announced the creation of additional health visitor posts that suggest a commitment towards maintaining health visiting despite wider public sector fiscal restraints (Department of Health, 2011).

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 Peckover, 2009). This study aims to examine British health visiting which has an important role in delivering services to children and families 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. Although portrayed as a 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 (Davies, 1988; Lloyd, 1986). Thus, early health visiting was orientated towards the private spheres of home and motherhood, laying the foundations for future professional practice. As Davies (1988, p. 58) 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 that 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 that constructs health visiting as a response to 19th-century public health problems has been far reaching in shaping contemporary professional identity (Burke, 1990; Craig and 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 approach 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).

Although the historical origins of health visiting have generated much debate, there has been less interest in tracing its development during the 20th 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 acquired professional status along with nursing and midwifery, and maintained state sponsorship, although uncertainties about its role and purpose continued. Its tenacity may be due to professional organisation and trade union affiliation, whereas 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).

In 1974, 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. This reflected developments in public health, which informed by bio-medicine, was becoming more orientated towards individual, therapeutic and behavioural change approaches. Over the years, an expansion of the health promotion remit of health visitors to include work with the adult and older population (Department of Health, 1992; HM Government, 1999) as well as alterations to the child health surveillance programme that 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 1980s 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, although 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. Although 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 (De La Cuesta, 1993; Mackenzie, 2008; Smith, 2004). Indeed, Mackenzie (2008, p. 1035) drawing upon experience of implementing public health policy in Scotland observed '... a lack of shared understanding amongst staff of what public health meant either conceptually or in practice'.

The drive to tackle health inequalities has required services to be targeted to those with highest need and this inevitably created tensions to the universality of health visiting provision (Elkan and others, 2000a). An important framework for practice known as the 'principles of health visiting' include the search for health needs (Cowley and Frost, 2006), and this supported drives to undertake health needs assessment at individual and population levels (Blackburn, 1996; Twinn and others, 1990). 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 a public health project in Scotland, Mackenzie (2008) 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). Furthermore, the project 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, pp. 1032–1033). This raises further questions for practice as the contemporary child health policy framework shaping health visiting assumes that, after the initial contact and assessment of need, future contact with families will be substantially reduced (Department of Health, 2009).

Safeguarding children: health visiting in recent policy

Although public health provides an important backdrop for understanding the history and context for health visiting work in the UK, the realm of child protection policy and practice provides an additional layer for understanding how this professional role has developed. Health visitors have a long history of working with families where children are vulnerable and at risk of harm (Appleton, 1994; Bass, 1995; Crisp and Lister, 2004; Ling and Luker, 2000). This is largely due to their front-line role that involves universal access to young children and families and has thus placed them in a key position for the prevention, detection and monitoring of child maltreatment (Appleton, 1994; Crisp and Lister, 2004; Robinson, 1982). There has been much debate about the surveillant elements of health visiting work (see e.g. Dingwall and Robinson, 1990; Peckover, 2002), although their specific child protection functions have received less attention. As Cowley and others (2004) have commented,

In the last decade, there has been a dearth of research or papers commenting on the child protection functions of health visitors. This silence on the subject runs counter to the experience of most practising health visitors whose daily work is still taken up with much child welfare work. However, it reflects the official rhetoric, which is that child protection duties are primarily the concern of social, not health, services. (Cowley and others, 2004, p. 506)

The health visiting role in child protection processes includes, for example, making referrals to social services, attending and contributing to case conferences, core groups and legal proceedings as well as engaging in multi-agency case work with vulnerable children and families, roles and responsibilities that reflect the increasingly proceduralised context of child protection in the UK (HM Government, 2010b; Parton, 2006).

The policy reforms designed to safeguard children and young people introduced by the previous Labour government were, however, particularly salient for health visitors (Chief Secretary to the Treasury, 2003; Department of Health, 2004; Parton, 2006). In heralding a more comprehensive approach to the welfare and safety of all children, these reforms were ambitious and reflected the increasing recognition that child maltreatment is a public health issue (see Gilbert and others, 2009). Key elements of these reforms included the emphasis on early intervention, multi-agency working and information sharing to achieve an outcome-based approach to the welfare and safety of children. Some critical commentators have argued that this increased the scope of state surveillance in the lives of children and young people and led to a new era of 'net widening', which may achieve little to secure real protection for children and young people at the highest risk of significant harm (see e.g. Munro, 2007; Parton, 2006).

The safeguarding children reforms have a number of implications for health visiting drawing them into new models of multi-agency working and information sharing at an early

intervention level. This required engagement with technologies such as the Common Assessment Framework, which as White and others (2009) have argued has the potential to constrain rather than support professional practice. The reforms also require health visitors 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, 2009). Referred to as 'progressive universalism', this underpins, for example, the Healthy Child Programme (Department of Health, 2009), which states

If we are to reduce inequalities in children's health, wellbeing and achievement, we need to focus on the most vulnerable children and families, and allocate resources accordingly. One of the HCP's key roles is to identify children with high risk and low protective factors, and to ensure that these families receive a personalised service. (Department of Health, 2009, p. 14)

Progressive universalism poses tensions 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 (Peckover, 2009; Department of Health, 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 (Peckover, 2009) including, for example, poverty, mental illness, substance misuse, debt, poor housing and domestic violence (Department of Health, 2009, p. 14). Whilst this draws upon their professional intuition to recognise when children are vulnerable or in need of protection (Appleton, 1994; Crisp and Lister, 2004; Ling and Luker, 2000), there are concerns that this policy is being implemented at a time of staff shortages 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). In a wider critique of the safeguarding children agenda, 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 of 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 five 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 (Care Quality Commission, 2009a; Lord Laming, 2009).

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. (Lord Laming, 2009, s 5.21, p. 57–58)

The publication of the Lord Laming (2009) Report 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). Although 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.

These multiple demands on health visiting come at a time of resource shortages. A report by the Audit Commission about the health of under-5s estimated health visitor workforce numbers have declined by 13% since 2004 (Audit Commission, 2010, p. 25). Consumer groups have also expressed concern about the impact of falling numbers on service delivery (Family and Parenting Institute, 2007; Russell, 2008). This is not only due in part to the ageing workforce, but also exacerbated by policy initiatives such as the Family Nurse Partnership, a pilot programme of targeted home visiting being rolled out in England and Wales that employs many health visitors (Audit Commission, 2010; Care Quality Commission, 2009b; Cowley and others, 2009). Although this may be remedied as a result of planned governmental investment in health visiting, the impact of such announcements are yet to be realised in practice (Department of Health, 2011; Department of Health and others, 2009; HM Government, 2010a, p. 19).

This review of recent policy reforms in the areas of public health and safeguarding children suggest a key role for health visiting. They also create particular difficulties due to the expansion of the safeguarding children gaze and the requirement to target service provision within a universal framework. However, despite these policy developments, 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 gendered and spatial dimensions of health visiting work make it partly invisible (Edwards, 1998; Mayall, 1993). 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 that are obscured from public view and often within the private domain. Understanding the 'location' of health visiting has been further muddled by numerous spatial and organisational reconfigurations. These have seen health visitors not

only *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, not only 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 e.g. Chalmers, 1991; Cowley, 1995) with little attention being paid to more mundane elements such as the spatial, organisational and temporal aspects of home visiting. There are, of course, difficulties in 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). Studies that have examined health visiting work range from small-scale largely qualitative studies of professional practice often undertaken by individual researchers with a health visiting background (see e.g. Clark, 1973; Cowley, 1995) to more focused research and trials (see e.g. Elkan and others, 2000b; Morrell and others, 2009; Wiggins and others, 2004). Although these studies have made a valuable contribution to date, there has not been a coherent programme of research about health visiting (see Community Practitioner and Health Visitors Association/Unite, 2009; Cowley and Bidmead, 2009).

The absence of such scrutiny of health visiting through scholarship reflects a wider epistemological dislocation. Health visiting, 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 has been explored by Hoskins (2009) who in identifying the lack of coherent evidence base for health visiting in relation to public health work points to its limited foothold in universities particularly at professorial level, and lack of dedicated high-quality journal outlets. As he states 'These factors have combined to stifle academic debate and new ideas as to what public health nursing is and could become' (Hoskins, 2009, p. 96).

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 (1985) has observed this is an abstract concept and may contribute to professional uncertainty, particularly as it is diverse and socially constructed (Blaxter, 2004). There have been various attempts to develop a theoretical or conceptual basis for health visiting. Bryans and others (2009, p. 564), for example, have proposed a framework to conceptualise health visiting practice based upon the ecological, 'person-in-context' framework developed by Bronfenbrenner (1979), widely used in social care frameworks (Bryans and others, 2009). Plews and others (2005), drawing on research examining mother's perceptions of health visiting, suggest that the theory of social support provides one means for describing and explaining the benefits of health visiting for clients. 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.

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, 2000c) 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, 1992) and has shaped a great deal of theorising and writing about the profession. In contrast and given the influence of post-modern ideas in scholarship about health and welfare (see e.g. Cheek and Rudge, 1994; Fox, 1994; Parton, 1991), it is notable that health visiting has not been theorised through the lens of post-modernity. This may reflect the location and relationship of health visiting to the academic world 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 that incorporates a broad concept of risk and requires early intervention. Alongside these, very real policy tensions 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. Although the gendered nature of health visiting work contributes to its invisibility, it also has a relatively weak position within the academic world 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 remained a key and a universal service within the British welfare state. This may be 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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