PhD Thesis

Title:

Addressing the Needs of Children under 'Universal' and 'Vulnerable' Caseloads – A Psychosocial Case Study of Health Visitors within an Inner London Borough

Submitted By

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Contents

Glossary / Abbreviations

CPP	Child Protection Plan - for children who are placed on local authority register as having needs under s.47 of Children Act 1989 for protection due to actual or potential significant harm caused by: physical, emotional or sexual abuse or neglect.
CIN	Child In Need - for children who are placed on local authority register as having needs under s.17 of Children Act 1989 for additional support to achieve or maintain a reasonable level of health or development.
Conditional Positive Regard	A concept developed by Carl Rogers and used to describe situation where HVs only give acceptance to parents/carers and families who have met their set conditions, standards, behavioural changes, parenting advice and/or expectations.
HV/HVs	Health visitor / Health visitors
HVS	Health visiting service
KPIs	Key Performance Indicators
LAC	Looked After Child
Needs	Parents or carers have responsibility to meet the basic survival needs of their children, including feeling of safety, shelter, education, food, clothing, stability, medical care and protection from harm. These also include emotional needs such as love, routines and structure, positive role model.
Universal Children	Children and families whose needs are addressed under routine health visiting services, including health promotion, child development and parenting services.
Unconditional Positive Regard	This is in contrast with CPR and describes a situation where HVs engagement with parents, carers and families focuses on the needs of the child, regardless of who they are.
Vulnerable Children	Children and families whose needs require both universal and additional interventions from the HVS. SCRs: Serious Case Reviews

Abstract

The health visiting service (HVS) offers preventative 'universal' and 'enhanced' services, and remains the most cost-effective method of providing early support to families to reduce inequalities and enhance outcomes for children (Department of Health and Department for Children Schools and Families, 2009). Child abuse remains an emotive subject and people are emotionally moved when they hear about a child suffering serious injury or death due to abuse or neglect by a caregiver. The blame culture is often evident in the lessons from Serious Case Reviews which investigate deaths of children known to multi-disciplinary safeguarding partnership agencies. The focus on blame means lessons are often dislodged from engaging with practitioners and organisations to enhance child-centred service, built on *compassion* and *sensitivity (*Rawlings, et al, 2014). This study seeks to explore **h**ow HVs respond to the diverse needs of children within the conflicting demands of contemporary practice which involve relationship building with children and families, meeting commissioning targets as measured in key performance indicators (KPIs) and achieving the organisational objectives of promoting safety, reducing inequality and enhancing outcomes for children.

The approach adopted in the study was a three-phase process developed in a mixed methods research to address the research questions. In phases one and two, data were collected from 100 clients' case notes using stratified random sampling methods and mixed methods to analyse the data. The case notes included were records of children who came in contact with the HVs between January 2016 to December 2016, and case notes which did not meet these criteria were excluded from the study. In phase three a quota sampling method was applied to select 20 HVs who worked in an Inner London Borough within the specified period; and were interviewed, with interview data analysed in this phase. The HVs employed via staff bank or agency were excluded from the study. The research received approval from Middlesex University Ethics (appendix 8c) and the local NHS Trust Ethics Committees.

The key finding of this research is the significance of client-professional relationship which emerged as the overridding factor influencing child and family assessment, needs identification, engagement with services that enhance outcomes for children. Whilst significantly high numbers of children from Black and Minority Ethnicity (BAME) background were classified as vulnerable compared to White children, significantly less number of BAME families was seen to access HVS compared with White families. Because of the desire to secure and develop relationship with families and address the needs of children, HVs spent a disproportionate amount of time working with vulnerable families compared to those receiving universal services. Other influencing factors include: uncertainty in defining threshold of needs and interventions, interpretations of risk and

vulnerability, high work demands and low control over client's acceptance of service offer or engagement with professionals seem to generate high level of emotions. These also raise anxiety among HVs which provoke practice that tends to suggest defensiveness and paternalism towards families.

The key finding of this research is the significance of client-professional relationship which emerged as the overridding factor influencing child and family assessment, needs identification, engagement with services that enhance outcomes for children. Whilst significantly high numbers of children from BAME background were classified as vulnerable compared to White children, significantly less number of BAME families were seen to access HVS compared with White families. Because of the desire to secure relationship with families and address the needs of children, HVs spent a disproportionate amount of time for vulnerable families compared to those under universal services. Other influencing factors include: uncertainty in threshold definitions and interpretations of risk and vulnerability, high work demands and low control, and high level of emotions and raised anxiety among HVs and these provoke paternalism and defensiveness in practice.

It could be argued that the influence of forensic approaches to addressing needs of families have driven health visiting practice to focus on risk assessment and child protection procedures at the expense of its traditional preventative and supportive work based on relationship with families thereby undermining child-centredness. The research findings have implications for health visiting practice and policy makers in seeking reasonable balance on demands from HVs to implement the national Healthy Child Programmes and responding to additional needs of children and families. The critical issues are for commissioners and managers to prioritise the emotional demands of health visiting work, and also to provide consistent supervision, reflective spaces and family-focused relationship training as the core of any approach and policy to safeguard and protect children.

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Chapter 1 - Introduction

"A future cannot be brought into being until we experience and consciously call to mind the meaning and significance of tragedy, both as a private trouble and as a public issue at this point in history" (Lawrence, 2000, p2O9).

"There can be no keener revelation of a society's soul than the way in which it treats her children". Nelson Mandela

1.1 Background

The focus of this thesis is on developing understanding about how health visitors define and classify children as under 'universal' and 'vulnerable' caseloads, exploring the psychosocial forces that influence this process. Thus I examine the dynamics of 'health visiting identity' and 'child-centeredness' as relevant psychosocial concepts for this thesis. I also consider the concepts of 'risk' and 'vulnerability', policies, a broad-spectrum of academic-informed literature on children and family practice, including health and social care, and ethical principles in decision-making within the changing political and policy contexts in child health and development against the backdrop of 'risk society'. I draw on psychoanalytic principles to offer analysis of findings for this research, and by integrating the theoretical framework and literature review I was able to address the research questions. The knowledge produced from this thesis can inform future policy, practice and research. Health visitors (HVs) are registered nurses/midwives with additional training to provide community public health service based on best evidence of what works for individuals, families and communities; enhancing health and reducing health inequalities through a proactive, universal service for all children 0-5 years and for vulnerable populations targeted according to need (Institute of Health Visiting, 2018). The 'universal Service' provides a platform from which to reach out to individuals and vulnerable groups. Located at the centre of challenging and seemingly dichotomous positions, HVs 'advocate for and support' children and families; but are sometimes criticised as using 'surveillance' to identify faulty or defective parenting and this surveillance is likely to increase anxiety among parents. The aims of work around child abuse and neglect prevention strategies have sometimes been weakened by blame culture driven by 'risk society', thereby creating a complex agenda associated with fear and emotions that increasingly raises identity crisis likely to stifle confidence and work

satisfaction within the Health Visiting profession. The gradual shift from a relationship-based ethos as core within the role of HVs is perceived to be fracturing its prior commitments to a preventative public health agenda that support families, thereby provoking alteration in modes of knowledge that informs health visiting service (HVS) and practice. The divergence between the historical and current role of HVs is influenced by professional tensions, variability in thresholds for defining risks and needs and have been caught in the vagaries of inconsistent policies and bureaucratised approaches to safeguarding and child protection in the last three decades. There is a relatively low number of children who suffer abuse and neglect compared to other western and developing countries (Arora, et al, 2015). However, the emotions and public outcry following child abuse incidents often provoke responses predicated on blame and scapegoating thereby infusing high levels of anxiety and tensions into practice; and statutory reforms and policies which tend to be reactive rather than proactive toward 'child-centeredness'. Thus drawing on the views of 20 HVs, statutory documents and academic materials together with contemporaneous notes of the official account of HVs' interactions with children and families in HVS within a London Borough, this thesis provides a detailed analysis of practice and policies in relation to children. The focus is on how HVs understand the needs of children, recognise 'risks' and develop strategies to prevent the child suffering significant harm from his or her care giver or parent.

The argument I put forward in this thesis is that for an effective response to the needs of children and families in HVS within contemporary society, there is a need to re-conceptualise the 'person in practice' – the child, parent and practitioner, which acknowledges the uniqueness of circumstances of individual child and family, rather than 'forensic-based' ways of working (Foucault, 1998; 1995; 1991; Bowlby, 1958). The centrality of the approach is the 'child and young persons' alongside parent-practitioner relationship, acknowledging the complex and holistic – rational, unpredictable and emotional - nature of human behaviours. This study draws significant inspiration from the work of Menzies Lyth (1990; 1960; 1960a). The attention of Isabel Menzies Lyth, a British psychoanalyst, was repeatedly drawn to the high level of distress, tension, and anxieties among nurses. She found that it was increasingly difficult to tolerate such anxiety as generated in the course of their work with the patients they cared for, hence voluntary withdrawal from duty or nursing training, spiral in rates of absenteeism, sickness, staff turnover, poor staff retention were predominant features that hospital organisations had to contain with. It was becoming important for Menzies Lyth (1960), to understand the nature of the anxiety and the reasons for its intensity and what could therapeutically bring relieve to ameliorate the experience. The relief of nurses' anxieties proved to have a close connection with the organisational interventions which introduced effective staff-patient allocation techniques, giving attention to nurses' skills, experience, the needs and number of patients allocated. In psychosocial studies, I recognise the equal interest to understand 'emotions' and 'affect' of HVs and their work in a

research context but not as a psychotherapist or psychoanalyst, hence I focus the thesis on psychoanalytic concepts and principles to illuminate core issues within the psychosocial research method (Schofield, 1998) to examine the nuances of public health and safeguarding children roles in HVS.

1.2 Chapter Two

This chapter explores the theoretical orientation of this research based on psychosocial principles focusing on 'child-centeredness' as an overarching framework for this thesis. I describe a brief history of health visiting and how the role has developed over the years, with challenges and opportunities for future changes. The HVs work with children and families and interactions with individuals is a function of unpredictable behaviours and subjective actions influenced by a number of psychosocial forces. Thus the HV-client connotes emotional dilemmas associated with encounter with these diverse behaviours developing transference and counter-transference dynamics explored in this chapter. Child-centeredness is enhanced in contexts where universal and vulnerable children's needs are appropriately identified and addressed.

1.3 Chapter Three

This chapter examines health visiting, safeguarding and child protection policies, statutory and non-statutory guidance as summarised in appendix 13; and I examine how HVs attempt to integrate these policies, along with psychosocial and risk theory into their decision-making processes. I trace the historical principles of safeguarding and child protection policies in England, and argue that these policies are intertwined within public health and wellbeing domains that are integral to HVS agenda. This raises the issue of power in relationship which clients often perceive as surveillance by government agents, including professionals e.g. doctors, health visitors and social workers, as they exercise power over clients through their expert knowledge. The understanding places high demands on HVs from organisation, KPIs and the need to protect children from harm. I attempt to adapt ideas, which have been explored and developed by social work academics, in describing the responses of some HVs to these emotional demands in practice using the psychoanalytic principles, highlighting such characteristics as '*turning a blind eye'* (Steiner, 1985), which means failure to see what is before one's eyes or seen as an '*attack on linking'* (Bion 1967), the systematic interruption by HVs to prevent link to their source of anxiety. I also explore the idea of 'good enough parent' by Winnicott (1973) and Bettelheim (1988) to develop understanding about expectations from parents and the multi-faceted factors which impact on parenting.

1.4 Chapter Four

This chapter describes the research methodology I adopted, and is divided into five sections to justify the research methods adopted in the study. Firstly, it explores the basis for mixed research methods, and highlights the relevance of case notes and interviews as main sources of data in the 3-Phase research design. Secondly, it sets the inclusion and exclusion criteria for both case notes and HVs who participated in the research and offers description of sampling decision-making and methods. Thirdly, the section covers data collection and data analysis in each of the 3-Phases. Fourthly, the validity and generalisability of chosen research methods are explored. Finally, a summary of the chapter is provided, reflecting on the spiral process that emerged in the research process. As this study is focusing on HV-client relations and encounter with daily lives of families, mixed methods research, therefore, provide multiple lenses through which problems can be seen and addressed. However, the design process led to mixing more qualitative data than quantitative data in the research, leading to an emphasis on a qualitative approach with less focus on quantitative methods. However, the quantitative aspects contributed in complementing the breadth and depth of knowledge about the work of HVs. I concluded the chapter with a personal reflection on the research and its interaction with local policy and practice as an insider-researcher in a senior role.

1.5 Chapter Five –Research Findings

This chapter provides the summary of findings from the research, bringing together the descriptive and interpretive narratives from case notes and interview of HVs (table 5.1). The findings address the primary research question so as to achieve the research objectives. Whilst findings from Phase 1 answered the research question by identifying and analysing characteristics of case notes, Phase 2 focused on the content of case notes already reviewed in Phase 1. Phase 3 findings are based on descriptive accounts from 20 HVs interviewed; highlighting the subjective, psychosocial processes that influence their definition of children's' needs and risk of child abuse, how these were addressed under the principle of 'Proportionate Universalism' and the ethos of 'child-centeredness'. 'The client-HV relationship emerged as a fundamental concept in HVS. Other significant findings in defining needs of the child were by assessment of risks and health needs. However, the effectiveness of this process and outcomes depend on HVs' attitudes, experiences, training, cultural orientations and organisational culture. The process generates significant emotions and anxieties among HVs. whilst some HVs have developed resilience through reflectivity, reflexivity and supervision; others find it difficult to cope, resulting in paternalism and defensiveness in practice and poor outcomes for children and family.

1.6 Chapters Six - Eight: Discussion of Findings

In this chapter I discuss the central findings focusing on parent-HV relationship as a significant theme that touches the fundamental principle of HVS. There are compelling reasons from philosophical, policy and practice perspectives to place relationships at the heart of HVS. The significance of relationship-based practice is established in traditional social work (Ruch and Julkunen, 2016; Ruch, et al, 2010; Ruch, 2007), but this concept is not emphasised across domains of health visiting practice. Despite the importance of relationship, the HVS organisation does not acknowledge this concept as integral to addressing the health needs of children. However, the parent-professional relationship is essential to the achievement of 'child-centredness' and 'thinking family' ideas for successful implementation of HCP outcomes in which HVs are lead professionals (NHS England, 2014; DOH, 2009). It is argued that relationships with children, parents and families can be complex, and HVs may lack awareness about 'self' and negotiation of inter-personal boundaries. Work culture in the contemporary HVS environment does not effectively promote relationships. This chapter highlights needs for an urgent and radical shift to allow issues of power, agency and status to be addressed. I explore the social and psychoanalytic principles in policy and research to make sense of how these integrate into the decision-making of HVs and how they define and classify children according to needs and the the emotional impacts on the practitioners. I discuss how HVs conceptualise 'risk and vulnerability' in relation to the prevention of child abuse and neglect in their caseloads. The response to needs of children through Proportionate Universalism aim is to reduce 'risk and vulnerabilities' of families; but is often encapsulated in power relationships as expressed in parent-HV interactions.

1.7 Chapter Seven - Conclusion

In the concluding part of this thesis, I provide a summary of the thesis, with implications for health visiting and other professionals working with children and families. HVs remain at the forefront of early interventions for children and families, according to public health agenda, involving supports and health surveillance. However, this chapter highlights the shift from traditional health visiting practice in response to needs in modern society as encapsulated in the increasing risks and complexity of children's needs, inconsistent organisational supports and low work morale and emotional impacts on HVs. This highlights the significance of client-HV relationship in HVS founded on a public health philosophy rather than forensic-approach and pathogenic undertones. Thus the argument raised in this thesis supports strategies and interventions that promote the practitioner-client relationship as enhanced through training, restorative supervision and offer of a safe space to reflect on the 'risks' and 'needs' of children and families. I examine the experience of of HVs, their distress and emotional wellbeing, which raise the potential for error in

judgements, ‘transference/counter-transference’ into parent-HV relationship and decision-making process.

1.8 The Research Question:

How do HVs respond to the diverse needs of children within the conflicting demands of contemporary practice which involve relationship building, meeting set targets as measured in key performance indicators (KPIs) and achieving the organisational objectives of preventing harm to children?

1.9 Research aims and objectives

- To understand the psychosocial influence on how HVs define and classify children under ‘universal’ and ‘vulnerable’ caseloads in their practice and how the concepts of risk and vulnerability relate to safeguarding and child protection roles and policies.
- To explore the circumstances of ‘vulnerability’, in a child and family, their needs and how HVs respond to these needs in early support and interventions in practice.
- To understand the challenges HVs face in assessing risks and responding to the needs of children and families, the potential barriers and facilitators of health needs assessment and how these challenges are overcome in practice.
- Understand how HVs develop relationships with parents in order to reduce child abuse and neglect and ensure children meet their developmental and health outcomes
- To explore the sources of professional tension and anxieties and corrective strategies to sustain health visiting practice

1.10 Rationale for the Choice of Research Interest

Over the years I have worked in different clinical settings including: forensic nursing in young offenders and adult prisons, general nursing in hospital wards, midwife in hospital and community, and currently in a specialist health visiting (safeguarding) role / researcher. I have recognised the value of relationship, especially for working in partnership with parents and families who demonstrate receptivity, enthusiasm and show interest in getting support around safety, their health and wellbeing and their children’s. I recognise some parents may not engage with services to support their needs, hence my interest in exploring how HVs develop resilience, especially in their relationship with parents to achieve child-centredness in their practice. I have followed with interest the debates on how health professionals perceived ‘risk’ and ‘vulnerability’ in children in relation to prevention of child abuse and neglect whilst working as a midwife and supporting mothers who experienced difficulty in bonding physically or emotionally with their

children, and unable to establish secure attachment with their infants. The interest became rekindled when I started my work as a HV with specialist interest in safeguarding; a role which requires me to: provide safeguarding supervision to HVs, including clinical and non-clinical staff within the organisation. Whilst in this role, I proactively engage with HVs to deliver frontline services and provide specialist safeguarding information, advice, guidance and support to promote safety, health and welfare of children. The role also involves offering expert clinical and professional advice to a range of HVs and clinical staff in all matters relating to safeguarding and protection of children, as consistent with Local Authority and NHS safeguarding and Child Protection procedures. At the frontline, some HVs have reported encountering difficulties initiating relationship with clients; and this hinders the offer of on-going support to children and families under 'universal' and 'vulnerable' caseloads, especially those requiring intensive, multi-agency involvement.

It is within the above context that this study developed, exploring the contemporary and historical role of HVs, with particular reference to psychosocial theory in the scoping literature. I examined the relational orientation of these roles, as against 'forensic' or 'surveillance' based practice in health visiting; which involved seeking the meaning of 'relationship' and how HVs routinely conduct interactions with parents and families in practice and policies. The literature around professionalism in the context of modern HVS suggests broad ambition in promoting public interest and enhancement of standards across health and social care settings (Smith, 2008). Given the modernisation of the profession in recent years, it shows that HVS places inherent psychological and social demands on HVs, and the HVS needs to increase capacity in responding to this advancement to keep pace with socio-political interferences and ambitious regulatory changes which seem to place emphasis on Big Society (Cameron, 2015) and professionalisation rather than relationship to achieve outcomes for children and family (Nursing and Midwifery Council, 2016; 2010; Daniel, 2012; 2010). There is increasing acknowledgement of impact of skill, personal conduct, professional experience and behaviour, as growing and welcome recognition of changes in HVs' involvement with children and families (Adams, 2009). However, the argument remains that greater work lies ahead to consolidate and justify public investment into the HVS in reducing inequalities, and making real difference in the outcomes, but the measurement of these outcomes has been task-oriented (Cowley and Adams, 2014; Adams, 2015). This thesis has given me the opportunity to harness my repertoire of knowledge and skill acquired from these clinical settings to contribute to existing knowledge and enhance thinking that can positively influence practitioners, policy-makers and commissioners of services for children and families.

1.11 Key Theoretical Framework that Informed the Research

The literature review for this thesis captured different theoretical principles which informed the research journey and the fundamental framework for this thesis. The four core principles shaping the practice of HVs was developed by the Council for Education and Training of Health Visitors - CETHV (1977), still relevant in contemporary service, are associated with psychosocial influences which include: Firstly, the HVS is built on preventive model involving working with individuals and community under universal, universal plus and in partnership with other professionals to enhance health and wellbeing of children and families (Cowley and Adams, 2014). This involves building relationship with parents and family to search for health needs of the children and situations where the child might suffer actual or potential harm. Secondly, HVs are required to proactively develop strategies that stimulate awareness of an individual child's health needs, discover parental strength and where existing difficulties in family might impact on the child. Thirdly, HVs need to understand the community health needs and facilitate health-enhancing activities. Finally, the HV consolidates this awareness of individual, family and community health needs and common factors that threaten the safety and wellbeing of children to lead in influencing positive changes in policies affecting health of individual children and local communities (CETHV, 1977, p7). Thus, one of the significant areas of note about the core principles of health visiting is 'health promotion' which entails provision of integrated, relational framework that are underpinned by specific value and view of health rather than a list of competencies, KPIs, skills or interventions (Cowley, 2002).

Based on the above consideration, the overarching theoretical framework for this thesis rests on psychosocial theory and its influences on child-centredness. However, the literature review covers chapters 2 and 3 where I explore these theories, policies and guidances to draw understanding of the associated unpredictability of individual behaviours and decision-making. I explore the perceptions and judgements of HVs and how these influence their relationship with clients on the basis of competing demands from the profession, organisations and societal influences. I make use of psychoanalytic theory to help interpret the data, develop this understanding by raising the epistemological position of the research findings as I link the literature review with findings to inform new knowledge from this research.

1.12 Study Limitations

I acknowledge possible issue of bias from: subjective views of HVs may be reflected in the case notes. Another limitation is the the influence of my insider status as a researcher and manager interpreting these subjective documents. To mitigate this bias, I gave attention to rigour at every stage of this study to meet PhD academic standard and also make meaningful contribution to knowledge.

Chapter 2: Setting the Theoretical Context of This Thesis

"… can anyone tell with absolute certainty the difference between the sound of those who are in despair and the sounds of those who want desperately to believe?" (From fugitive pieces by Anne Michaels, 2009).

2.1 Introduction

In this chapter, I explore the evolving identity of HVs, health visiting policy, practice and their impact in determining and addressing the needs of children under 'universal' services and for 'vulnerable' families. I locate the theoretical basis of health visiting role and practice, with changing policy and identity of HVs, who are often described as midwife, nurses or social worker. I develop the thoughts of humanistic psychotherapist Carl Rogers (1951) and psychosocial theorist Erikson (1982) to locate the theoretical basis for this thesis. There are relevant concepts for HVs to understand in Rogers' (1951) theory about stages of human development from childhood and their relationship with significant others as HVs interact with children, family, other professionals and the public. The discourse developed in the chapter elaborates Rogers' argument for professionals to develop *unconditional positive regard (*Rogers, 1959) in client-professional relationship. The chapter explores Rogers' (1951) argument with perspectives on the psychosocial theory of Erikson (1982), drawing on the principle of '*compassion'* and *'sensitivity*' to child needs and the importance to promote '*congenial*' environments where children can thrive.

I also explore theoretical basis of HV's relationship which develops through social interactions and understanding of people, their culture, practices, and ability to contain their emotions. It is shown that a meaningful relationship between HVs and parents is crucial element in the implementation of mandated and additional contacts as integral part of Early Intervention programmes (Cowley, et al, 2013). However, policy, practice and research orientations have not shown consistency in acknowledging 'child-centredness' as key psychosocial principle of health visiting, especially the professional and emotional dilemmas associated with their work through encounter with diverse behaviours (Appleton and Cowley, 2008a; 2008b; Appleton, 1996). Researchers in health visiting have tended to separate the 'social', 'personal' and 'organisational' strands of HVS (Bryans, 2005; Carr, 2005; Craig and Smith, 1998), which undermine the synergy required to maintain focus on the child, whilst seeking appropriate support for parents. The chapter also provides understanding of the framework and critique 'risk'' theory in the context of barriers toward achieving child-centeredness and strategies to overcome related hindrances.

2.2 Setting the Priority Right

The priority of the work of HVs is focused on the 'child' primarily and 'family'; but client-practitioner relationship remain the medium to reach the child, but such relationship can be complex and holistic, considering behaviours of human in terms of their rationality, unpredictability and emotions. The health visiting practice needs to prioritise the needs of the child, and have the capacity to contain challenges emanating from contemporary issues facing children and young persons, whilst resisting the temptation to resort to the often-persistent but ineffective forms of containment associated with focus on statutory involvement in families except where the child suffers potential or actual significant harm from abuse or neglect (Children's Commissioner, 2017; Almond and Cowley, 2008). Emphasis on relationship in practice as a counter-cultural approach to health visiting work provides opportunities for HVs to develop professional responses which are able to address the complex needs of children and families, promote the professional and emotional well-being of the practitioner. For the clients, this enables the practitioner to recognise changes early, offer early support to build resilience, encourage healthy lifestyles and aid physical, social and emotional development of children (Freud, 1997; Klein,1975; Bowlby, 1958). The emphasis in relationship approach in practice, however, is contingent upon epistemological perspectives, such as those embraced by reflective and reflexive practitioners (Schön, 1991). Where practice is informed by reflectivity and reflexivity, the practitioners can have holistic understanding of their clients' needs and vulnerabilities, their own needs and informed knowledge about children in practice.

2.3 Who is a Health Visitor?

Abbott and Wallace (1998) traced the history of Health Visiting Service (HVS) as originated from the Ladies Sanitary Reform Association, formed in 1862 in Manchester and Salford to respond to incidence of high infant mortality rate in the poorer districts. These women were recruited to visit the homes of poorer parents and to teach them a range of different areas including hygiene, child welfare, mental health and social support (Twinn**,** 1991; While**,** 1987). The role and identity conflict began following the formation of NHS as HVs as their relationship was to lie with GPs or medical officers; and the confusion between HV's and social worker's role (Malone, 2000; Abbott and Wallace, 1998). As the service developed in the era of Victorian philanthropy, it became gradually formalised as a public health profession and service, during the twentieth century. The HVS was moved into the National Health Service NHS in 1974, alongside district nursing, community midwifery and public health, which were formerly delivered through the Local Authority. The health visitors (HVs) began to be attached to general practice from year 2000, offering universal services which was the most common conventional approach in HVS. In contemporary arrangements, fewer than one in four HVs are attached with the general practice,

with some HVs based in community health centres, Children Centres, other local authority premises where there are no GPs or 'mobile working' with tablet, laptop or mobile phone (Condon, 2009). In this role, HVs were described as 'case finders' through their universal access to families; social workers were identified as 'case workers' as they reactively work with families with identified problems (Malone, 2000). In cases of safeguarding and child protection, this lack of clear boundaries between the two roles continue to be problematic (Malone, 2000), with adverse impact on the children and families.

The HVs are trained to recognise risk factors for child abuse, in the course of developing relationship with parents to provide preventative universal interventions; can pick up triggers of concern and signs of abuse and neglect (Appleton and Cowley, 2008a; 2008b). They are also the lead professionals for early interventions for children 0-5years (NHS England, 2014), offering opportunity for early recognition of children who are suffering or are likely to be abused or neglected and therefore initiate further safeguarding procedures. There are conflicts and difficulty in frontline practice when applying externally determined priorities rather than assessing children and families individually and providing specific response to their health needs (Condon, 2008; Cowley, 1995a, 1995b). This raises the importance of relationship where HVs can maintain regular contact with vulnerable and complex families, especially those who do not meet the threshold of need for statutory interventions (NHS England, 2016). Thus, they require time to establish and develop a meaningful personal-professional relationship through contacts with the child and family so they can consider the full history of the family situation. This continues even where there is existing child protection procedure in place during crisis period and in the future (HM Government, 2015). The child protection role of HVS is demonstrated to be one of early identification (case finding) from broader preventive model, with early interventions which include referral to Children Services. The 'case finding' or 'surveillance' process applies both generally in universal services and in the specific context of a child protection process. According to Working Together to Safeguard Children (HM Government, 2018), the lead professionals in child protection process remain with the social workers and Social Services are commissioned by the Local Authorities. Currently there is no formal expectation that HVs work as lead professionals in situations where a child protection plan is in place. However, there is rapid change in health and social conditions leading to new legislation, new patterns of working and new expectations of consumerism; especially as the commissioning of HVS moved from the NHS to Local Authority from 2015 (NHS England, 2014). Thus HVS requires flexibility and adaptability to meet the challenge of changing socio-economic and political circumstances; with indications that HVs may be in the position of redefining their professional roles, identity and in an evolving relationship with child, parents and families.

There are concerns that: "...*working with vulnerable families has an impact on resources which are often already stretched for the health visitor*..." (Burchill and Pevalin, 2012, p23); and this contributes to raised anxiety in HVS. A large scale national survey of health visiting contacts, interventions and activities studied by Cowley, et al (2007) suggests that where HVs are anxious and under pressure, interventions become defensive. Thus the priority of interventions tends to be confined to needy groups as identified by the HVs, including families where children are considered 'at risk' and 'vulnerable'. As a means of ad-hoc local coping strategy, service priority can shift to vulnerable children and families (BBC News, 2015; 2013), with reduced focus on preventive work under universal interventions (Bailhache, et al, 2013). There is an overarching view that targeted services in response to the needs of vulnerable children and families take significant amount of time from HVs and threaten a shift in emphasis of support for children with universal needs. This leaves disproportionately less resources for HVs to offer universal health promotion to children and families under the Healthy Child Programme (Nettleton, 2016; Public Health England, 2015). There are strong views that 'vulnerability' as a concept develops from the risk perceptions (or prescription) of HVs in child protection, and its operationalisation depends on individual and institutionalised culture for risk of child abuse and neglect (Kirkpatrick, et al, 2007; Appleton, 1994). These discourses are explored in the thesis and continue to bring challenge and ongoing debate about the ways in which risk of 'harm' and 'abuse' are conceptualised in health and welfare (Action for Children, 2015; (Department for Education and Skills, 2003). Recent changes in policies, legislative framework and practices for state interventions on behalf of children in the UK are linked to the underlying perceptions and assumptions about health visiting identity, risk of child abuse and neglect (Daniel, 2012). However, the complexity of family dynamics, the routes and pathways to 'harm' pose challenge to the work of HVs in contemporary practice and outcomes for children (Daniel, 2012).

2.4 The HVS and Fundamental Nursing Principles

Despite rapid increase in birth rate and growth in evidence about the importance of early interventions, the HVS workforce in the UK shrank by 20 percent between 2004 and 2010, following years of poor investment by the government. The arguments advanced for this decline fall in three areas. Firstly, the HVS has witnessed significant regulatory changes which led to the qualification and title of 'health visitor' being removed from statute in 2004, a point that has been criticised as indicating a lack of support for the role (Cowley, et al, 2013). Secondly, a guide to child health surveillance highlighted in Hall and Elliman (2006), reduced the number of health visiting contacts required for health promotion under universal service from seven to one, with the

proposal that additional contacts should be optional, depending on individual need, circumstances and professional judgement. Thirdly, it was argued that the dearth of evidence to demonstrate the impact of health visiting role meant service commissioners rechannelled funding from HVS into other services (Bunn and Kendall, 2011). The Healthy Child Programme – HCP (DOH, 2009) brought a significant shift in response to the early years' evidence, which led to the government's drive in implementation of a 'Call to Action' policy based on a four-year intervention to promote and develop the HVS profession and prevent the rapid decline its workforce (Department of Health, 2011; Centre on the Developing Child, 2010). The HCP (DOH, 2009) recommends five mandatory reviews of child health and development that health visitors are expected to lead and deliver as minimum universal service level (Public Health England, 2015). The drive in implementing this policy saw expansion in workforce capacity of HVS up to 2015, with additional 3,985 HVs recruited which represented 49% increase on the HVS workforce in England. However, a survey by the Institute of Health Visiting - iHV (2020) shows that the number of HVs has declined again from 12,094 in 2015 to 9164 in 2019, representing 24% reduction in workforce within 4 years (iHV, 2020, p16). In the report commissioned by the iHV (2020, p18), health visitors reported poor job satisfaction, experience of mental health problems associated with work stress, and experience of altered sleeping pattern due to worry, tension, anxiety at work, and also probably related to austerity. However, the report failed to explore the fundamental issues in practice which might have influenced morale and outcomes for children, family and practitioners.

HVs and parents value professional-client relationship, and each universal contact provides an important opportunity to strengthen such relationship, develop a shared understanding and build on previous knowledge of the family's priorities and needs (iHV, 2020a). However, HVS are unable to provide continuity of carer to most families, despite the evidence that its services are predicated on 'relationships' as significant marker valued by parents and integral in achieving outcomes for children and family (iHV, 2020; Almond and Cowley, 2008). In locating the theoretical basis for this thesis, I reflect on one of the eight principles in nursing practice which requires nurses to show '*compassion'* and *'sensitivity*' developed by Royal College of Nursing (RCN, 2019) in partnership with the Department of Health (DOH), the Nursing and Midwifery Council (NMC), clients, members of the public and health care professionals. In order to demonstrate 'compassion' and sensitivity', nurses are required to adopt a client-centred approach which focuses on the individual's personal needs, wants, desires and goals so that they become central to the care and nursing process. It means putting the individual's needs, as they define them, above what healthcare professionals identify as priorities in their practice (McCormack and McCance, 2017); and developing a plan of care with people that fits with what

that person is ready, willing and able to action (Rollin, 2011). In client-centred approach to care, nurses ensure that care is individualised and nurses' relationships with their clients are fundamental to that individual's experiences of care. Thus, the client's role is one of partnership, rather than a passive receiver of care; and it is suggested that such relationship promotes self-esteem and self-efficacy, which synchronise with the thoughts of humanistic psychologist Rogers (1959; 1951).

2.5 Client Centred Care and Carl Roger's Thoughts

The origins of client-centred care are traced to humanistic psychotherapy; and Carl Rogers (1951) argues that humans develop a view of themselves from childhood based on their interactions with significant others. If an individual is loved, valued and respected, he or she feels worthy of love, value and respect and can reciprocate or project same feelings to others. Rogers called this *unconditional positive regard (*Rogers, 1959). Rogers also argues that if an individual is only valued for behaving in a certain way, the person can learn to hide some thoughts and behaviours – *conditional positive regard*. In a relationship where there is a *conditional positive regard* the interactions that develops are influenced by a lack of *congruence* (Rogers, 1959). Congruence is the similarity which exists between the person we see ourselves as, and our ideal self; and if we think we are a failure, we are afraid to 'be ourselves', preventing behavioural change and personal growth. In his argument, Rogers (1951) believed we as humans need to learn throughout our lives in order to achieve personal growth, but this can only occur in situations where there is *unconditional positive regard* which exists within trusting, genuine and open relationships built on partnership, in professional practice. In a client-practitioner relationship, *conditional positive regard* towards clients can generate feelings of, distrust, insecurity, paternalism, discontentment, and projection of disguise thoughts, rejection and anxiety (McCormack and McCance, 2017; Pal and Saksvik, 2008). Compassion and trusting relationship are central in a person-centred nursing care, and it requires the nurse to be genuine with their clients, to empathise with them – that is understand the client's world from the client's perspective - and to value their views, culture and needs without judging them (Chapman, 2017)**.** The client is then able to develop a sense of *congruence* over time, when the self and the ideal-self meet; a process described by Rogers (1959) as *self-actualisation.* This process enables clients to gain confidence and self-esteem, making them open to new feelings and experiences, focusing on life as a process rather than a goal and valuing deep relationships with others, thus becoming an active rather than passive participant in their care (Royal College of Nursing-RCN (2019). Thus, Rogers (1959) emphasised that for persons to 'grow' or change', they need an environment and relationship that offer them genuineness, openness, acceptance where professionals, for instance, see clients with *unconditional positive regard*, compassion and

empathy whereby clients are listened to and understood. Where these relationships are lacking, it is difficult for healthy personalities and positive resilience to develop as they should. In acknowledging the thoughts developed by Roger (1959), every person has potential to achieve *'self-actualisation'* as represented in their achievement of goals, wishes, and desires in life.

Whilst the focus of nurses is their patients, the primary concern of health visitors is the '*child*' and '*family*', as the child cannot be assessed or considered in isolation of the 'parents' or 'carer'; and the nurse-client relationship can be understood through the theoretical principle in humanistic psychotherapy. Much health visiting research and practice in relation to child health, safety and family wellbeing lacks a theoretical framework; thus the discourses and nuances of practice often remain unanchored to a theoretical base (Bidmead, et al, 2016; Appleton and Cowley, 2008b). However, health visiting practice emphasises rational behaviour, personal responsibility, partnerships, and recognises parental rights within the requirements to address the needs of children primarily and that of family under 'universal', services and those requiring additional supports (Brotherton and Cronin, 2013; Bryans, 2005). This focus is understood as child-centeredness explained further in this chapter.

HVs do rarely participate in public discourse, so the image of the profession often lacks clarity – some perceive HVs as midwife, nurses or social worker; others carry default description as partly created by HVs themselves (Baldwin, 2012). According to Davies (1988), health visiting connotes a complex, diverse and varied role, and its continued evolution suggests different narratives about HVs, their professional relationship and identity. From its conception, the HVs have been referred to as '*the mother's friend'*, '*mini social workers'*, and '*public health nurses*' supporting children and families, for instance, as their services 'dips into' few related professions, including nursing, education and social work (Baldwin, 2012; Davies, 1988). Hence, the self-identity of HVs is a complex construct that includes, but not limited to this public image, work contexts, education, social and cultural values (Hoeve, et al, 2914; Bannister, et al, 2013). Hence I locate the theoretical basis of this thesis on the thoughts advanced by humanistic psychologist Rogers (1959; 1951) and psychosocial theory of Erik Erikson (1982; 1964) built on the principles of '*compassion'* and *'sensitivity*' to needs and circumstances of children and their families. The psychosocial perspective in HVS is a process which enables HVs to understand the developmental needs and social behaviours of children, as they explore the interactions and relationship environment that parents and children generate. The HV is expected to recognise and differentiate nurturing environment from an adverse environments that can damage children's social, emotional and physical developments, and to offer early support, interventions

and/or trigger the involvement of Children and Social Care where the child is at risk of suffering significant harm (Morris, 2013; Hoogeveen, 2005).

The unique distincticti on between the roles of HVs and SWs highlights the main differences from their training is the nurse training- ie biological underpinnings along with psychosocial. Thus, HV who practises with a biopsychosocial eye assesses children and families to make sense of the (i) way children and parents feel about and view themselves and express their emotions, (ii) relationships between parents, being the principal creators of the relationship- environment in which children live, (iii) relationships and interactions between parents and their children, (iv) contextual view of relationships between parents, family and the outside world, including parents' engagements with other health and social care professionals, (v) relationships between children and older or younger siblings, and (vi) relationships between children and the context in which they live beyond the family, including their interactions with peers, school, professionals and services with whom all children routinely come into contact (Bidmead, et al, 2016; Cowley, et al, 2015; 2007). The HV's interaction with children and development of child-centeredness are linked to Erikson's (1982) argument that personality develops from infancy to adulthood in different stages; and the person's psychosocial experiences are connected with their emotional, psychological and environmental determinants in the life course, which could have a positive or negative outcome for personality development. According to Erikson's (1964) thoughts, healthy personality and the acquisition of basic virtues occur in a '*congenial*' environment which enables a child to form characteristic of strengths that the ego can use to resolve subsequent crises in adolescent and adulthood (Erikson, 1982). In considering the physical, emotional and social developmental milestones of a child, the HV need to recognise that lack of stable base for a child can result in reduced ability of the child to achieve healthy personality and sense of self. Hence, there are overlaps between the psychosocial ideas expressed by Freud, Rogers and that of Erikson, but whilst Freud's and Rogers' theory focuses on the importance of basic needs and socio-biological forces influencing individuals during childhood, Erikson expands these thoughts to include individual's experiences into adulthood, depicting a truly psychosocial theory. However, this thesis highlights the interplay of these thoughts in the context of ideas from psychoanalytic theory adapted to help interpret data generated in this study. Hence, I adapted the thoughts of some psychoanalysts, including: Menzies Lyth, Bion and Winnicott to interpret data and and relate these to the emotions and resilience of HVs in their practice.

2.6 Psychosocial Principle in Developing a Child-Centred Care Environment

Based on the principle of humanistic psychology developed by Rogers (1959; 1951) and psychosocial thoughts of Erikson (1982; 1964), the role of HVs can be understood in the context of helping children to live in 'stable bases' to achieve good health outcomes, develop social understanding and interpersonal competence. The inference drawn from both theories suggests, the more integrated and reciprocal children experience social relationship the more involved, skilled and socially knowledgeable they will be (Ashton, et al, 2016). A significant component of HV-parent relationship carries psychosocial characteristics, which are capable of influencing behaviours, personalities, mutual interest and understanding of both parents and professionals. These highlight the importance for HVs to always demonstrate their professional identity, emotional empathy, moral sensitivity and social adroitness (Bell, 2001; Joseph, 1985). It means the HVs consistently foster opportunities and promote environments that allow children to live in secure, warm, attentive, responsive, constructive, sensitive and reciprocal relationship. In their practice, the HVs should be able to assess children's needs in relation to their current social environment, to understand the dynamics of family relationships and individual behaviour, decide on the kind of support families and children require under 'universal' or 'vulnerable' category, and in partnership with parents, plan the kind of help and training parents want in order to establish responsive relationships with their children. Where the parents consistently fail to make the home environment safe for children, HVs assess the risk and may need to escalate these concerns to the Children and Social care, and also get involved in decision-making which, on few ocassions, could lead to removal of children from their parents' care (NHS England. 2014; Peckover, 2013; 2002). The fundamental backdrop of psychosocial principles in HVS is that the quality of relationships between health visitors and their clients matters, so also are relationships between child, parents and family. This is not viewed as only congenial social experiences but also as an essential requirement in the formation of individual selves who have compassion and are psychologically coherent, emotionally empathic and socially competent. A child-centred care is enhanced in a '*congenial*' environment as argued by Erikson (1964); it means there is '*unconditional positive regard' (*Rogers, 1959*)* in HV-client relationship, a principle which allows parents to feel that they are not being judged, and that their strength is acknowledged, allowing them to develop trust for HVs and the HVS. However, a '*conditional positive regard'* can generate feelings of tensions and distrust in parent-HV relationship which could result in negative projection towards the HVs (Smith, 2004; Bell, 2001).

The HVs carry out different aspects of psychosocial assessment for children and families in order to elicit and respond to sensitive information and the needs of children, parents and families (Bigras, et al, 2015; Browne, 1995a). Children and family assessment in contemporary HVS

covers different aspects of circumstances which can impact on health and developmental wellbeing of the child; and HVs are expected to use both structured tools and professional judgement in a flexible and partnership approach to determine and address the psychosocial needs of children and families (Bradbury-Jones and Taylor, 2013; Bell, 2001). To develop a child-centred care, it is crucial for HVs to understand the needs of the children and family. Thus, HVs are required to work with parents and families from pregnancy, during birth until the child is aged 5 years, showing sensitivity, compassion, and genuine interest in the well-being of children and other family members. However, studies show variations in HVs interpretations of policies and practices in identifying and addressing the needs of children, especially those that actually suffer or at risk of suffering significant harm (McDonell, et al, 2015). The psychosocial perspective of children needs includes addressing issues which can trigger experience that lead to negative impact on their emotional and social development. For instance, children exposed to the impact of parental mental health, substance misuse or domestic violence may experience adverse outcomes in their physical and emotional development (Mellanie, et al, 2013). The complex interactive occurrences within diverse psychosocial factors and needs of families, as argued by Hollis (1964), require professionals to use multi-dimensional approach in child and family need assessments, including initiatives that reflect rational and intuitive judgement drawn from extensive observational skills and clinical experience. An overview of children and parents recruited into government's Troubled Families programme (Ministry of Housing, Communities and Local Government, 2019) shows that 8 out of 10 clients had housing, occupational, financial and physical needs (Levitas, 2012). Thus, assessment of child's health and social circumstances involves exploring family and life history of the parents, their living situation and finances, support network, parenting style, pattern and coping skills, cultural factors, adverse childhood experience, and impact of these issues on parenting ability (Appleton and Cowley, 2008a; 2008b). During assessment it is emphasised that HVs listen to and record the voice of the child and young person to support their involvement in decision-making about their lives, although this is inherently challenging, particularly in the context of safeguarding processes (Donetto, et al, 2013). In understanding the psychosocial environment in which children and family live, HVs require reflection on their own personal life experiences and the impact this may have on the process of exploring psychosocial issues in the client-HV relationship (Lindahl, 2011; Rob, 2006). In their interactions with parents, the HVs need to create emotional comfort for themselves through reflectivity about their personal experiences which might stifle their confidence in asking parents some difficult questions such as experience of abuse as a child, domestic abuse or parenting practices which might cause the child (Bradbury-Jones and Taylor, 2013). Psychosocial issues in early parenting may be common, but where these are not addressed early, they may have lasting effects with poorer outcomes for children and their families. The policy guidelines outline various services to be offered to new parents to support child health and development, and prevent child

abuse and neglect, but variability in offer and access to parenting support continues to raise questions about the decision-making process of HVs and partnership, how they work with parents and in partnership with other professionals (Brotherton and Cronin, 2013; Clulow and Donaghy, 2010).

Whilst most parents accept offers of health visiting services for early help to improve health and developmental outcomes for their children, and to enhance their parenting skills and abilities; a number of parents do not see these as important. The 'hard-to-reach' families are often isolated as they can develop some resilience, convincing themselves that their circumstances are different from everyone else's and, therefore, cannot be addressed by professionals (Brotherton and Cronin, 2013). The parent lacks active interest in changing their behaviour, parenting practices or dealing with difficulty which might expose the child to significant harm in the family; often opposing partnership working with professionals to improve health outcomes for their children (Evangelou, et al, 2013; Coe, et al, 2008; Doherty, et al, 2004). However, a HV whose focus is child-centeredness seeks to develop a '*congenial*' environment (Erikson, 1964); and 'u*nconditional positive regard' (*Rogers, 1959*)* towards non-engaging parents. This involves three key steps: (a) adopting a non-judgemental approach in HV-parent relationship, (b) emphasising parents' abilities and strengths and offering alternative ways to look at problems; and (c) seeing how parents can help themselves, or see the need to be supported by others to address difficulties in the families (Hogg, et al, 2013).

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2.7 Non-Judgemental Relationship and HVS

A report from what clients want from HVS shows that they value non-judgemental relationship from professionals (iHV, 2020a), and according to psychosocial concept of Erikson (1964), such approach to care enhances clients' self-efficacy and their confidence. To facilitate a non-judgemental environment, a HV needs to first interact with their clients as human being in developing relationship to foster child- and family-centred services. According to Carl Rogers (1959; 1951), professionals who demonstrate a special kind of non-judgmental attitude can inspire positive attitude from their clients; which is what he referred to as the: *unconditional positive regard*. To develop '*unconditional positive regard*' in HV-client relationships, it is necessary for HVs to become conscious of, and reflect on their values and assumptions in the context of issues which might affect their own personality and professionalism. This can become barriers towards understanding the emotionally disturbed child or parent and their vulnerabilities. Evidence suggests that one of the major barriers to this understanding is the pre-conceived or judgmental attitude on the part of health or social care professionals (Evangelou and Boag-

Munroe, 2009; Dhir, 1999). Whilst, an act of child abuse or neglect is unacceptable, parents, who find they are '*judged'* as to their moral rightness or wrongness of their parenting styles are not free to express themselves or disclose important information about. A non-judgemental relationship or work approach does not connote tolerance of unacceptable acts or behaviours of parents, for instance, in cases of child chastisement, domestic violence or other forms of child abuse and neglect. Rather it demonstrates a detached attitude which transmits to the client the idea that the HV is seeking only to understand why he or she acts and feels the way the client does. To develop a non-judgmental attitude, it is not essential that HVs compromise their high professional standard and personal conduct by colluding with parents whose acts or behaviours can cause children in their care to suffer actual or potential significant harm (Clulow and Donaghy, 2010). In such a case, the non-judgmental attitude of a HV should transmit to the parent the idea that child abuse is unacceptable, thus, parents need to gain insight into the impact of their behaviours, physical or mental health conditions on their ability to meet the needs of their children. With a non-judgemental approach, the HV listens to clients and offer them professional help to address their parental difficulty. Thus, it is necessary for HV to accept clients as persons who deserve and need help; but it is not important to accept their behaviours, which means HVs need to develop compassionate attitudes and sympathetic understanding of why clients act or behave the way they do and help them mobilise their strength and strive to achieve self-efficacy (Jaffee, et al, 2013; Harold and Leve, 2012). Children and parents need to be able to express themselves, or sensitive parts of themselves, within a safe environment where they feel they will not be judged; and this can inspire trust-building with HVs. In most circumstances, the only tool a HV has to work with is herself/himself, and in nursing this is described as: 'therapeutic use of self'. Thus, knowing one's self is the foundation upon which 'psychosocial' concept is built; and is an essential factor for adapting a non-judgemental attitude in practice (Johnston, et al, 2013**;** Lagerway, 2010). Professional attitude that promotes '*unconditional positive regard'* toward clients (Rogers, 1959); and demonstrates a special kind of non-judgmental attitude can inspire positive responses from clients. According to Rebraca (2008) it is crucial for HVs knowing themselves first as initial strategy in developing therapeutic relationship with their clients. The HVs cannot disguise their troubled thoughts for too long because their true feelings could be revealed through body language, gestures, and tone of voice during interactions with clients who are often sensitive to their HVs' feelings.

Murphy, et al (2013) highlight the resurgence of relationship-based practice in social work, and its theoretical basis which is built on the concept of a person-centred perspective. However, the applicability of this concept is significantly incompatible with forensic orientation in contemporary statutory social work practice. Thus, following the full principle of person-centred approach in practice according to person-centred theoretical and philosophical underpinnings is arguably

encumbered with potential conflicts because of the social workers' capacity to truly accommodate person-centred theory. Given the existing capacity in HVS, it is acknowledged that relationship-based practice, with particular attention to child-centred approach, is considered within the context and influence of risk management, meeting organisational KPIs, and achieving the organisational role of preventing harm (NHS Healthy Child Programme, 2019). I acknowledge the assumption that relationship-based practice in HVS is founded on child-centred approach, but I challenge its consistency to legitimately support families' ability and capacity towards self-determination, given the existing service configuration and priorities. The challenge is based on the premise that the key characteristic of child-centeredness is integrated within principled non-directive practice, which is not fully seen to exist in contemporary health visiting practice (Bidmead, et al, 2016; 2015; Bidmead, 2013).

2.8 Emphasising Parents' Abilities and Strengths

It is suggested that clients feel confident in developing their self-esteem where practitioners acknowledge and promote their strength and abilities (McMillen, et al, 2004). The HVs perception of the strength and abilities of parents may not be understood as reflecting '*conditional positive regard'* (Rogers, 1959), but as ways of valuing the capacity, skills, knowledge, connections and potential in the child or parents, and both are seen as mutual partners in the client-HV relationship, and in their involvement with the family. Acknowledging strengths does not mean ignoring challenges, or spinning struggles and difficulties family experience into strengths. The strength-based model in safeguarding and child protection work is driven from the Signs of Safety model developed by Bunn (2013) with emphasis on the context where solution-focused interventions and non-judgemental experiences of families are priorities. The argument is that relationships must be forged and maintained despite the coercive nature of child protection interventions, biases towards pre-judgment of families and different perspectives of professionals.

It is, however, argued that where HVs adopt this approach they offer opportunities for collaboration - helping parents to seek solutions and do things for themselves, thereby allowing them to become co-producers of support, rather than passive consumers of support (Morgan and Ziglio, 2007). This partnership allows parents to work together to determine an outcome for the children, allowing parents to draw on their strengths and social assets (Bidmead, et al, 2016; 2015). Thus, strength-based approach in assessing the needs of children and families is principally concerned with the quality of the relationship that develops between the HVs and parents, recognising the elements that the parents seeking support bring to the process (Bunn, 2013; Turnell, 2012). Some researchers have

criticised strengths-based approach in health and social care practice; arguing that it is not new or different from other traditional methods of practice and that they are not based on evidence of efficacy (McMillen, et al, 2004; Staudt, et al, 2001). A strength-based approach is about emphasising the use of professional engagement and judgement, as opposed to procedural approaches, focusing on clients, taking a holistic and co-productive approach to keep clients at the centre of all decisions, identifying what matters to them and how to achieve best outcomes. In health visiting practice, it is about enabling parents who voluntarily seek to find the best solutions to address their needs, and supporting them in making independent decisions about how they parent their children (Morgan and Ziglio, 2007).

2.9 Promoting Self Help and Coping Abilities of Parents

Develop a '*congenial*' (Erikson, 1964) environment in practice can foster child-centeredness, and HVs need to promote self-help and access to services for parents to support parenting in a non-stigmatising manner. Any parent who is experiencing emotional turmoil, abuse in their relationship, or who is very anxious about his or her child not thriving may feel withdrawn and unwilling to engage with professionals, and such distancing can result in the child suffering significant harm. With such feelings, parents may not bring their child for appointments or give access to HV to see the child at home. Winnicott (1971) recognises the importance for an individual psychologically to create a stable '*inner space',* and for a parent who experiences difficulties in relationship, such 'inner space' has potential of being instable. Thus, they may not be able to separate emotion and mentality, hence critical decisions, including the health and well-being of their children, are influenced by opposing opinions and desires, leading to emotional pressure, emotional imbalance and dysfunction, which can be chronic and severe (Winnicott, 1986). Thus, the HV needs to offer a non-stigmatising environment to listen, allow parents to feel safe to share their troubled feelings. According to systems theorist Bowen (1976) good listening can promote self-help, explore emotional incongruity of parents and explore how they can obtain support to develop their emotional strength and individuality.

Bowen (1978) argues that individuality develops as a person establishes and functions in an emotional relationship, engages in a goal-oriented activity, with a mental system which helps guide decision-making about important issues. One of the priorities for parents should be keeping their children safe from abuse and neglect. It is seen that a parent may have the ability to retain relative individuality in periods of stress and able to maintain more flexibility, while another can experience difficulties in adapting to circumstances in their families, thus unable to manage emotionally (Pengelly and Woodhouse, 1991). In assessing and making decisions regarding the needs of children and families, the HV seeks to recognise and support parents who may not cope

better with life stresses (Crossley, 2016). Coping with psychosocial demands reflects several actions parents take in order to escape from all the tensions that confront them in families. In health visiting, the term coping refers to ways parents develop positive resilience to deal with certain internal and external demands, which, sometimes, are beyond personal resources and require the support of professionals. The increasingly changing relationship between children, parents, families and the environment leads to new demands and potentials for negative coping strategies become common (Collins and McCray, 2012; Cornock, 2008). Providing early intervention and support to parents may enable them develop coping strategies that enhance their ability to respond to the needs of their children and family. Intervention, in this context, corresponds with the descriptions of social work academic, Trevithick (2006) as embedding evidence-based learning into health visiting practice in partnership with parents to influence health and wellbeing of children, parenting behaviours or practices. Interventions may be educational, listening contact, counselling or engagement with other services, undertaken for a number of different reasons, such as to guide parenting, behavioural change and development of self–esteem (Hanley, 2015). The focus of HV's interventions is to enhance outcomes for children, protect them from suffering significant harm, reduce inequality of access to universal services, help parents gain insight into the impact of adverse experiences in the family and personal behaviours on their parenting ability; and interventions are in the forms of health promotion and surveillance, client education or non-directional listening (Hearn, 2011; Hall and Elliman, 2006). The parent-HV relationship that reflects *conditional positive regard* from the practitioner shows potential for barriers in accessing psychosocial support according to the needs of children and families (Rogers, 1959), and there are suggestions that HVs can address family difficulties and the uncertain emotional situations faced by children require muti-professional interventions (Theodoratou-Bekou, 2008). Moreover, it seems important to for HVs to emphasise the preventive characteristics of interventions and support offers available to families. This may lead to a decrease of fear of stigmatisation (Harold and Leve, 2012), but more work is required to overcome barriers such as distance to support offer or lack of physical motivations among parents of most vulnerable and hard-to-reach families who mostly require parenting support to reduce incidents of child abuse and neglect. In applying diverse approaches to identify and address the needs of children under 'universal' and 'vulnerable' child policies, the HVs require adequate understanding of physical and emotional development of children, information about the physical, and psychosocial circumstances of the child and families obtained from individual and partnership work with clients and other professionals (Bailey, 2013; Hoskins, 2009).

2.10 The Health Visiting Identity and Children's Outcomes

Since its conception, HVS has struggled to define its role but no clarity has emerged to remove uncertainty over its professional identity (Cowley and Adams, 2014). This has been associated with a number of factors, such as: its contentious spread across child and family health, midwifery, education and social care; its strong link to wider public health priorities; its evolving responsibility in safeguarding and child protection to prevent child abuse and neglect; and its evolution from 19th-century volunteering role into 21st-century professional nurses provide an opportunity for a revitalised and dynamic HVS (HM Government, 2018; Adams, 2015). The diversity in political priorities have also sharpened the vision and agenda of health visiting profession thereby impacting on its identity, and remain key drivers of change and identity crises for the profession. The government agenda transferring commissioning of HVS to Local Authority heralded significant transformations to the NHS in England, especially to the funding of HVS (NHS, 2014). However, it is yet to be seen whether these changes bring impact on the profession and give HVs a stronger identity, both outside the NHS and the wider community (Adams, 2015). It is evident that professional identity is not stagnant, but alters and develops over time within the frame of changes to the professional roles, boundaries and public perceptions of the profession; and HVS is one profession where these changes have been continuous, offering both opportunities and challenges along the way (Adams, 2009). In general, change in the NHS is continuous and with different political agendas and priorities, the role of HVs has also altered, giving rise to perceived threats to health visiting identity and the conflict between focusing on the individual and working with the community (Craig and Smith, 1998; Davies**,** 1988). The identity of HVs is seen as having a fundamental importance in responding to needs of children to prevent abuse and neglect, as trainee and qualified practitioners can expand their leadership roles and skills, with positive implications for children and parents. The ideas about professional identity and roles can profile HVS management, for instance, in the contested area of optimum skill mix and staffing levels to support children under 'universal' and 'enhanced' services, and to shape the extent HVS reform affecting roles such as HVS sitting on the same competitive funding priorities with social care service commissioning in Local Authority. The psychosocial impact of these changes remains the concept of 'child-centeredness' in relation to health visiting identity; and it is clear that the variability in supporting role and focus on 'surveillance' of family, are often seen as conflict in public health and child abuse preventive work (Lagerway, 2010).

What can be contentious psychosocial construct is the identity of HVs in relation to 'child-centeredness' or 'family-centeredness', but these constructs are not well explored in health visiting literature. In the language of nursing policy and practice, 'patient-centeredness' remains a key psychological and psychosocial principle that define identity and change in professional

attitudes (Hobbs, 2009; Watson and Smith, 2002). Thus, addressing the needs and offering support for children to prevent abuse and neglect remain primarily linked to the component of health visiting professional identity. However, the degree to which this support is seen as a part of health visiting professional identity has had relatively less attention in the contemporary health visiting literature (Bigras, et al, 2015; Watson, 2001). Traditionally, support in HVS is articulated as being a task-focused approach and is grounded in the relational empathy and connection between the parent-HV relationships (Cowley, et al, 2015; 2013; Davies, 1988). An extended analysis of 'child-centred' support describes the concept as an eclectic range of elements, from providing a process of partnership working with parents, behaviour adaptation; assessment of normal and atypical patterns of child, parent and family development, behaviour and emotional support for parent decision-making (Kochenderfer, et al, 2015). In this thesis the 'child-centered' support, as a psychosocial concept, involves complex and sustained attention in parent-HV interactions to prevent or alleviate risk of child abuse and vulnerabilities of children, as well as developing therapeutic engagement based on a knowledge of, and relationship with the family.

Child-centeredness in health visiting theory and knowledge development traditionally includes a strong discourse for 'supporting parents', and the construct of support is multi-faceted when considering emphasis on conflicting needs of a child, parent outcomes and organisational objectives (Thorpe, et al, 2014). In health visiting, the focus on the 'vulnerable' child has been shifted to include those in families that are struggling and require early help as highlighted here::

> "*Now is a good time to reflect on the immense efforts made in the last five years to integrate universal and more specialist services for children and young people. We have come a long way and seen massive investment in our schools and early years settings and increased attention paid to preventative services and early intervention. But there is much more to do – we have not yet achieved what we set out to do, to provide a seamless continuum of services from the universal to the specialist, designed and tailored to the needs of the child, rather than professional silos*." **(**Davis, 2010).

These have been the subject of different conceptualisations and theoretical frameworks in the history of HVS since the 1990s (Lagerway, 2010; Malone, 2000; Stone and Kestenbaum, 1974). The description of Barlow, et al (2008; 2007; 2005), suggests that the dominant construct of 'supporting' in HVS is predicated on home visiting, and this remains an intuitive construct which is expressive and requires HVs' emotional and physical presence (Kahneman and Klein, 2009). These constructs can be operationalised, but measurement of outcome elements by HVS organisations have been confined to KPIs (Butler, 2015; Shaw, et al, 2013).

As demonstrated from the discourses above, 'child-centeredness' and 'family-centeredness' are strong focus of health visiting work, but these require compassion and sensitivity to the circumstances of the child and family, recognising family strength, beliefs and concerns about help-seeking and engagement, with verbal and non-verbal interaction between HV and the family. In effect, 'child-centeredness' has traditionally seen deep roots in the professional identity of HVs who are deemed to have responsibility for preventative work to enhance child health, safety and developmental well-being (NHS England, 2014). Safeguarding and child protection is a context where it is known that child abuse prevention, and health outcomes for children are shaped by wider determinants of risk, vulnerabilities and their health needs. Thus, it seems likely that: i) a narrow definition of child-centredness cannot achieve required outcomes for children and family, and ii) measuring these broad outcomes in HVS definition of child-centredness consistently continues to be difficult in practice, but remains defining factor that shapes public debate about the 'supportive' and 'surveillance' priorities in HVS. The emphasis is on re-establishing the traditional support pathway for families to align HVS with needs of children in contemporary settings and public health agenda, and reduce potential for failure of set priorities in HVS (Adams, 2015; Davies, 1998).

The preventative process thus requires understanding of the theoretical principle for risk and vulnerabilities focusing on 'child-centredness'. It is acknowledged that 'risk management' and supportive workload required in cases for vulnerable children can be heavy and Williams (1997) suggested HVs spend '*around 20% of their time'* with 'vulnerable' families who only '*made up 5% of their caseloads'*. The current magnitude of workload with this category of families is unknown (Cowley, et al, 2013, p136), and the complexity of needs of children and families are increasing. Through the case-finding and surveillance process under universal interventions, children with 'vulnerability' are identified and transferred to 'vulnerable caseloads' (NHS, England, 2014). As a universal but voluntary service, health visiting enjoys a unique position in regard to its potential to affect the life course and life chances of children and young people. While the key national policy - Healthy Child Programme (DOH, 2009), led by HVs and predicated on parent-HV relationship, the policy contains a major focus on parenting support, especially 'supporting strong practitioner-parent relationships and promoting stable and positive relationships within families. However, there is little evidence to suggest that approaches that promote parent-HV relationship or positive couples' relationships have become central to contemporary health visiting practice (Cowley, et al (2013). This phenomenon is worrying, given general understanding that the bedrock of HVS is parent-HV relationship, and research shows that couples going through transition of becoming new parents are at risk of reduced relationship satisfaction which might lead to negative projections into parent-HV relationship (Bidmead, 2013; Bidmead and Cowley, 2006a) and poor

outcomes for children. The work of HVs raises significant level of anxiety; there is not only a dearth in understanding the sources of these anxieties, but also coping strategies of individual HV and mechanisms with which organisations contain such anxieties.

2.11 Child Centredness and Importance of Relationship

Day, et al (2014) argues that the earlier we can intervene to enhance parent-HV relationships, the more likely we may achieve better outcomes in reducing children's exposure to potentially harmful levels, and types of distress and conflict experienced by vulnerable children and families. There is a link between poor parental relationship quality, and conflicts among parents as associated with the development of insecure infant-parent attachment which lends further weight to the idea that practitioners should be aiming to intervene early and reduce difficulties experienced by struggling couples in their relationships (NHS England, 2016; 2014). The significance of parent-practitioner relationship is frequently underestimated by those designing and developing services to support families in bringing up their children. A project designed to enhance the effectiveness of parenting support for vulnerable families can sensitise practitioners in providing couples support and relationship advice resulted in reduced risk of depression among mothers in the study (Clulow and Donaghy, 2010). The argument of Harold and Leve (2012) centred on the impact of conflict and unhealthy parent-practitioner relationship, and evidence that frequent and intense conflicts between parents, if poorly resolved, can also be very harmful, with potential negative effect on children and young people. The manifestation of such effects includes display of higher physiological symptoms of distress, including elevated heart rate among children, in response to overtly or direct hostile exchanges between parents. In such chaotic environment, infants and children show signs of emotional distress by crying, acting out, freezing, and withdrawing from or attempting to intervene in the conflict itself (Cohen, et al, 2005; Cohen, 2003). The ambition to develop frontline health visiting services through parent-child and HV-family interractions is relevant in analysing 'child-centredness' A stable, positive relationship in family reduces the exposure of children to abuse and neglect mostly resulting from impact of parents' distress and conflict (Hardwick and Woodhead, 1999; Taylor and Tilley, 1989). The emotional dimension rooted in health and social care work can be traced back to psychological and psychosocial principles which emerged in the mid-20th century (Horney, 1950), and both raised the importance of previous experiences and how emotions are managed and understood through relationships. Some of the inspiring ethical concepts that guided the relational based model in social work includes: purposeful expression of feelings, controlled emotional involvement and acceptance (Horney, 1950). However, such psychosocial models of practice were criticised following claims that they primarily focused on the inner worlds of individual child, parent or practitioner, thereby minimising wider societal and political factors (Hollis, 1964). The argument also held that, such practice ran

the risk of recognising child and family needs and offer of interventions with individual rather than contextual approach. However, it remained self-evident that, despite such critiques, relationships are central to social work and health visiting (Bryan, et al, 2016; Bailey, 2013). The danger is HVS becoming too technical/rational, based on KPIs and bureaucratic procedures rather than on ethical and relational endeavour, because potential cultural shift can lead to relationships becoming too 'woolly' and difficult to understand or measure.

2.12 Child-Centeredness and Risk Theory

Child-centeredness is compromised in situations where children suffer harm due to risk of abuse and neglect; and this section examines theoretical framework relating to risk of child abuse and neglect, highlighting perceptions and volatility of these risks in the context of unpredictable parental behaviours and 'risk society' (Bailey and Pill, 2011). Donzelot shares Foucauldian views that some aspects of children and family policies are construed as covert forms of state control over families (Donzelot, 1980; 1997). Foucault's concept of surveillance does not just see power as instrument held by the government, but believes it diffuses and permeates throughout the society and found within all relationships, including professionals e.g. doctors, health visitors and social workers, as they exercise power over their clients through their expert knowledge. Donzelot (1980; 1979) extends these ideas to the family, by looking at how professionals observe and monitor risk of child abuse in families, he argues that social workers, health visitors and doctors use their knowledge to control and change poorer families, referring to this process as: 'the policing of families' (Donzelot, 1979). Donzelot argues that policy is a form of state power over families, for instance, state may seek to control and regulate family life by imposing compulsory parenting orders through courts. A parent's lack of ability to contain a truant or badly behaved child may attract use of statutory process in child protection to ensure attendance of parenting classes to learn the 'correct' way to bring up children.

Dingwall (2013) criticise the pessimism in Donzelot's analysis of childcare policies and practice, arguing that the systems to safeguard and protect children are resistant from both perceptual and organisational perspectives - with the `rule of optimism' stifling identification of child abuse. The 'rule of optimism' means that professionals are likely to give clients too many chances to the detriment of children outcome in the hope that situations will get better rather than want to acknowledge otherwise and make hard decisions about the child. Such systemic failure undermines child-centredness and reflects ambivalence within the society in relation to legitimacy of state intervention into family life. Dingwall, et al (1983) remark:

> "*There seems to be a discernible trade-off between accountability power and intrusion. The most intrusive surveyors, health visitors and doctors, are the least subject to state direction and have the fewest resources to enforce or entice compliance"* (p219).

For instance, acceptance or refusal of services from HVS is voluntary, thus taking the structural and cultural processes together serve to represent:

> "*a powerful acknowledgement of the continuing force of family autonomy*" (ibid) , in the face of stiff pressure in a manner described by Donzelot as being:

> "*Set within the double network of social guardians (e. g. magistrates) and technicians (e. g. social workers, health visitors), the family appears as though colonised. There are no longer two authorities facing each other: the family and the apparatus, but a series of concentric circles around the child, the family circle, the circle of technicians, and the circle of social guardians"* (Donzelot, 1980, p103 with original emphasis).

The discursive changes for the construction of risks within these circles continue to shift as emphasised by Parton (1996):

> *"My central argument is ... that risk is not a thing or a set of realities waiting to be unearthed but a way of thinking .. and practices"* (p98).

It is argued that the convergence of these political and social processes inform an emphasis on the construction and identification of risk within safeguarding and child protection policy development. The emergence of neoliberalism, with focus on global market forces and `an individualised conception of citizenship' generate `dislocation in most areas of economic and social life, reinforcing a whole variety of insecurities, uncertainties and fears' (p99). This is brought about by `the collapse of "welfarism" and the growth of neo-liberal critiques ... ushered in quite a new situation and one where notions of vulnerability are not simply re-cast but given a much greater significance' (ibid).

The approach to risk situations, prediction and management of child maltreatment are refined upon a range of factors, framed in terms of child abuse, child in need or for early interventions. Similar to the description of environmental dangers by Beck (2009) and Giddens (2008), there is a shift from noticeable and physical evidence of abuse to circumstance where risk construction involves identifying both actual and potential abuse. As Parton, et al (1997) observe that the focus of attention child protection is more than visible child abuse, but includes the policing and surveillance of childrearing practices.

These focuses attention to the psychosocial circumstances of the child, showing that, the preventative work of child abuse has been shifted and:

"*signs of abuse have been replaced by ... a regime of signification where notions of "high-risk" now both constitute the metaphor for child abuse and characterise the focus of the work itself* (p218).

The government commissioned report on child protection policies and practice by (Munro, 2011) and Marmot, et al (2012a; 2010) raised significant awareness on early interventions. Thus, the focus has shifted from reactive to early help (Cowley et al, 2015) and Child-Centred Approach highlights statutory duty placed on Local Authorities to ensure children and families receive early help, especially those who fall beneath child protection thresholds (Munro, 2011). The early intervention programme gains the inter-party involvement by Conservative in dealing with the problems of educational failure, family breakdown and other symptoms of the broken society as a priority in Conservative Government (Cameron, 2008); and the New Labour (Brown, 2010). Thus the local policies of HVS place priority on 'risks' in terms of identifying vulnerability in children to offer early interventions so that initial difficulties experienced by children and family can be addressed before problems require more expensive and forensic involvement of statutory services, e.g. managing difficult behaviour, healthy nutrition, promoting child health and development, signposting for relationship and parenting support to help families solve or manage conflicts (Smith, et al, 2012).

In a similar argument Parton (1996), suggests that policy and practice that emphasise risk basically serve to maintain social order, suggesting certainty and safety based on fundamentals that project an aura for scientific decorum:

"*The language of danger having turned into the language of risk ... gives the impression of being calculable and scientific ...It is also future-orientated and predictive. It looks forward to assess the dangers ahead (early intervention)*" (p105-6).

However, the position is that risk construction has not much to do with predictability than: "*as a forensic resource*' (Parton, 1996, p106). Thus, policy development in safeguarding and child protection is influenced by societal perceptions of risk, entrenched in individualised scheme of accountability which is interwoven within social structures with: "*different types of blaming system*" (p106). The 'Cleveland affair' is a dramatic instance of over-intervention and child protection being confronted with hazards and insecurities induced and introduced by modernisation itself (Ferguson, 2017; 2011).

It is generally argued that the 'system failure' found to be involved in child death inquiries is associated with:

"*Modernisation risks surrounding the deaths of children in child protection cases are "side-effects" produced by modernity itself. This is implicit in the child death inquiries where the difficulties revealed are conceptualised as system failures and defined in terms*

not of an under-supply of practice, but of the multitude of (uncoordinated) work that went into the cases" (Parton, 1996, p224).

In his criticism of the system of child protection in the United Kingdom, Parton (1996) remarks:

"*The system which had been set up to identify, regulate and police child abuse was itself culpable. The scientific basis to the way we had attempted to tackle child abuse seemed to have as many negative consequences for children, families and professionals as it did positives*" (p108).

There is a perception that lack of trust in professional expertise in relation to safeguarding and protection of children leads to increasing emphasis on audit, KPIs and Payment by Results (PbR) in modern day health visiting policy and practice (NHS Healthy Child Programme, 2019). However, many researchers have underscored the importance of a shift from such preoccupation with a procedurally driven certainty and to allow rediscovery of `uncertainty' and `ambiguity' in safeguarding and child protection practice. Thus, Parton (1998) argues that the work of safeguarding and:

"…child protection ... is much better characterised in terms of uncertainty than of risk, and ... the notion of ambiguity is central to its operation and the way it is experienced by the children and carers on the receiving end and by the other professionals with whom we work ...Notions of ambiguity, complexity and uncertainty … should be built upon and not defined out" (p23).

This research argues that safeguarding and child protection policy development and practice based on uncertainty open up an innovative, proactive way of thinking supported through meaningful professional-client relationship, whilst risk connotes anxiety and tension. Paton observes that:

"*A commitment to uncertainty opens up creativity and novel ways of thinking which are in danger of being lost in a climate obsessed with concerns about risk, its assessment, monitoring and management'* (ibid).

2.14 Criticism of Family Assesment of Risk of Child Abuse

Donzelot (1997;1980) extends the idea of child abuse risk to the family, by looking at client-practitioner relationship as they observe and monitor families, and he argues that social workers, health visitors and doctors use their knowledge to control and change poorer families, referring to this process as: 'the policing of families' (Donzelot, 1997). This argument depicts a shift from normative assumptions about 'child-centredness', resulting in regulation of individuals (Cohen, 2002, p9). It typifies the state's intervention in families and the upbringing of children as parental responsibility can be taken over by or shared with the state, especially where doing so would

lessen the psychosocial challenges and risk of harm to a child (HM Government, 2004). Although the Children's Act (HM Government, 1989) highlights the need to involve child and parents in state interventions within families; it is argued that the voices of children and parents are often not heard in decision-making regarding the future care of children in need of protection. This further undermines the ethos of partnership and client-professional relationship as observed by Lord Laming (2009; 2003) in his report: "*The Protection of Children in England: A Progress Report*", with criticisms that many authorities failed to adopt reforms following lessons after death of Victoria Climbié. Marmot, et al (2010) advocated for children and family policies for early year should create '*congenial*' environment for support in parental education, work, income, housing and awareness of services in community in which children live. Whilst statutory involvement in families might provoke negative perceptions among parents, outcomes for children and family can be enhanced through relationship, which is a pre-requisite for "early help offer" of services to every child and family who fall beneath child protection thresholds (Munro, 2011). The observation of Levitas (2012) suggests that politically-motivated agenda such as the Trouble Family programme (House of Common, 2017) might be working against the ethos of relationship building and psychosocial principles advocated by Erikson (1982).

However, a review of different constructs and argument that framed understanding of risk and child abuse and neglect suggest mismatched of knowledge of child abuse and responses among practitioners; and interventions to address abuse in practice are inadequate, and successful responses are not understood perfectly (Bilson and Martin, 2016; Devine and Parker, 2015b*).* The traditional health and social welfare approaches to respond to concerns have been associated with increase in re-abuse. However, approaches that grounded in relationship, with innovative and resourceful insights have been shown to result in low recidivism among certain populations. The gaps in traditional relationship, where it exists, showed significant number of intervention efforts tended to focus on parents, whilst the developmental and health needs of children were ignored (Marmot and Bell, 2012) Bilson and Martin, 2016). Where protective interventions were offered, the children were more likely to be exposed to further 'vulnerabilities' and 'risks' from harmful environments when placed in foster-home or institutional-care settings. Research and practice give limited attention to the differentiation in clinical approaches to accommodate the unique needs of children, adolescents, family and different social contexts in health visiting practice. Thus the explanatory frameworks in safeguarding and child protection interventions fail to address some of the:

> *"… complexity found in the "wicked problem" of child abuse* …" (Young, et al, 2014, p893).

2.15 Child Abuse Risk Theory and Conflicts in Modern Society

Conceptualisation of vulnerability and the discourses around risk of child abuse and neglect as analysed by different researchers remain opaque, and existing siloed approaches to address the problem are inadequate, often beclouded with uncertainty and limited clarity (Collins and McCray, 2012; Creighton, 2002). There are different theories to explain the motives and actions of child abuser but the real causes are uncertain, an argument which lends credence to posits by Dillon (1997) that:

> "... *we are often confused and dismayed by our ignorance of our own motives and actions" (*p9).

The theoretical construction of knowledge about the prediction and problem of child abuse and neglect has received insufficient attention, resulting in slow empirical and practical knowledge of the issues. The argument is that practitioners confront a bewildering diversity of physical, psychological and social manifestations of problems which are within the threshold of child abuse or neglect (Collins and McCray, 2012). However, the variability of the process which establishes the formulations and test of aetiological basis of these problems scarcely receives any attention. There are suggestions that lack of theory base for child abuse and neglect may be contributing factors for failure in programmes and policies to treat the problems than the lack of resources for interventions (Bourne and Newberger, 1977). It is relevant to develop sufficient understanding of the aetiology of child abuse and neglect in order to direct intervention efforts to approaches which are likely to yield optimum outcomes for children and families (Biggart, et al, 2016; Bittner and Newberger, 1981). For instance, an intervention programme to respond to child abuse case which is associated with parental psychopathology has been shown to be counselling, which seems to be the logical and traditional response (Bitmead, 2013; Chouliara, et al, 2012). However, the failure of counselling to effectively address the needs of many families in such interventions may not necessarily be parental failure, cultural differences or the psychotherapeutic skill and compassion of the practitioner (Roddy, 2013). Rather, such outcome is linked to failure in theoretical basis and understanding of the aetiology of the child abuse or neglect which, in most cases, is criticised to be too narrowly defined and unable to lead to broader outcome (Gadamer, 2004). Many researchers in child abuse acknowledge a number of assumptions about the physical, emotional and psychological consequences of child abuse for the child, his or her parents and family (Kettle and Jackson, 2017; McDonell, et al, 2015). In their analysis of the dangers of child abuse, Kempe, et al (1997) argued that the negative impact of abuse widens beyond harm to the victim. An example from Schmitt and Kempe (1975) highlights

a risk of repeated abuse for a physically abused child who is returned to parents without interventions can be far-reaching, with risk of:

> "... *5% of children killed and 35% ... seriously reinjured. …the untreated families tend to produce children who grow up to be juvenile delinquents and murderers, as well as the batterers of the next generation"* (Schmitt and Kempe, 1975; p111).

2.16 Reducing Risk of Child Abuse to Enhance Child-Centredness

The argument about 'Child Centredness' in HVS raises the policy requirement in the universal public health and targeted roles, to address needs of children and families in partnership with parents, carers and other professionals (Cowley, et al, 2015). This requires fostering relationship that empowers parents to enhance their parenting abilities, reduce risk of child abuse, protect themselves in order to protect their 'children from harm and facilitate behavioural change (Melhuish, 2013; Melhuish, et al, 2010). It means child-centredness involves actions in empowering parents to keep their children safe, get good access to health care, stay well, and be physically and emotionally available for their children in a stable base. While a majority of parents are able to provide adequate protection for their children, some parents may be struggling and therefore require HVs and other professionals to provide enhanced support to meet the needs of children in their services (DOH, 2009). Support may involve signposting parent for support from other services; or help them understand how their behaviours, lifestyles and choices impact on the safety, health and wellbeing of their children (Machin and Pearson, 2013**;** Barlow et al, 2007; Appleton and Cowley, 2004). Children in such situations become 'vulnerable' or 'at-risk' if parents fail to provide safe and secure base for them to thrive, learn and achieve. In a persistent or acute situation where abuse is suspected HVs make referral to the police or/and Children and Social Care (CSC) as part of the 'surveillance' role of HVs to safeguard and protect children (HM Government, 2015; 2013).

From this perspective, the client-HV relationship has two fundamental and indispensable dimensions sitting uneasily with each other. On one hand the HV gives advice and early support to parents; whilst, on the other hand, operating 'surveillance' system to recognise faulty parenting associated with child abuse or neglect (Cowley, et al, 2015; Carr, 2005). The on-going debates question the ambiguity around the basis HVs' risk assessment to identify, justify and classify children and families according to specified levels of 'vulnerabilities' that warrant offer of proportionate level of interventions in their practice (Kirkman and Melrose, 2014; DOH, 2009). However, there have been conflicting methods for assessment and classification of children, and whilst some tend to adopt their intuitions within, others follow analytical concepts based on descriptive guides in local policies (Department for Communities and Local Government, 2012;

DOH, et al, 2000). Unfortunately, there is dearth in evidence relating to the work of health visiting researchers that focuses specifically on how HVs perceive, conceptualise and operationalise the approaches to recognise children's needs, and how these are addressed contextually, given the complexities and fluidity of family settings and behaviours of individuals (Cowley et al, 2015; Evangelou and Boag-Munroe, 2009; Williams, 1997). This discourse highlights real challenges in deciding what child abuse or vulnerable child really is, and who should work with it, taking account of austerity and breakdown of a welfare safety net in our society, but the thesis acknowledge how HV fits in this new world to address the needs of children.

2.17 Transference and Counter-transference

At one end of the continuum, parents may not always agree with HVs or other professionals' risk assessments and sometimes there is a feeling that the HVs are overly judgemental or confrontational (Benbenishty, 2003). At the other end, some parents see the services as insensitive to their needs hence they become detached and non-engaging thereby missing professional support, and increasing the vulnerability and likelihood of the child having poor health outcomes (Brandon, et al, 2012; Evangelou, et al, 2013). In her study of 'T*roubled families: vulnerable families' experiences of multiple service use'*, Morris (2013) identified gaps in existing early year services for children and challenges HVs to '*think family*' in their RBP and develop new ways to involve with families. Psychoanalytic theory can help make sense of the dynamics at the point of engagement between HVs and parents, there are perceptions and assumptions held by parents about HVs and the services (transference); the HVs also have certain perceptions and assumptions about family (counter-transference), and how parents share or withhold information about the children, their needs and experiences in HVS (Barlow, 2007; Traynor, 1993; Newland and Cowley, 2003). In psychoanalysis, 'transference' and 'counter-transference' is reflected in clients-professional relationship; they are theoretical phenomena characterised by unconscious direction and redirection of feelings and experience, from primary relationship an individual has had with family, parent or significant person in their lives either from childhood or as adult, on to interactions in the client-professional relationship (Freud, 1925). Transference and counter-transference can involve positive or negative projection, resulting in feeling of love, rage, hatred, mistrust or extreme dependence; and as initially recognised by Freud, (1925) these phenomena, whether affectionate or hostile, have potential to enhance or threaten client-professional relationship (Freud, 1925).

There are arguments about developing a nuanced health visiting practice capable of recognising and working with the ways 'vulnerable' families 'do family', and the processes that support or inhibit interventions of HVs and engagement in RBP (Hogg, et al, 2013; Morris, 2013). These

requirements are within the Universal Heath Visiting Service (UHV), or Targeted Health Visiting Service (THV) under the Healthy Child Programme - HCP (DOH, 2009), and Working Together to Safeguard Children guidance (HM Government, 2015; 2013). There has been an increasing number of children involved in statutory services from 89,300 to 160,000 between 2009 and 2014; and within the period, children investigated and not found to be abused doubled by 118%, from 45 thousand to 98 thousand (Bilson and Martin, 2016, p5). This high number of false positives and false negatives are associated with policies which have failed to address the deep-rooted problem of inequalities and dichotomous protective service interventions for children (Hearn, 2011), raising some critical need for Child Centredness rather than current forensic approach in client-HV relationship (Bywaters, et al, 2016; 2015). The idea of risk society and iceberg analogy in safeguarding and child protection (Creighton, 2002) continue to influence 'child-centredness', leading to what Barn (1999, p5) described as as 'negative transferability'. There is genuine concern of 'unknown' number of vulnerable children and unpredictability of 'risk' of abuse which has ironically increases calls to reassess the very fundamental imbalance of 'power and authority' as parents, strangers, teachers, friends, health or medical practitioners navigating the discourses in child protection.

In their studies, Avis, et al (2007); Coe, et al (2008); and Van Doesum, et al (2008) identified parents' fear of being judged, 'prying' and criticism as barriers to engagement in client-HV relationship, pointing to the need for HVs to work with parents and children using a non-judgemental, strengths-based approach, but without compromising child-centredness. Kirkpatrick, et al (2007) found that in parent-HV relationship, parents valued HVs who inspired their confidence, ideas and feelings about parenting and did not impose views. This confidence-building and show of interest by HVs made it easier for parents to open up, thereby allowing HVs to build relationship and pick up on subtle clues which could lead to safeguarding concerns. However, HVs contacting social services without prior discussion with parents lead to "… *a breakdown of trust"* and relationship *(*Schrader-McMillan, 2011, p14). Despite initial concerns and negative preconceptions about HVs and social workers, parents greatly valued the relationships they established with their HVs and highlighted many ways they benefited (Schofield, 1998). These included increase in level of confidence, enhanced mental health, improved parenting skills, relationships with partners "… and *changes in attitudes toward professionals"* (Kirkpatrick, et al, 2007, p35).

2.18 Summary of Chapter

In summarising this chapter, the humanistic psychology of Rogers (1959) and psychosocial concept of Erikson (1982), provide HVs with a theoretical knowledge of the impact of

psychological and social determinants of health and be informed about what those influences are on parenting abilities and impact on child health and development. The psychosocial perspective of children and families is therefore an extremely important part of health visiting practice, but often under-prioritised in preference to meeting targets as defined by priorities in key performance indicators (KPIs) local national policies (NHS England, 2005).
A psychosocial perspective in HVS assist HVs understand the character and quality of relationships, including client-professional relationships, analysis of parent-child relationships to make sense of problem behaviour or inadequate parenting and how provide early help. It can be seen that a clarity about psychosocial approach in safeguarding and child protection not only sharpens decision-making, particularly in the area of children's needs and caregiving arrangements, but provides opportunity to develop framework to understand the importance and success from family support and family centres, skills training for parents, patterns of development and outcomes for children. The psychosocial principles set understanding where there are legal issues regarding contact between children and their non-custodial parents, expectations and value of participation in co-parenting to provide routines and voice for the children. Thus, the analyses of relationship quality within the social environments where children live remain fundamental for HVs if they are to understand and support children's health, wellbeing and psychosocial development (Bryar and Cowley, 2017). Hence, it can be argued that the most significant element of health visiting identity is RBP as an integral aspect of holistic understanding of families; but literature shows this concept meets diverse challenges in policy and practice, especially in addressing the evolving psychosocial needs of families (Cowley, et al, 2015; Howe, 1997).

Recognising the risk of child abuse and neglect in families remain a significant aspect of child-centeredness, practitioners often need to apply complex thinking towards possibility for complex solutions within in a relational approach to support parents in creating ‘congenial’ environment for children. This requires HVs to examine the context of each child’s situation, ask some difficult questions such as:

“…what is happening, why, and what can/should be done?” (Young, et al, 2014, p894).

For a number of children, the responses from HVs to these questions could require interventions to co-arrange or co-construct different support strategies in parent-HV relationship; to engage with families in order to secure productive participation in creating safe and stable base for their children, or support families to develop missing parenting skills in a non-judgemental approach (Young, et al, 2014). These approaches in responding to needs of children and families may not be suitable in all circumstances. In certain situations, the HVs may require: to develop strategies that promote engagement of the family with activities that enhance community cohesion and

social capital, involvement of other agencies to explore peer group influences and criminal behaviours of the school age child in order to reduce 'risk' and 'vulnerabilities' of other children within the families and community (Bamford, et al, 2016; Latchford, et al, 2016). Given the level of current cuts and economic realities in Local Authorities, it is apparent that, even with the best of intentions and interventions in practice, the state has limitations as to how best and how well it can be parent to a child who is removed from his or her family home (Featherstone, et al, 2016; Evangelou et al, 2013; 2009). However, despite decades of targeted policy and practice, the current systems still focuses on individualism, lack 'co-construction' and key approaches that: are child-centred, contextual; do not use the synergy from collective actions, reciprocity, or harness the benefits of social and family capital in a relational approach (Young, et al, 2014; Glaser, et al, 2012). The excessive emphasis on 'risk-assessment' and surveillance' in safeguarding and child protection is gradually marginalising the RBP philosophy in offering early support to 'vulnerable' children to overcome adversities and enhance their developmental, social, emotional, economic and physical wellbeing (Devine and Parker, 2015b; Parton, 2014). The concern is that newly qualified HVs may be drawn into defensive practice by engaging in '*box-ticking'*, losing emphasis on child-centredness to stimulate their critical thinking that allows engagement with precarious and unpredictable areas of keeping children safe (Young, et al, 2014, p.895). The practice-theory gap suggests that there is need to develop child-centredness that connects specifically with theory so that practitioners are able to provide clear explanations of why they choose certain support options or actions and the likely strategies to achieve and measure outcomes based on clear decision-making process (Shannon and Young, 2004; Payne, 1997).

Chapter 3: Child-Centredness in the context of Policy, and Decision-Making of HVs

"*The child's shaky security depends, as he well knows, not on his abilities to protect himself, but on the goodwill of others. It is borrowed from the security of his parents. … Being a good enough parent, hence requires that we ourselves be convinced that this is what we are" (*Bettelheim, 1988).

3.1 Introduction – The Health and Social Care Philosophy

There has been a historical link between social care and health, and their policies are intertwined as outcome of one has impact on the other. In this chapter I examine a range of policy and philosophical positions in the UK and their influence on health visiting practice and decision-making of HVs. I explore the conflicting impacts of statutory and policy demands on health visiting practice. The chapter also examines the basis of child-centred approach in HVS practice, providing discourses that explore policies, the family legal process, statutory and non-statutory guidance and legal positions in addressing the needs of children and family, with sensitivity to culture which also contributes to what is known in family-centred service and children's rights. I develop the thoughts expounded by Donald Winnicott (1973) and Bettelheim (1988) and their discourses on the 'good enough parent' and contemporary views on parenting. These allow a sense in drawing some meaning in the context of contemporary health visiting practice to reconfigure the understanding of HVs and their relationship with children and families. The basic understanding of what informs decision-making process within the two contextual discourses is important in health visiting policy development. An investigation by Hackett and Taylor (2014) into the causal mechanisms affecting child protection decision-making processes suggests variations in child-centredness, especially with reference to assessment and early interventions. The significant causes of variability are broadly linked to internal and external factors. Internal factors include: organisational and environmental characteristics; and practitioner-client relationship. The external factors cover: government priorities, socio-political and economic factors. In their argument of the role of government policies in healthcare, Ray, et al (2013) identify the impact of media, for instance, in reporting high-profile child protection cases. Most times, these trigger excessively high referrals of children by health practitioners to statutory protective services, and 'transference' of risk aversive behaviour into practitioner-client relationship. Ray, et al (2013) acknowledged the need to bring in consistency in referral policy patterns based on strong interdisciplinary working relationship and evidence-based referral guidelines and process (Gregory, et al, 2012). The chapter concludes by examining the gaps in practice as highlighted from inquiries into incidents leading to death, child abuse or neglects.

Whereas the discourses in previous chapter focused on the theoretical principles, the application of these frameworks and contradictions are explored in this chapter.

3.2 The RBP, Child-centeredness and Family-centredness in HVS

One of the key public health and education's priorities in England is to ensure that all children are ready to learn at two and ready for school at five. In order to establish crucial foundations for good health and development, it is vital that families receive the right support during the early years of the child's life; and HVS are the lynchpin of that support (NHS England, 2013). The HV and school nurses have been called the 'child public field force'; and through their work with communities and families they have an important role to play in the delivery of other government priorities such as tackling childhood obesity, reducing smoking in pregnancy and passive smoking impact on children and improving the mental health of new mothers. The policy on universal health visiting points of contact are vital to ensure that all parents are supported to give children the best start in life, and as highly trained specialist nurses, HVs are ideally placed in a vantage position to assess and provide early to families identified to have additional difficulties. The overarching health visiting policy the shows child-centeredness encapsulated in Health Child Programme – HCP (DOH, 2009). However, the successful implementation of this policy by HVs is, to a large extent, dependent on their relationship with clients and other professionals involved in the family care (Nettleton,2016). The HCP (2009) universal services includes health promoting visit at 28 weeks pregnancy for health needs assessment and discuss with first time parents topics including: physical health, benefits of smoking cessation and breastfeeding, mental and emotional health, and the transition to parenthood to enhance the parent-child bonding experience and explore how parents can help their baby's early development. The second visit is a New Baby Review at 10-14 days after birth at home to check baby's and mother's health and wellbeing, provide support with feeding and give important advice on keeping safe, sleep, crying and colic. Another three mandatory visits take place at 6-8 weeks, 10 month and 27 month respectively to check child's development, immunisations, nutrition and dental care. At every contact the HV carries out ongoing assessment, discuss any concerns whether developmental or safeguarding issues with parents, with a view to developing some initial and workable solutions in partnership with parents to address the needs. Assessment helps with recognising difficulties early and ability to provide interventions as the HV can link up with other services to ensure processes are in place to support the child and family to address needs (NHS England, 2014; Condon, 2011).

As seen in chapter 2, the HVs' role includes working in collaborative partnerships to develop services that meet local needs and to publicise them to families (DOH, 2011); hence the position

that the role of HVs is pivotal to the uptake of 'universal' services, and to reach 'vulnerable' families who find services difficult to access (Cowley, et al, 2013). Routinely, partnership was lacking in practice, but where it existed HVs were more likely to make referrals to wider services, including speech and language, Early Help and nursery placements, and these approach showed the important role that HVs can play in driving sustainable development by assisting individuals and families within communities (O'Leary, et al, 2013; Sharpe, et al, 2000). As HVs develop a common approach to relationship building with clients, it is crucial to understand holistically the needs of children, parents and their own responses to specific circumstances to ensure their decision-making serves the best interest of children and families (Wilson, et al, 2011).

Reviews of key policies on safeguarding were found to resonate with the direction of policies in HVS, raising the importance of practitioner-client relationship. There is a significant need to shift from a pathogenic approach where HVs adopt a top-down 'expert' culture towards practice orientation which seeks the views and involvement of children, parents, families and other practitioners, through what might be identified as a process of co-production. The implementation of HCP (DOH, 2009), as the key health visiting policy anchors on relationship to achieve its outcomes and enable HVs address the needs of children and young people who require 'universal' or 'enhanced' support due to increased vulnerabilities. For instance they promote parental adaptation, behavioural change for more attuned, responsive and committed parenting, allowing parents to build skills, strength and resilience in order to prevent problems becoming entrenched in families and also reduce risks to children's health and wellbeing. The HVs are also to ensure that 'vulnerable' families who require enhanced support have access to specialist services, such as Family and Children Services, paediatrician, mental health, domestic abuse, substance misuse and disability services (Cowley and Frost, 2006).

In the *National Health Visiting Core Service Specification* policy, HVs are required to:

> "… *develop on-going relationships and support as part of a multi-agency team where the family has complex needs"* (NHS England, 2014, p9).

Another key policy for safeguarding and child protection - *Working Together to Safeguard Children,* requires HV to:

> "*ensure the effective protection of children is founded on practitioners developing lasting and trusting relationships with children and their families*" (HM Government, 2018, p.73).

Their decision-making must, therefore:

> *"… involve children, ensuring that their voice is heard and provide appropriate support, and involve families*" (p26).

In another important policy - *National Health Visiting Core Service Specification* (NHS England, 2014), there is requirement for effective relationships as central to successful outcomes for children and families, and it involves awareness of 'self' and negotiation of interpersonal boundaries. However, the policy directions, which are rooted in the need for effective personal/professional relationships, remain at misalignment with the culture in health visiting practice. There are increasing concerns about apparent shift in practice orientation from traditional relationship based to forensic or pathogenic approach in health visiting practice (Woolfenden, et al, 2014; Rollins, et al, 2012; Sudbery, 2002). Thus current practice cultures where HVs are significantly involved with 'vulnerable' children and families reduces HVs' capacity to prioritise relational approach in practice, requiring a radical re-alignment of issues around identity, power, agency and status to be addressed (Bidmead, 2013; Harold and Leve, 2012).

Munro (2010) argues that 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 which restrict their opportunities in achieving their potential in life. The narrative developed from critical review of literature on child abuse prevention and welfare in the UK shows a focus still remaining on secondary rather than primary prevention, and this approach is predicated on a number of risky assumptions - that practitioners can predict which children will be at risk of abuse or encounter problems (Munro 2010; Parton, 2006), that professionals have the capacity to intervene effectively, using coercion if necessary, to change the course of children's development, and that adequate resources will be available to meet the needs identified through screening (Cohen, et al, 2005). The policies do not fully acknowledge the the difficulties in synchronising RBP and coercive interventions to achieve set outcomes; undermine potential harm which may be caused by the process of surveillance of families and by labelling children as 'vulnerable' (Munro, 2007, p.53). In HVS the fundamental issues raised by Munro (2007) reflect some of the key challenges created by the top-down approach in developing a framework for children and families, particularly the policy on progressive rather than proportionate universalism (Owen and Statham, 2009). Another dimension of safeguarding children agenda which might generate negative transference among HVs is the role played by public and media scrutiny when cases have tragic outcomes (Rawlings, et al, 2014; Lundberg, 2013). 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 in adopting proportionate universalism to see all children in their home environment raise crucial importance for strong relationships with families. Laming argues that a

robust health visiting service delivered by practitioners who are alert to needs of potentially vulnerable children can save lives (Laming, 2009, p.57), and effective parent-HV relationship can enhance outcomes for children. The multiple policy and practice demands on HVs come at a time of resource shortages, an issue identified about the health of under-5s which identified that safeguarding remains a high priority for HVs and, in some cases, limited capacity made it difficult for them to discharge their wider health responsibilities (Cowley, et al, 2015; 2013).

There has been very little research into the experiences of users of HVS (Donetto, et al, 2013). However, available studies show the importance for HVs to develop trusting relationships and nurtured interactions, which help to build parental confidence and promote parents' choices in their own decisions about child and family health. Families expressed their desire for more and better co-ordination between services, especially for health visiting care of vulnerable children and young persons; and parents valued HVs' help, based on relationship and personalised to individual family circumstances and needs (Bailey, 2011*)*. As argued by Cowley, et al (2015; 2013; 2004), HVs require a range of theoretical, skill- based and technical expertise and evidence base knowledge to achieve the tasks set out in HCP; and one of such theoretical constructs explored in this thesis research is child-centeredness. Child-centeredness requires expert skills in communicating with all parents and enabling them to adapt and change; and also provide appropriate range of interventions to inspire parents' confidence in using various methods and approaches that enhance their children's health and wellbeing. A focussed relationship with parents requires genuine interest in the child and parents, allowing the HV to remain supportive, influential, connected, inspirational and facilitative to make it easy for parents to adapt to parenting or lifestyle changes with purposeful outcomes (Home Office, 2015 2012*;* Jaffee, et al, 2013; Katz, et al, 2007).

In essence, whether the HVS is offered in the home or clinic by HVs or health visiting team member, trusting relationships and continuity are key to building trust among parents (Bailey, 2013; Bidmead, 2013). Highlights from the in-depth qualitative exploration of parents' experiences of HVS identified that showing sensitivity to children and parents' needs were lacking in service configurations (Smith, et al, 2012; Bailey, 2011). However, good relationship with tailored support and meaningful information were central aspects that enhance uptake of HVS among difficult to reach families (Jutte, et al, 2015). Thus, parents can become more confident and interact with the child, discuss personally about their mental health and relationships, with potential benefits for both parent and infant. However, the success of this crucial role is intertwined in an individualised-relationship with parents and families which put HVs in a unique

position to offer early interventions to help families who may ordinarily struggle to access services (Cowley, et al, 2015; Almond and Cowley, 2008). In most clinical encounters, it is shown that parents value continuity of contacts from the same health visiting team member, which means advice was better personalised and better accepted by parents (Bidmead and Cowley, 2005). Where there is lack of relationship, parents tend to feel judged for their parenting approaches or lifestyle choices, as they may perceive advice offered is 'by the book' rather than personalised to their family's circumstances (Bidmead and Cowley, 2005a). This results in lack of trust, as parents become sceptical, with potential impact on subsequent encounters (Cowley, et al, 2007). A rather salutogenic approach develops through relationship where HV acknowledges the strength of parents, expresses praise and reassurance to help the parents develop self-confidence and trust in their judgement as parents (Adams, 2015; 2009).

A review undertaken by Jepson and Hardie (2017) about the experience of parents shows that families valued on-going support and relationship with known HVs, and this serves to maximise the impact of HVS in building confidence for positive parenting, healthy start for children's emotional resilience, which gives the best life choices. It is evident that the health visiting policy is embedded on achievement of healthy relationship between clients and professionals; and in a RCT by Dodge, et al (2013), client-professional relationship was the focus in practice which led to significant reduction in smoking during pregnancy, fewer reported cases of child abuse and neglect, improved and safer environment for child development, and more children under age 5 years being school-ready; and reduction in school exclusion and juvenile delinquency (Dodge, et al, 2013). Practitioners pointed out that developing good relationship with families was vital and enabled them to identify concerns about children and family needs early before it reached difficult stages (Dodge, et al, 2013). This approach is the adopted model in Family Nurse Partnership (Rudge and Holmes, 2009).

3.3 Promoting Child-Centeredness in Health Visiting Policy

The contemporary health visiting service tends to foster components of transformational leadership but lacks acknowledgement of emotions, values and unpredictability of people and uncertainties in organisations. As seen in social care policy, there is idealised focus on child-centeredness without clarity on ethical standards and inspirational motivation that promote development and commitment to professional-client relationship and best practice, to inspire intellectual stimulation that encourages creativity, innovation and

consideration for others' abilities and needs (Ruch, et al, 2010, p239). The health visiting policy implementation strategies need to take cognisance of the importance of 'relationship' in practice which requires a 'non-coercive' partnership and 'inclusive orientation', to bring effective interactions between clients, practitioners and other professionals (Ruch, et al, 2010). Thus, it can be argued that key characteristics in traditional social work practice are fundamentally relevant in health visiting policy and practice to enhance outcomes for children, family and practitioners. The primary importance of relationship remains encapsulated in health visiting policy, but it remains obscured in KPIs, practice orientations and poorly explored in research. Moreover, relationships are central to health visiting practice, and this is shaped by the nature of need of children and family – inclusive of 'universal' and 'enhanced' service offers, which often require interactions as the primary means of interventions, either as: 'the end in itself' or, as it is more commonly utilised, a 'means to an end' (Ruch and Julkunen, 2016; Ruch, 2007). HVs place emphasis on relationship as it offers a medium through which they can engage with and intervene in the complexity of an children's internal and external worlds. The argument is that, HV and parent's relationship are recognised to be significant sources of engagement and provides information for practitioner to understand parent-child interactions, assess needs of the child and family and decide how best to support them; and the relationship is simultaneously a means by which any early help or intervention is offered and accepted (Cowley, et al, 2013; 2007).

3.4 Child-Centeredness in Statutory and Non-Statutory Guidance

The Children's Act (HM Government, 1989) defines a child as aged **-** 0 (including unborn) to 18th birthday, and the welfare of the child is paramount which suggests children should be brought up within their own family whenever possible. In relation to a definition of child-centred care, the cornerstone of the argument is that children are competent and that there is capacity within the system for professionals to establish different relationships with the children and family, with highlights that children have varied needs and voices to be heard (National Children Bureau, 2018).

A child-centeredness is an approach that is fundamental to safeguarding and promoting the welfare of every child who may be vulnerable due to abuse from within the family and from individuals the children come across in their day-to-day lives. In safeguarding and child protection, the term means professionals adopting a practice method that keep the 'child in focus' when decisions are made about children's lives and working in partnership with them and their families. These risks occur in different forms, including: sexual, physical and emotional abuse; neglect; exploitation by criminal gangs and organised crime groups; trafficking; online abuse; sexual exploitation and the influences of extremism leading to radicalisation (HM Government, 2018; Gambril and Shlonsky, 2011). Irrespective of the form of abuse or neglect, professionals

are expected to put the needs of children first when determining appropriate cause of action to be taken; thus practitioners should see and speak to the child; listen to what they say; take their views seriously; and work with them and their families collaboratively when making decisions on how to support the children's needs (Condon, 2011).

The Children's Act emphasises that children be kept informed and should participate when decisions are made about their future. Thus working in partnership with parents to meet the best interests of the child, respecting each professional role and to communicate effectively are crucial in developing a child-centred practice. In assessing the family, the HVs must understand who has parental responsibilities (PR) for the child. According to the Children's Act (HM Government, 1989), PR means all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his/her property. Thus only those with PR can consent to a child receiving medical treatment or health visiting interventions. The birth mother will always have PR, except where the child has been removed on an adoption order; and fathers have PR if they were married to the mother at the time the child was born ***or*** they are registered on the child's birth certificate (HM Government, 1989). When children and young people are involved in protection processes, they tend to feel they have little control over events; and the likely focus of professionals' work will be on issues of risk and abuse. It is argued that children would like to talk about things other than problems and also have opportunities to air their anxieties. Studies show that children appreciate having access to someone who they can speak to in confidence, while ensuring that their safety is not compromised (National Children Bureau, 2018; Rawlings, et al, 2014).

The United Nations Convention on the Rights of the Child (UNCRC) is an international agreement that protects the rights of children and provides a child-centred framework for the development of services to children. The UK Government became signatory to the UNCRC in 1991 and, by doing so, recognises the right of children to express themselves and receive information about their care. HVs need to understand the policy, guidance and legal framework in relations to how these synchronise into promoting a child-centred practice in a way that elevate the interests, wellbeing and views of children. This is significant because children are affected directly and indirectly, by practically all policy decisions, and yet children cannot influence them through traditional channels. Both children and parents are often confused about what is happening to them; and there is need to address this with the rise in the number of cases being taken to family courts (Barlow and Scott, 2010). Professionals must understand that whilst it is parents and carers who have primary care for their children, local authorities, working with health and other organisations and agencies, have specific statutory duties and responsibilities to safeguard and promote the welfare of all children in their local area. The Children's Acts (HM

Government, 1989) set out specific duties under section 17 for services to children in need; and section 47 for social workers to undertake enquiries if they believe a child has suffered or is likely to suffer significant harm (HM Government, 1989). The Children and Family Court Advisory and Support **(**CAFCASS) parenting training offers an effective way for parents to address relationship problems away from court, helping parents listen to their children's views and to make child-centred options and arrangements. The Separated Parents Information Programme – SPIP (CAFCASS, 2017) can help parents achieve safe contact programmes by engaging their common goal on the children, handle emotions and improve communication. They also run Domestic Violence Perpetrator Programme (DVPP) which may lead to challenging harmful parental behaviours and support change (CAFCASS, 2017). The CAFCASS works collaboratively with other services to increase awareness about issues facing children and young people in family; raise awareness of the impact of family breakdown on children and young people's mental health and how professionals can support them to build positive resilience. CAFCASS also work with agencies to develop ongoing understanding and practice on how and when a child should be involved in their case (Ofted, 2018). The court is supported to make child-centred and safe decisions based on cogent, well-balanced and analytical risk assessments of the child and family undertaken by CAFCASS, although Ofted reports identified instances of poor case planning in establishing children's views and progressing cases quickly enough (Ofted, 2018).

3.5 Child-Centeredness and the Family Legal System

The family justice system deals with the failure of families, parenting and of relationships; often the psychosocial and behavioural factors associated with such failures include partner's poor anger management skills, violence, abusive traits, drugs and alcohol. The decisions taken by local authorities and courts about the health, care and wellbeing of children have fundamental long term consequences for children, parents and for society generally (Barlow and Calam, 2011). In their operation, the family justice system must therefore take the interests of children as central, and decisions are expected to take the wishes of children into account as they need to know what is happening and why (HM Government, 2018). When professionals interact with children, great care should be given to the child's age and understanding, with sensitively to their needs. The HVs may involve in families where issues such as parents' separation arise, with potential for complex and emotionally charged circumstances and most children struggle with all the turmoil of family separation (Roche, 1999). The risk is that the legal process of separating can itself cause further difficulties which might put the child at risk of harm, for instance, where there is lack of exit planning as spouse leaves abusive relationship (Bradbury-Jones and Taylor, 2013). Some arrangements imposed by the courts, such as non-molestation orders or child

contact agreements, for instance, may lack flexibility and can fail (Sidebotham, 2001). Whilst it seems better that parents resolve relationship issues by themselves if they can, some may need help to find routes to resolve their disputes short of bitter court proceedings. Where there is relationship breakdown, parents may benefit from the family mediation service which offers an independent, professionally trained mediator to help parents work out an agreement about issues such as: co-parenting arrangements for children after you break up and child maintenance payments (Øverlien, 2014). However, parents who demonstrate understanding about the needs and emotional wellbeing of their children are more likely to work out co-parenting arrangements which offer stable base and 'congenial' environment for their children to thrive and be safe. The HVs can support parents to achieve this with better parenting information and early help services. When cases involving children's care are determined in family courts, child-centeredness is expected to reflect in such decision-making to determine whether a child's placement order is in the best interests of the child (Department of Justice and Department of Education, 2011). The decision of the court as to whether an order to remove a child from family home must take into account the child's needs, wishes and feelings, and most importantly, whether or not parents or family were able to meet those needs with '*good enough parenting*' characteristics (Ministry of Justice and Department of Education, 2011, p.99). The relationship between local authorities and courts can be challenging at times, but to promote child-centeredness, the system has to work together rather than each group sitting on the side-lines to criticise the other. Hence, the courts, local authorities, health and other professionals should work together to tackle differences, as failure in one part of the system must be seen to be a failure of all (HM Government, 2018). Thus the overarching principle in achieving child-centred practice requires HVs to understand the legal position for family, gain confidence in assessing and identifying critical issues which might help parents achieve a '*good enough parenting*' ability to address the needs of family early in a more effective approach that promotes the welfare of children than reacting later.

3.6 'Good Enough Parenting' and Child-Centeredness

Good enough parent is a concept derived from the work of paediatrician and psychoanalyst Donald Winnicott, in his efforts to provide explanation for what he called '*the sound instincts of normal parents...stable and healthy families'* (Winnicott, 1973, p.173). The idea of the 'good enough parent' was developed on the one hand to defend the ordinary mother and father against what Winnicott perceived was the growing threat of intrusion into the family and children's life from professional expertise (Winnicott, 1973). On the other hand, it was to offset the dangers of idealisation built into some psychoanalysts' views of the 'good object' and 'good mother' (Winnicott, 1973, p10), by rather stressing the importance of actual nurturing and '*stable*' environment parents provide for their children. The argument of 'the good enough parents' as

advocated by Winnicott is the use of realistic on-going approach by parents to meet the child's needs, survive the child's anger and frustration with the necessary disenchantments of life (Winnicott, 1973). The idea of Winnicott's can be extended to child-centeredness which focuses on parents developing a good enough environment that promotes emotional wellbeing and mutual respect in parent-child relationships. Winnicott was concerned with mothers and his description was the 'good enough mother' (Winnicott, 1986). However, Bettelheim (1988) not only generalised the concept to include both genders of parents, but also simplified the term, in a way that makes sense to parents and professionals. According to Bettelheim (1988), '*g*ood enough parents' does not mean achieving perfection in parenting or perfection from children. Drawing from the argument of Bettelheim (1988) and Winnicott (1986; 1973) 'child-centeredness' is not the expectations that parents should be perfect in their parenting*, as* perfection is not within the grasp of ordinary human beings, and it typically interferes with that lenient and compassionate response to the imperfections of the others, which alone offers good human relations. The key danger with professional expectation of perfect parent is that every blemish, including those that are beyond the capacity of the parent, becomes magnified, with lack of sensitivity. Striving for perfection as a parent can increase anxiety and stress as imperfections in human beings are unavoidable, and as they are part of the human condition, a strength-based approach becomes crucial in enhancing outcomes for children (Daro, 2002). The belief that perfection is possible in parenting promotes a tendency to blame; and with such reasoning, any problem arising must be someone's fault. Parents may blame themselves, their spouse or their children when they think or feel judged by professionals that things are not right; and blame remains the bane of every family in which it occurs. Bettelheim's (1988) argument highlights the erroneous convictions in modern times that: "*problems should not occur and that someone has to be at fault when they do; this causes untold misery within the family unit, aggravating the original difficulty and sometimes even putting the validity of marriage and family into question" (*Bettelheim, 1988, p.75*).* This argument lends credence to the view of Lash (2007) about `risk society' and Lányi's (2011) discourse on blame culture in our society.

Whilst 'good enough parents' show respect to their children and try to understand them for who they are, and their feelings; these parents do not think of themselves as the producers, creators, or shapers of their children. They understand the reciprocity in the parent-child relationship which goes both ways, but not entirely, in the sense that the two parties are equally important, deserving of happiness, opportunity to create their own goals or identity and striving to achieve them, with no harm to the other. In another sense, professionals also see parent-child relationship as unequal as child is young, the parent is adult, stronger, wiser and better at reasoning (supposedly), and the parent takes charge of resources that the child needs for survival. A 'good enough parent' therefore strives to make this unbalanced relationship work by

getting to know who the child is, in order to understand child's needs, cues and wants (Condon, 2011). In order to embed this understanding in child-centred practice, health visiting support can increase confidence of parents in knowing his or her child. It means the parent "*will examine the child's motives, try to understand his thoughts, appreciate his desires so as to comprehend what the child hopes to gain, and why and how" (*Bettelheim, 1988). A HV-parent interaction which focuses on an approach that problems should be avoidable, might lead to a direct or indirect defensive berating of parents, which defeats any attempt to understand and truly help them (Daniels and Livingstone, 2014). On the contrary, child-centeredness is reflected in a 'good enough parent' where professionals see problem for what it is, working in partnership with parents to solve, and not see problem as a tragedy or an occasion for blame or shame. The initial step in solution-focused relationship is for HVs to understand the family problem from child's and parent's point of view, without assuming that their behaviours or actions are wrong and must be corrected (Hogg, et al, 2013). Parents may not provide clear reasons for their actions, and may not even have insight into the impact of their behaviours on the health and wellbeing of their children, or on their parenting ability. Shifting the focus to non-judgemental understanding does not mean that parental behaviours are acceptable; but the insight such as this can promote a positive, cooperative, relationship-building route to solving the problem, in which the parent and professional think and talk together about possible solutions to improve the child outcomes (Hearn, 2011). The epistemological position here is that child-centeredness inspires professionals to develop motivation that seeks to understand parent's needs, which, in turn, can lead to a workable solution in which the parents feels supported to care for their children rather than being judged about their parenting (Barlow and Calam, 2011; Barlow, et al, 2007). In a child-centred practice, HVs are driven to support parents to become 'good enough parents' in an environment where children feel secured and protected rather than abused or neglected; can trust their parents and have a good enough space in which to play, explore, learn, with opportunities to make friends and interact with others safely beyond the family (Donetto, et al, 2013).

3.7 The Child-Centred Decision-Making

The nuances of HV's observation, information-seeking and interactions anchor on relationship with parents and family in a process which requires attention of the HVs, with mind opened to all impacting or impinging experiences of the child and family. In developing such framework rational and intuitive considerations are crucial to explore every contact for impressions, thoughts and feelings about the contextual circumstances of the child. The sort of attention described here allows reflexivity and reflectivity whereby the HV links previous experience to

current clinical situation, positioning self in order to relate to others and also be able to seek space to engage with own experiences. Thus the health visiting role can generate emotional feelings likely to provoke 'intense psychological and emotional impacts, resulting from interactions with children, families and other professionals. An integral aspect of decision-making is observation of parent-child interactions, where professionals seek to establish the quality and dynamics of such interactions to determine behaviours or situations which can put the child at risk of abuse and to support parents in finding solutions to address their family needs (Hingley-Jones, et al, 2017). It means the initial focus is not child abuse, fault-finding or to prescribe what parents should and should not do. Rather, the HV's attention as an intuitive and analytic practitioner carries enormous professional curiosity to know more about the circumstances and experience of the child and family in an attitude which allows the HV to:

> "… s*urrender himself to his own unconscious mental activity, in a state of evenly suspended attention, to avoid so far as possible … the construction of conscious expectations…to catch the drift of the patient's unconsciousness with his own unconsciousness* (Freud, 1923, p239).

The HV reaches a point where decision is made from intuitive and analytic observations, drawing on 'facts or feelings', developed from 'instinctive or systematic reasoning' (Whittaker, 2018; 2016), but with expectations to discover something new, unexpected or less than conscious. In this process, as argued by Bidmead (2013), the HVs brings past lived experiences, knowledge, preconceptions and 'framing' to the task of interaction and observations to gain contextual insight into the context of the child and family. Thus, the HV's approach resonates with Bettelheim's (1988) view on t*he primary tools of good enough parenting,* which, he argues, are seen in characteristics that reflect: *conscious reflection, maturity, and empathy.* Parents are more likely to listen to and follow parenting traditions and advice from friends and relatives who know them and their children well than from HV who does not know them or can be trusted; hence, to know how best to support their clients HVs need to strive to understand them through conscious reflectivity and reflexivity , compassion and empathy when developing professional-client relationship. The observation of parent's interactions with their children to understand the interpretation and responses to their children's cues and feelings, provide HVs meaningful step in recognising how to support parents to become confident in their parenting. Parents who have such confidence will be calmer and patient, less anxious in their interactions, thereby providing a greater source of security for their children, than parents who lack confidence in parenting their children (Bettelheim, 1988; Winnicott, 1986).

In their assessment, the HVs are expected to demonstrate professional skills and experience during observation of parent-children interactions to recognise parenting needs; but this require empathy towards the child and the family (Appleton and Cowley, 2008a). Empathy is the key to any successful relationship with children and family, as it enables the HV enters the child's and parent's circumstances and their frame of mind. Based on Bettelheim's (1988) argument in client-professional relationship and decision-making, empathy considers other person as an equal - not in regard to knowledge, intelligence, or experience, and certainly not in maturity, but in regard to the feelings and motivations for certain actions and behaviours. President Obama (2007) lamented the deficit in empathy and compassion among professionals in understanding psychosocial life of individuals. His comment is relevant to societies everywhere: '*we are in great need of people being able to stand in somebody else's shoes and see the world through their eyes*' (Obama, 2007). Health visiting is one of the professions where empathy really matters, and at different times practitioners, managers and policymakers all need to be able to stand in the shoes of children and families and see the world through their eyes. Empathy does not suggest HVs collude with parents whose actions and behaviours put the child at risk of harm and neglect (Johnston, et al, 2013). For empathetic and compassionate HV, child-centeredness in decision-making involves an 'emotional empathy' which shows feeling about the child's needs and difficulties of the family; and 'cognitive empathy' which requires understanding the perspectives of other psychosocial factors as fundamental for good decision-making. Evidence shows that most child and family policies failed because those making decisions were too remote from the reality on the ground (Gilbert, et al, 2012). However, the psychological burdens of care can be a major factor in staff 'burnout', which in turn can make it harder for practitioners to be empathetic in their decision-making (Maharaj, et al, 2019).

The above discourses lend credence to the priority of HVs to develop an inclusive and dynamic client-practitioner relationship, with attention to the holistic context of clients including health and psychosocial issues as significant in achieving outcomes for children and families. The focus of HVs reflects relevant characteristics in traditional social work theory and practice which placed emphasis on relationship-based practice (Hingley-Jones and Ruch, 2016; O'Leary. et al, 2013). The HV-client relationship impacts on decision-making process in health visiting practice, but this is not clearly recognised as priority in policy and management of HVS. The issues drawn from health visiting literature above shows variability policy priorities and needs of parents and professionals in the front line service, leaving gaps that are not fully addressed to support health visitors in their decision-making to achieve child-centeredness. Firstly, there is lack of recognition that every encounter of HV with parent and family is unique; and human behaviours are unpredictable, complex and multifaceted, i.e. individuals are not just rational beings but have affective – conscious and

unconscious dimensions that can enrich but simultaneously complicate human relationships. However, it is shown that human behaviour and professional relationship are significantly integral component of any health visiting interventions (Cowley, et al, 2013; 2007).

Secondly, HVs provide an intimate link between the internal and external worlds of individuals - HV or parents and it is crucial to integrate psychosocial factors as opposed to polarise responses to social problems. Thus HVs value 'the use of self' and the relationship as the means through which interactions can develop and interventions are channelled (Hoeve, et al, 2014). The health visiting work can be described as a 'self-in-action' task in which practitioner operates within the ambit of contact involving two or more individuals who come together. There is a challenge for HVs and organisations that operate within limited norms of what constitutes acceptable personal and professional boundaries (Evans, 2010; McCabe, 2010). Gharabaghi (2010) argues that boundaries in care relationships are relational, necessitating an emphasis, not only on distance, but also on positive connection. Thus it is important for HVs to differentiate between boundaries which are ambitious and can be deployed with sensitivity and flexibility, and their barriers in order to prioritise consistent application (Gambrill, 2005). There are demands sometimes in practice for individual HV to act in ways that might be thought to be subversive of practice norms and bureaucratic procedures (Coe, et al, 2008; Doherty, et al, 2004). For example, a HV's offer of the kind of flexibility required in negotiating routine or enhanced contacts to meet the needs of children and families in their practice. The potential difficulties likely to be seen in a KPI-driven and highly bureaucratic practice, however, is a tendency for organisations to operate fixed understandings of the lines between professional and personal domains, thereby undermining the intricacy in balancing boundaries. This leaves practitioners vulnerable to some form of discipline should they cross externally determined boundaries in their practice (Stanford, 2010; Taylor and Tilley, 1989).

Thus, in health visiting practice, 'self' can be described as the unique 'individual' in practice, influenced by combination of social and cultural values, emotions, beliefs and experiences that contribute to who we are (Ruch, 2010). These influential factors are not rigid and, as we develop relationships, we draw upon what we feel is essential to engage with others within a given practice context. This becomes more complex by the addition of professional values, roles, expectations from the organisation and society (Beck, 2009). Thus, the 'use of self' remains significant, but presents clear challenges for HVs in managing the balance between professional, organisational and personal elements of their practice. Debates on this balancing act have not been explicit, but it should be harnessed

and used to bring about changes rather than being shied away from (Baldwin, 2012; Twinn, 1991). There is, however, interdependence between HVs and parents/families, where, for instance, both parties bring their own parenting styles and contexts to the encounter, laying the foundations for trusting and dynamic relationship (Johnson, 2014; Bailey, 2011). This places demands on HVs who need the capacity to develop and enhance relationships that can bring a level of trust which promotes the sharing of emotions - in a form of 'containment' and 'reciprocity'. The key requirement for this is a degree of emotional confidence in order to fully gain understanding of the feelings of children, parents and significant others in the family, and be able to communicate this in a genuine and attuned manner (Biggart, et al, 2016; Douglas and Brennan, 2004).

Finally, the role of health visiting organisations are pivotal in promoting child-centeredness through supporting HVs to develop effective client-HV relationship in practice as mechanism to contain and manage emotions generated from elements within this process. These characteristics set strong tone in the debate on addressing the needs of families but without recognising relationship as fundamental in achieving meaningful outcomes for children; and both health visiting organisations and practitioners have roles to play in developing and sustaining supportive client-professional relationships, especially in unique, complex and challenging family circumstances which might trigger child abuse and neglects. This raises the need to reconceptualise both HV's behaviours and organisational mechanisms that promote child-centeredness and relationship with clients. The epistemological position of this concept places equal importance on the uniqueness and complexity of professionals' knowledge and experiences, including the rational and emotional aspects of their behaviours in practice (Barlow and Calam, 2011). The key preventative public health roles of HVs is their responsibility in monitoring and checking children's health reviews, immunisations, growth centile charts to prevent the risk of collusive relationship with parents. The HV encounters professional and emotional dilemmas in decision-making for children as they need to differentiate between focus on the difficult experience of parents while simultaneously struggling with their own experiences and emotions (Barlow and Calam, 2011).

3.8 Policy-Practice Gaps from Serious Case Reviews

The argument I developed from Serious Case Reviews (SCRs), is that safeguarding and child protection statutes, policies and guidance tend to be reactive to risk society concept as repeatedly reflected in SCRs (appendix 13). These reactions often follow child deaths associated with abuse or neglect; and they tend to have brought confusion and provoked similarly fracturing

effect on ‘child-centeredness’ and the outcomes for children. The changes in events suggest that policy and research to tackle child abuse require focus on public health approach, with emphasis on context as well as individuals rather than building policy on lessons from single serious case review (Greenway, et al, 2013). I explore the policy-practice gaps in safeguarding and child protection in the context of HVS, with specific focus on the work of Margaret Rustin (2005) and the psychoanalytic perspective of her critical review of the Victoria Climbié Inquiry report. In their systematic review, Kirkman and Melrose (2014) show the key ‘behavioural and organisational’ factors that complicate or reduce the ability of practitioners in making highly complex, challenging decisions involving children. The key findings from these reviews showed more of failings than strengths in health and social care organisations (NSPCC, 2019), especially highlighting practitioners:

- Lack of sufficient knowledge or understanding of past history of children and families to inform decision-making.
- Reluctance to go beyond presenting issues.
- Anxiety that escalation of concern might lead to parents becoming alienated and disengaging from services.
- Insufficient professional curiosity, lack of common language and simple assessment framework through which professionals could discuss their concerns. General indication that ‘being curious’ about what lay beyond the threshold of the home is ‘not my responsibility’.
- Collusion and acceptance of disguised compliance whereby parents/carers engage with professionals pretentiously so that child abuse is not identified and acted upon.
- Poor monitoring of children in families experiencing difficulties, lack of evidence to show assessment or care plan.
- Inability to: recognise abuse, provide response and early therapeutic interventions to children; poor information-sharing, excessive or untimely referrals to statutory protective services (Jones, 2015; 2001; Brandon, et al, 2015; 2012; 2009).
- Lack of recognition that child abuse and neglect occur within the spectrum of universal and high risk level of needs for children. Along this continuum, safeguarding concerns can arise at universal services “*through to the sharp end of Child protection services*” (Rawlings, et al, 2014, p58).

SCRs are usually initiated when a child under 18 years old died or is seriously harmed in maltreatment (abuse or neglect), and there are lessons for interagency working (HM Government, 2018). In some of the cases, children who suffered abuses had contact with the HVs and/or school nurses and report suggests service quality regarding healthcare and support for children, in some cases could have been better (NSPCC, 2019; Wilson, et al, 2008; Williams, 1997). The support of HVs was acknowledged to be relevant in supporting vulnerable families, but the main limitation was the absence of standardised data recording of interventions (NSPCC, 2019). In other subsequent SCRs, the role of HVs has been put in public scrutiny; and there have been instances where HVs have to make court appearances to present case about their role in the care of children prior to serious incident or the death of a child. The reviews highlight gaps in practice which could lead to adverse consequences for the children (Brandon, et al, 2015; 2012; 2009; 2008; Horwath, 2013). In the reviews it is evident that the priority of some parent-HV encounters were not focused on 'home visit', where children could be seen in their homes, which is the core of all health visiting service provision (Hood, et al, 2016). However, there are gaps in developing and nurturing HV-client relationship to allow offer of a flexible service to clients in a way that is tailored, purposeful, therapeutic and measurable. The absence of such parent-HV relationship suggests difficulty in determining parent- infant relationships and meaningful relationships across the workforce - partnership working and skill-mix (Bidmead, et al, 2016). Bidmead and Cowley argued that parent-HV relationship should bear characteristics which reflect a:

> *"Respectful, negotiated way of working that enables choice, participation and equity, within an honest, trusting relationship that is based in empathy, support and reciprocity"* (2005, p.203).

Ironically, the scrutiny of practitioner's role in statutory child protection remains reactionary and occurs in response to potential or actual situations of serious incidents as against proactive measures in child-centeredness which should ensure there are safe systems to safeguard and protect children and young people before concerns results in difficulties (Horwath, 2013). Munro (2011) highlighted the need for a stronger focus on gaining understanding around the underlying issues that make professionals behave in the way they do and what prevent them from being able to safeguard and provide adequate protection to children. Her observations suggest that the focus of social care system is more on what happens rather than why incidents occur; and this occurs due to lack of relationships. She suggested a contextual approach, encapsulated in practice, to ensure organisational settings provide professionals working with children the right skills, knowledge and confidence to respond appropriately to the needs of vulnerable children (Fish, et al, 2012; Finch, 1997).

A number of factors have been identified as hindrances towards embedding lessons from SCRs into practice, especially the system for disseminating lessons which can be over-prescriptive (Rawlings, et al, 2014). Firstly, it is highlighted that lack of effective child-centredness, as shown in poor communication system, prevents lessons being tailored to provide meaning and reach practitioners within and across services and agencies (Jones, 2015; Rawlings, et al, 2014; Brandon et al, 2012). Secondly, there are criticisms that the length, time and content of SCRs publications generate an ethos of 'blame,' avoidance, apathy, defensiveness and increased workload which are mostly exacerbated by media publicity (Jones, 2015; 2001; Brandon, et al, 2015; 2012; 2009). Thirdly, in view of consideration that SCRs are published nationally, the dispersal, political and public sentiments associated with some of the cases make it difficult for most of them to be given local attention, and incidents of child abuse that attracts attention are then skewed and determined by national media selectivity and in coverage (Brayley, et al, 2014; DOH, 2014a; 2011). Finally, the number of recommendations from SCRs applied to generate new safeguarding and child protection policies and procedures are usually overwhelming; and the reports are not accessible in terms of common language to make the lessons meaningful and manageable across agencies and professions locally (Rawlings, et al, 2014). The SCR process is costly and the requirements for their full publication raise concerns regarding confidentiality and frenzy of the media provoked by risk and blame culture when incidents occurs (Rawlings et al, 2014).

There is poor learning and training culture across and within Services; and practitioners have insufficient regular, appropriate and purposeful training to embed lessons from SCRs into health visiting practice. This is further complicated by the repetitive nature of lessons from SCRs, leading to lack of attention and engagement from front-line practitioners, who have limited input in the generation of these lessons to enhance relevance and applicability in RBP (Evangelou, et al 2013; Evangelou and Boag-Munroe, 2009). The development of safeguarding and child protection policy and procedures in reaction to lessons from SCRs do not take account of the sensitivity to the scale, locality, proportion and context of the case (Rawlings, et al, 2014). Most changes are rapid, requiring changes and implementation which has significant impact on practice and front-line practitioners, leading to confusion, tensions and anxiety relating to workload, roles, responsibilities and accountability. The human and emotional elements of policies and procedures do not show sensitivity to the needs of local services and practitioners in terms of interpretation, judgement and decision making, thus negatively influencing practice (Epstude, et al, 2008). Too many changes at national and local levels tend to be directive, destabilising and undermining the ethos of child-centredness and local needs of services and practitioners who may already have too heavy workloads to embed changes into practice (Jones, 2015; Rawlings, et al, 2014; Engle, et al, 1996).

3.9 Gaps and Impacts of Child-Centredness in Contemporary Practice

In the UK, child abuse has raised common public concerns in recent times, with news reports providing updates about the subject in relation to proven or alleged cases of abuse involving politicians, criminal street gangs, priests, teachers, doctors, sports coaches, pop stars and celebrities in entertainment (Gilbert, et al, 2012; Barlow and Calam, 2011). Childen are caught in cross-fire within situations of domestic abuse in families, which became dire during COVID19 lockdown (NHS Confederation, 2020). There are criticisms of current mono-approach to child protection seen as undermining child-centeredness; raising emphasis for a shift in pattern from forensic attitude and blame culture in establishing culpability for abuse towards strength-based and effective family support (Bentley, et al, 2017; Bunn, 2013; Turnell, 2012). It is suggested this approach can have positive impact on reduction of 'risk' and 'vulnerability' as policy looks at both contexts and individuals. Policy can therefore be informed by the population health research which integrates data from routine health and social care information, the judicial system and education rather than build child abuse policy on lessons from enquiries into individual child death (British Medical Association**,** 2017; Jones, 2015). The epistemological principle underlying this policy approach is to gain understanding of the type of professionals, patterns of contacts with interventions to children and family, establishing those children who might not have any early or preventative services, duplication of services for which outcomes are better linked to input from specific services (Runyan and Zolotor, 2011).

It is suggested that a dearth in randomised control trials for HVS and protective service interventions does not allow full evaluation of effectiveness of such interventions in preventing child abuse. In welfare and coercive interventions such as child placement out-of-home, it is difficult to assess what works and for whom (Thoburn, et al, 2013; Thoburn, 2010; Reading, et al, 2009). In conceptualising 'child-centeredness', health practitioners focus interventions on families who position themselves to benefit from early support in parent-child interactions to make real impact in reducing 'risks' and consequences of significant harm on abused children (Rivara and Johnston, 2013). Practitioners and researchers are of the view that changes in existing guidance clarifies that 'safeguarding children is everyone's responsibility'; however, HVs and other health professionals still have limited capacity that can integrate into their practice a direct access to children and family therapeutic interventions, without channelling through Children Services; in order to allow the Children and Social Care to focus on complex contextual issues affecting children (Woodman and Gilbert, 2013). This highlights a need for HVS to have a more proactive shared role in providing ongoing and early support, monitoring and management of parents whose health and behavioural needs increase the risk of harmful interactions between parent

and child, and other vulnerabilities for the families (British Medical Association, 2013; 2012; 2007).

A review of various, policies, statutes and government guidance on safeguarding and child protection (appendix 10) and SCRs shows changing definitions of risks of child abuse and vulnerabilities. However, these changes inevitably compound fears and the anxieties of practitioners, with likely impact on 'child-centeredness' and outcomes for children and families (Woolfenden, et al, 2014). Firstly, child protection policy and practice have been constructed within increasingly reactive and defensive paradigms; with less priority to harm prevention through proactive strategies to help children early in a relationship-based approach. The ECM document (table 3.1) highlights the plights of children as:

> *"… they also face more uncertainties and risks: children face earlier exposure to sexual activity, drugs and alcohol. Family patterns are changing. There are more lone parents, more divorces and more women in paid employment all of which has made family life more complex"* (HM Government, 2003, p14).

Secondly, the reactions of HVs and other practitioners to the confusion created by conflicting recommendations and interpretations of child protection policies and lessons from SCRs could be associated with negative projections from HVs into parent-HV relationship. However, the experience of few HVs might reflect the argument of Ruch, et al (2010), which highlights an approach of RBP in social work which integrates the principles of psychoanalysis and psychosocial in practice. Their views appreciate the complexity of work approach based on exclusive RBP whilst coerciveness still exist, which enhances an epistemological position that is consistent with the psychoanalytic principles adapted for this thesis to recognise what child-centeredness means to HVs and how this impacts on their emotions and well-being. I argue that this is a rather narrow perspective of what RBP could be, but it is necessarily narrow due to the basic argument that health visiting practice is not able to hold true to the value and principle of respecting clients' autonomy and right to self-determination in the face of austerity and coercive interventions in families to safeguard and protect children (Murphy, et al, 2013).

The templates for practice were set by the cases of Victoria Climbié and Baby Peter Connolley (Haringey Local Safeguarding Children Board, 2009) inquiries but further conflict and professional dilemmas were encountered in balancing the needs of the child's safety against the rights of the parents, a significant dilemma in 'child-centeredness'. This followed the Conservative health minister, Tony Newton speech in 1988 when he told the House of Commons: *"proper action to protect children would not be allowed to trample on the rights of*

parents", hence the Children's Act (HM Government, 1989) placed the 'paramountcy' of children's best interests against parental rights. The 'dilemma of liberalism', as Dingwall (1983, p.220) calls it, is that society wants children protected from harm and other parental abuse while, at the same time, keeping the family as a bastion of liberty. In recent times social work has suffered intense public criticisms, disempowerment and loss of trust, and these perceptions extend to health and other professionals concerned with child welfare which, inevitably, result in professionals becoming discouraged from a more interventionist rather than supportive stance, to the detriment of the ethos in 'child-centeredness' (McDonell, et al, 2015; Mackay, 2005). There was a cold climate which existed until the policy makers began to understand the impact of intergenerational abuse on children, with domestic abuse as key factors. In their policy, New Labour introduced rather 'forensic' approach to responding to the needs of 'vulnerable' children, notoriously resonating less by protection than policing: managing 'problem families', antisocial behaviour and crime; introducing a new difficult dimension in 'child-centredness' (Levitas, 1998).

The death of another child, Victoria Climbié (Lord Laming, 2003), provoked a sea of change in safeguarding and child protection policies, leading to government introducing Every Child Matters (HM Government, 2004), in efforts to repair the damage done to parent-practitioner-profession relationship. Unsurprisingly, other high profile inquiry followed (appendix 13), such as the death of Baby Peter Connolly (Haringey Local Safeguarding Children Board, 2009), when the then education secretary, Michael Gove commissioned Professor Eileen Munro to review services in 2011. Munro issued a warning which showed a further conflict against the eroding professional-client relationship as she highlighted that the ability of the system and individuals to be child-centered had been compromised and the centrality of relating to 'vulnerable' children and their needs have been overtaken and "*obscured*" by culture of policy compliance (Munro, 2011, p8). Every serious incident involving child death or other significant harm incites public outcry, and official responses can redefine 'risks' and 'vulnerabilities' in a child, thus responses tended toward reactive rather than contextual and preventative approach, with therapeutic parent-practitioner relationship as shown in the case of Victoria Climbie (Rustin, 2005).

3.10 Victoria Climbie

The role of HV in preventing abuse and neglect of a child was succinctly identified in the case of Victoria Climbie when Lord Laming summarised expectations from HVs as follows:

> *"… to provide "child surveillance" … make sure that the child in question is developing properly and interacting appropriately within the family. In order to carry out that role, regular visiting will be required"* (Lord Laming, 2003, p291).

The report provided detailed analysis of the sequence of events which took place, and attributed responsibility for failures and errors to individuals involved with the case. Its recommendations opened up space that provoked rethinking, but Rustin (2005) argued that the method of investigation was predominantly procedural focus and inadequate as a means of exploring the systemic problems which gave rise to poor service-provision, and of identifying solutions to these. There were many clues in the report that brought meaning to what happened, although their significance for learning from the entire tragedy was missed, such as failure to explore why professionals found it impossible to see what was happening, despite glaring evidence of the child suffering abuse; and why some went further to give false evidence (Rustin, 2004). It is recorded that when the HV became aware that Victoria had suffered non-accidental injuries, there was no evidence to show that she did make referral to escalate her concerns in a manner expected of a reasonable practitioner with expected expertise in a similar situation. Lack of awareness of local policies was identified as one of the failures in this case, as Lord Laming decried HV Crowe's:

> "… *lack of awareness of the procedures that she was supposed to follow when dealing with cases like Victoria's. While I have considerable sympathy for Ms Crowe's individual situation as a busy health visitor having to cover a role with which she was unfamiliar, the fact that she was in this position reinforces, in my view, the need for clear and accessible procedures for her to follow"* (Lord Laming, 2003, p294).

Whilst this remark might, no doubt, have left the HV with feeling of blame, anxiety and fear, others would argue that there should have been some punitive actions against the HV, whilst others would be asking the question: why did the HV not act differently? Bion (2007; 1988; 1962a; 1967) considers the difficulty practitioners may have to think clearly about their clients, to 'hold them in mind', but effective professional thoughts which stimulates curiosity can be enabled by the quality of professional-client relationships and child-centred focus. Within this perspective, a more 'vulnerable child' is the one who has become 'unthought' about and is not 'held in mind' by professionals and the systems.

To provide help to someone necessitates a capacity to think about the individual and become emotionally attuned to the circumstances and experiences of the individual. Thinking is influenced by several factors but anxiety stands out as particularly influential (Bower, 2005). There are three essential ingredients for successful parent-HV engagement, but which are often lacking in professional-client relationship: open and transparent information, honest consultation and effective participation (NHS England, 2013; DOH, 2012; 2012a).

3.11 Child-centeredness - 'turning a blind eye' and 'attacks on linking'

Rustin (2005) cited the psychoanalytic terms from Steiner (1985) and Bion (1967) to highlight the defensiveness of professionals against 'recognising reality' about the circumstance of Victoria, which suggests severe distortions in the mind's capacity to function. She gave particular attention to the frequent examples in Laming's (2003) report about professionals '*turning a blind eye'* (Steiner, 1985), which means failure to see what is before one's eyes because doing so could cause too much psychic disturbance, and various forms of '*attacks on linking'* (Bion 1967), the systematic interruption between things which logically belong together, again a defence which was employed because to make the link would be a source of painful anxiety to the professional.

In psychoanalytic theory, *'turning a blind eye'* and '*attacks on linking'*, are two forms of defence frequently found to predominate in individuals who presents with a borderline pathology, and this fact gave a strong signal to the significant amount of dysfunction which Laming's report depicted in health and other services with respect to safeguarding and child protection. The descriptions clearly delineated organisations which were described as functioning in a way comparable to the borderline patient (Rustin, et al, 2003); and many of their staff at different levels of seniority were unable to face reality and operated as a consequence of ways designed to protect them from the catastrophic impact that they believe a proper confrontation with reality would engender.

Freud (1997) likened *'turning a blind eye'* to an analysis where the unconscious is gradually revealed as an important mechanism that leads to a misrepresentation and distortion of psychic reality. These psychoanalytic ideas are helpful in exploring obstacles and conditions for learning from experience among health professionals specifically about consequences of failure in relationship with the clients; a defence that shows possibility of getting close to professional's feelings and perceptions of a frustrating situation. The subjective feelings (personal, professional and cultural) of these professional stemmed from the perceptions that the problem they faced was too complex to deal with, hence they unconsciously avoided these unbearable feelings, with the consequence that violation of Victoria was not recognised, hence not possible to learn from to prevent problem being repeated. Steiner recognised the protective structures and individual create when dominated by fear of reality as 'psychic retreats' (Steiner, 1985). In the same way an individual patient can persuade his or herself instinctively that reality can truly be avoided, if they remain within the narrow confines of their personal psychic retreat, so a practitioner within the health organisations described in this report, and the organisations themselves as characterised by their structures and practices, seem to have been convinced that they were capable of escaping the thought about their contact with Victoria and her aunt, Kouao. As HVs, thinking

involves the acknowledgment of meaning to our experience; and the absence of a sense of meaning was a phenomenon the report continually highlighted, and this made it difficult for professionals to envisage the personal responsibility of their actions (Laming, 2003).The borderline defences are associated with mental pain, they describe conflict between opposing forces, ultimately the forces of love and hate, and the guilt usually aroused by awareness of uncertainty. Rustin's (2005) critical remark suggests that many of the actions (or moments of inaction) described in the report as obvious evidence of incompetence relate to the desire of professionals to keep a distance from the intense feelings stirred up by exposure to human cruelty and madness. To understand more about what happened at the operational front, Rustin (2005), mentioned 'unconscious mirroring' between clients and professionals. The carer's statements to the professional who tried to support her were full of both confusion and lies. Unconscious mirroring often makes it difficult for professionals to understand the difference between malicious dishonesty and the kind of confusion about truth which is part of borderline psychotic state.

At the level of rational discourse, it is easy to say that joined-up thinking and collaborative practice are required for better child protection work. The HVs, in their practice, may face hostile, threatening and non-compliant behaviours, which produces damaging effects on thinking, physically or emotionally. Some parents may proactively sabotage efforts to bring about change or be disengaging passively; while others use 'disguised compliance' to subversively undermine health and wellbeing support aimed to benefit the child, or parent not admitting to their lack of commitment to change. However, the argument is that 'child-centeredness' should remain paramount at all times and where professionals are too scared to confront the family, they must use this to consider what life is like for a child in such environment (Bywaters, et al, 2015; Bywaters, 2015a). It was remarkable to see just how successful Kuao was able to achieve this aim so that HVs, doctors and other professionals were frequently acting, as if in collusion with her, on the belief that Victoria had something wrong with her. This was variously identified as a disease (scabies), behaviour problems (enuresis and other disturbed behaviour) and possession by an evil spirit, and in all ramifications, the problem was agreed to be that Victoria needed to be cured. Her conviction and the power of her vision continuously obscured the facts which led to projective identification, in which the thinking of the professionals was taken over by elements of Kouao's conviction in a mirrored relationship (Rustin, 2005). This projection in client-professional relationship causes one to consider the infantile anxieties which the tasks of child protection evoke in health visitors and other professionals. Rustin (2005) recognises the predominance of the feelings of: helplessness, dependence and deference to organisations; of not knowing

enough, needing to comply with rules mindlessly like a terrified child (essentially like the observed behaviour of Victoria herself in the presence of her carer), of fear and anxiety in wanting to return to the 'normal' world as soon as possible. Thus, the feelings aroused with the difficulty in assessing, identifying and addressing the needs of children under universal and vulnerable caseload can be hard to make space for; they are uncomfortable, and they are liable to cause trouble in the sense of demanding more thought and more work if the needs of children are to be taken seriously (Rustin, 2004). The common account in the child abuse research is that the child's shame and guilt about the abuse experience, in addition to the fear of the abuser, enforces secrecy. In her analysis, Rustin (2005) suggests that 'respectful uncertainty' should lie at the heart of the family-professional relationships. Such comments refer to a difficult domain, to the individual worker's thinking about the case of child abuse, and to the unavoidable anxiety particularly linked to uncertainty and subjectivity. This is the area of professional work most easily interfered with by anxiety arising from close contact with the difficulties of clients, both professional anxiety related to the culture of organisations – about capacity building and fear of blame (Reder, et al, 2001).

Bion (2007; 1967) recognises a psychotic part of the individual personality which develops as the destructive attacks on anything which is felt to have the function of 'linking' one object with another and the significance of this form of destructive attack in the production of some symptoms which meet the borderline psychosis. The idea of attacks on linking, as described by Bion (2007), may depict a practitioner's drive to communicate the internalisation of a destructive relationship between self and the primary object. Melanie Klein describes the link as the infant's fantasies of sadistic attacks upon the breast (Klein, 1975), of the infant's splitting of its objects, of projective identification, which is the name she gives to the mechanism by which parts of the personality are split off and projected into external objects, and finally her views on early stages of Oedipus complex **(**Rustin, 2005**)**. This could explain the enactment in the professionals-clients relationship, whereby fragmentation and numbing of thinking of the professionals might well be a pointer to a primitive catastrophe relived in the psychoanalytic setting. From her behaviours, there were strong suggestions that Kouao's mental state was severely disturbed, and the report showed that the impact of *her* confusion and distortion of the truth seemed to have invaded the minds of many professionals who came in contact with Victoria and family. Kouao had a tendency to get professionals to see things the way she saw them in every client-professional contact or relationship. Rustin (2005) also identified '*attacks on linking'* as another defence mechanism which reflected in the approach of some professionals who came in contact with the family as they became disconnected from the combined impact of Victoria's and Kouao's

states of mind, the delineation of which could be very painful to absorb. From the psychoanalytic perspective of Rustin (2005), unless health professionals have a theory and practice which allows them to perceive such levels of distress and have a context in which they can assess its impact on them, instead of being pulled into identifications and counter-identifications, the needs of the child cannot be addressed in a child-centred approach. Bion (1963) called the figure which attacks links of emotion and reason between objects that occurs when the relationship between mother and infant lacks the normal links of primary communication by projective identification as an internalisation of an 'ego-destructive super-ego'. Bion (1963) thinks that the chief source of the failure of primary communication in such cases emanates from an inborn disposition of excessive hate and envy in the infant whose situation is worsened if the mother is unreceptive and diminished, but abolished if the mother can introject or contain the infant's violent feelings while remaining balanced.

This disconnected link could result in 'defensiveness' and situations of 'conditional positive regard' **(**Rogers, 1959) which reflects potential for raised practitioner's anxiety, as professional's priority is affected by the fear of failure or blame being a danger or an enemy to be: 'either attacked or fled from' (Bion, 1963). The relationship deteriorates further into an experience where the practitioner becomes detached physically and emotionally and even completely dissociating from the very 'vulnerable' child – Victoria whom professionals were meant to help. However, the expectation is that practitioners should:

> *"… use all the information (or relationship) to identify difficulties and risk factors as well as developing a picture of strengths and protective factors. No system can fully eliminate risk. Understanding risk involves judgement and balance. … Professionals should make decisions with the best interests of the child in mind, informed by the evidence available and underpinned by knowledge of child development"* (HM Government, 2015, p24).

The theoretical importance of the idea about '*attacks on linking*' among HVs is useful to explain the state of mind of HVs in relation to their inability to link the child's feeling and needs with the mind when there is an ongoing fear of blame or disaster. The report highlighted some apathy among professionals in showing genuine interest in the safety and wellbeing of Victoria, suggesting links between their psyche and minds was perverse, cruel, and sterile (Rustin, 2005). However, the Laming report failed to fully explore the unconscious anxieties which undermined the capacity of professionals who came in contact with Victoria to take in the facts of her circumstances in order to respond to her needs. Following Rustin's psychoanalytic perspective in analysing the states of mind of those professionals who came in contact with Victoria, the professional responses reflected ways of escape for the professionals or defences against extreme mental pain as illuminated in the puzzling and repetitive facts revealed by the Inquiry.

3.12 Summary of chapter

In this chapter, I have focused on exploring different constructs in policy, theoretical and statutory framework, highlighting gaps between policy and health visiting practice, which particular focus on safeguarding and child protection. I explore the decision-making process of HVs, highlighting gaps in policy and practice from a critical analysis of Lord Laming's (2003) report as explored by Rustin (2005). Under 'universal' services, the HVs undertake mandatory contact with children for routine interventions and offer additional supports to 'vulnerable' children and families to address their needs. The focus remains the child,, and the role is intertwined with safeguarding and protection of children from abuse and neglect. The responsibilities of HVs and their involvement with children and families are articulated in health visiting policies, statutory and non-statutory guidance, and these documents generally acknowledge that relationship between professionals and clients are important in achieving outcomes for children and families. However, supporting children and families in their circumstances require clarity in decision and awareness that a strong parental couple or co-parenting relationship provides emotional bedrock for child's health and development which is particularly crucial in the early years of life (Barlow, et al, 2007). Some individuals still find it challenging and stressful becoming parents and going through the process of making reasonable adjustment to family life; and these situations are sufficient to cause significant difficulties for parents, thereby increasing relationship distress and potential risk of child abuse. The chapter explored the idea of 'good enough parent' by Winnicott (1973) and Bettelheim (1988) to develop understanding expectations from parents and the multi-faceted factors which impact on parenting.

The position I advance in this thesis from review of literature is that policy and government guidance to tackle child abuse require focus on public health approach, with emphasis on context as well as individuals rather than building them on lessons from single serious case review. Policies and guidance that are reactive tend to bring confusion and provoke fracturing effect on 'child-centeredness' and negative outcomes for children and families. It is noted further that the focus on child protection in a forensic rather than relationship-based approach seems to be tilting too far towards policing families instead of offering supportive services in an honest and non-judgemental manner. This correlates with the focus of Munro (2005a) on systems approach in child protection, which differs from the traditional way of examining practice, errors and its influence on the needs of children and family. The traditional inquiries invariably tend to confine their priorities to the extent of finding human errors; whereas a system approach treats human errors as the starting point and examines the whole context in which professionals work to see how these impact on their ability to perform effectively. However, these narratives call for

reconceptualisation of HV-client relationship to promote 'child-centeredness' and HVs' perceptions about child abuse, awareness of their 'emotions' and sensitivity to children's needs. The culture of anxiety generated by fear of blame can divert the focus on child-centeredness; thus, in making clinical judgement and decisions, HVs need to exercise personal knowledge, intuition, practice wisdom and ability to articulate the basis of their actions (Newland and Cowley, 2003). This process involves assessment, interpretation of the child and family's situation followed by implementation and evaluation of interventions (Mulcahy, 2004). In essence, HVs seem to combine professional judgement and quantitative assessment to inform their decision on the levels of needs and interventions for the child and family. However, it is acknowledged that well-articulated decisions and plans for support are only useful to the extent of available resources and availability of enhanced interventions to address diverse needs. The literature shows that decision-making of some health professionals tend towards forensic focus on safeguarding and child protection, which minimises the value to child-centeredness in HVS; and lack of good relationship in practice has led to unmet needs for children (Lepori, et al, 2007).

HVs can be seen as facilitating an intimate link between the internal and external worlds of children and families; and often practitioners and organisations miss opportunities to examine the context of a child and integrate psychosocial factors, but focus on polarised responses to health and social care problems; and these approaches put professionals in difficult positions, with some unintentionally lacking ability to demonstrate empathy and compassion. I have also explored Rustin's (2005) psychoanalytic narratives about the professionals and organisations behaviours, actions and inactions in relation to the case of Victoria Climbie; recognising two defences that contributed to failure to protect the child from significant harm, and therefore are barriers to child-centeredness. These include**: *'turning a blind eye'*** (Steiner, 1985) and '*attacks on linking'* (Bion 1967). There was a significant level of attention given to key psychoanalytic issues, including mental pain, borderline functioning, infantile persecutory anxieties, confusion, defensive splitting and mirroring processes as outcomes of the inadequate responses of professionals and institutions profoundly linked to the worrying impact of trying to manage complex family circumstances.

Chapter 4 - Research Methodology

"We were led to realise the central importance of treating the researcher him- or herself as an active social agent who struggles to understand social processes through entering the life-worlds of local actors who, in turn, actively shape the researcher's own fieldwork strategies, thus moulding the contours and outcomes of the research process itself" (Long and Long 1992 p.ix)

4.1 Introduction

I divide this chapter into five sections to provide justification for research methods adopted in this study. Firstly, I explore the basis for mixed research methods, and highlight the relevance of case notes and interviews as main sources of data in the 3 -Phase research design. Secondly, I set the inclusion and exclusion criteria for case notes and HVs who participated in the research; providing description of sampling decision-making and methods. Thirdly, the section covers data collection and data analysis in each of the 3-Phases. Fourthly, I explore the validity and generalisability of the chosen research methods. Finally, I provide a summary of the chapter, showing a reflection on the spiral process that emerged in the research process.

4.2 Justification of research method

Mixed methods research is defined as an emergent research methodology which advances the systematic combination or "mixing," of quantitative and qualitative data within one investigation or sustained programme of inquiry (Creswell and Plano Clark, 2011). Thus the aim of mixed research methods in this study was to combine data sampling, collection and analysis to reflect quantitative and qualitative research characteristics which enhanced integration, leading to more synergistic and broader inquiry and analysis of data to address the primary and associated research questions. The method is sometimes called: "*the third methodological movement*" (Creswell and Plano Clark, 2017, p1). It is a research:"…*in which the investigator collects and analyses data, integrates the findings, and draws inferences using both qualitative and quantitative approaches in a single study* (Creswell and Plano Clark, 2017, p3). It provides multiple ways of gaining knowledge in social research. Greene (2007) argues that mixed methods research provides: *"multiple ways of seeing and hearing, multiple ways of making sense of the social world, and multiple standpoints on what is important and to be valued and checked*" (Greene, 2007, p20). In the last decade, mixed methods research procedures have been developed and refined to suit a wide variety of research questions (Creswell and Plano Clark, 2011).

The primary question of this research was: 'How do HVs respond to diverse needs of children within the conflicting demands of contemporary practice demands which involve relationship

building, meeting set targets as measured in key performance indicators (KPIs) and achieving the organisational objectives of preventing harm to children? The delivery of 'universal' services in the local HVS involves implementing 5-mandated contacts as commissioned by the Local Authority (NHS England, 2014; NICE, 2014a). Other children referred by HVs to Children's Services may require statutory supports according to the Children's Act (HM Government, 1989) under section 17 as Child in Need (CIN) or section 47, or Child protection Plan (CPP), or the child my be a looked after child (LAC), where the state has parental responsibility. Children under 'vulnerable' caseload are those receiving 5-mandated contacts, with additional contacts or interventions because they are on CPP, CIN, LAC, unseen by the HVs or have other 'vulnerabilities' which put them at risk of abuse or neglect; but some may fall below threshold for statutory interventions. The 3-Phase research design process (section 5.3) brought together quantitative and qualitative approaches to address the research questions, thereby widening the scope of data sources and enquiries. From interview of HVs, I was able to explore sub-research questions such as: how do HVs initiate and develop the parent-HV relationship? How do they think and make decisions to determine 'risk and vulnerability' of children and what approaches do they apply to address the children's needs? The limitation of a single methodology provided a strong reason to review the study approach in Phase 1 which led to a multi-strategy that set the epistemological position of this study on mixed research methods. These provided '*multiple ways of seeing'* the documented and verbal accounts of HVs in relation to their work and how these impacted on them and their profession (Creswell and Plano Clark, 2017, p5). Thus, the study was underpinned by recognising the mixed method tradition advocated by Creswell and Plano-Clark (2018). However, the conduct of this research followed an iterative process which I developed and evolved from three core pathways. Firstly, its underlying assumptions established the framework for both design and analytic decisions. Secondly, the critical processes, especially in Phase 1 of the study, were informed by operational tools drawn from qualitative and quantitative methods and evolved through the study as it progressed through the 3 Phases. The research question generated from the design of this mixed methods were: `*progressively narrowed and ... focused during the research process'* (Strauss and Corbin, 1998, p41) - with the preliminary questions being reformulated into the following sub-questions:

a. How do HVs define children as 'vulnerable' or 'universal' in terms of assessment, risk identification, and the level of support given to children and families in practice?
b. What significant differences exist in HVs' time commitment and approaches to address the needs of children, and implement the 5-mandated health contacts alongside early intervention work to prevent significant harm or further abuse and neglect to 'vulnerable' children?
c. How does the parent-HV relationship develop to support decision-making in relation to meeting the needs of children under 'universal' and those considered as 'vulnerable'?

Whilst the interpretive qualitative data collection approach was relevant in addressing questions (a) and (c), the quantitative data collection strategy was useful in addressing question (b), however, some work of Creswell and Plano-Clark (2018) were useful in combining qualitative and quantitative methods to answer the overall research question.

4.3 Bridging the Gap between Qualitative and Quantitative Methods

In pursuing mixed methods research, I gave attention to the argument of Creswell and Plano-Clark (2018) that:

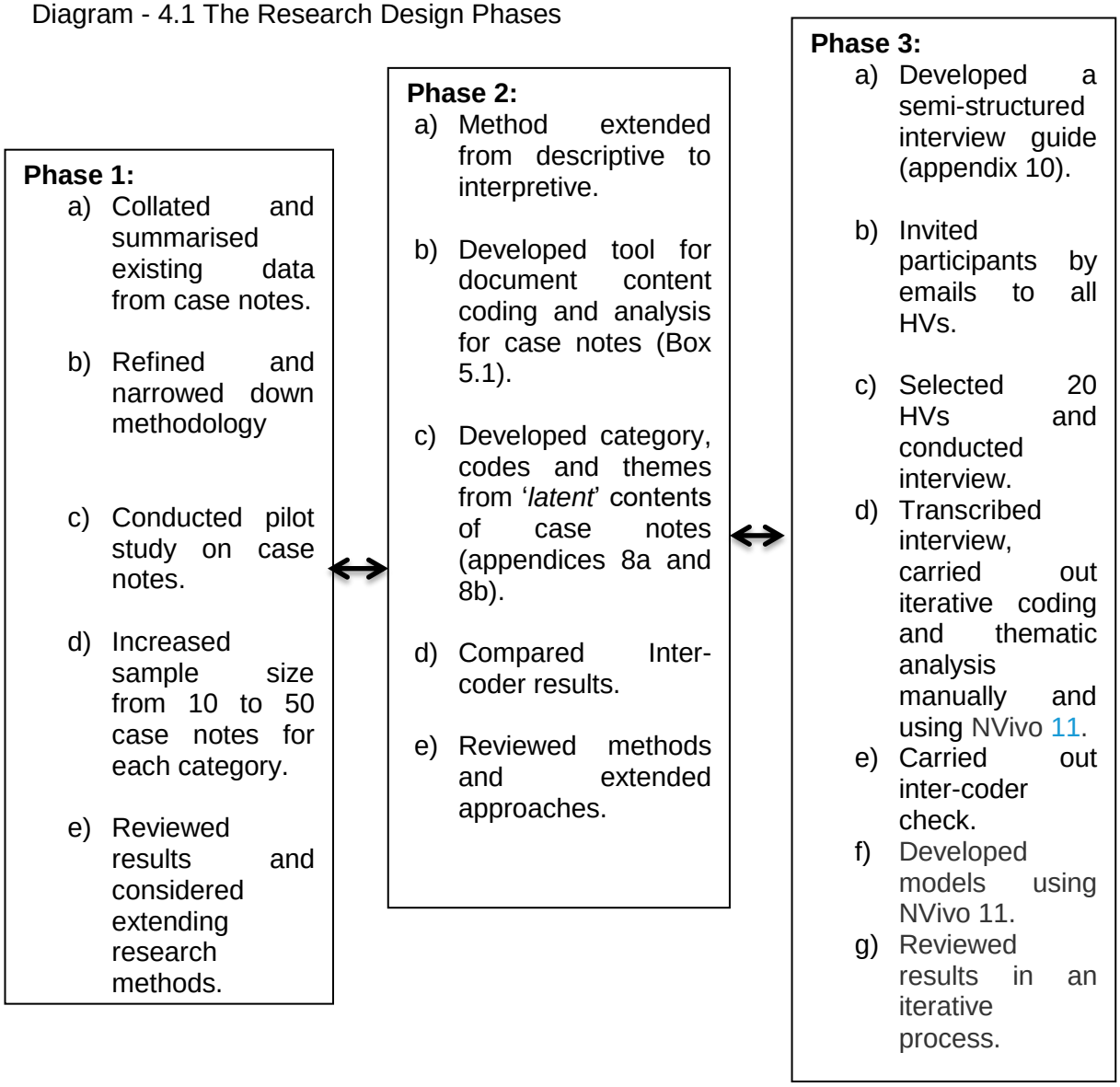
> *"… mixing method is an intuitive way of doing research that is constantly being displayed throughout our everyday lives*" (p1).

For instance, physicians consider quantitative laboratory results together with qualitative life story and symptoms of patient when making diagnoses and formulating treatment plan. Greene (2007) suggests mixed research provides: "… *multiple ways of seeing and hearing*" (p20). As multiple ways are visible in everyday life, mixed method research, therefore, provides multiple lenses through which problems are seen and addressed. Thus in this research, mixed methods combined the

> : "…*elements of qualitative and quantitative research approaches … for the purpose of breath and depth of understanding and corroboration*" (Creswell and Plano-Clark, 2018, p4).

As the project developed, the design process led to mixing research methods with more qualitative data than quantitative data, highlighting an emphasis on a qualitative approach with minimal focus on quantitative method. However, the quantitative method contributed in complementing the breadth and depth of knowledge about the work of HVs. Thus, I: "… *integrated (or mixed or combined) the two forms of data and their results*" (Creswell and Plano-Clark, 2018, p5) to provide useful answers to the research question, thus able to make contributions to knowledge in HVS and policy development.

Diagram - 4.1 The Research Design Phases



4.4 The 3-Phase Research Design Process

The 3-phase research design process (diagram 4.1) provided a complementary and iterative approach to addressing the research questions. In phase 1, I reviewed the scoping literature which showed a dearth of research papers in health visiting in the area of research chosen. It was, therefore, difficult to follow or repeat a particular study design in this research. Consequently, I recognised the gaps in literature and was opened to 3 options for data sources to address the research question as described in the 3-Phase research process which was more of a spiral, rather than linear, approach that which involved navigating around the 3 Phases.

4.5 Ethics Committee Approval

The study commenced following approval from Middlesex University Ethics Committee and the local NHS Trust Ethics Committee which approved research designs. This allowed me access to case notes and to interview the HVs. The case notes sampled were given unique identification number 01-100 to ensure people names remained anonymous and to protect confidentiality of children and families. All names, addresses and phone numbers in case notes contents were removed; and the identities of HVs were also protected by using unique numbers to identify participants.

4.6 Inclusion and exclusion Criteria

Phase 1

The aim of analysis of case notes was to draw out meaningful qualitative and quantitative data to address the research questions. For instance, it was possible produce qualitative data by collating HVs' contacts with clients, determine the parenting quality of parents from the parent-child relationship as recorded by HVs, purpose and benefit of such contact, and establish how child-centred considerations are integrated into decision-making process. The aim was also to identify patterns and frequencies of contacts and interventions to provide quantitative data for this research. The case notes included in this study related only to children ages 0-5 years old. The child must have been receiving either 'universal' or additional services due to one or more factors identified by the HVs that indicated the child was 'vulnerable'. The child was registered in local HVS caseload; lived geographically within the local catchment area or transferred to school nurse or outside the borough between January, 2016 and December, 2016. The 'vulnerable' case notes category included children receiving additional services under the description - Universal Plus (UP), Universal Partnership Plus (UPP); and Complex /High Risk (C/HR); whilst the 'Universal' category included children specified as receiving such services. The case notes of parents and older siblings are outside the remit of HVS; and those outside the set study period were excluded.

Phase 2

In this Phase, the set criteria in Phase 1 remained but the focus was on latent contents of the case notes.

Phase 3

This phase involved interviewing of HVs with the aim of obtaining frontline information about their experience of interactions with families to address the needs of children; to understand their approach in making decisions about children's health and well-being, the challenges and anxieties associated with this role and how this is overcome. There were 20 HVs who met the inclusion criteria and consented to participate in the interview. The HVs included were qualified

and trainee HVs, whether their role was operational, strategic or specialist capacity in the local HVS anytime within the set period in Phase 1. The HVs who did not meet these criteria, such as agency and temporary Bank HVs, were excluded from the study.

4.7 Sampling Methods

Phase 1

The first data sampling option was to develop an interpretive research method to focus on exploring the subjective views of HVs in defining and classifying needs of children under 'universal' and 'vulnerable' caseload and how they address the needs of children. I first considered observation as method of data collection, whereby I could observe interactions of HVs during contacts with children and families at home or clinic settings in order to understand how they related with families. The choice of observation could not progress further because of stringent requirements from NHS research committee, the difficulty emanating from consent to observe vulnerable children and families. Hence, an alternative approach was to explore the distinguishing characteristics of 'child centredness' and the 'parent-HV relationship' previously identified in the literature and to relate these principles in gaining insight into how the needs of 'universal' and 'vulnerable' families are recorded and addressed in case notes - looking at 'manifest' data contents. Firstly, I saw what Bowen (2009) describes as *manifest* data by building on what was already known about the number of contacts children must be offered under universal services. Secondly, the 5-mandated contacts provided detailed information about 'universal' public health work of HVs and additional services, including range of activities such as: interventions or liaisons for preventative work and to provide physical, developmental, emotional and social support to children and families. These contacts were visible in the case notes and all the activities associated with them could be counted and linked to the expected time it took to complete each of such activity in similar setting. The process of counting provided some idea about the numbers of mandated and additional contacts HVs provided to 'universal' and 'vulnerable' families. There are questions as to the number of documents that is sufficient for analysis to address research questions, but O'Leary (2014) suggests that documents should come from variety of sources. Hence children's case notes were divided into two separate strata – 'universal' and 'vulnerable' groups. From the 'universal' stratum, 50 sets of case notes were randomly selected, and from the 'vulnerable' group, 50 sets of case notes were drawn, with each child's record having equal opportunity within the stratum to be selected, thereby reducing sampling bias (Creswell and Plano Clark, 2017).

The method of randomisation I chose was stratified random sampling approach with the aim that case notes from each of the two caseload groups (universal and vulnerable) had equal chance of being selected for the research. The process meets the description of Creswell and Plano Clark

(2017) about stratified random sampling approach. However, the reason for choosing 50 case notes from each group was essentially in consideration of the capacity to manage the vast data generated from these documents, which I considered were sufficient in providing summarised data for coding and analysis process (appendices 8a and 8b). The sampling method was considered appropriate in addressing the research question relating to the work of HVs with children in their practice; and what characteristics assisted them to define children as having additional needs or being 'vulnerable' in comparison to those receiving 'universal' services. Bowen (2009) raises question about how many documents a researcher should gather for meaningful data and analysis, and O'Leary (2014) suggests wide array of documents is better, and my sampling decision was supported with his argument that: the quality of documents should supersede quantity.

Phase 2

In this second Phase, the sampling principle of Phase 1 was extended based on arguments of Bryman (2006; 2001) that descriptive and interpretive data can be developed from a single data source which, in this study, was the 'case note', but for multiple purposes.

Phase 3

I reviewed the previous two Phases and realised that direct accounts of HVs would provide broader knowledge about their practice in relation to how they *define, classify and respond to needs of children i*n their caseload. Hence, interviews were chosen to provide data for an interpretive research method, focusing on exploring the views of HVs and their subjective relationship with families. It introduced different perspectives in exploring the experiences and feelings of HVs about their relationship with parents, families and work practices in an approach informed by the psychoanalytical concepts of Bion (1961) and Menzies Lyth (1990; 1960).

At the time of study, the population of HVs in post was 75 including two trainee HVs, with a vacant position of 8 HVs yet to be filled. There were 3 male and 72 female HVs from different ethnic backgrounds and working in various capacities including managerial and specialist HV positions across the 6 clusters served by the HVS in the borough. Following ethical approval from the local NHS Trust an initial email invitations were sent to all HVs in the form of an introductory letter inviting them to participate in the study voluntarily. A reminder email followed in 4 weeks through the generic NHS emails for HVs, which meant the invitations were received by all 75 HVs. In response to these, 21 HVs indicated their willingness to participate in the study. However, one participant was excluded because she was an agency HV who had only worked in the HVS for 4 months. The remaining 20 HVs who responded were based across in the 6

clusters and I scheduled interview appointments with them using Outlook calendar, and interviews took place in locations where the HV worked.

Coincidentally, the target sample size for interview was 15 HVs and the rationale behind this decision was based on views of Kvale (1996) about the limit or sample numbers feasible in a PhD qualitative research. Corbin and Strauss (2008) recognised that one of the key limiting factors in data collection is the point where the researcher reaches a sense of "*theoretical saturation"* (Glaser and Strauss, 1967, p61). The meaning of saturation has been interpreted in different ways, but Glaser and Strauss considered it as intertwined data collection and analysis from one category until newly collected data no longer adds isight or meaning, before moving on to collect and analyse data in another category to discover diverse conceptual elements that address the research question (p.36). Bertaux (1981) argues that *"saturation of knowledge"* (p37) rather than 'theoretical saturation' is what influences the sample size for interviews, and for this study, the number was extended from 15 to 20 HVs to draw varied views from HVs. The description of Bertaux shows that the researcher learns a great deal from the first few interviews and at fifteenth interview, for instance, the researcher recognises patterns in the interviewees' experiences (ibid). He suggests that additional interviews provide confirmations of what the researcher has already sensed especially in a homogenous group (ibid), like the HVs. In view of the homogeneity of the health visiting group, I felt a sample size of 20 HVs provided sufficient data to address the research question (Bertaux, 1981). In non-random sampling, such as quota sampling method, selection of participants follows a particular set of conditions and is generally used in studies where the sample needs to be collected based on specific characteristics of the population (Cassell and Symon, 1994). The sampling process in this study took account of HVs in 6-high impact areas of HVS (NHS England, 2014), including parenthood and early weeks, perinatal mental health, breastfeeding, healthy weight, minor illness and accidents, healthy 2 year olds and getting ready for school. For instance, the selection of HVs needed to reflect their generic health visiting skills and specialism in high impact areas, with their additional skills in management, child protection supervision, domestic and substance abuse, and trainee HVs. Hence, the sampling of HVs interviewed can be described as 'quota sampling', whereby I consciously reflected prominent characteristics in the general population of HVs. According to Cassell and Symon (1994), quota sampling is a non-probability equivalent of stratified sampling which starts with characterising the population based on certain desired features and assigns a quota to each subset of the population.

4.8 Data Collection

Phase 1

The NHS England (2014) provides N*ational Health Visiting Core Service Specifications,* which builds on the *Healthy Child Programme led by Health Visitors (*DOH, 2009) to guide the practice of health visitors. These specifications reflected in policy and HV practice within the local NHS Trust where this study took place. The Trust also commissioned independent '*Time and Motion'* study in one of its 3 main clusters to guide on time allocated for universal activities undertaken by HVs. Whilst contacts with children in 'universal' caseloads are defined and predictable in terms of frequency and time requirements, evidence in scoping literature of this thesis shows HVs struggle to define a 'vulnerable child' and also have difficulty to determine the appropriate number of contacts and amount of time to involve in responding to their needs. This was a spiral process rather than simultaneous data collection approach (Creswell and Plano Clark, 2017) as shown in the field notes (appendix 14).

The focus was to identify manifest data that highlighted the distinguishing characteristics of the parent-HV relationships, and HVs' definition and classification of 'universal' and 'vulnerable' children. Thus the most relevant data collected related to the number and type of contacts offered to children under 'universal' and 'vulnerable' caseloads; and the amount of time HVs spent to complete these contacts (table 4.2).

In the table 4.2 a-e shows data drawn from case notes within 'universal' and 'vulnerable' categories; and data include: ethnicity and level of needs as some children required involvement of Children Services to provide social support especially Looked After Children and those registered on CPP or CIN plan but managed by HVs. In the table, section 4.2 d provides the list showing categories of abuse for vulnerable children in the case notes.

Table 4.2 – Manifest Data Sheet – Case Notes

Variables	Universal Case Notes	Vulnerable Case Notes
a) Sample Size	50	50
b) Ethnicity Type:		
White British	24	7
White Others	12	9
BAME	14	34
c) Level of Needs :		
CP Plan/ CIN Plan		44
Other Vulnerability		6
d) Statutory Services		
Child Protection Plan (CPP):		
Emotional Abuse		8
Sexual Abuse		4
Physical Abuse		10
Neglect		16
Child In Need Plan (CIN)		8
e) Other Vulnerability:		
Domestic Abuse (DA)		19
Mental Health (MH)		23
Disability (DIS)		5
Substance misuse (SM)		12
Social Issues (SOC)		9
Gang (GAN)		5
Multiple Factors (MUL)		38
f) Voice of the child recorded	5	15

Phase 2

In seeking data from this Phase, I explored the underpinning reasons and relevance of HVs' contacts; HV's report of how interractions developed regarding their relationship with families. I sought the rationales, quality and purpose of contacts within the case notes, alongside the nuances of decision-making processes of HVs. The data were, therefore, drawn from what Bowen (2009) calls '*latent*' contents of the case notes applying the tool provided in diagram 4.1.

Phase 3

In this process I developed a semi-structured interview guide (appendix 10), following a review of requirements for HVs to meet the 5-mandated contacts for all children. This meant that I could

embed the requirements into a semi-structured interview guide to address the research question regarding how: *HVs develop relationship with parents to respond to the needs of children in universal and vulnerable* caseloads. I followed the responses from email invite to HVs in a group account to invole participants who volunteered in the research (appendix 10).

Interview questions design (appendix 9) presented some challenges but it evolved essentially around a `trial and error' process as described by Hollway and Jefferson (2000, p27). These authors, in their research into `*people's fear of crime*' (p14), described how their interview process had to evolve from: "... *initial pilot attempts using a semi-structured interview schedule through ... adaptation of the biographical-interpretative method to ... free-association narrative interviewing"* (p53). In their argument, it was evident that their development of an initial `*highly structured, question-and-answer*' approach strengthened the defences of both researcher and interviewee but produced `*disappointing*' results (p27). The intention of their interview guide was to provide a tool that could elicit descriptive data for sufficient narrative that allowed the researchers to elicit `*stories'* grounded in `*actual life-events'* (p32). The work of HVs in this study involved *actual life-events'*, sometimes having to navigate through the lived experiences of children and families, who may be facing very complex circumstances. Thus the interview approach took account of the research question also explored: how HVs perceived their relationship with parents; address the needs of children according to their specific circumstances. It also established deeper understanding of how HVs developed resilience against influences brought on them as they contain the complex needs of children and families. I started the process with an initial test of the semi-structured interview questions which was followed with some modifications based on my initial experience in the field with HVs. In determining useful interview questions for the study, I modified some of the structured open-ended questions in the same approach described by Wetherell et al (2004) in order to achieve the research objectives. The approach relied on a semi-structured interview guide to elicit rich stories that covered the nuances of health visiting work, narratives about their role and how they overcome anxieties associated with the work they do. The interview guide provided a schematic view of topics needed to be explored in the interview; whilst I also ensured that the process was not over-directed to allow HVs' construct narratives of their experiences within the role. With the guide, I was able to achieve optimum use of interview time, which allowed respondents to explore the subject systematically and comprehensively whilst focusing on the core and evolving questions.

Table 4.3 Demographic Information of Health Visitors Interviewed

Ethnicity	
White	8
Other White	2
BAME	10

HV's Specialist Role	
GP Lead	5
CP Supervisor	4
Manager	2
Domestic Abuse	1
Other HVs	8

Gender

Male	2
Female	18

The demographic of the HVs showed 8 were from White UK ethnicity, 2 other White and BAME were 10. Some HVs had dual roles both as HV and other specialism including: managers -2, GP Leads 5, Child protection Supervisors 4, and Domestic Abuse HV 1. Apart from 2 men, all of the HVs were women. The ethnic composition was fairly representative of the population of HVs in the borough. The 20 HVs who participated brought their diverse experiences from the 6 clusters within the HVS in the borough, and these reflected cultural diversity, pockets of deprivations and health inequalities of families within the area. The participation of HVs 16 and 18 was of particular interest as they brought in their experiences of being part of serious case review - SCRs following child death in the HVS.

4.9 Data Analysis

Phase 1

The interpretive method allowed critical analysis of case notes to develop HVs' definition of a child as having 'universal' or 'vulnerable' need. Thus the quantitative data provided numbers and description about HVs' contacts with families (Bryman, 2006). On one hand, this involved descriptive statistics to draw data such as the frequency and time spent by HVs to complete contacts with children under 'universal' and 'vulnerable' caseloads (chapter 5, table 5.1). The data showing time HVs spent to support 'vulnerable' families was compared with HVs' time spent on activities to support families within 'universal' caseload (table 7.1).

While I was able to develop knowledge about the decision-making process of HVs and how they respond to the needs of children, the differences left me more puzzled, leading to the need to seek further clarifications about HVs contacts with families. The estimated time for each activity allowed meaningful comparison between the two categories of services for children. The Routine (R) contacts were labelled with description R0 - R4; and enhanced (E) contacts labelled with

description E0 - E4, reflecting accounts of children with additional needs. The analysis of quantitative data invoved descriptive statistics using Excel version 2016 to: summarise contacts, classify the data into codes, draw up their frequencies and calculate estimated time taken by HVs to complete the contacts. It also involved presenting other characteristics of the children in sample studied – ethnicity and other vulnerability factors as summarised in tables 4.2 and 5.1. The analysis allowed presentation in bar charts for visual comparison between the two categories of children's case notes. It was also useful to see case notes where '*voice of the child'* was recorded or not recorded. The *manifest* content allowed the researcher to focus on those contacts, interventions, assessments, comments and other facets of texts that were visible, easily observable, and countable (Neuendorf, 2017).

Phase 2

Phase 2 represented an extension of the study design from positivist in Phase 1 to include interpretive elements (section 5.2). Analysis of data gathered in this phase was interpretive, enabling me to develop meaning from the context and interactions with families as embedded within each contact, In this Phase of analysis, I acknowledged the process highlighted by Bowen (2009) to analyse patients' records, taking account of key characteristics of quality of healthcare documents as highlighted by NMC (2018; 2016). In order to have a structure to guide the analysis, I developed a tool (box 4.1) as a frame of reference which contained questions considered pertinent in addressing the primary and sub-research questions.

In a number of instances, the child health record provided detailed information about health and social circumstances of the child, capturing the journey of the child through health and social care systems, including: assessments, supports, family situations, parenting concerns and outcomes for the child. The initial examination of these documents enabled me to give voice and meaning around the work of HVs and how these come across to the clients (Bowen, 2009). Therefore, the child case notes served as evidence of care continuity for every child, and remained a useful source of account showing the relationship with parents and involvement of practitioners in the care of children and families.

I adopted the guidance in case notes analysis tool in box 4.1 in a sequential but systematic approach that allowed interpretive analysis of a body of information from the case notes according to document analysis process advocated by O'Leary (2014) and Bowen (2009). In this context, I drew on the definition of document analysis as a form of qualitative research method in which the researcher interprets documents to give voice and meaning to address the research questions (Bowen, 2009). The iterative process involved coding *latent* case notes content into themes, applying rubric (box 4.1) in the form of questions as suggested by O'Leary (2014). To

understand context, the meaning of the HV-family relationship, I gave attention to particular words used by HVs to describe their encounters with families, developing categories and themes that provided meaning to the research questions. I approached the process with a critical but open mind, taking the texts in case notes as written by HVs in a way that is described by Babbie as a: "*study of recorded human communications*" (2015, p391), with the aim of finding out how HV conducted parent-HV interactions, define and classify children and ways of responding to the children's needs. My interest in applying document analysis was to understand interactions of HVs with children, family and other professionals as recorded in the '*contents*' of the case notes.

It is argued that document analysis allows a researcher to evaluate documents' contents as: "*first-pass document review*" (Bowen, 2009, p.32), providing the means of identifying meaningful and relevant passages to develop patterns, categories and perform thematic analysis from the document's data (Bowen, 2009).

As I applied the document analysis in Phase 2 of this research to examine inherent or non-observable contents of the case notes and apply interpretive research method to address the research questions (appendix 7a and 7b). Thus, the *latent* contents of the case notes provided description of parent-HV iinteractions, contexts and influencing factors that guided HVs to provide contacts / interventions to children and families. In applying the analytical questions in box 4.1, I took cognisance of the style, tone, agenda, facts or opinions that existed in the case notes, unveiling the hidden meanings held within the documents. I integrated the approach advocated by Krippendorff (2018; 2013; 2004) and Schawndt (1998) to systematically read and analyse contents of case notes as applicable in: *"… research or other documents, interview or focus groups data …* " (Schreier, 2012, p3), thereby making meaning from HVs' recorded evidence of contacts to understand the process they adopted in defining and classifying children into 'universal' or 'vulnerable' caseload management.

Within the analytical process, I took the case notes as units of coding in order to develop categories, continued to evaluate and: '*modify the coding frames to develop themes'* (Schreier, 2012, p6). This process led to mapping relevant quotes that provided 'meaning' to the research questions, taking the approach suggested by Krippendorff that 'meaning' derived from analysing contents of document:

> *"… came to be thought of as inherent qualities of documents … The message is the 'container of content', a vehicle for shipping meaning from one place to another"* (2013, p2).

Box 4.1: Case Notes Qualitative Data Collection and Analysis Tool

a. Manifest questions

- What are the reasons, modes, frequency and process for contacting children and families in 'universal' and 'vulnerable' caseloads?
- How did the HV communicate with parent/child; assess and determine level of need for the children?
- Do HVs routinely involve children and reflect the 'voice of the child' in all decision-making affecting the children e.g. need and risk assessment, planning, interventions/supports and evaluation of outcomes?
- Is there evidence of professional curiosity in seeking/sharing information with other professionals?
- What organisational, professional and personal support mechanisms do HVs draw upon to enhance their decision-making process?
- What are the characteristics of universal and vulnerable children?

b. Latent questions

- What common factors influenced decision-making of HVs?
- Did the interactions reflect characteristics of Relationship-Based Practice?
- Was the contact based on needs of the child and family?
- Are there influences known or unknown to HVs that could have prompted the contacts (emotional factors)?
- What type of analysis can be drawn from the responses of HVs to the needs of children?

Thus the record of HVs' contacts with families as written in the case notes was a 'vehicle' that shipped meanings of their encounter at the time and place to allow the researcher to interpret and analyse the value and quality of such contacts in terms or purpose, relevance, and response to the needs of children in a constructive sense.

An overview of the processes highlighted in Phases 1 and 2 shows the focus was on case notes, and the analysis of text brought understanding about types of interactions and interventions as

described in the HV's use of particular words, phrases and concepts, separating facts from opinions in the case notes (box 4.1). It enabled me to identify relevant passages for pattern recognition, allocating the themes into categories to develop knowledge. I carried out careful, focused reading and re-reading of each case note contents, as well as coding and category construction in an approach described by Bowen (2009, p33) as a process of *"evaluating documents in such a way that empirical knowledge is produced and understanding is developed"*. The approach was considered an efficient and cost-effective method of document analysis; and served as a manageable and practical resource, accessible, reliable and *"non-reactive*" source of data in this study. It is argued that the critiquing of document within social research can be an important research tool in its own right (Bowen, 2009, p33). However, my experience from practice and the research processes enhanced my knowledge to 'review' the research question relating to: how HVs define and classify a child as having 'universal' or 'vulnerable' needs; and what informs their perceptions of Parent-HV relationship; and assessment of 'risks' that a child might be suffering or likely to suffer significant harm. With the other aspect of the research questions I aimed to explore my understanding of how HVs respond to the needs of children and families in their decision-making process. There was a gap that required a direct account from HVs to address the research question, hence the need to progress the research to Phase 3.

Phase 3

This section involved the development of a semi-structured interview guide, coding and thematic analysis manually and use of NVivo 11 software. The initial analysis process started with listening to the recorded interview and their transcription, followed by grouping into categories, coding and thematic analysis, applying the process highlighted in Braun and Clarke (2006). The transcripts contained amount of data considered too large for manual analysis, hence I applied NVivo version 11 which allowed development of an analytical framework to address the research questions (diagram 5.3i to 5.3iii). I developed a framework using NVivo 11 to provide a graphical view of the relationship between HVs and families in practice.

The data analysis methods adopted in this research were subject to similar adaptive processes that resonated in the previous two phases; and they provided opportunity to connect with the interviewees at human level with natural curiosity to learn more about their practice. The aim was to address aspects of the research question, especially how they responded to children's needs and the strategies to overcome the emotional impact associated with this role. This was crucial for the process of narrative development and evaluating the pilot interview questions, which allowed me introduce changes subsequently. There was a predominance of narratives framing health visitors' experiences in their work with children and family. Thus, responses from participants provided the analytic basis to probe and elicit salient points relating to the nuances of

parent-HV relationship, and HVs' work with children and families. The main aim of this approach was to make sense of the interactions, behaviours, feelings and actions of HVs.

A list of codes was developed from the iterative process to index the transcribed data, with some flexibility of introducing new codes, removing old ones or merging them to form cluster of codes. In the subsequent stage, I abstracted themes from the cluster of codes, grouping them to represent basic, organising and final themes. Initially, it was necessary to classify the codes under different headings, display them on the table and move them around to have an overview of various concepts reflected in the codes. I structured the underlying patterns and clusters and developed them into final themes, identifying salient differences between each respondent in the transcribed interview data, as highlighted in Braun and Clarke (2006). The theme development in this process is explained further in section 6.9f.

4.10 Developing Themes to Address the Research Question

In view of the vast amount of interview data the task of analysis became onerous, hence I moved from manual analysis to employing the NVivo 11 software to code and analyse transcribed interview records. This process was initially found to be difficult, but it was a commonly acknowledged problem when using NVivo for the first time (Bazeley and Jackson, 2013). Therefore, gaining understanding to develop a version of the analysis methods that fitted this research took a long time. However, I followed a critical process to analyse and interrogate data in a systematic way; and I found NVivo 11 was a useful package to adopt according to the process outlined by Bazeley and Jackson (2013; 2007), I developed free and tree nodes and undertook analysis of all the interview data in this study. The aim of applying model from NVivo 11, for instance, was to present individual code describing the process of decision-making of HVs to address the research question, highlighting how they define, classify and respond to needs of children (Bazeley and Jackson, 2013). I linked the nodes to models, which enhanced the analytical process by shifting from describing to critical analysis of the complex objective and subjective concepts HVs apply in their work with families. The model development enabled organisation of central characteristics around the global themes.

4.11 NVivo 11 Software

I adopted the guidance of Bazeley and Jackson (2013) to inform the data entering process in NVivo11 and the process is described in this section. I transferred all the interview transcripts for 20 HVs onto NVivo, and open coded the contents to generate descriptions of how HVs defined children as 'universal' and 'vulnerable' in their encounters with families, leading to 33 different descriptive codes being generated at node level. Prior to this stage, I had already completed an

iterative analysis on paper, but transferring to NVivo11 allowed advanced codes and themes to be developed and grouped together (Bazeley and Jackson, 2013). This process enhanced the use of '*tree nodes'* to gain conceptual clarity that gave direction to the open codes in NVivo11, according to the process described by Bazeley and Jackson (2013, p118). The *tree nodes* were grouped to hold together the codes on the same themes; and the dataset management followed useful guidelines set through NVivo 11. Applying the '*tree nodes*' meant that I was able to identify and categorise the nodes and codes in relation to answering the research questions, integrating framework for thematic analysis process highlighted in Braun and Clarke (2006). I applied a similar process to each interview, providing descriptive nodes so that the whole process became iterative and shifted between transcripts in NVivo11 to manual analysis on paper. This inductive process resulted in relevant codes being generated, so that some 'tree nodes' were merged while others were discarded if they added no value to the general themes across the wider data set or contributed to answering the research questions.

The framework developed from NVivo11 (diagram 5.3i to 5.3iii) showed inter-woven relationships between 'assessment', classification of children as 'vulnerable' or 'universal', and how HVs responded to the needs of children and families. Triggers of anxieties and protective mechanisms HVs found to be supportive were also highlighted in the models. I did not start applying NVivo11 from the very beginning of this research, consequently, all the data entry was completed at later part of the study and some aspects of the field notes developed during interview and case notes analysis were in danger of being lost. Hence, I fell back to combining paper and NVivo11 to provide findings summarised in section 7.5. For the benefits of future research, I would recommend a development of clear guidelines for coding before entering codes into NVivo11 and to start using the package early to avoid loss of information. The combined sources of qualitative data (interview and case notes) enhanced the merging of interpretive coding from transcribed interview data (appendix 12) and analysis of case notes contents in Phase 2 of the study.

4.12 Validity and Generalisability of Research Methods

In order to enhance the validity of methods adopted in this study, I developed a document analysis technique (box 4.1) to provide a guide for case note analysis. I acknowledged the argument of O'Leary (2014) regarding emotions, personal bias and prejudices likely to influence authors of written documents; I relied on HVs account as recorded in case notes for Phases 1 and 2 of the study design. The accounts of HVs might not reflect the accurate and complete events and interactions between children and families. However, Phase 3 of the study involved interview of HVs, giving opportunity to cross-check some of the accounts recorded in the case

notes. Firstly, Bowen highlights that document analysis should not consider the data as: *"necessarily precise, accurate, or complete recordings of events that have occurred"* (Bowen, 2009, p33), hence contents of documents were taken with caution. Secondly, O'Leary (2014) also highlights the potential for researcher's bias and subjectivity in interpretations of *manifest* and *latent* contents of documents or interview transcripts in a way that is likely to impact on validity and reliability of the mixed methods research. In other to increase the validity of the research findings, I engaged one of the participants, a manager who is a PhD holder, as an inter-coder that applied the tool in box 4.1 to analyse 3 case notes and outcomes were compared with the analysis I undertook (appendices 7a and 7b). The results showed significant inter-coder agreement from the 3 case notes analysed by 2 practitioners. The strategy followed suggestions of Bowen (2009) as a means of enhancing the validity of qualitative and quantitative analysis of documents; and the process showed an efficient and effective way of gathering data because documents are manageable and practical resources for research (Bowen, 2009). The overall mixed research methods allowed the use of multiple method including interviews of HVs. The transcribed interview data was reviewed by three HVs interviewed to ensure transcribed data recorded was correct.

4.13 The Relevance of Case Notes and Interview as Data Sources

In choosing children's case notes and interviews as data sources, I recognised three reasons that justified this choice as highlighted in studies by Shaw, et al (2013), Setz and Innocenzo (2009). Firstly, Shaw et al undertook a study to develop several in-depth analyses of cases for patient services; and they collected quantitative data of health records of patients and also gathered qualitative interview data from doctors, nurses and healthcare assistants. They compared quantitative (record evidence) and qualitative (interview evidence), to investigate patient care. There is a strong argument that documents provide significant and cost-effective source of data in healthcare research (Neuendorf, 2017; Bryman, 2001). Bowen (2009) also suggests that the '*manifest*' and '*latent'* contents of documents are useful sources for qualitative and quantitative research data. In similar approaches, I collected quantitative data from children's case records and interview data from HVs (Shaw et al (2013), using model as adapted in box 4.1.

Secondly, studies show that nursing researchers such as: McKim (2017); Luck et al (2006) and Anthony and Jack (2009) obtained data from multiple sources to address their research questions. Luck et al described such approach as being "*a bridge that spans the research approaches"* (2006, p107), providing the basis for the 3-Phase complementary approaches aimed to bridge gaps in addressing the research question in this study. In many nursing

research, data collection from multiple sources occurred sequentially in two phase designs (Creswell, 2013a; 2013b), where the researcher investigates research phenomenon at different and separate stages (Anthony and Jack 2009). However, the 3-Phase design was developed in a non-linear or spiral-process, which allowed iterative forward and backward shifts in the research process.

Finally, whilst looking at the case notes, I was informed by the views of Setz and Innocenzo (2009) who conducted research using nursing documentations to understand and establish how nurses make decisions, and discovered intended and unintended outcomes of nursing care for patients. In a similar approach to the work of Setz and Innocenzo (2009), I sought data from case notes in this study, taking cognisance of the guidance for quality nursing records and care continuity as outlined by Nursing and Midwifery Council - NMC (2018) and Nursing and Midwifery Board of Ireland -NMCI (2016). The guidance shows that nursing case notes should include: "*assessment of the patient's physical, psychological and social wellbeing, the views and observations of patient or family; plan of care and an evaluation of the care outcomes*" (NMCI, 2016, p11). Wood (2010) argues that nurses are accountable to ensure the records about clients' care reflect: "*clear decision-making processes, channel of communication, and evidence of adherence to policies and procedures* … (p20).

The variables generated from case records were broadly classified into *manifest* and *latent* contents (Bowen, 2009), representing contacts easily visible or countable interactions / interventions between HVs and families; and invisible but complex factors associated with these contacts. Thus the *manifest* content of case notes which allowed quantitative analysis to compare data in 'universal' case notes with data in 'vulnerable' case notes, according to Creswell and Plano-Clark (2018, p12) quantitative method allows:

> "… *the investigator compares two or more groups in terms of a cause (or independent variable) that has occurred* " .

Thus, the two domains represented the nuances of HVs' work with children as recorded in case notes to allow critical analysis and develop understanding and explanations of tensions within this area of work. The statistical analysis applied included: mean and charts presenting analytical and pictorial comparison of the work of HVs in these domains, with focus on exploring possible impact of one on the other.

Data collection from case notes came with the assumptions that HVs followed their professional code (NMC, 2018) for keeping good and accurate record as essential professional and legal requirements for practitioners; it is argued that in practice this might become low priority for nurses. In health visiting documentation is crucial as evidence of decision-making and continuity

of care for children, on the basis that: "*If it's not written down; it didn't happen…"* (Andrews and St Aubyn, 2015, p20). Case note is '*nursing documentation'* which is written as legal and professional evidence of advice, health assessment, reviews, interventions, supports and outcomes for children, thereby communicating the process for decision-making about children and families (Mahler, et al, 2015). Warren-Gash (2017) suggests that client's case notes provide information about demographics, clinical interventions, and details of clients' engagement with services in acute or community settings although they: "*vary in contents, format and access permissions*" (Warren-Gash, 2017, p5). NICE describes patient's case notes as '*real world data*' and a potential source that could enhance its decision-making process: "*case data represents an initiative that could potentially meet many of NICE's real-world data needs… and NICE is in discussions to better understand and prepare for potential of using these data* (Kneale, et al, 2016, p5).

4.14 Summary of Research Methods

In this chapter, I provided extensive description and justification of the research methodology I adopted in this 3-Phase study process. The study started out as quantitative in approach, requiring descriptive data collection and analysis, but subsequently extended to qualitative method involving interpretive analysis of data to address the research question. Whilst the main analysis methods for qualitative data in case notes followed the document analysis technique of O'Leary (2014) and steps highlighted by Bowen (2009), the thematic analysis of qualitative interview data adopted the process advocated by Braun and Clarke (2006), and NVivo11 guidance of Bazeley and Jackson (2013) to develop themes and models. The quantitative data analysis applied descriptive statistics to explain variables and summarise data from case notes. Thus, the process led to developing a framework that provided a useful method to understand HVs' accounts, recognise and record similarities and differences in characteristics that defined children as 'universal' or 'vulnerable' following their encounters with families. Given the above understanding, the 3-Phase design process gave this research a pathway that met the descriptions of a mixed methods research as it combined descriptive and interpretive methods to address the research question. The initial approach intended in this research was quantitative method, using data from case records. However, this single method could not address the research question, though it provided useful insight to develop a shift in epistemological basis of this study. It provoked further qualitative inquiry which became predominant approach. The epistemological discourse offered in this mixed methods research was considered crucial as a means to harness strength that are inherent in both quantitative and qualitative methods, especially when considering complex and sensitive subject of safeguarding and protection of children from abuse and neglect. The qualitative method involved personal interaction with HVs,

and such relationship enriched my understanding and personal interpretations I made about HVs' decision-making process. The quantitative method on its own, left a gap in knowledge relating to lived experiences of HVs, poor understanding of the research context and setting where the HVs work. Adopting mixed methods research design brought together the voices of HVs directly and recorded account of their experiences, thereby providing the opportunity to explore their personal biases and emotions within the complex interactions with children and families. The next chapter provides the findings from the 3-Phase research design process that guided both data collection and analysis in this study.

4.15 Personal Reflection on Research Methods and Study Setting

As a researcher I recognised the importance of maintaining an informed reflexive consciousness to contextualise my own subjectivity in interpretation of case notes contexts and interviewing managers and peer practitioners within the HVS, interpreting interview data and representing my experience in the research process.

4.15a Insider-Researcher and Ethical Dilemma

In considering resercher reflexivity, I will describe my personal and professional motivations for conducting the research alongside the extent of accountability towards the practitioners who participated in the research. The intention was not to eliminate but acknowledge and reconcile the power positions within my dual managerial and frontline practitioner holding family caseload, and an insider researcher with the challenge of differentiating and consolidating behaviours and demands of clients, colleagues, organisation and the academic standard of the university.

It was evident that the power and positionality issues are beset with paradox and ambiguity. However, I was able to unravel and comprehend such intricacies and complications by following the suggestions of Reed and Proctor (1995 p.195) where the researcher considers colleagues as co-participants in the social, educative process to open up value issues for critical enquiry and discussion. Whilst I prioritised children's safety and well-being, I followed exploration of practice in an approach that upheld confidentiality, strength-based and constructive criticism, rather than taking a punitive position, with the aim that participants, along with myself, could exercise professional insights, developed imagination and ability to interpret and learn from everyday action in their work setting. Managing the power implications of my role as a manager and positioning as an insider researcher gave me insight as a practitioner within my research project, and this offered me a valuable opportunity to have critical view and understand a range of my work perspectives (Bassey, 1999). My relationship with participants remained critical and I carefully monitored my position in the research process to maintain focus on the research

agenda; the uniqueness of the setting and the nuances of health visiting work. It meant securing opportunities for professionals to express themselves, show their feelings and willingness to defend and validate their work and knowledge claims. As I wore two caps within the role of a researcher and manager/practitioner, it was imperative to situate and engage myself with some ethical dilemmas as integral to the epistemological positions of the research. In my experience as a practitioner with multi-skills and professional experience in midwifery, adult nursing, child forensic nursing and health visiting, the research reflects my interest in past and contemporary contexts and experience of complex circumstances of children and their families. I navigated through practice and gave attention to new knowledge generated as the study progressed. It added to my repertoire of experience available to share with other practitioners, especially about the dilemmas HVs encounter in their role as advocate for vulnerable children and surveillance to pick up risk-factors for actual or potential situations of child abuse and neglect. This was crucial in exploring the epistemological positions of the research and remaining in a supportive position for children, families and other practitioners. From extensive reading of various research studies, it appears that a discussion of the epistemological and methodological issues around intersectional risks, vulnerability and child protection in HVS have been neglected in health research. Temple and Young (2004) emphasise that, as researchers, it is important to acknowledge our locations within the social and professional world, and explore how these locations influence our views of things. I therefore acknowledge the '... *power relationships...'* between the participants and myself (Temple and Young, 2004, p164). However, seeking to give meaning to the voices of participants in any research study requires interpretation and inquiry process which can be influenced by the researcher's professional, social and cultural identities. As an insider-outsider researcher I confronted different challenges and opportunities as a result of my positionality in the current research context. In relation to the issue of access, I reckoned my interactions in individual and professional contexts allowed access, rapport and trust among practitioners (Mercer, 2007; Cassell and Symon, 1994). However, there are ethical contentions that judgements in mixed methods research, such as this, cannot be generalised without due consideration to the context where the research study is undertaken (Tomlinson, 2015; Hollway and Jefferson, 2000). As a researcher within an organisation where I work, I saw participants as colleagues and co-researchers which gave them the confidence to provide rich data and self-reflection as key feature of involvement.

The research participants were peer practitioners and managers, and most considered the research participation as an educative opportunity. As a researcher and also a HV in specialist safeguarding role, I may be seen to have advanced professional knowledge which serves as a source of understanding that informs current research. However, no matter where I position myself, it remains crucial that I cannot disregard constructive questioning of my own inside

knowledge. It meant shared professional identity with my participants, while I negotiated objectivity and accuracy with the same rigour as other researchers before I entered the research setting. Within the field, I encounter similar ethical and methodological dilemmas associated with positioning, disengagements and conflicts in shared relationships.

During interactions with HVs, I observed practitioners looked deeply into situations using their eyes, their feelings, their words, their moves in and out of the situations to create connections with reality. I found a deep, heartfelt reaching-out that was expressed in words and non-verbal cues by HVs as they spoke about their practice, which enabled me to build connections in response to their experiences in the frontline of practice. Decision-making about children and families was seen as task which seemed like the ability to play a 'scale on a musical instrument', making it sound like a symphony – there were synchronisations between repertoire of experience, confidence, cultural orientation, level of education, social and professional skills of HVs. My insider position offered capacity for empathy whilst having critical view of the influences on the decision-making and ability of HVs to manage potential anxiety generated by their work. What became apparent was the experience of interplay between HV giving meaning to situation through his or her way of being and acting in practice either proactively or reactively to address the needs of children and families, some of whom had adverse experiences. These highlighted situations from interactions with families and, in a number of cases, there were uncertainties as responses of HVs to needs of children fell outside the realm of prescribed policies or professional norms; but, again creating experiences that spoke through the situations they confronted in practice. Thus situations of uncertainty could impact positively or negatively on the child and family.

Further uncertainty in HVS was brought about by the transfer of commissioning for HVS from NHS England to Local Authorities from 2015 (NHS England, 2014). Currently, there are deeper cuts in services commissioned by Local Authorities, with concerns about the weathering of HVS. It is rather unprecedented for HVs to vote for strike action as was witnessed in Lincolnshire following dispute over pay and what was described as "erosion of professional standards" in the HVS after transfer of commissioning to Local Authority (Stephenson, 2019; 1999). Most HVs wondered how health visiting policy and practice would develop in the future, considering the increasing dichotomy in their surveillance role in detecting faulty parenting and public health specialist role in supporting the health, development and wellbeing of children. Whilst these two key roles are important, a significant increase in one aspect stifles the level of involvement of HVs in the other, given the static or dwindling resources resulting from government's agenda to continue cutting health and social care budgets. For these reasons, this study is timely and relevant for further research, academics, policy and practice development.

4.15b The Study Setting

The study took place in three regional sites of health visiting that serve diverse populations within a London inner city borough, with mixed population and health needs for children and families. The borough has an estimated population of 263,150 (Office of National Statistics, 2016), is a growing economic opportunity resulting from recent increase in the focus on some part of London as an area of growth and development. However, this growth remains alongside significant deprivation and inequalities within the local population and this continues to bring disproportionate impact on child poverty. In 2015 the borough was ranked eleventh compared to its 2nd position in 2010 on the overall table of most-deprived Local Authority in England. The report shows, with regard to determinant of health, the borough has made progress in the area of: access to local services, health, education, income, employment, housing, living environment and crime, as highlighted in Index of Multiple Deprivation – IMD (Department of Communities and Local Government, 2015). The overall latest results indicated that the borough has become relatively less deprived compared with other neighbouring local authorities in London and England, especially in terms of determinants of health affecting children. However, there are relatively more pockets of deprivation in relation to violence and crime compared to other parts of London (Department of Communities and Local Government, 2015). It is estimated that in 2015 there were 3 in 10 residents in the borough who were affected by a common mental health condition, 16% of the population suffered anxiety and depression disorders. These contributed to the increasing prevalence of 'toxic trio', a term commonly used in the local community service to describe combined impacts of mental health, substance abuse and domestic violence on children. Child poverty continues to be high as measured by the percentage of children living in families in receipt of benefits, universal credits or incomes below 60% of national median incomes before housing costs. Commissioning of the health visiting services was transferred from NHS England to the Local Authority, but bids to provide health visiting and safeguarding services won by two providers - the local NHS Trust and another NHS trust outside the borough. All HVs working in the six clusters were led by five team coordinators and two managers. Within the cluster are other skill-mix, including community nurses, nursery nurses, healthcare support workers and the school nurses. In the safeguarding department there is a lead person, domestic violence specialist health visitor, safeguarding named nurse and child protection supervisors who provide training, supervision and professional development supports to HVs and other practitioners in the community.

Coincidentally, whilst the research was ongoing, there was an incident involving 13-month old twins under universal health visiting service, one died from physical abuse and the other suffered serious injury from father in the same incident. Father did not seek help or have insight into the

impact of his domestic violence and severe mental health problems on parenting of their twins (child N and O); with his condition made worse by cannabis-induced distorted thinking and occasional hallucinations. In the subsequent SCR (Smith, 2018), the independent investigator remarked that:

> "… *the health visitors were timely and reasonably thorough. Father's presence at the health visitor's initial and follow up visits served to deny mother the opportunity for sharing any account or fear, of domestic abuse. The inability to address this issue should have been recorded by the health visitor. Furthermore, seeking and recording a response to the possibility of mental health difficulties or substance misuse was overlooked*" (Smith, 2018, p13).

4.15c Reflection on Policy and Practice

As a child protection supervisor linked between Safeguarding Children and Health Visiting teams, I have observed significant changes in my practice in the course of this research. My relationship with practitioners and clients has strongly tended toward relationship-building in teaching, supporting, liaising and effectively promoting my engagement with reflective and supervisory ethos. In addressing some policy-practice gaps, I encountered some ethical dilemmas in having to escalate unsafe practices and the research confidentiality for the participants. Hence, I had to provide written reports periodically or as necessary, highlighting concerns identified in practice as backed up with the research evidence and this approach has led to some changes by commissioner and provider of HVS in the local policy, practice, staff training, client's feedback and evaluation processes. However, a significant amount of work still remains especially in acknowledging and addressing the emotional impact of health visiting work on HVs and outcomes for children. Not only did I have my insider knowledge, but it was useful to have access to people and information that could further enhance that knowledge, challenge the status quo of policy and practice from an informed perspective and an in-depth ideas of many of the complex issues and policy-practice gaps to enhance child-centredness.

Chapter 5 - Research Findings

'Modernity is a risk culture ...Risk assessment invites precision and even quantification, but by its nature is imperfect. Given the mobile character of modern institutions, coupled to the mutable and frequently controversial nature of abstract systems, most forms of risk assessment ... contain numerous imponderables' (Giddens, 1991, p4).

5.1 Introduction

In this chapter I provide findings of this research following the 3-Phase research design described in chapter 4, and bringing together the descriptive and interpretive narratives from case notes and interview of HVs (diagram 5.1). The findings address primary research question as to how HVs engage in parent-HV relationship; define and classify children under 'universal' and 'vulnerable' caseloads, how they respond to needs of children under each category and the impact of this role on their emotions. Whilst the findings from Phase 1 answered the research question by identifying and analysing diverse relational characteristics from case notes, Phase 2 focused on the content of case notes already reviewed in Phase 1. Phase 3 findings are based on descriptive accounts from 20 HVs interviewed; highlighting the subjective processes they adopted in developing parent-HV relationship, identifying factors contributing to vulnerabilities in children and to address their needs under proportionate universalism.

5.2 Research Findings from Phase 1

It was evident that both 'universal' and 'vulnerable' children were offered the 5-mandated contacts commissioned by the Local Authority for all children in HVS; but children classified as 'vulnerable' were offered additional contacts which were varied, unpredictable and most times without clear rationale to justify such contacts or interventions. Hence, in Phase 1, the findings highlighted unique characteristics in the case notes that brought out the differences, in both interactions and contacts; between children and families who were included in 'universal' and those under 'vulnerable' case notes (Box 5.2a). The differences in characteristics offered some insights into the concepts HVs adopted in classifying children into these categories, and how this could define the conduct of their relationship with families in practice.

5.3 Characteristics of Children in 'Universal' and 'Vulnerable' Case Notes

The definition and classification of children as 'universal' or 'vulnerable' and the supports or interventions given to each category of children were, to a large extent, subject to clinical judgement and 'risk' perceptions of individual HVs, with some practitioners making reference to assessment guidance in local threshold documents - *National Assessment Framework (*Department of Education, 2004*)* – as part of their assessment and decision-making process.

Box 5.3 - Findings from Phase 1

Characteristics of children: Vulnerability factors were associated with multi-factorial difficulties.
Universal: The HVs did 185 contacts for 50 children, and average total HV's time spent for each child was 54.7mins per child.

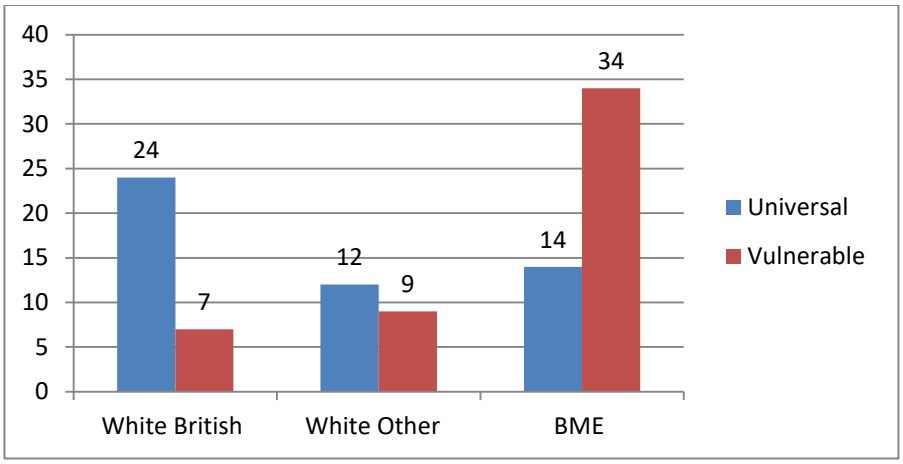
Vulnerable: The HVs did 1423 contacts for 50 children, and average total HV's time spent for each child was 8.6hrs per child (table 8.1)

Ethnicity and vulnerability: Disproportionately high number of BAME children classified as vulnerable compared to white families (chart 8.2a). Disproportionately less number of BAME families accessed support compared to white family (chart 8.2b).

5.4 Ethnicity and vulnerability

In chart 5.3a there were 24 white British children, representing 48% of total number of children in the case notes who received or accessed universal HVS. The number of Black and Minority Ethnic (BAME) children accessing the services was 28%; and the BAME accessing universal services were mostly Asian, followed by mixed ethnicity, but less black Caribbean or African children. Accessing universal services was constructed to be synonymous with parental compliance with services to promote health, wellbeing and safety of their children.

Chart 5.3a - Ethnicity of Children



It involved access to routine antenatal assessment, child health and developmental checks and reviews, immunisations, other health appointments and parenting programmes; and uptake of information to support parenting ability, thereby preventing early risk factors for child abuse and

neglect. For instance, a record of a child from white ethnicity showed a proactive parent who appeared to value HVs by making contact with the services:

> *"Phone call received from mother informing that she was told that a health visitor will be visiting her from the area as she recently moved into the area, mother stated that she has not seen any health visitor now 1 week since she moved in. Mother was re-assured and informed that her allocated health visitor will be making contact to see her by next week. Mother was also informed of the clinic times at XXX and advised to attend child health clinic in 2weeks. Mother was receptive of advice"* Case Note 40.

The parent's participation in parent-HV relationship in this case demonstrated evidence of pro-active parenting genuinely involved in the health and development of the child. Chart 5.3a also shows that the number of children classified as 'vulnerable' were 34 children who came from BAME background, representing 68%, compared to 28% White British children in the total category of 'vulnerable' children. The composition of BAME children under this category showed disproportionately high number of Black children (32%) and mixed ethnicity (31), compared to children from Asian (5%) background. This raises further puzzling questions about parent-HV relationship among parents from BAME and what hinderances could be preventing access to services.

Figure 5.3b - Uptake of Universal Early Intervention Services (%)

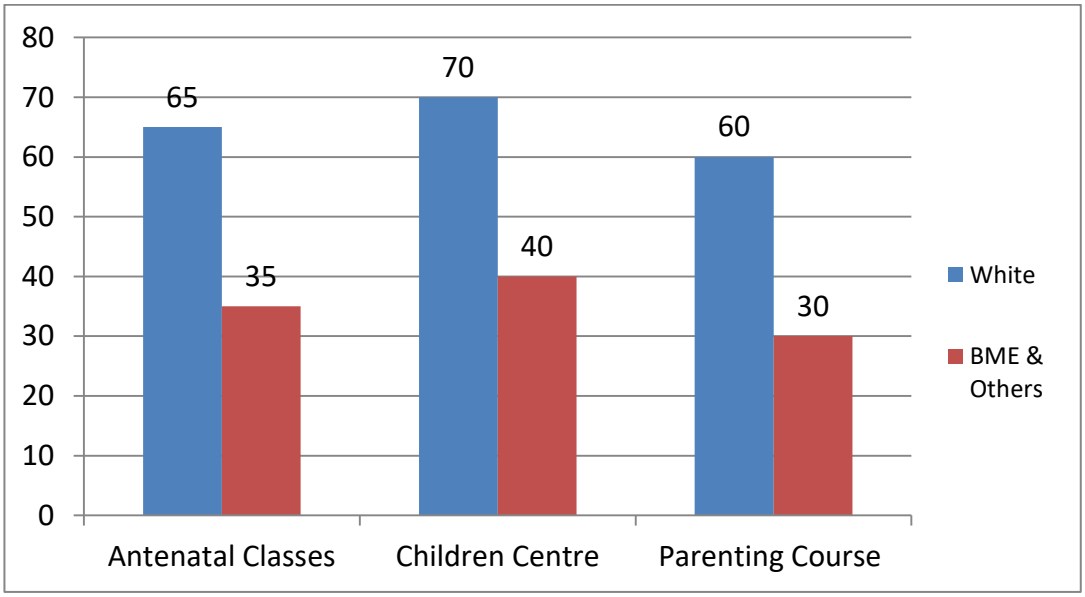


Chart 5.3b shows the percentage of white and families from BAME and Other children who accessed free universal Early Intervention Services, including free antenatal classes, children centre activities and positive parenting course run by midwives and Family Support Services working in partnership with the HVS to reduce inequalities, support parenting of children and enhance their outcomes. One of the significant findings from this phase is the evidence of a

significantly low uptake of 'universal' services among children and parents/carers from BAME. This suggests increased likelihood of missed opportunities to receive useful health information or interventions from health professionals that could help correct some potential errors which could become triggers that lead to children and families becoming 'vulnerable' and sometimes requiring statutory supports.

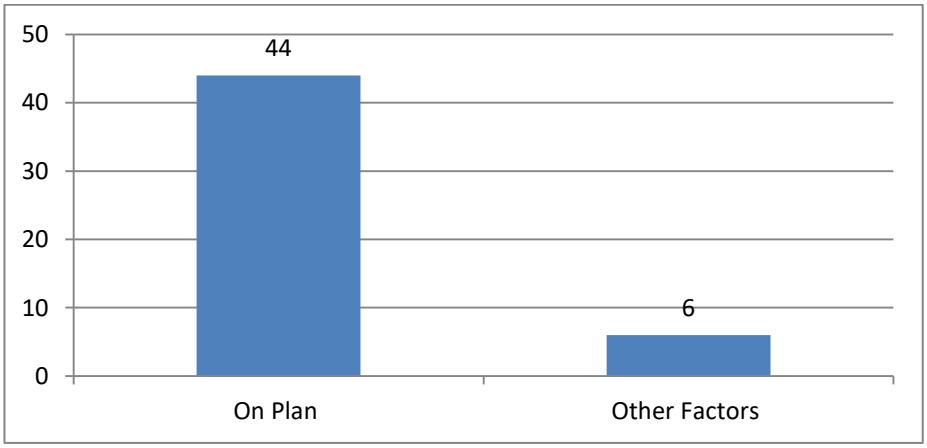
Taking the findings in appendix16, there are strong indications that HVs spent reasonable proportion of their time on non-direct interventions or contacts with children and families. Such non-face to face contacts include, phone calls, writing invite letters, text messages, liaison with other professionals following failed attempts to see child and parents, opportunistic home visits which, in 80% cases, resulted in failed visit due to lack of access to the child home. There is also strong view that such high proportion of time spent on non-face to face contact were due to clients becoming 'hard-to-reach' or non-engaging, and the HVs increasingly becoming fearful that things might go wrong and they would be blamed if the child suffered significant harm. There were strong indications that HV might succeed in seeing the family but fear within the parent-HV interactions about broken relationship did not seem to allow thorough assessment or probing questions to be asked in relation to risk of child abuse and neglect. In relating findings in chart 5.3a with chart 5.3b, there was disproportionately higher number of BAME children defined and classified as 'vulnerable' than white families; whilst there was disproportionately smaller number of BAME and other families accessing early intervention meant to enhance parenting ability, prevent harm and improve outcomes for children and families. These findings raise some puzzles around HVs' interactions with families, especially when considering 'transference' and their containment of parents' behaviours which can be uncertain and unpredictable. Whilst the majority of parents were identified to access services and engage in parent-HV relationship, some families were hard-to-reach which triggerred significant numbers of non-face-to-face contact mostly in attempts for HVs to see the children. Failed contacts increased fears of HVs about what could happen to children in families, leading to further attempts to reach 'vulnerable' children; thereby stifling resources of HVs to offer services such as health promotion or implement other innovative public health agenda to benefit and meet the needs of families under 'universal' services (appendix 13).

5.5 Level of Needs for 'Vulnerable' Children

Chart 5.3c shows the level of need for additional support given to vulnerable children, who were seen to require different levels of interventions, depending on outcome of risk assessment completed by the HVs. This highlighted the circumstances of particular child, including existing strength, needs and supports. There were 44 children or 88% requiring statutory protective services - children placed on a child protection plan (CPP) or child in need (CIN) plan. The HVs

recorded evidence of parent-HV interactions as HVs recorded integrated work in partnership with parents, social workers and other professionals to ensure that children were protected from significant harm. It was also evident that children under CPP were under close monitor, primarily, by Children Services and HVs who reported any safeguarding concerns to the social worker. It meant HVs could turn up in the house either announced or unannounced; whilst, in some cases, HVs had to attend meetings where parenting abilities of the parent/carer were subjected to scrutiny. There was evidence where HVs recorded strategies developed with parents towards achieving agreed plans to enhance the experience of children, either to address health, social or financial concerns, and this work required a significant amount of time and efforts. Another key factor from the analysis was the non-inclusion of 5 unseen children as 'vulnerable', and by principle, they were off universal services without some work to establish the wellbeing of the children. These concerns were escalated with the manager for further investigation as part of my responsibility, as an insider researcher, to safeguard indirect research subjects.

Chart 5.3c – Vulnerable Children and their Level of Needs



Some recorded interventions for 'vulnerable' children included plan for HVs to attend and support children and parents to complete protective plans as agreed by all stakeholders in child protection conferences. It was seen that the scope of work for HVs included taking active part in both initial and review conferences, and other professional meetings as highlighted in appendix 8 and quoted below from case note 58:

> ****Child Protection supervision with HV XXX*** Child M is 27-month old female child, currently she and her 2 school-age siblings are under CIN plan (stepped down from CPP on 13/12/15 under category neglect) due to domestic abuse from father towards mother,*

*and maternal mental health. There are concerns about parents' ability to stimulate M, … Father is to work with domestic abuse services (DAIS) to manage his anger as part of conditions in the CIN plan. … and mother has deteriorated recently, not accessing services offered to her. She does not take her prescribed medications for depression, saying 'I no longer need them'…. *HV to participate in CIN meeting and present report* (Case note 48).

The decision-making process as shown in case notes highlighted three possible outcomes for children placed on CPP. Firstly the child might be removed from CPP and the case closed if circumstances have changed and no further identified vulnerability factors that put the child at risk of abuse. In such cases the HVs continued to monitor the child and family for 6 months or more before transfer to universal category if no further safeguarding concerns were identified. Secondly, social worker's assessment might show the child's need as falling below threshold for intensive interventions; thus decision was made to transfer the child either to CIN or MAT (Multidisciplinary Team) for medium and low-level support. The HV was required to carry out child and family need assessment for Early Help before the child and family is discussed in MAT where the type and intensity of ealy help is determined. Finally, where the vulnerability factors were high and persistent, parents lacking the capacity to care and protect their children from harm and neglect and no potential for improvement or change in behaviour or parenting style, the Children Services could go through the court process for an order to remove the child temporarily or permanently from parents. Thus the child became looked after (LAC), which meant the Local Authority had full or shared parental responsibility under the Children Act (HM Government, 1989). The HVs were involved through these processes and, in extreme circumstances of high risk of child abuse; children were removed permanently from parents/carers through adoption process. Integrating child-centredness within this process typifies the complexity and unpredictability of parents' behaviours as involvements of Children Services in families often provoked anger, distrust and fear among parents who felt threatened that their children would be removed, and such emotions were transferred into parent-HV relationship.

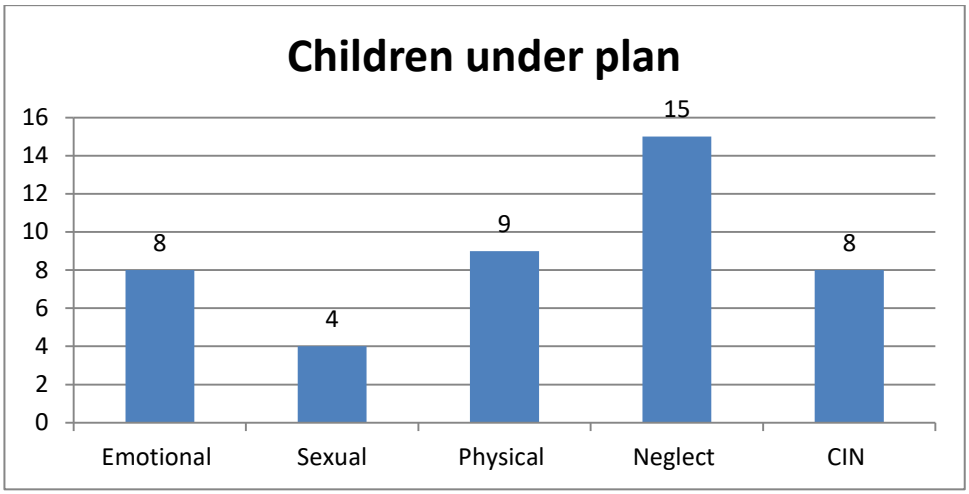
"both parents have been non-engaging and mother became disruptive in the CP Review meeting as she acused social worker of lying about her parenting capacity and refusal to accept random drug test offered by social worker" Case note 62

5.6 Child Vulnerability and Category of Abuse

Chart 5.3d provides further breakdown of category of abuse recorded as vulnerability factors for the children under the four statutory classifications – physical, emotional, sexual abuse and neglect. In chart 5.3c, there were 44 children on plan, comprising CPP and CIN. This is further

classified into various abuse categories in chart 5.3d, which shows neglect represented 42% of the total number of children on CPP while sexual abuse was 11%.

Chart 5.3d – Category of Abuse / Children under Statutory Services

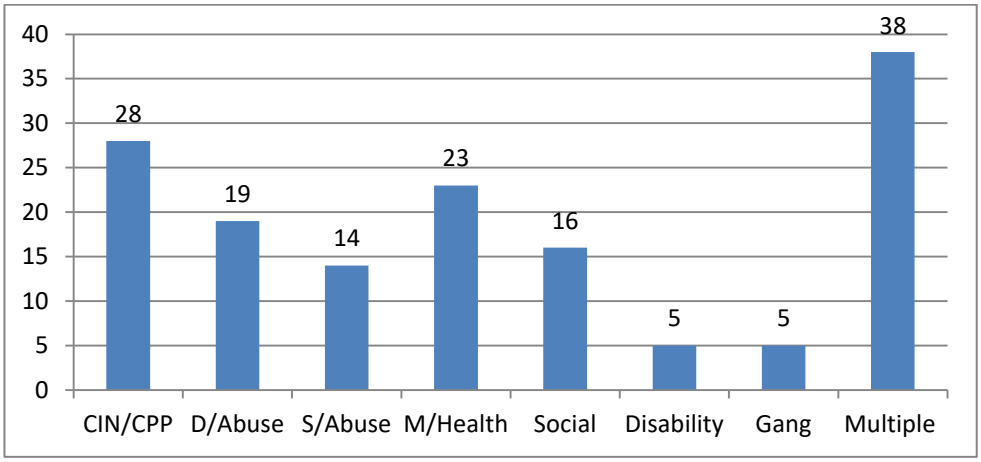


There were other factors which HVs took into consideration in defining and classifying children as vulnerable. Chart 5.3e below shows that whilst the toxic trio - domestic abuse, parental and child mental health and substance misuse - were significantly high among children under this category, there were instances of multiple factors being associated with difficulties experienced by children and these were further complicated by parents' unwillingness to access help.

5.7 Other Vulnerability Factors

As shown in chart 5.3e, thirty-eight or 76% of vulnerable children were those exposed to multiple or complex factors including parental gang affiliations, substance abuse, mental health and domestic violence, thereby putting the children at increased risk of actual or potential abuse or neglect.

Chart 5.3e – Other Vulnerability Factors



5.8 Summary of Contacts with Children and Families

At the time of this study 75 HVs in Whole Time Equivalent (WTE) were in the HVS; and in appendix 8c I provide detailed summary of contacts/interventions HVs had with children and families, with those under universal services receiving 185 contacts, which required 45.6 hours of health visiting time to complete; whilst vulnerable children had 1,423 contacts which took 430.5hours from HVs time.

The findings in appendix 13 were significant as they provide strong basis for further questioning, for instance, seeking various reasons for the 7-fold difference in health visiting time to respond to the needs of 'vulnerable' children compared to those under 'universal' services. According to the principle of proportionate universalism in HCP (DOH, 2009), it was also evident that practitioners' responses to address needs of children and family must be proportionate to health needs, risks and context of the child and family, hence their decision to inform classification of children under 'universal' and 'vulnerable' services.

For instance, appendix 8c shows two types of contact designated with letter 'R' for 'routine' or 'universal' contacts and 'E' for 'enhanced' or 'vulnerable' child contacts. The contact E2 has the highest occurrence, 32% of total contacts for vulnerable children and families. The code E2 comprises: opportunistic contacts or unannounced visits to parents' homes, liaison with other professionals and services. The case notes for vulnerable children showed that a significant amount of HVs' time was spent on liaising with other professionals to seek, share or corroborate information about 'vulnerable' children. The HVs also spent time attending what they described as 'opportunistic' visits and 9 out of 10 of such visits did not result in seeing the child due to lack of access into the family homes:

Case Note 63: "I made telephone contact today following previous letter, and text to parent for transfer-in assessment, but no responses. Attended opportunistic visit and could hear people in the house when I knocked hence I dropped an introductory note with HV contact details, but they refused to open the door. Plan: Still very concerned about the children… will liaise with GP, SW and nursery".

The code R1 described contacts such as: phone calls and texts sent to parents regarding their children, and this category was second highest contacts for vulnerable children, representing 26% of the total case notes in that category. Another, crucial aspect of concern about children's care was hearing their 'voices' in the HV's decision-making, and these were explored in quantitative and qualitative contexts.

5.9 The Voice of the Child (VOC) and child-centredness

The idea of recording voice of the child 'VOC' is a national health and social care priority to promote child-centredness, ensuring that practitioners involve children and young people in all decisions relating to their health and social care (CQC, 2016). Whilst there were direct quote recorded for children who could speak about their needs, for much younger pre-verbal children, the HV recorded cues, evidence of bonding and secure attachment between the child and parent, projecting indications of stable or unsafe base for the child. The levelling of child's needs is a significant decision and requires high level of critical thinking about the impact on the child, but findings from case notes showed that most children did not have their voices represented and recorded in the decision-making process.

Despite the significant level of involvement of HVs with families, especially where 'vulnerability' has been identified, many children were not informed or involved in decision-making about issues affecting their health and well-being as shown quantitatively in table 5.1 below.

Table 5.2 - Record of Voice of the Child (VOC) in Case Notes

	Universal	**Vulnerable**
No. of Case Notes Sample	50	50
No, where Voice of the child were recorded	5	15
In %	10%	30%

The HVs recorded comments or views of children and young people in decision-making about matters relating to their care, health and wellbeing or issues likely to impact on their future

outcomes. Table 5.2 shows that only 5 children (n=50) or 10% of the total sample of 'universal' case notes had their voices recorded; which suggests that 99% of the children did not have their voices effectively represented in relation to their care. However, HVs recorded the voices of 15 'vulnerable' children (n=50), representing 30% in the case notes.

Box 5.1 – Summary of Findings in Phase 1

Findings in Phase 1 were based on sample 50 case notes from 'universal' caseloads and 50 case notes from 'vulnerable' caseloads. There were 185contacts, with total of 45.6hrs of HVs' time spent to provide services to universal children; and 1423 contacts 'vulnerable' children who took 450.5hrs of HVs' time. The average time HV spent with children under Universal services was 54.7mins, compared with 8.6hrs spent on each 'vulnerable' child in the sample (table 7.1). Vulnerable children were seen to have multiple difficulties affecting them or parents, including mental health, gang affiliation, substance misuse and domestic violence; and these were influencing factors when defining and classifying children as 'universal' or 'vulnerable'. Another significant finding was the 5 children (30%) who were unseen by the HVs, and these children were classified as 'universal', meaning they were not identified to have additional needs despite the evidence that HVs did not see the children to assess their needs. This in contrast with the subsequent report from HVs during interview that they followed '*unseen child'* policy.

From risk point of view, the implication of this inconsistency is that children, who were not seen by the HVs, should have been considered 'vulnerable', which would have meant trigger of professional curiosity to ascertain the health and wellbeing of the children. The local Unseen Child Policy requires that in cases where a child cannot be seen, the HV must record steps taken to exclude 'risk of harm' to the child. Expectations from HVs include: liaison with family GP to confirm child's last attendance and reason, parents' current address and phone number, Children and Family services to establish if family is known to them, opportunistic home visit and evidence from letters, texts and phone call during attempts to reach the child and family. Where all these have been established and documented, then the child would be discharged from HVS caseload. There was no evidence of such work recorded in some children's case notes, and this suggested situations of false positives where children were classified as having no additional needs, when there was no evidence to demonstrate that.

These findings still left gaps for me to understand the quality and rationales of HVs' contacts with families and further questions about parent-HV relationship as demonstrated in under-

representation' of BAME families in uptake of early year services and their 'over-representation' in 'vulnerable' caseload, leading to findings in Phase 2 (appendix 16).

5.10 Research Findings from Phase 2

In this phase I provide findings from an in-depth analysis of case notes, applying the document analysis tool developed in box 4.1. The findings are discussed under two categories: risk assessment as the key process of decision-making for health; and how voice of the child is reflected in this process (Box 5.10).

Box 5.10 - Findings from Phase 2

Study Phase 2

- Quantitative and Qualitative (subjective) Health Need and Risk Assessment strategies
- Risk perception was influenced by HV's experience, interpretation of threshold and work approach
- Evidence of uncertainty as to the influence of bias or 'indeterminacy' in HVs' decision-making process.

5.11 Risk Assessment and Classification of Children According to Needs

In order to determine the appropriate 'levelling' of a child and family needs, the HVs undertook risk assessment for all children in every contact. The word 'levelling' was commonly used in practice and record keeping to describe the classification of child and family's needs as requiring 'universal' service or 'vulnerable' (universal plus, universal partnership plus or high risk) services to inform the input such family required from HVS. The process of risk assessment evident in the case notes were either 'structured', 'unstructured' or both.

Structured Approach

The structured approach, on one hand, involved applying existing assessment tools described in the literature, including National Assessment Framework, EPDS, GAD-7, Safeguarding / Child Protection Risk Assessment, SafeLives and ASQ-3. These tools provided some objective measurement of risk thereby guiding the HVs in their decision-making in relation to defining and classifying children as either 'universal' or 'vulnerable'. The case note 57 shows entry by HV that:

> *"Mother reported new partner XXX, not the children's father, had been abusing physically her … Mother also said she withdrew her statement because she felt threatened. … The children are currently placed on CPP under category emotional abuse. SafeLives*

assessment was completed with a score of 20/24 *and referral made to MARAC" C*ase note 57.

The HVs conducted risk assessment using SafeLives questionnaire to determine risk of child suffering actual or potential harm as a result of exposure to domestic abuse in the family. They also assessed parental mental health using EPDS to identify concerns which might impact negatively on ability of parents to care for their children, for instance this case note shows HV's encounter with parent with mental health issues:

"… *Appears to have difficulties coping due to mental health and relationship difficulties. The current EPDS was 19/30, compared to previous record of 14/30, but I think she is minimising her mental health difficulties which has deteriorated since she stopped her medications"* case note 57.

Unstructured approach

The unstructured risk assessment, on the other hand, was often applied jointly with risk assessment tool to justify risk and their concerns, leading to referral or other enhanced interventions. This subjective approach meant the definition and classification of children as requiring 'universal' or 'vulnerable' services depended on the risk perceptions of individual HV as shown in this case note:

"… from the parent's responses to completed GAD-7 assessment, the score was 3/21 but his communication, lack of eye-contact and general presentation showed high level of concerns about his anxiety. His interactions with the children were much disorganised. Parent was unwilling to gain some insight into the impact of his raised anxiety on his parenting. ***Action****: I have shared these concerns with the GP, Children Services and will review in 2 weeks under Universal plus Services*" Case note 84.

The parent-HV interaction shows interplay of subjective and objective views of the HV and parents, and HVs routinely sought consent from parents / carers prior to interventions or referrals to other services. However, there were instances where referrals were made to other services without parental consent and this led to broken parent-HV relationship:

"… *I have made referral to MARAC based on professional judgements as victim refused to give consent despite explanation. … Also made referral to domestic abuse intervention service (DAIS) and Children Services as Mother would benefit from counselling and some supportive work around relationship building and strengthening family. Mother felt I betrayed her and she refused to engage with HV."* Case note 70.

The analysis of case notes in Phase 2 showed that HVs have a role in providing early interventions for children under 'universal' services, and the Children Services were mostly

involved in providing statutory support to 'vulnerable' children under safeguarding and child protection. They applied diverse qualitative and quantitative strategies to assess risks and establish levels of needs to inform contacts or early interventions offered for children and families. However, in 30 percent of the 'vulnerable' case notes, there was no clarity in assessment process or rationale for contacts or interventions given to these children. In significant number of these cases there was evidence of significant time spent on attempts to establish contacts or engage with vulnerable families, reflecting some pressure and frustration on HVs in parent-HV relationship, especially with families who are hard-to reach, avoidant, showing disguised compliance or difficult to engage. There were four 'latent' characteristics evident in the 'vulnerable' case notes:

a. Contacts and interventions were feasible where parent-HV relationship was effective with focus on the child.

b. Dichotomy in threshold definition of 'risks' between 'social workers' and HVs which sometimes resulted in delay for statutory interventions to support 'vulnerable' children. Services and interventions from the Early Year Services and the Children's Centres are reducing due to funding cuts.

c. 'High work demand' and expectations from HVs, for instance, to achieve the 5 mandated contacts for children and provide additional supports to safeguard and protect them from significant harm.

d. 'Low control' in terms of HVs lacking statutory powers to enforce compliance and engagement with parents, carers and families as the HVS remains 'voluntary service' but requiring participations of clients in a relational approach. This reflects the impacts of social class (Gillies, 2007) in our society. In her book *Marginalised Mothers: Exploring Working-Class Experiences of Parenting,* Gillies (2007, p19) identified the existence of social class inequalities in the society as '*an elephant in the room'*, which is rarely articulated or acknowledged as such. The issue of class inequalities might be considered rude, unsettling or embarrassing and insensitive subject to discuss, but it reflects a reality of our society as shown in the impact of COVID19 pandemics among BAME groups compared with the White population (NHS Confederation, 2020). This study highlights that there is more acceptance and uptake of HVS among families in higher social class than those among low social class.

On one hand, some case notes showed the view of HVs that certain children receiving statutory services from social workers did not require such services but the cases were still open to Children Services as CPP or CIN. On the other hand, 4 vulnerable case notes showed conflicts between decisions of HVs and the views of social workers. Whilst HVs classified the 4 children as 'vulnerable' and requiring additional protective services, the social worker did not see such 'risk' as meeting their threshold of needs to warrant interventions. In some instances, this dichotomy has resulted in delay for statutory interventions to support 'vulnerable' children and families who really needed help as shown in these case notes:

> *"D, the father of child X is in prison following charges for drug offences, murder, and incidents of domestic abuse towards the mother, but was still controlling mother, T, whilst in prison".* Case note 55

The HV shared these initial concerns in referral to Children Services who responded with decision that the risk of harm to X was below intervention threshold, as perpetrator of abuse was removed from the family home and now in prison. There were repeated concerns from the HVs recorded in the referral to social worker to provide statutory interventions but no action was taken:

> *"…Concerns: Maternal mental Health, Suicide ideation , High level gang involvement and risk of counter gang attack on the child; mother not engaging with mental health services and GP, and history of excessive cannabis use by mother" (*Case Note 55).

It took 6 months following report of initial concerns before Children Services accepted HV's referral; and the child X remained subject to CIN plan for more than 3 years; leading to some positive behavioural and lifestyle changes recorded about mother and her parenting ability; with improved child's development, whilst D remained in prison. It was evident that perceptions of what constituted risks and vulnerability between or within services was an influencing factor in defining child as 'universal' or 'vulnerable' and these could enhance or impede early interventions in response to needs of children and families. The tone of contents of the case notes carried a sense that the HVs involved with this family could have experienced extreme anxiety and concerns about the safety of X within the neighbourhood, until there was statutory intervention which included rehousing the family in another area to prevent gang rivalry attack.

It was also evident that due to 'high work demand and low control', HVs explored diverse methods of exercising surveillance on families based on their risk perceptions and professional curiosity; seeking to ensure children receive 'universal' care, with appropriate response to

additional needs due to difficulties within the families. Such approach, as shown in the case notes above, included: cold calling, 'opportunistic' home visits or liaison with other professional to obtain information or updates which could help HVs in their decision-making about the child. However, there were missed opportunities to listen to the voice of the child in the above case.

5.12 The voice of the child

The qualitative analysis of the case notes showed that HVs recognised the needs to hear and record voices of children at every contact. However, their priorities tended to focus mostly on the needs of parents rather than the children. The voice of the child within such complex and troubled environment were not routinely reflected in the decision-making for most 'universal' and 'vulnerable' children. This meant possible missed opportunities for children, especially those with disability or developmental delays as they could not have their views represented concerning their needs and how these could be addressed in health visiting services.

Box 5.2 - Summary of Findings in Phase 2

In defining and classifying children as 'universal' or 'vulnerable', most HVs incorporated health need and 'risk assessment' in their decision-making; taking account of strength and resilience families had, and could access in difficult times. Such assessment helped HVs determine level of needs the child and family had, thereby informing offer of interventions appropriate to their needs. I identified two key issues which raised questions about the decision-making process of HVs. Firstly, there were instances where no explicit process was followed to define and classify children or offered rationale for contacts. Secondly, considering that qualitative decision-making process involves subjective judgement, which in itself, can be negatively influenced by 'negative emotions' - personal bias, it is uncertain that the 'under-representation' of BAME children in 'universal' services and their over-representation in 'vulnerable' caseload might not have been influenced by such bias. It thus meant that significant and disproportionate number of contacts for 'vulnerable' children was targeting BAME families based on wrong perceptions that this group were most at risk of child abuse and neglect. The puzzle from this finding still could not resolve questions about parent-HV relationship, views about whether the approach adopted by HVs was influenced by personal bias from 'transference / counter-transference' matrix and their pre-conceived views about BAME families. In this sense, ethnicity emerged as factor that should be given further consideration in terms of uptake for services and exposure to vulnerability factors (charts

5.2a, b and d). These phenomena offer a potential research area to explore the relationship between low uptake of parenting services among BAME families in relation to those from white ethnicity, and over-services and high representation of BAME children in 'vulnerable' caseloads. The themes developed in analysis of case notes in both Phases 1 and 2 were limited to the record of HVs' accounts covering their interactions with families. This raised the need to explore findings in Phase 3 to understand how HVs conduct parent-HV relationship as a means of response to children needs; and the emotional challenges associated with their role.

5.13 Research Findings from Phase 3

This Phase provides findings from analysis of interview data. The primary research question for this study was concerned with how HVs develop parent-HV relationship, and respond to children's needs under 'universal' or 'vulnerable' caseload. I also sought to understand how they responded to the needs of these children, barriers experienced and how they overcame such difficulties. The findings from interview of HVs aimed to address the primary and sub-research questions; and these are explained under 4 themes developed from analysis of interview data shown in box 5.11.

Box 5.11 - Findings from Phase 3

- Child-centredness and Assessment of risks and health needs

Risk and Health needs assessment, recognition of strength and vulnerability factors

- Parent-HV relationship and 'child-centredness'

Influence of HVs' attitudes, characteristics and practice orientations and response to needs of children

- Raised anxiety and coping strategies of individuals and organisations
- Organisational culture

5.14 Child-centredness and Assessment of Risks and Health Needs

One of the key themes developed from the analysis of interview with HVs was the consensus that conducting full 'risk and health needs assessments' for all children were primary task for all HVs in their practice.

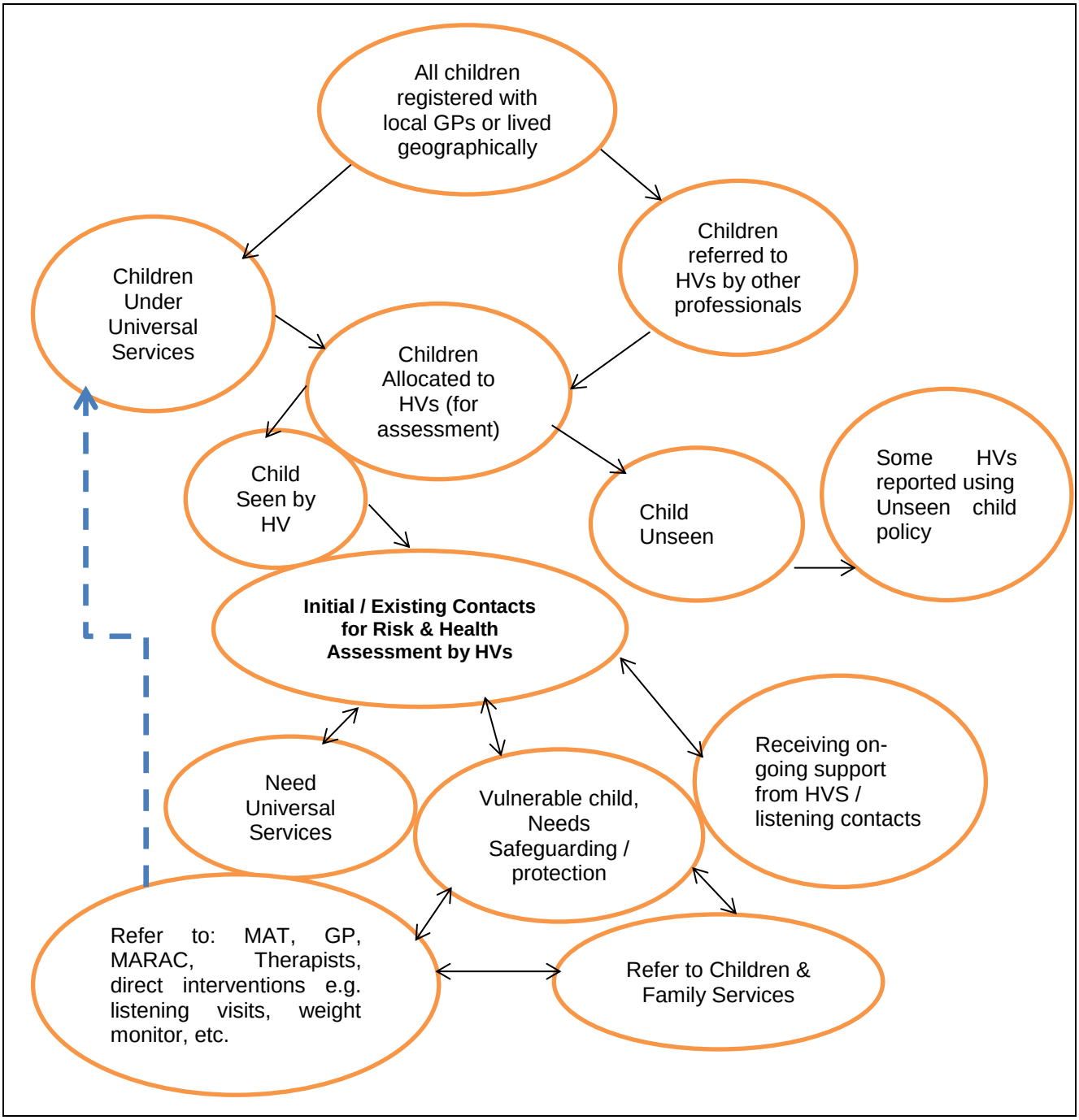
From the themes developed, ‘assessment’ was associated with a number of activities which helped HVs define and classify children as ‘universal’ or ‘vulnerable’. In order to provide clarity about the ‘assessment and referral’ themes, I summarised the accounts of HVs in NVivo11 (diagram 5.11(i)); which shows ‘assessment’ was required for all children allocated to HVs. The rationale for assessment was to identify needs and determine whether children and families required ‘universal’ or ‘vulnerable’ services which meant enhanced interventions to safeguard and protect the child from significant harm:

> “*So as a health visitor, am always looking for, and searching for health, so in doing that I ask various questions, to ensure that I get … to the bottom of the assessment that am doing and that assessment allows me to determine whether that child is well protected or that child may be at risk of child abuse or sort of harm , and so during my assessment I would do that and make sure I guard against future problems occurring for that child”* HV05.

Some HVs reported that they could not routinely see all the children allocated to them as named HV due to work pressure, which meant some children were unseen. Whilst most HVs mentioned ‘unseen child policy’ was applied in their decision-making, few did not mention how they dealt with unseen children [diagram 5.11(i)].

> *“… there is unseen child protocol that we must follow, so it's important to have a good network with other professionals because you have to communicate … search with other teams in regards to, you know, is this child in another address that we don’t know about? If it’s a new birth visit, midwives… you know, have they seen the child, has the child been discharged from hospital, what is the situation? So it's about if we can’t find this child, then we have to consider referral and communicating with Social Services if this child is known to them … So it’s about following the protocol and ensuring that we can gather as many information as we can so we can draw a picture of where this child might be”* (HV 17).

Diagram 5.11 (i) – Assessment and Interventions Routes



5.15 The Assessment Process

The HV's accounts show that they carry out assessment for all children they contact (diagram 5.3i); and the key objectives for assessment were to gather evidence, make decisions or professional judgements regarding the level of children's needs, and to inform interventions they offered. The interventions mostly mentioned by HVs included: direct work with the children and family and / or referral to other services for specialist inputs. When need has been established

following assessment, HVs reported they could then define and classify the level of support as under 'universal' or 'vulnerable'. This definition also determined future parent-HV relationship and liaison with other professionals.

> *"… so basically as health visitors, part of our role is to do a holistic assessment, we use the assessment framework to assess the families, so that is the first thing that we do before everything else, and nowadays with basically the Healthy Child Programme, we actually start seeing them from antenatal periods, so from that time that is when it gives us the opportunity to assess if there's any risk and also it gives us the opportunity to ask if there is any past history or if it could be domestic violence or it could be mental health or substance abuse and to make referral to other services , because you'd find that one thing may lead to the other, yeah"* (HV08).

An overview of the decision making process from accounts of HVs as in diagram 5.11i suggests when a child was allocated to a named HV, it was the responsibility of the HV to 'define' and 'classify' the child either as 'universal' or 'vulnerable' through the assessment process. There was expectation that the allocated HV would establish contact with parents / carers and arranged to see the child(ren) either at home or clinic to carry out 'assessment'.

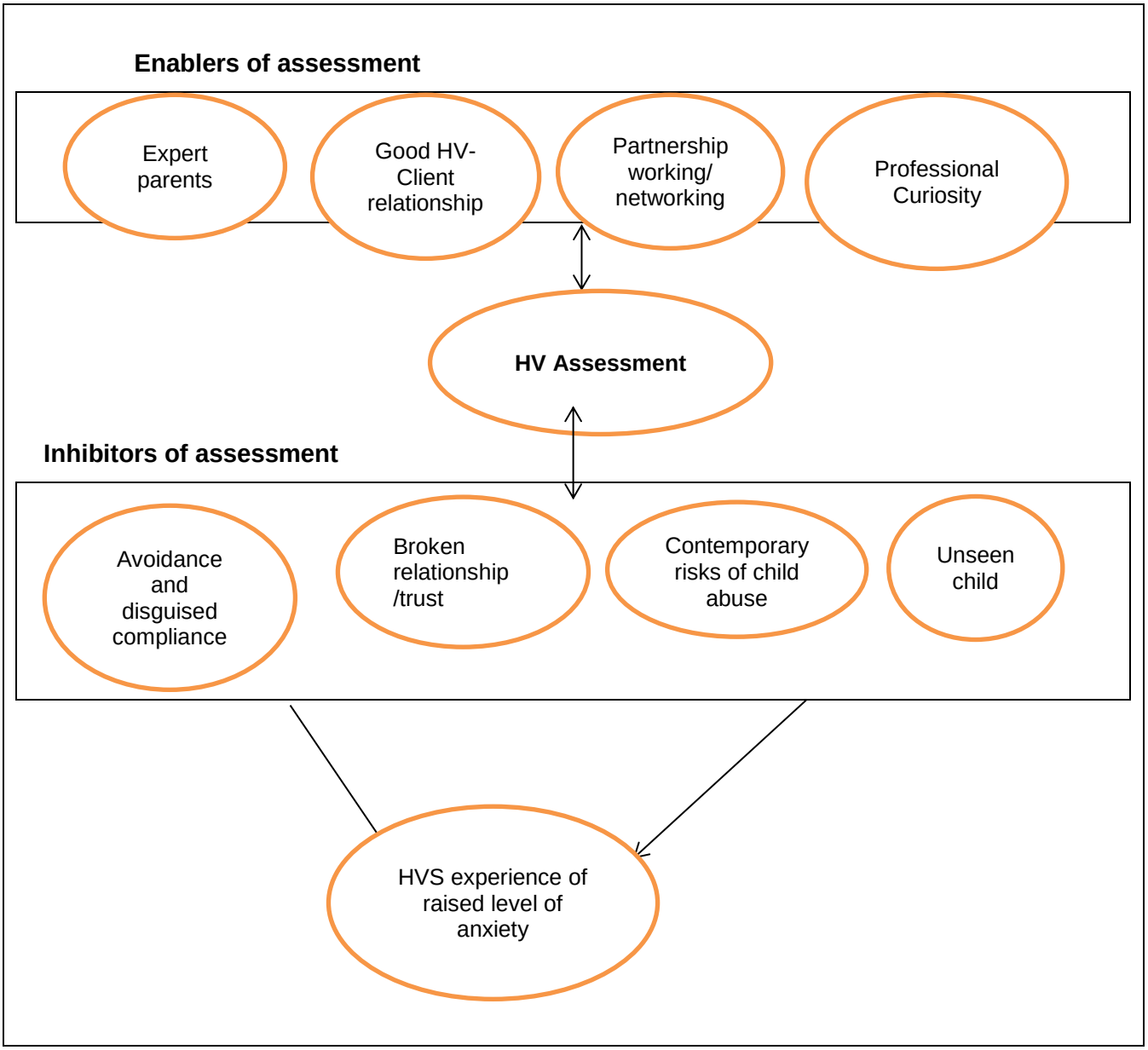
There were three possible outcomes for children assessed by HVs (diagram 5.11i): Firstly, they reported cases where no safeguarding concerns were identified but parents / carer were offered generic public health or parenting advice and then discharged to 'Universal Services'. Secondly, the HVs offered some families active interventions but subject to effective parent-HV relationship, willingness of parents / carers to accept such interventions as: parenting support, health promotion advice, home safety advice, child's weight monitoring, child's behaviour or sleep management, listening contacts or other practical support to address difficulties in some families. They reported significant piece of work for vulnerable children were with those families identified to have difficulties but their needs had not met the thresholds for Children Services or MAT for early intervention supports. Finally, children identified as having safeguarding concerns or additional needs were referred to Children Services or MAT, and the pendulum between these two services moved according to changes in family circumstances (diagram 5.11i).

5.16 Facilitators and Inhibitors of Assessment in HVS

Within the analysis of HVs' accounts, I developed themes which provided some understanding about factors considered as enablers of HVs' assessment process for children and families. Whilst the key enabler of intitial and on-going assessment and interventions was effective parent-HV relationship; lack of trust and broken relationship were key inhibitors of holistic assessment.

The enabling and inhibiting factors that influence HVs' decision-making process emerged from narratives of their description of experience from working with families as explained further in section 5.19.

Diagram 5.11(ii) - Enablers and Inhibitors of Assessment



From diagram 5.11 (ii), parents / carers who accessed services to support their parenting and responded to the health and developmental needs of their children in timely and proactive ways were seen to be demonstrating the characteristics of 'expert parents', and useful features in Child-centredness. They took the lead in following professional advice rather than being nudged to ensure their children had good health and developmental outcomes.

The accounts of HV 03 and others showed that professional judgement and clinical decision-making were important factors in assessment of children and families, and other key characteristics of enablers and inhibitors for assessment as reflected in a diagram 5.11 (ii).The experience, knowledge and confidence of HV in making effective clinical judgement were dependent on training, skills and experience of individual HVs, with students and newly qualified lacking the confidence to make complex decisions:

> *"Safeguarding children is a subject that I find very difficult because you are trying to build up relationship with parents in the first place, so what they disclose or don't disclose to you is up to them" (HV 19* years of experience 2*).*

The common view of HVs is that developing relationship with families and willingness of parents to engage with health visiting service were essential for timely assessment of children and families to determine their levels of need. Thus HVs valued trusting relationship they have with families and they saw it as pivotal to gaining useful information for assessment of children under 'universal' or 'vulnerable' services.

> *"That means if the trust in broken, they don't want to see you in their house. And once the trust is broken they are very resistant to the services that you might want to give to them. And unfortunately if this happen also there is impact on the child's wellbeing, again to introduce safeguarding to such family will be a real hard work which means we kind of use the approach which again makes them really very resistant in saying look we would need to do this or that, otherwise we will have to refer you to social services" (HV 05).*

5.17 Attitudes and Practice Orientation of HVs

The attitudes of HVs towards parents and their work had influence on parental engagement with HVs and their perceptions about the health visiting services. The accounts of some respondents showed a culture of paternalism in attitudes of HVs and defensiveness in practice, leading to raised anxieties from fear of blame if adverse event occurred. The narratives from accounts of HVs also showed significant work-related stress and burnout as problems for management of HVS. For some HVs, their responses to the needs of 'vulnerable' children and families within the context of blame culture and risk-averse society provoke over-involvements. The emotionally demanding nature of the job was seen as contributory factor in a culture of paternalism and defensiveness in practice (diagram 5.3iii).

Parent-HV Relationship

It was evident that conducting health visiting activities, including assessment of children and uptake of support by parents, were essentially built on 'relationship' and trust, grounded on the HVs' experience, skill and compassion with 'emotional intelligence' reflecting their interpersonal and intrapersonal ability. The HVs who showed these skills were able to navigate the complexity of safeguarding and child protection components of their health visiting role, enabling 'positive transference' and containment of their own emotional responses in addition to parents' and colleagues' emotional distresses.

> *"I felt it was important to establish relationship to work with parents, I always, tell them the reason why it might be necessary for them to adjust or change parenting style…, most of the time they tend to see reason, you understand but I will tell them the importance of me working with them so that we can get things right for the child and themselves. So if we do this work together and we are not getting anywhere I would explain why I need to do referral to other services or Social Services if it was safeguarding issue*" HV 18.

Active listening and communication in an open and strength-based relationship were also important factors to be taken into consideration when developing paren-HV relationship:

> *"Yeah, communication … you know, is very important and listening to them is very important as well. Building a relationship, that's very, crucial for you to be able to work with the families for them to understand because if you don't explain they wont know exactly why you are doing what you are doing – it could be very difficult to achieve outcomes for children"* HV 16.

The HVs reported their training, policies and practice wisdom provided them with a repertoire of knowledge to draw upon when initiating relationship with some parents with chaotic life experiences in order to assess and respond to the needs of children and family.

> *"Well you know with training in the new models that we are having now, with the initial visit, the antenatal visit, that enabled me to build a relationship with her, so already she knows me, she trusts me you understand, she can confide in me, so that really helped, which is one of the models that is quite good, working with complex cases from an early start helps me to really build a relationship and know them better*" HV 19.

Child-centred practice require practitioners to work in partnership with all parents; and the HVs worked with some vulnerable families where children had or were experiencing distress and trauma, and these had potential for emotional impact on HVs as they empathised with the children and families they worked with. Much as the HVs made efforts to contain and manage the

emotions of these children and families, they had to contain their own emotions on a frequent basis.

> "*For me I guess the most stressful thing is coming across the angry person, the frustrated families, and they are unwilling to change or because of limited resources, or* intergenerational abuse *that they transfer on to you because you represent the state. I find that really difficult because of that blockage and barrier, it's really difficult to get past and develop relationship for meaningful engagement, and it's very, very draining" HV08.*

There was a significant amount of emotional energy, transference and counter-transference involved in the process of self-containment for HVs, and this was further complicated by the ever present tensions, and professional dilemma around managing the balance between protecting the vulnerable children and addressing the distress of parents:

> *"Oh yes, sometimes you do lose that good relationship that you built with the parents… because once you have made the referral…. they will now see you as the bad guy because you are the one person they would have thought that you wouldn't do such things, but however you need to at every point explain that my focus is the child. I always say to them ' You are adults, you can speak up for yourself, you can look after yourself, obviously sometimes to a certain limit and you need support; however the child cannot even do that, you are the responsible person for that child. However if you are in a situation that you are not able to protect that child, we have to protect both of you, so I always say 'Be selfish to be selfless' – so be selfish in the sense that you look after yourself, to be able to look after the child" HV07.*

5.18 Emotions and Anxiety in HV-parent Relationship

The narratives of HVs' accounts showed high emotions among some HVs who could not manage the anxiety provoked by their experiences from life and working with children and families who have witnessed or suffered trauma, abuse or neglect and the consequences of such circumstances. However, some HVs were seen as having repertoire of coping strategies to draw upon and these played a key part in containing high stakes emotional situations through meaningful parent-HV relationships rather than directional or paternalistic approach with families who might otherwise be, hard to reach. This is described in strength-based and reflexive characteristics in Child-centredness adopted by these HVs:

> *"... you need to look at how you are coming across. Also fundamentally sometimes we have our own agendas so we want that family to be here but they are there, so as a practitioner it would be unrealistic to say 'You should be doing this and you should be doing that' because that's our goal and what we want. We need to start with where the*

family is and I think if you actively listen to the family, you will get more engagement that way, so it's a degree of self-awareness of what you are expecting of the parents and sometimes just open... using open questioning with them to elicit that sort of response they have" HV 13.

"So the scope in our job to pick up these things just during routine visits is huge, and every day we see so many challenges in issues about child abuse. I have tried to be reflective and reflexive, gain new insight in the work with children and their difficulties. I think the reflection with psychologist has been very helpful too" HV09.

Further engagement with parents was evident in managing different decision options within the parent-HV relationship to respond to needs of children and parents. The Child-centredness enabled responses to develop over time, for instance the offer of: listening contact, initial remedial work with parents to encourage behaviour change, referral to MAT for early interventions or involvement of statutory services for possible removal of a child to place of safety.

" so I had worked with the family for almost a year building relationship, the parents felt comfortable working with me, and being able to raise any concerns if there was any. I could offer listening contact, suggest behaviour change or need to escalate concerns, if it was just one contact initially the family would have retreated or parent will never disclose anything or feel very nervous every time that we had to see her, but she was very relaxed, so relationship building was quite important" HV 15.

At the time of interview, the majority of HVs recognised the relevance of Child-centredness, reported they liked their job and remained motivated through the differences they make and contributions to reduce inequalities and enhance outcomes for children and families. However, among younger HVs, the motivations were low; 7 of the HVs interviewed alresdy left the service within 2 years in their post. I selected three HVs in table 7.12 to highlight 'words' and 'phrases' during interviews; this suggested how they have developed a coping mechanism that helped them foster positive mind-set to counter the stress and anxiety associated with the health visiting role in order to contain some complex needs of families. Among the representative sample of those HVs who expressed commitment and motivation to continue in their role, it was evident that they brought 'positive transference' into parent-HV relationship.

"But it is important to always remain focused, and look at the strength of parents in supporting their children; raise concerns and not allow your relationship with parents to kind of make you blind of where the problem is, and I think as HVs because of our caring

role, we may at times think oh maybe the next time it will be better, but we just have to continue. We have to raise concerns, regardless of how the parents feel about it, but in a non-judgmental way and without bias and wrong perceptions in interractions with parents, HV16.

The account of four HVs showed evidence of 'paternalism' as a culture in parent-HV relationship, in which HVs were the persons possessing knowledge and power to make assertions and decisions about how parents should do the parenting of their children, holding sway over parents' conduct and patterns of behaviour to 'conform' with prescribed norms in HVS.:

"*She had been told not to use that walker, and I said 'You are still using it' … the child is not actually sitting, …so you need to stop using those things and begin to put this child more on the floor … and you also need to encourage the child' and then I said 'after we will review you again in about 4 weeks' time to make sure that the child is beginning to make some progress'' HV12.*

It was rather difficult to differentiate if this pattern of parent-HV interaction resonated from cultural influences and background of HVs as the characteristics of most HVs who displayed such paternalistic tendency were from BAME background, for instance the account of HVs 12 and 15:

"*The social services actually wanted to take this child off her again, but I started work with her, … I will make sure that she comes to the clinic and I will speak to her, I will tell her that 'Look, they have taken four children off you, you understand, but you need to prove it to them, if you know you want to keep this child, you have to do what you are told to do" (*HV 15).

The views of these HVs and their paternalistic behaviours showed systematised beliefs and practice based on statutory prescriptions in 'task-oriented' child protection processes. Their aim was to ensure that what these powerful HVs believed to be 'good' was the permitted and prevalent mode of conduct among the less knowledgeable, less competent, and less powerful – the vulnerable parents, carer and families. It came across strongly that Child-centredness often involved having difficult conversations which required deeper understanding of the aesthetics in motivational communication, but this seemed to be lacking in the accounts of HVs 12 and 15 as shown in their description of the parent-HV interractions. However, other HVs were more sensitive (HVs 01 and 08) and focused on parents' strength in the interractions:

"*I don't want to make them feel I impose myself on them. However, if you've made that initial contact and find out you are an encouraging person rather than telling them what to do, I think then they will engage with you more, and start building on that trust and relationship, really"* HV01.

"She said they were becoming too intrusive. At the first contact, I guessed, her thought was like: gauge you, want to assess you, can she trust you, can she have a good relationship with you? So it's always good you don't direct parents on what to do" HV08

These findings present an area of limitation in this study, highlighting the need for further research to explore the influence of culture and HV's practice. The number of HVs from BAME background is small in the sample to suggest their views represent the general population of HVs. However, the over-representation of children from BAME in vulnerable caseload, and low uptake of HVS interventions and supports among children and families from the BAME background is not unconnected with the underlying inequalities, socio-economic disadvantage common among these communities. These inequalities are subjects that generate further debate even in current COVID19 pandemic (NHS Confederation, 2020).

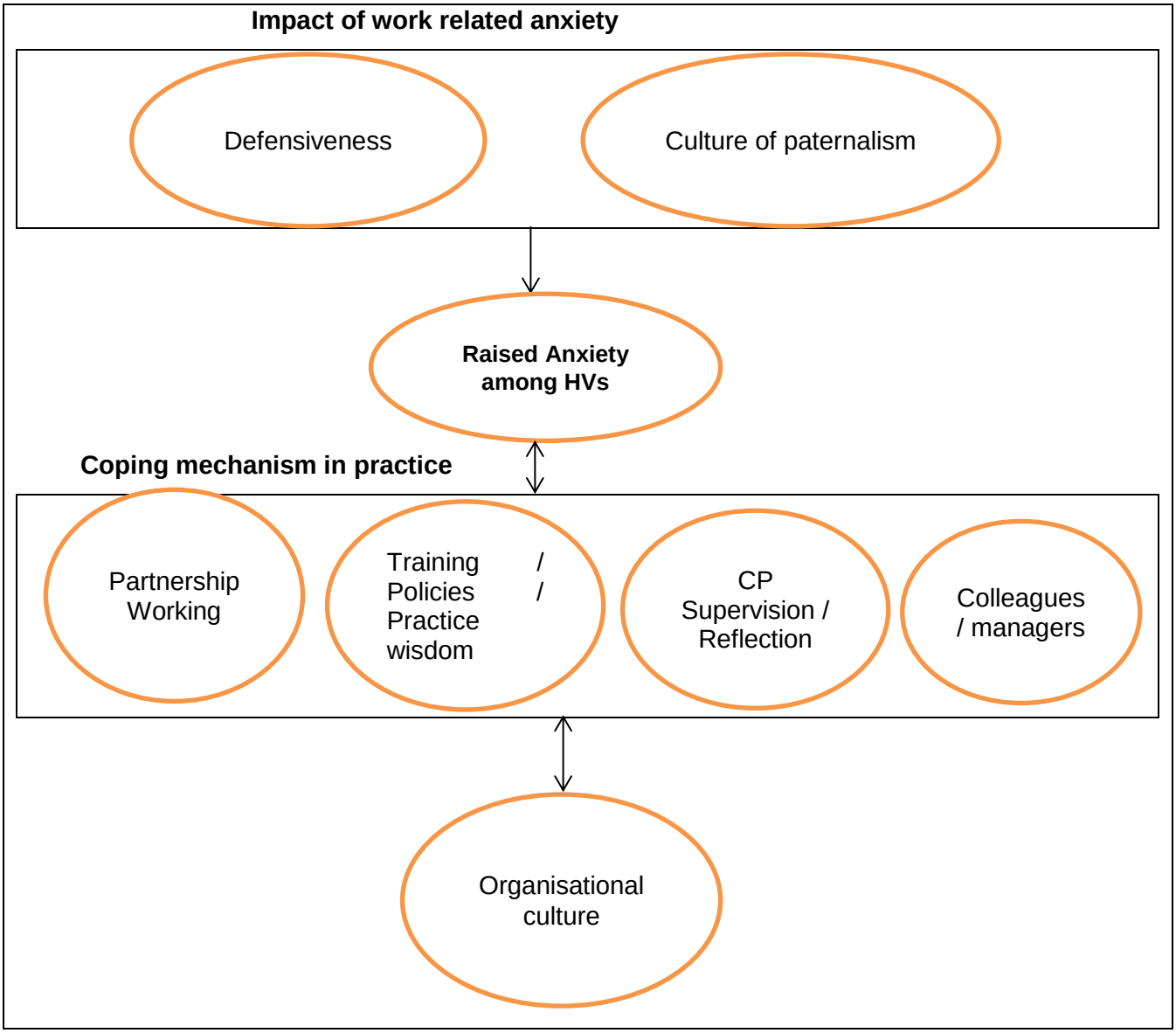
5.19 Defensiveness in Practice

The transference of various influences from HV's personal experience, practice culture, high work demands, complex needs of families some HVs have developed different 'basic assumptions'. Thus the narrative of some HVs showed their practice as defensive, with so much emphasis on individual HVs protecting themselves from making an error and completing the required KPIs; thus giving a higher priority to self-protection from blame rather than responding to the needs of children and family, as shown below:

"Supporting parents, y*eah, it depends on individual professional. Some people embrace it, other people feel it's too much depending on their workload and resources, it's too much to get involved in certain issues, but you do have to supervise, you need to be signposting parents to the fact that if they are not adhering to this advice that you give them, if there is a safeguarding issue or a serious case review, they will have no leg to stand on and they are accountable and will be blamed"* HV13.

"You just need to cover yourself, document what you have done" HV 17

Diagram 5.11 (iii) - Attitudes of HVs and Working Culture



Defensive practice is linked to 'box-ticking' practice that is not based on the ethos of Child-centredness and real needs or expected outcomes for children and families, and such instances could be possible explanation for the disproportionately higher number of contact / interventions for 'vulnerable' children – universal services saw 185 contacts, whilst vulnerable children had 1,423 contacts.

> "… *all the universal and safeguarding work we do sort of feels overwhelming… yeah, I do struggle with capacity I think sometimes I just have to see them and fill the template, no time to spend and listen to concerns of parents"* HV09.

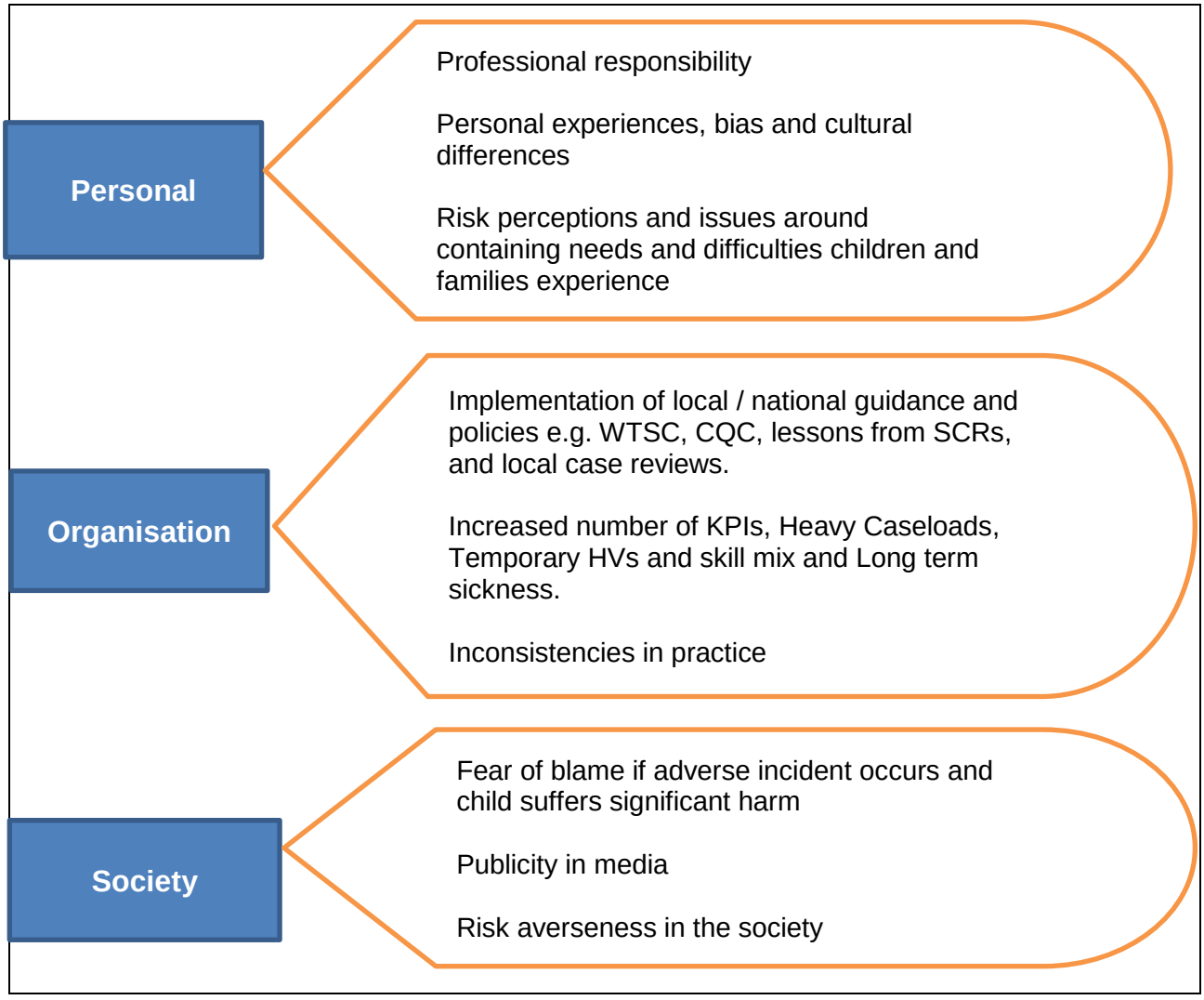
These findings raised fundamental issues around concerns for two errors in practice – false positives and false negatives errors. For instance, by shifting focus of interventions in HVS to

vulnerable children there was unequal attention to other children resulting in unmet needs of children under 'universal' services**.** There were instances where children with no risk of abuse would be offered interventions even from Children Services, whilst children with serious concerns were considered as below threshold for statutory interventions from Children Services. All these were mostly influenced by attitudes of HV and how they approach their work practice as shown in diagram 5.11(iii) – highlighting transference-counter-transference matrix.

5.20 Raised Anxiety and Coping Strategies

The main sources of anxiety leading to transference and counter-transference included: personal, society and organisational factors (diagram 5.11(iv)).

Diagram 5.11 (iv) - Sources of Anxiety to HVs



Personal sources of anxieties were projected into the parent-HV relationship when HVs allowed their cultural, childhood or personal experiences to overshadow their analytic or subjective

reasoning in Child-centredness resulting in mismatched priorities between the children and family needs and the health visiting interventions. There were strong indications of fear of media publicity if a child should suffer an abuse; and the risk aversiveness in the society with organisational culture where priority and outcomes were KPIs-driven, rather than relationship based, lent credence low work morales and increased anxieties among HVs.

At operational level, the organisational factors associated with raised anxieties were mainly two areas of inconsistencies between contents analysed from case notes and reports from interview of HVs about their practice, for instance, the 'Voice of the Child - VOC' and 'Unseen child' policy'. The VOC and 'unseen' child were highlighted from the Care Quality Commission (CQC) reports on how children and young people showed positive engagement when involved by services, but professionals did not ask children frequently enough about their views and feelings concerning their care and wellbeing; and on some occasions parents and carers prevented professionals from listening to the children (HM Government, 2018; Care Quality Commission, 2016; Ofsted, 2011). In this study, most HVs reported they asked children and young people about their wellbeing and views concerning their care. However, case notes analysis showed that this was not routinely the case, and there was lack of clarity in differentiating what should ideally be regarded as views of the HVs and VOC as shown in diagram 5**.11 (v)**:

Diagram 5.11 (v) – Sample of VOC Recorded in Case Notes

'Universal' Case Note	'Vulnerable' Case Note
"Baby had become restless, but observed she got settled after feeding: My mother respond to my needs in a timely manner…. However, I would wish to live is a settled home where my father is no longer abusive to my mother and my siblings are happy too." Case note 14	"…*X appears to be happy living with her father who is trying to establish routine and structure for X, and X is responding well too…These demonstrate love and care between X and her father as seen in this contact". Case note 62*

Another area of confusion arose from the 'unseen child' policy implementation process and how it was recorded in the case notes – question as to whether this was to highlight the views of HV or the child's. Whilst some HVs reported they followed 'unseen' child policy by providing actions taken in attempts to locate the where about of a child, others did not follow the process. It appeared the understanding and embedding of the policy in practice depended on interpretation of individual HV which made it ambiguous to follow. The description provided by some HVs

demonstrated how they arrived at decision of discharging a child who was 'unseen' from the HVS. A mere mentioning 'I follow the unseen child policy' did not offer description of how they took decision.

> "… *in terms of escalation route, you are following the Unseen Policy which is very clear about what you do so you are not just sharing that information about the lack of engagement*" HV 18.

5.21 Organisational Culture and Support Mechanisms

The organisational culture in the HVS influenced the working culture and emotional experience of HVs in their role (diagram 5.3iii). There was evidence of 'high demand, low control' situations in terms of HVs' experiences of working with families, especially in clusters recognised as having high level of deprivations and low level of engagements with services. Health visitors raised concerns around work demands, including: KPIs, increasing caseload, inflexible work patterns, work pace and the working environment for individual HV and teams. The environments where HVs worked were shared with other services, and some clusters were losing offices to make some savings for the NHS Trust, with introduction of 'mobile working' which was unfamiliar to some HVs. Consultations took place, but most HVs felt they did not have 'control' or say regarding the way they did their work. The increased level of anxiety was evident in manager's report of high incidence of short - and long-term sicknesses and occupational health reports of stress among HVs.

In general, the organisation provided training, but whilst the number of agency HVs were increasing, staff shortages still persisted due to high sickness absence and vacancies, thus many HVs had to cover essential services and could not attend booked trainings regularly. However, 90% of HVs reported they completed their core mandatory training and the re-organisation process appeared to bring minimal changes in staffing and specialism. The HVs acknowledged they received support through encouragement and training provided by organisation, but gaps still existed.

> *"I do see some gaps and I think a lot of it depends on the practitioner's experience and what they have been exposed to and some of it is about training, whether they are up-to-date with training and whether they have looked at their own professional development so some of it is training, … whether professionals want to have professional curiosity and accountability, it all basically boils down to the practitioner" HV15.*

The narratives from HVs' account showed they valued and promoted good communication and healthy working relationship with colleagues within the health visiting teams, a source of strength

in promoting positive working practices and avoiding conflict at work. There was role clarity between HVs, nursery nurses and other skill-mix within the HVS.

5.21a Influence from Inconsistencies in Organisational Practices

The HVS are required to meet expectations given in key performance indicators (KPIs) and other priorities as set by commissioners and government agencies. These include implementation of local / national guidance and policies e.g. Working Together to Safeguard Children – WTSC (HM Government, 2018), Care Quality Commission - CQC, NICE guidelines, lessons from Serious Case Reviews (SCRs), and others policies (chapter 3). The HVs reported increasing number of KPIs, caseloads, temporary staffing for HVs and skill-mix and long–term sicknesses contributed to increased anxiety at work.

5.22 Building Effective Coping Strategies in HVS

There was consensus that child protection supervision offered an opportunity for HVs to off-load their concerns; the support from colleagues, managers, Children and Family Services were valued by HVs as further mechanism to gain in-depth insight into complex cases of vulnerable children.

> "*…so my role is overseeing the service, managing the service, and one of the key aspects of my role is working very closely with the safeguarding team to ensure that staff are well supported in their safeguarding role, providing the health path of that role and also that we have got processes, policies and procedures in there to make it a robust service … say we have a duty for candour as well, so if there's any issues or any incidences that we actually identify and learn from those, for example serious case reviews, so embedding that learning into practice and also if we have had any error, mistakes that we hold our hands up and discuss it and learn from it, and then also identifying any risk in terms of individual risk and service risk" HV11.*

The accounts of HVs suggest that they adopt different strategies to describe their work with vulnerable children, especially those families that are hard-to-reach; and whilst significant number of HVs reported they followed unseen child policy for non-engaging families, others described using additional strategies and actions to achieve child-centredness. The common phrases from HVs 5, 7 and 16 represented the sort of professional curiosity and resilience in promoting child-centred practice. The account of the 3 HVs resonates the common theme from a number of other HVs who showed resilience in their practice. For instance, HV16 used the phrase: "*asks everything, don't believe everything and check everything*", to suggest the type of

inquisitive mind HV should follow to understand the specific circumstance of the child and address the needs accordingly.

Table 5.12 HVs' Descriptions for Coping Strategies against Raised Anxiety

HV5	HV7	HV16
-Have a plan -My supervisor supports -Share information -Contact Social Services -Child protection Training -Check policies -Clear decision-making	-See CP supervisor -Follow policy -seek colleagues and manager's support -Safeguarding Team -Lessons from Serious Case Review -Read child record -Good judgement	-My CP Supervisor -Training -Sensitivity and in-depth knowledge -Ask everything, don't Believe everything and Check everything -Making notes - Understand my role -iHv resources

> *But clinical supervision on top of it is something that I firmly think should be available but it's not currently given to tackle increased stress, and I think you should be able to go to a practitioner that may not be in the same discipline as you because then you can fundamentally look at things from a different perspective instead of KPI driven or the sort of political side to it and look at yourself as a reflective practitioner and it's something that I feel should be happening"* HV19:

Table 5.12 suggests that HVs have various approaches in coping with their work demands, for instance, all HVs acknowledged the importance of discussing cases with their child protection supervisors, managers or social workers; reading case notes and showing sensitivity, with in-depth knowledge about families and their needs were useful in bringing insight into decision-making of HVs.

Box 5.12 Summary of Findings from Phase 3

The findings from Phase 3 are explained under four key themes and the discourse highlights lived experiences of HVs in their practice, the challenges and how they overcome difficulties. Firstly, from most HVs account, they define and classify children under 'universal' or

'vulnerable' caseload by undertaking risk and health need assessment which involves 'structured' or/and 'unstructured' approaches. Secondly, there was variability in work orientation of practitioners and this was influenced by characteristics of HVs in terms of their years of experience, cultural background, training and role. Some HVs' work attitudes came across strongly as 'strength-based' whilst others were 'paternalistic', with more of 'defensiveness' to avoid blame and making mistakes. Thirdly, HVs who showed these characteristics were seen to have difficulties in their relationship with parents; and practising under such influence tended to influence decisions whilst struggling with raised anxieties arising from demands to contain the needs of families, and organisation's work requirements e.g. 5-mandated contacts and also able to contain their personal needs. However, most HVs still have the passion and motivations to improve outcomes for children and keep them safe from harm. Hence, they developed strategies for RBP to cope in practice, utilising what works better as their coping mechanism. Finally, the organisational culture in HVS influenced work practices and levels of anxiety experienced by HVs in their role, with emphasis on meeting KPIs and achieving the organisational outcomes.

5.23 Summary of Findings from Mixed Methods Research - Phases 1 to 3

This section provides summary of the research findings from a mixed methods approach covering the study Phases 1 to 3. The key findings from this study is the significantly higher number of BAME families who were classified as 'vulnerable', and low uptake of services compared to children from White ethnic background. The importance of 'relationship' is acknowledged in health visiting and safeguarding policies, government statutes and guidance. From the analysis of case notes and interview of HVs, the relationship between HVs and parents, families and other professionals were significant factors that enhanced or hindered child need identification and uptake of support or interventions offered to families to achieve outcomes for children. Ironically, the HVS organisation did not acknowledge this concept as integral to addressing the health needs of children. Thus, there was no training or other supportive mechanism that could increase HV's confidence in initiating, developing and sustaining relationship with parents and family. There were instances where HVs recorded in case notes and some reported in interview about the difficulties they encountered in professional relationship with parents including: rejection, accusation, avoidance or disguised engagement, but the HVs felt not well supported by the organisation to ensure the children are prevented from suffering harm. There was underlying assumption that HVs possess the skill to navigate complexities in professional-client relationship, which often require breaking: cultural, social, language and educational barriers to foster a relationship with parents, provoking anxiety in practice.

Thus, assessment of risk and health needs was pivotal in practice to enable HVs define and classify children and families as 'universal' or 'vulnerable' in a process determined by the parent-HV relationship and ethos of Child-centredness. These include: 'expert parents', strength-based relationship; partnership working / networking and professional curiosity. However, factors perceived to be inhibitors of effective assessment included: avoidance and disguised compliance; broken relationship / trust and other contemporary issues on safeguarding children. The overaching concept of 'child-centredness' as reflected in parent-HV relationship were seen to be applied differently in two different groups of HVs and these impacted on responses to children's needs and outcomes for the family. The theme developed shows that HVs consciously or unconsciously value HV-client relationship in defining and addressing the needs of children under 'universal' and 'vulnerable' caseloads. The definition and classification of children as 'universal' or 'vulnerable' and the supports or interventions to address the needs of children in each category were, to a large extent, subject to subjective clinical judgement and 'risk' perceptions of individual HV, with some professional making reference to assessment guidance in local threshold documents. Children from BAME background were more likely to be classified as 'vulnerable' than those of White British ethnicity. The HVs were seen as playing key part in containing high stakes emotional situations by developing or seeking to develop meaningful engagement with families who were otherwise, hard to reach. Thus, combined findings from this study highlighted two emerging grops of HVs described as – Group 1 and Group 2 with different characteristics and approaches to work as reflected in their description of parent-HV relationship.

5.24 Local Community and Organisational Culture

The HVS served a highly mixed local community, with increasing middle class population who were likely to access the HVS. However, white British families were more likely to access services; whilst children from black minority ethnicity were more likely to be classified as 'vulnerable', and the BAME child was likely to suffer actual or potential harm resulting from abuse or neglect. Following advice of HVs was constructed to be synonymous with parental compliance with services to promote health, wellbeing and safety of their children. The account of HVs suggested that organisational culture impacted on the levels of anxiety they experienced in their role. There was evidence of 'high demand, low control' situations in terms of HVs' experiences of working with families, especially in clusters recognised as having high level of deprivations and low level of engagements with services. Health visitors raised concerns around work demands, including: KPIs, increasing caseload, work patterns, work pace and the working environment for individual HV and teams. The environments where HVs worked were shared with other services, and some clusters were losing offices to make savings for the NHS Trust, with introduction of 'mobile working' which was unfamiliar to some HVs. Consultations took place, but most HVs felt

they did not have ‘control’ or say regarding the way they did their work or related with families, which suggested influence on how they define and classify children as ‘universal’ or ‘vulnerable’. The increased level of anxiety was evident in manager’s report of high incidence of short - and long-term sicknesses and occupational health reports of stress among HVs.

Chapter 6: Discussion of Findings: HVs' Decision-Making in Response to Risk and Child Need Assessment

'Trust and risk, opportunity and danger - these polar paradoxical features of modernity permeates all aspects of day-to-day life' (Giddens, 1990, p148).

6.1 Findings from this Research

In chapters 6, 7 and 8, I discuss the important findings in this research in relation to the research objective and in addressing the research questions. This and next chapters provide discussions of findings as drawn from discursive narratives of this research, relating them to various theoretical frameworks developed in the thesis about the role of HVs in recognising and addressing the needs of children and families. I have chosen psychosocial, risk and psychoanalytic theories to provide bridging arguments that connect findings in the 3-Phase research design with reasonable theoretical interpretations of those findings and policies. These discussions raise useful epistemological basis that generates knowledge and reflections on policies and health visiting practice, spurs interest to dissect and challenge current epistemological positions on these subjects and their potential impacts on children and families. In this research finding:

- There was significantly high number of contacts and interventions made by HVs for children defined and classified as 'Vulnerable' in comparison with those under 'Universal' caseloads, with BAME children over-represented in 'vulnerable' caseload when compared with children from White British Ethnicity group. These lend credence to the argument of Gillies (2007, p20) that the '*rich and 'poor' continue to live in very different worlds in the UK*', and this calls for changes in policy and practice the way inequalities are understood and experienced, while reasserting the significance in acknowledging its adverse impacts on outcomes for children.
- Risk Assessment carried out by HVs primarily formed the basis of their decision-making to determine the threshold of needs and the level of supports required by a child and family.

- Key factors associated with significant variability in number of contacts, which sometimes undermined the 'rights of parents' were multi-factorial, including: **Individual HV's** (risk perception, knowledge, experience, fear of making mistakes, training and cultural background); **Organisational** (high demand and low control tasks, high number of caseloads per HV, complexities of families, focus on KPIs, and differences in threshold definitions between HVs and social workers); **Society** (blame following incidents of child death, abuse or injury, risk averseness in society and media activities).

- The frontline experiences have led some HVs to depend on different coping mechanisms such as ‘supervision’ and ‘reflective space’ to enhance their ‘relationship-based practice. However, others developed emotional projections seen in ‘raised anxieties’ characterised in practice which tended to be ‘paternalistic’ and ‘defensive’, with potential of stifling the primary task of HVS which is: ‘reducing inequalities, promoting safety and improving outcomes for children’.

- There was ambivalence in organisational acknowledgement of anxiety and lack of consistent supports to HVs regarding their mental health needs as shown in high number of long-term sickness due to work-related stress, high staff turn-over, increase in number of temporary HVs and inconsistencies in provision of reflective space for HVs.

I explored the relationships between different theories, policies and practice in this thesis to highlight how HVs perceived and conceptualised relationship with their clients. I extracted various significant components and influences to integrate aspects of research findings that combined and interacted together. These provided the process for critical thinking that allowed me to understand the research findings in relation to HVs’ interactions with families to make more sense of the general and broader explanatory schema. Following the argument of Merton (1967; 1949), the aim of the discussion section was to unify diverse theories into a coherent method that provides a critical level of abstraction in the concluding part of this thesis. Thus the discussion of research findings are explored through underpinning theoretical principles, and discussed under three broad categories: **a)** Child Need Assessment and Risk theory in HVS, **b)** Proportionate Universalism in decision-making process of HVs; whilst in chapter 9 , I explore **c)** Emotional impacts of health visiting work: from the lens of psychoanalysis**.**

6.2 Assessing the Needs of Children and Parents

This section considers the needs assessment of children and families, and how these are encapsulated within the risk assessment process and understanding of risk theory. Assessing children and parental needs remained pivotal in HVS as a prime step towards recognising children at risk of suffering actual or potential significant harm. There was persistent reference to ‘risk-assessment’ as core activity in HVS in modem day society and the associated recourse to various, primarily defensive or reactive modes of practice and policy. From the discursive methodologies to that examined various accounts of HVs in case notes and interviews, there were highlights of inconsistencies in the process of risk assessment and the ‘case finding’ approaches adopted by HVs to identify, classify and respond to the needs of children and families.

The HVs were seen to be placed in positions to apply their knowledge and skill in identifying the needs of children and their parents. However, these needs have been evolving as practice continue to shift from the traditional 'risk prevention' strategies focusing on teaching poor parents about child care, accident prevention, home hygiene, immunisation against infectious diseases; to near '*forensic'* approach in modern times where health visiting practice seemed to be drifting towards 'surveillance' and 'suspicion'. The HVs now require new skills and strategies to recognise children at-risk of radicalisation, child sexual exploitation, child trafficking, female genital mutilation among other forms of child abuse and neglect (HM Government, 2018). The needs and dynamics of families as identified by HVs have changed in complexities and constitution over to reflect the reality of modernity, thus the assessment of HVs reflected the context of risk seen in modern families and this was characterised with diverse social, economic and emotional complexities that impacted on children and their well-being.

The HVS is a universal and essentially home visiting service and is therefore very well placed to identify children and families where there are additional needs (Cowley, et al, 2013); and HVs reported that many care-givers valued their work, as their role remained pivotal in promotion of child health and development and positive parenting practices. Findings from case notes and views expressed by HVs suggest that some parents perceived the role of HVs as pursuing government surveillance agenda that brings the state into family life, for instance, through nudging for prescribed parenting norms, setting out expectations that inform how parenting should be conducted in families, with element of control or sanction (Barlow and Calam, 2011).. However, there were interdisciplinary differences in definition of 'needs' as shown between what Children Services constructed and interpreted as a need for 'vulnerable' child within their threshold of needs for children and young persons within the case notes, and the perceptions of HVs as frontline professionals who routinely come in contact with children and families in their practice as shown below:

> "…*my duty is to ensure that they are well, their well-being is well protected. So as a HV, am always looking for, and searching for health need, so in doing that I ask various questions,… or that chid may be at risk of harm and in need of protection… in my assessment I would do that and make sure I guide against future problems occurring for that child*" (HV17).

Parton (2011; 2008; 2005) shared the arguments of Beck and Giddens regarding the impact of modernity. The changes in traditional needs of families in terms of 'risk and safety' reflect the arguments in Giddens' theory on contemporary society which he suggests is under the influence of some significant forces leading to shifts in social agenda as seen in the loss of tradition and dis-embedding of time and space (Giddens, 1992; 1991). Within the discourses of contemporary

HVS, the arguments of Beck and Giddens remain central in supporting the position taken in this thesis that the interactions of social norms within families in modern society have relative impact on the overall wellbeing of children in particular and the wider society. Importantly, such interactions influence the effectiveness of policy development and implementation for children and families, targeting specific behaviours and outcomes which raise the importance of the focus of this research on HVs and their work in preventing child abuse and neglect (Barlow, et al, 2010; 2008; 2006).

6.3 Differentiating Children's Needs in 'Universal' and 'Vulnerable' Caseloads

Whilst there were similarities in the manifestation of the needs of the 'vulnerable children' and those under 'universal' caseloads, there was no overall consensus on how the additional needs of the 'vulnerable children' were defined, conceptualised or operationalised. Some HVs interviewed seemed to support the views that the needs of 'vulnerable' child depended on existing or potential personal, environmental, economic or social factors identified through assessment carried out by the HVs under 'proportionate universalism'. However, other HVs construed the needs of 'vulnerable' children in term of the government's description of families who cause burden to the state – the 'Troubled Families':

> "I *worked in inner London area … very dense with population of people, with troubled families with families that really need help from the health visitors because of vulnerabilities"* HV 05.

> *"Yeah, issue in the troubled family, being able to bring them from the level of their vulnerability, … to a level where they are now willing to go out there and contribute to themselves first, to their family and then to the community*" HV 07.

> *"I have a very young vulnerable mother, well known to services and from troubled background … not engaging with the services and not even working well with the HVs because I think she felt judged*" HV 13.

There were inconsistencies among HVs in relation to how they defined and classified children under 'universal' and 'vulnerable' caseloads. On one hand, the views of some HVs regarding the needs of children were mostly seen from skewed perspective focusing on individual rather than wider contexts where child or young persons lived. On the other hand, the understanding and service strategies for implementing child protection policies and lessons from Serious Case Reviews and their risk perceptions appeared to generate inconsistencies in HV's definition of needs for 'vulnerable' children and those under 'universal' caseloads. This phenomenon lends credence to the arguments of Beck and Giddens that risk may be construed and thought about

differently, depending on context and treatments; can generate conflicting underlying uncertainties and anxiety. Preston-Shoot and Agass (1990) describe these conflicting agenda as a `double-bind' for professionals:

> "… *it is impossible to escape the conclusion that … workers, particularly in child abuse, are confronted with a double-bind, required both to protect children and yet not infringe parental rights. The dilemmas inherent in this are denied, as is the difficulty in finding any "right" answers in an environment which frequently contains hostility, complexity and unpredictability*" (p113).

The process of differentiating needs of children was undertaken by HVs in a generally structured and routinely conducted during the 5-mandated contacts or where additional contacts were indicated according to Healthy Child Programme (DOH, 2009). Whilst some HV followed guided templates with simple, narrative-based questionnaire which contain mixed questions about the nature of concern for a child and family, other HVs provided summarised report of their decision-making, as shown in an 8-month developmental assessment completed by a HV:

> ***"Growth/Physical health****: Child X appeared cheerful and alert, dressed in clean clothes appropriate for her age and weather. X skin was bright and well perfused. … Immunisations are up to date … no recent A&E attendances. Weight was at 75th centile (within usual range for X) Social and Emotional Skills. … Language and development: … Parenting capacity: The family live together in a rented 2-bed flat which was clean, good bonding and attachment observe, both parents were proactive and receptive to advice to meet the needs of X… No parenting concerns identified from this assessment.* ***Plan****: continue to provide Universal services"* Case Note 61

Subsequent documentation showed that child X was subject to CPP due to vulnerability from his 12 year old sibling who had gang affiliation and involvement in violence, exposing X to high risk of significant harm from counter-gang attack. The approach in identifying children's needs by some HV lacked focus on contextual dimensions in safeguarding of children; denying a broad-based view of child's needs to allow possible exposure to intra-familial and extra-familial risks that might increase the level of vulnerability or resilience of young people to abuse or becoming 'abusers' (Bamford, et al, 2016). As young people navigate extra-familial contexts they tend to encounter healthy norms which promote pro-social relationships or they may be exposed to harmful norms that create potentials for abusive and exploitative relationships which, sometimes, lead to victim-perpetrator overlap (Latchford, et al, 2016; Bamford et al, 2016). Perhaps, there is a sense that not all child abuse will ever be prevented- and the overall strong 'risk management' strategy have resulted in England having the lower rates of child abuse and neglect than other Western countries (Marmot, et al, 2012a; Hall and Slembrouck, 2001), although more needs to be done. However, many aspects of assessment by HVs centred on the four global terms of child maltreatment specifically the emphasis would be on obtaining and organising information in all

four tiers of concern, described by what HVs have heard, seen and observed instead of using more global terms such as sexual, physical, emotional abuse and neglect. The outcome of assessment of child circumstances provided guides to offer of interventions or supports according to tiers of concerns and, that could indicate preventative support to test the family capacity to change during a time limited trial as an integral part of HVS:

> "*you sort of need holistic picture of the child and family … yeah the interventions itself and the kind of strategy you apply to ensure a successful outcome. … I used the Solihull Outcomes, and I decided they warranted some listening visits which I offered initially, but no changes hence a referral to the Multi-Agency Team meeting (MAT), they provided a Family Support Worker for her"* HV16.

Most HVs interviewed agreed that assessment must be holistic to determine the level of vulnerability for children and young persons for early interventions. As seen below, the need differentiation process required HVs to apply the 'rule of optimism' and observational skills effectively to recognise and differentiate needs to prevent significant harm to a child, thus portraying the dual role of providing support and detection of faulty parenting as resonated in the narratives:

> "*I remember I attended a routine home visit to complete new birth assessment. The parent reported everything was fine. I completed the visit and almost left the home when 6-year old girl came from upstairs room. I asked parent if that was their daughter, they said no. Asked the name of the child and date of birth, they said the parents brought her for holiday in UK. I felt I should have been more curious, referred to Children Services as it transpired in a different scenario that the girl I had seen had been trafficked to the UK*" HV20:

This lack of 'professional curiosity' led to Beaumont's (2008, p69) question: "… *how accurate can risk assessments become*?" The question is against the background of intolerance of error or imprecision influenced by the techno/scientific models of 'risk-finding' in contemporary 'risk society' as brought into health and social care. The HV here is blaming herself for failing to recognise risk earlier. This resonates with Munro (2005) argument for a non-blaming approach to child protection enquiries, emphasising the need for a learning culture similar to the practice, for instance, in the aircraft industry. The argument raised in this thesis highlights the limitations of such expectations in children and family services as interactions with human beings can be predominantly unpredictable and prone to error. However, this argument does not negate the failure of health and welfare services to protect 'vulnerable' children from significant harm and potential for such failure provoking public outcry against professionals. It is near impossibility to predict future harm to children in their family who the child trust and depend on to protect and nurture. In any circumstances, it was seen as paramount for professionals to understand holistic

circumstances of children they come in contacts. In efforts to achieve this, HVs were seen to undertake need assessment, although the approaches differed as shown in case records and from narratives of interview. Whilst some HVs adopted systematic approaches, including both qualitative and quantitative for their assessment and provided clear analysis to inform their judgement and decision-making (appendices 7 and 8), others did not have any structured approach but relied on intuitive clinical judgement:

> "*So as a health visitor, am always looking for, and searching for health, so in doing that I ask various questions, to ensure that I get absolute questions that am looking for to get to the bottom of … that assessment allows me to determine whether that child is well protected or that chid may be at risk of abuse or sort of harm, and … make sure I guide against future problems occurring for that child*" HV17.

6.4 Relevance of Continuous Assessment of Child Needs

Case records showed that current circumstances of children and families were not routinely reflected in their case records, for instance, the '*alerts*' (warning about specific need of a child or parents) and '*level of need*' of children did not convey current information about some children and their families. Assessment and documentation of children's circumstances should routinely be a continuous process (Devine, 2015a; Department of Education, 2009), as situations of the family could change at any contact from universal to the child becoming 'vulnerable' and requiring high level of inputs, depicting the fluidity and relative state of children's needs and 'vulnerability' as a concept:

> *"Anything can happen so that's why we follow an assessment process so we look at everything regardless, at new birth or follow-up visit. Even if we have seen this family before, you have to go with an open mind, you need to expect anything, … things can change, … the situation with children can change, parents may be overwhelmed, …so you are building up on the assessment that you have done before, … for example I discovered a man on sex register banned not to near children, but he was living with mother who wasn't aware; it was picked up in assessment*" HV16.

Whilst outcomes of HVs' approach in need assessment to establish level of 'vulnerability' of children were based mostly on physical examination such as weight, presentation or signs of injury, developmental milestones; the outcome of parents assessments were occasionally based on quantitative measures such as scores from Safelives assessment (appendix 7), EPDS or GAD-7, reflecting the importance of qualitative and quantitative elements in clinical decision-making of HVs:

"From the assessment, mother reports she feels low in mood. I had conversation with mother and father in regards to importance of gaining understanding of the impact of mental health on their parenting ability, father has history of PTSD and both are not engaging with professionals, the EPDS and GAD-7 scores were 15/30 and 10/21 respectively. Called GP and booked appointment for both parents and they agreed to attend. Plan: Continue to review vulnerable Child H to monitor growth and development. Reassess and monitor parents' mental health and anxiety" HV48.

In other instances issues such as domestic violence, drug abuse, poor emotional states, … low self-esteem, depression, and abject poverty were trajectories that HVs identified as leading to 'vulnerabilities' of children and families. A HV also discussed how the idea of 'vulnerability' was complex and intertwined, although she did not elaborate this perceived difficulty. From her account and narratives of case notes, it shows the term 'vulnerable' could be applied not only to describe a child at risk of harm, but broadly to describe 'a state' highlighting diverse difficulties a family may be experiencing and the need for interventions from services:

"It *is complex, for instance … this family that the housing conditions could hinder the child's development as he does not have space to play. … Dad talked about his housing situation and how he feels no one listens and care. … the child and father are co-sleeping on cushion on the floor…, there was infestation of bed bugs, so many things has caused the child to be vulnerable*" Case note 27.

All HVs interviewed referred to 'assessment' in relation to child's 'need' and 'risk' of abuse and neglect, as being pivotal to either describe the circumstances of the child in the context of 'universal' or 'vulnerable' caseloads, and to recognise signs of actual or potential harm a child may suffer - taking account of how a child felt, thought and acted in response to various situations within the family. These views resonate with the argument of Doherty, et al (2004), Gambrill (2005) and Gambrill and Shlonsky, 2011) about the importance of continuous assessment of children. Inconsistencies in assessment featured strongly as one of the common flaws in clinical decision making and the discursive position of Gambrill (2005), it appears skill in assessment stands as an essential component that stimulates curiosity among practitioners to enhance practice. There was consensus among HVs that assessment must be 'holistic' or 'contextual' rather than focusing on individual factor; and their account suggested that assessment required applying different human senses including: visual or observational, hearing, smelling and touching. The HVs took visual view of the environment, people, behaviours, and interactions, physical and emotional presentations of pre-verbal and communicative child, young person and adult.

6.5 Risk Theory and Need Assessment in HVS

The focus of the work of HVs is about children and families, and some of these families were seen to have very complex needs which put the children at risk of suffering significant harm. Hence, the HVs applied various skills and tools as explored further in section 7.3 to identify, differentiate risks and classify the needs of children and families. These processes are encapsulated in what Foucault (1998; 1995; 1991) describes as 'governmentality' in decision-making process of practitioners.

6.5a Relating Child's Needs to the Concept of Risk

Applying the idea of 'governmentality' to the concept of risk provides a basis to understand the nature and development of risk-based techniques in government services; and, in contrasting position to Beck's 'risk society' theory, governmentality stresses the divergence in risks discourses as a governmental technique, and emphasises the fundamental implications for the governed who may be impacted by these techniques (Foucault, 1998). It is also in contrast to cultural perspective of risks which is focused on the sociological ways that describe association between risk and specific aggregation of social meanings and group processes; governmentality concentrates overwhelmingly on governmental plans and programs rather than the epiphenomenon or risks (Foucault, 1998; 1995). From these perspectives, it is argued that risks can be construed as sometimes based on a neo-liberal goal, using an approach and governmental strategies that enhance its regulatory powers to monitor population and individuals (Kochenderfer, 2015). The social and health workers are seen as agents in implementing government plans, and working together remains crucial to achieve this, and the outcomes for children depend significantly on HVs working together with other professionals including social workers. However, poor communication between practitioners and services have continued to impact on the process for identification of children's needs; and the views of HVs 06 and 12 reflected current gaps in communication:

> "… *yeah, and you are trying to contact the social worker, you are finding it really difficult so there's like a communication breakdown with the rest of the network"* HV 06.

> *"I think they are brilliant, Social Services, and social workers brilliant, but there's parts that we do feel that communication could be much better. When they close cases, very rarely they will send you an email to say 'This case was closed.' Sometimes to get feedback it's quite difficult – you know you have to call and call again*" HV12.

From the interactions of HVs with other practitioners, parents and children, it can be argued that the discourses of risks in preventing child abuse and neglect are, to a great extent, governed

thorough a web of heterogeneous network of 'experts' - actors, institutions, knowledge and practices, but findings show that these experts and their decisions might not always offer best options for children and families (Kochenderfer, 2015; DePanfilis and Girvan, 2005). The report of HV 13, highlights variability and inconsistencies which resonates in views among professionals regarding the needs of families and the likelihood of contentions, even where communication exists.

> "The SW *took family to court which decided child should be taken off her parents. My view was based on a positive report about what I assessed over time rather than historical concerns held about the family; because to me she was doing very well, and I was challenged. The SW: said 'Oh, this child is supposed to be crawling by now, sitting up by now' and I told her that 'this is a child that we were really worried…but family have done very well so far. I said: I am happy with this child's progress…. The court's decision was rescinded. Child very happy with parents now*" HV 13.

The potential bias in decision-making emanates from variations in risk perceptions of HV and SW, for instance, and this suggests impacts on HVs' definition of children as 'universal' and 'vulnerable' and priorities set to respond to their needs. The contentious position shared by social theorists such as: Beck (2009; 2007), Giddens (2004; 2004a), Bauman (2997; 2000; 1998) and Lash (2007) is that contemporary Western society is in a transitional period which has seen proliferation of risks as a direct outcome of modernisation, and these have contributed to risk of child abuse and other vulnerability of children:

> "*… there is also political factors that need to be addressed, so poverty in families and, there's a lot of stuff that is going on with local authorities as well that can have an impact on families, you know, cases where you have had 6 or 7 social workers for one family within a short space of time, where is the continuity in that? ... and the same with health"* HV 15.

6.5b The Nurturing Family and Risk Society

Significant amount of HVs' work focused on families as traditional basis where children are brought up and nurtured (Dean, 1999); and it is argued that modernisation has contributed to *detraditionalisation* of families, with potential negative impacts contributing to child abuse and neglect (Beck, 2009). *A*ccording to Foucault's governmentality theory (Foucault 1991), the reality of 'risk society' is driven from behaviours of individuals in families. Beck (2009; 1997) referred to family as:

"… *the site of major upheaval and production of risks as a result of 'detraditionalisation' and responses to fundamentalism…*"

Lupton (2013) also recognises 'risks' as a movement along trajectories which begins from families and extends its discourses to institutions. The view of Luton (2013) can be described as a rather traditionalist concept which have extended risks to 'marriage' and 'family' life where children live and are nurtured. Beck (2007a; 1997) and Giddens' (1999; 1992) share the traditionalist views of family but still hold fundamentalist's argument that traditional family has been influenced by modernisation, creating a 'global family', with complex risk factors affecting children. The fundamentalists believe risks, threats and anxiety to individuals, families and the society are brought about by the processes of globalisation (Lupton, 2013). The propositions of Beck and Giddens assumed some `uniformity' across the society when defining the needs of children and the likely threat towards achievement of such needs; but Foucault's principles of governmentality provides the diverse epistemological context and strategies to understand risks of harm to children and impact on families (Castel, 1991). The work of Foucault is grounded on an historical account of the changes influencing contemporary families and societies (Wuthnow, et al, 1984). The HVS operates as agents of government, providing support to families in order to reduce inequalities, improve safety, wellbeing and development of children in our society. Their role in identifying these needs and offering interventions is constantly challenged by debates over what should be acceptable parenting norms, which resonates Foucault's question as to how government and its agents should operate in modern societies:

"… *how governance should be ruled, how strictly, by whom, to what end, by what methods, etc…?"* (Foucault,1991, p88).

Drawing on the work of Foucault allows a development of an integrated framework for understanding how HVs assess and prevent risk of child abuse, by looking at the epistemological modes which situate as dominant discourse of risk in contemporary society. Drawing a social perspective view from risk theory by Foucault (1991), stimulates an extended analysis, even when resistance to the dominant discourse of risk occurs as observed by Lupton:

"Information about diverse risks is collected and analysed by medical researchers, statisticians, sociologists, demographers, etc…" (2013, p116).

In this context, there is an extended and constantly changing process which problematises risks in society to allow calculability and exertion of the principle of governmentality. From these processes certain individuals or groups are identified as being 'vulnerable' or posing some dangers to others. The explanation of Lupton resonates strongly in government's ill-informed report about 120,000 families in England (Levitas, 2012), who were particularly targeted for

intervention due to multiple problems, including crime, anti-social behaviours, unemployment, mental health problems, domestic abuse and substance misuse:

> "… *issue in the troubled family, being able to bring them from the level of their vulnerability, trouble … to a level where they are now willing to go out there and contribute to themselves first, to their family"* HV 19.

So the risk perceptions and assessment of children's needs by HVs were seen to be influenced by government-driven agenda regarding families, with pre-conceived views that described them as:

> *" 'at-risk' or 'high-risk', requiring particular forms of knowledge and interventions. … through … surveillance from … diverse range of agencies*…" (Lupton, 2013, p116).

There was also individualistic approach as the need assessment process adopted by HVs was more focused on individual child and family rather than wider contexts of risks, a position which contradicts the views in contextual safeguarding of children and can adversely impact their outcomes (Firmin, et al, 2016).

As the debates on modernisation and influence on the needs of children continue, the potential harm to children becomes more subtle, as risks facing modern families are increasingly complex and difficult to manage. Thus, the HVs require knowledge about contemporary issues to define the needs of children. Instances occurred where HVs seemed to be confronted with knowledge gaps in gaining understanding about the risks and needs of children in contemporary families, given unpredictability and variability regarding parental behaviours and the dynamics of wider family members. For example, children have been exposed to individuals who might want to demonstrate their feeling of injustice, isolation or anger promoted by religious or political fundamentalism and enhanced by internet and social media. Some other risk include: radicalisation, county lines, child slavery, child sexual exploitation and paedophilia (Kamaldeep, 2013; Hoogeveen, 2005); and the identification of vulnerable adult can be contentious and depends on judgements, skills and risk-perceptions of individual HV. The risk assessment and decision-making processes require both pragmatic and social constructionist views to reflect in professional thinking (Douglas, 1985), hence a further discussion around the risk and need identification process of HVs in section 8.3c.

6.5c Mary Douglas' Continuum Risk Theory and Needs of Children

Mary Douglas positioned her concept of risk mid-way on the continuum between realism and social constructionism (*Douglas, 2005; 2001; 1997; 1992; 1986;* 1985). She asserts that cognitive science presents too narrow a view of rational action so that whatever that is seen outside this becomes irrational:

"…*so instead of a sociological, cultural, and ethical theory of human judgement, there is an unintended emphasis on perceptual pathology…"(Douglas,* 1985, p3).

The main difficulty with constructionist approach is the tendency to reduce behaviours associated with risks to an individualistic level. Douglas' emphasis is that cognitive science does not generally take cognisance of the symbolic meanings created through the social implications which human attaches to things and events. Cognitive science often constructs individuals and their needs as calculable and emotive-free actor, assuming that the responses and priorities of the actors are shared in the philosophy of utilitarianism (Lupton, 2013). This provokes expectations from HVs to utilise available evidence, their practice wisdom, emotional intelligence and cognitive abilities to recognise and differentiate situations of actual or potential child abuse or neglect which might bring significant harm to a child and young person. A number of researchers in cognitive science and other techno-scientific fields interested in risk perception and management have enthusiastically subscribed to the views of Douglas, but sometimes in a more distorted way (Lupton, 2013). Douglas theorises that, the psychological literature on risks has started to refer to 'worldviews' or belief systems exemplifying how the world operates and develops through membership of social groups as well as through individual experiences (Douglas, 2005; 2001). Thus findings of this research show the likelihood of bias, prejudices predicated on the cultural orientation, beliefs and social preferences of HVs and their ability to perceive or recognise individual and collective needs of children:

"… you also have your own feelings and motivations and judgements …be aware of your own conduct and how you are approaching it. … I struggled at first to differentiate what should be considered as abuse as I suffered worse abuse than what I saw in some families, so I tended to minimise signs of abuse. I had to seek counselling myself for me to know where to draw the line" HV15.

The account of HV15 highlights aspects of risk narratives and epistemological position around variability in judgement and perceptions of risk among HVs. These raise some concerns as such decisions have to do with people's lives in many aspects, and the consequences can be serious if HVs do not make the right judgement concerning the child. Lupton describes this phenomenon as 'real world' as she extends risk narratives to differences in perceptions among professionals within and between groups:

"the cultural relativity' of judgements about risks, including the differences between groups within the same culture in terms of what is considered a risk and how acceptable it is thought to be', … but a range of risks or dangers exist in the 'real world'" (Lupton 1999b, pp38-39).

6.6 Proportionate Universalism and Decision-Making Theory in HVS

The Healthy Child Programme (DOH, 2009) policy specifies the principle of 'proportionate universalism' which requires that practitioners' response to needs of children should be proportionate and according to identified health determinants and needs `of the child and family. There are expectations that services, including HVS, must optimise available resources according to the concept of utilitarianism (NICE, 2017; Dixon, et al, 2009). It was also argued in chapter 5 that the concept of utilitarianism is based on organisational and ethical principles where decisions and interventions are based on outcomes which bring the greatest good to the greatest number of people, and least harm to the lowest number of people (Mill, 1993). In safeguarding and child protection, determining what action brings greatest benefits or protective factors requires critical examination of all possible needs and potential interventions within the given family setting, and the potential outcomes primarily for the child, parents and family (Dixon, et al, 2009; 2005; Werner, 2000). Where children have been identified as 'vulnerable', they require enhanced interventions and targeted contacts to reduce inequalities, whilst routine mandated contact were offered to children who had no need for enhanced interventions (Marmot, et al, 2012; 2010; Webb, 2003). Thus 'proportionate universalism' takes account of the larger societal organisation and community structure, which shows creation of partnership as essential in effort to reduce inequalities in local determinants of health (Pickett and Vanderbloemen, 2015; Platt and Turney, 2014).

At the strategic and operational levels of decision-making in HVS is the consideration for health equity where attention is given to the determinants of health as the root causes of health inequalities, difficulties in families and importance for priority populations to be identified based on criteria of relative social and health disadvantages (Ashton, et al, 2016; Arora, et al, 2015). In public health, child abuse and neglect remain key determinants of poor health and outcomes for children, young people and significant factors responsible for Adverse Childhood Experiences – ACEs (Ashton, et al, 2016). In drawing the attention of policy-makers in Family and Early Year services and commissioners, there is strong emphasis on early interventions to reduce the impacts of child maltreatment and adverse experiences on outcomes outcomes for children and associated health and social care costs (Baginsky, et al, 2017; Ashton, et al, 2016).

6.7 Application of the Principle of Proportionate Universalism by HVs

This research findings shows that HVs apply the principle of Proportionate universalism in defining and classifying children as requiring interventions according to needs - 'universal' or 'vulnerable', for early interventions.

> *"So as a health visitor, am always looking for, and searching for health needs, so in doing that I may repeat contacts, ask various questions, to ensure that I get .. to the bottom of*

*the assessment that am doing and …to determine whether that child require universal services, is well protected or that child may be at risk of child abuse or sort of harm , and so during my assessment I would do that and make sure I guard against future problems occurring for that child" (*HV05).

The account of HV05 highlights the view of Munro (2008a), and suggests that the health visiting work makes heavy demands on reasoning skills for decision-making. With an issue as important as children's health and welfare, e.g. *"guide against future problems*", it is crucial to have: *"the best standard of thinking that is humanly possible. Mistakes are costly to the child and family*" (Munro, 2008a, p.153). It means 'proportionate universalism' enabled HVs to determine appropriate level of services for children and families, recognising the position that, within the spectrum of health gradient, programmes, services and policies must include a diversity of responses to meet different levels of disadvantage within the population, as in contrast to exclusively targeting the least disadvantaged groups (Marmot, 2012a; Marmot, et al, 2010).

It is within expectations in practice that vulnerable children are offered increased number of interventions and support to reduce inequalities and other risk factors of abuse and neglect (Appleton and Cowley, 2008a). However, the perplexity highlighted in these research findings (table 6.2) is the apparent disproportionality in number of such interventions and contacts seen to be offered to 'vulnerable' children compared to children in 'universal' caseload.

Table 6.2 – Summary of HVs' Contacts with Children

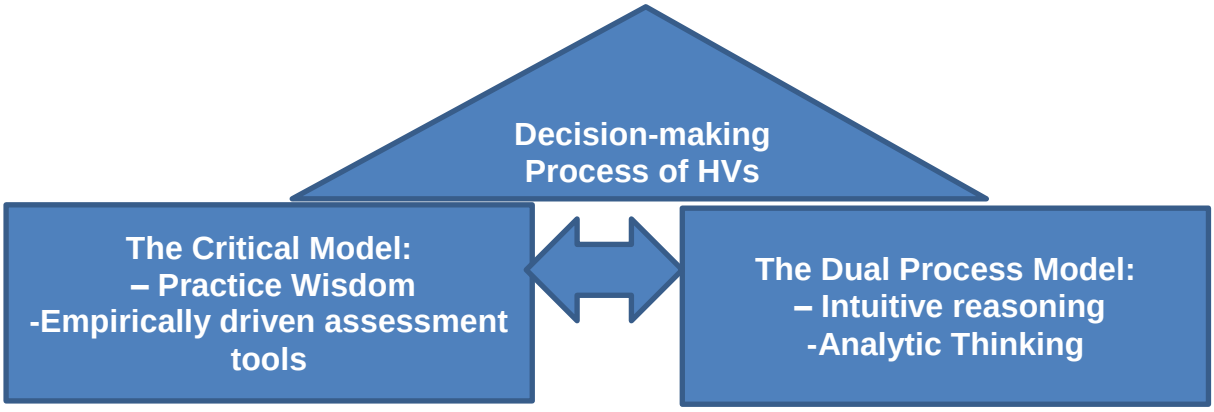
Universal Caseload	**Vulnerable children's Caseload**
▸ Total Contacts - 185 ▸ Total Time (WTE) – 45.6hrs ▸ Average Time Per Child – 54.7mins	▸ Total Contacts - 1408 ▸ Total Time (WTE) – 430.5hrs ▸ Average Time Per Child – 8.6hrs

Against the backdrop of 'proportionate universalism' these findings raise fundamental questions about decision-making of HVs as they engage with children and families in practice. The involvement of HVs with clients is seen at 4 level of services (Community, U, UP, and UPP) which formed the focus of this research. It is recommended that caseload size per HV in WTE should not exceed 250 children (Institute of Health Visiting, 2018; 2018a; 2016), but HVs reported they see significantly higher number of children than this recommendation, with cases of increased number of vulnerable children in their caseloads.

6.7a **Decision-Making in Frontline Health Visiting Practice**

Assessment, identification and offer of interventions to prevent risk of child abuse and neglect form the core of decision-making of HVs and provided the basis of their definition and classification of children under 'universal' and ;vulnerable' case load titles.

Diagram 6.2 – Decision-Making Model of HVs



This process is summarised in a triangular diagram 6.2 below and discussed in this section. Decision-making provides guides to levelling on children's needs as shown in appendix 19; and there is fluidity in each level of needs, hence interventions by HVs. This required a constant review of process that moves children and their families between different levels of needs in response to the children's prevailing health or developmental needs, economic and socio-ecological circumstances.

6.7b Integrating 'Proportionate Universalism' into Decision-Making

In this section I examine how HVs integrated the principle of proportionate universalism' into their decision-making in practice. All HVs are, primarily, nurses or midwives and literature highlights gaps in providing better understanding of the relationship between decisions nurses make and the evidential knowledge that informs such decisions (Raynor, et al, 2004). The 'proportionate universalism' principle helped HVs to prioritise needs of children and families. From diagram 6.2, I examine decision-making process of HVs based on findings from case-notes and interview of HVs, within the framework of proportionate universalism and two key theoretical concepts: a) Critical Theory Concept (Kincheloe, et al, 2018; 1994; Giroux, 1988), and b) The dual-process model advocated by Whittaker (2018; Kahnerman, 2011; Kahneman and Klein, 2009). The discourse provides insight into practitioners' judgement and continued engagement with research, including lessons from inquiry in Serious Case Reviews relating to child's death or significant incident and how these influence health visiting practice. Thompson and Dowding (2001) suggest that differences in decision-making approach in safeguarding and child protection

practice may be linked understanding of the core theoretical, conceptual and ethical frameworks that apply in practice situations to reflect in their decision-making.

6.7c Understanding the Dual-process Model

This dual-process model draws its principle from critical model but its focus is based on the premise that decision-making involving health and well-being of children should embed intuitive and analytical reasoning (Whittaker, 2018; Kirkman and Melrose, 2014; Benbenishty and Chen, 2003). Findings from case notes and interview of HVs showed practitioners made difficult decisions which sometimes involved limited knowledge, uncertainty, time pressures and strong emotions. According to Whittaker (2018), such circumstances can place significant demands on reasoning skills, especially where risk of child abuse is suspected and: "*the cost of errors and poor judgement can be unacceptably high*" (p.1967). In the literature, the decision-making of HVs were seen to involve structured and unstructured approaches, with the former taking accounts, for instance, of scores from assessment tools, and latter where HVs applied their professional judgements to make decisions (Bradley, 2017; Chapman and Sonnenberg, 2000; Benner and Tanner, 1987). The Munro Review of child protection brought the issue around practitioners' judgement into prominence, with the intention to restore the balance in decision-making by reducing descriptive guide in decisions (Munro, 2010) as evident in the account of HV below:.

> *"I use intuition a lot. It's good to have a structured framework for me because it helps to guide you... I am newly qualified and it's really useful for me to be able to know what to look for in terms of what would perhaps make a family more vulnerable, … body language is a huge part of it, whether … receptive to what you are saying, or …little reluctant to engage with you, might unconsciously sway your decision as to whether that family was more vulnerable in one way or the other"* (HV18).

Normative or prescriptive decision-making theory assumes decisions are based on known options, risks and benefits; and presents how practitioners should ideally be making decision especially with regard to health and well-being of children and young people (Whittaker, 2018; Kochenderfer, et al, 2015). The approach is seen to be appealing, and otherwise described as classical, rational or positivist in characteristics. However, application of its core assumptions in real-life decision-making faces significant body of psychological research challenges (Helm, 2016; Cooper and Whittaker, 2014; Kirkman and Melrose, 2014). Where decision-making of HVs is flawed, errors may arise with potential of adverse outcomes for children and families. Thus, most HVs applied "*The dual process model*" - intuitive and analytical approaches in order to identify the risk of child abuse and address their health needs to prevent harm. Thus, the diversity and contextual definition and classification of children as 'vulnerable' or 'universal' by HVs were associated with perceived circumstances of the child and family, with some families

presenting very complex and relatively difficult positions (Cooper, 2002; 1985). Hence, the assessment of some HVs was child-focused, with interventions driven by search for needs or risks' as highlighted by HV15 below:

> *"The child is always at the centre and the adult has to take the decision concerning the child. … to ensure that the biological parents are actually the ones that look after the children. In some cases this does not happen … those children would have to be looked after by the state, which is not the norm, but when there is risk, relationship or engagement with the family does not happen, … we have to take difficult decision because we have to safeguard the child"* (HV15).

In a flawed decision there is danger of fundamental errors in offer of interventions and relationships with families which may lead to loss of focus on the child and give rise to situations where practitioners:

> "*operate alone and unsupported'; `collude with families ... to avoid the real issues'; `act without a theoretical base and systematic, structured approach to intervention'; `maintain unrealistic optimism about families'; `become over-involved and overidentified with a family'; `avoid recognising and dealing with his or her personal feelings and values'; and `avoid contact with the child or family due to unacknowledged fears for personal safety"* (Department of Health, 1988, p.12).

Given the context of proportionate universalism, the onus is on HVs to ensure intuitive and analytical reasoning reflect in their perception and assessment of risk, hence decision-making to achieve meaningful outcomes for children and families under both 'universal' and 'vulnerable' categories (Holland, 2005). However, findings from this study has reflected difficulties arising from risk children are exposed to in contemporary society- including social media and impact on child and adolescent mental health:

> *"Mother was very depressed when … she disclosed further problems in the family. The 12-yr old child had changed school because a boy she sent her nude picture to later circulated same picture among other peers and this went viral. … The 12yr old locks herself in the room and stays off school, now she self-harms. I offer mother listening … made referral to CAMHS, Children Services and Child Psychology Services"* HV20.

The account of HV20 suggests that HVS has moved beyond post-Kempe era of pathogenic child's health and welfare services to salutogenic approach seeking to develop capacity through '*dual-process model'* to conceptually and systemically support strategies that safeguard and protect children beyond immediate safety outcomes (iHV, 2018; Kettle and Jackson, 2017; Kempe, et al, 1997). However, recent polarised debates have shown dispute between proponents and opponents of evidence-based practice (Raynor, et al, 2004; Sheldon, 2001), but in safeguarding and child protection, evidence of abuse and neglect may sometimes become

difficult to establish, especially when there is complicity with perpetrators of child abuse in the family (Reder and Duncan, 2004). The account below shows, in defining child according to their needs for 'universal' or 'vulnerable' services, some HVs relied on evidence to inform their decisions:

> "*Yeah, I was saying, you need intuition ... but you also need to provide the evidence, so there's got to be the evidence that there is neglect there, or there is a level of abuse, so that you can work in partnership with the family. So it's the collection of evidence as well*" (HV14).

In cases where parents demonstrate disguised compliance, identifying evidence of abuse or neglect to inform decision-making of HVs can become complicated (NSPCC, 2016a; 2010). However**,** decision-making for practitioners in current social environment goes beyond physical evidence or mere intuitive reasoning as sources of insights for practitioners and requires HVs to engage in a high level of analytic thinking (Whittaker, 2018, p.1989). There was evident of interaction between intuition and analytic reasoning in decision-making of some HVs. whilst decision-making process of trainee or newly qualified HVs tended to depend on prescriptive guide and their intuition, experienced HVs in specialist, managerial or other strategic roles were more analytical than intuitive. In the word of psychologist Herbert Simon, intuition is described as arising from situation when there is:

> "… *a cue: This cue has given the expert access to information stored in memory, and the information provides the answer* (to the given situation). *Intuition is nothing more and nothing less than recognition* of pattern" (Simon, 1992, p.155 with emphasis).

In health visiting, expert intuitive reasoning comes to play when HVs draw from their repertoire of knowledge and experience to make sense of cues in an interaction with child and family whether in a community, clinic or home setting that enables the HV to spot patterns and build narrative about that situation. Whittaker (2018), an advocate of '*The dual-process model'* in decision-making (p.1970) emphasises the importance of embracing a framework to aid understanding an intuitive and analytic reasoning as complementary rather than stringent opposite compartment of 'either/or' debate. From accounts of HVs, their thinking has shifted from a rather single process, to follow the argument in '*the dual-process model'* which views decision-making as interwoven in both intuitive and analytic processes (Whittaker, 2018; Kahneman and Klein, 2009). However, the intuitive thought comes to operation in a rapid and automatic mode when required, but the HV may not need much sense of voluntary choice in real life situation. For instance, when spouses engage in a telephone conversation, they often become aware of the mood of one another intuitively, in contrast, analytic thinking is controlled, requires some effort such as in complex mental operation (Whitaker, 2018). The discursive orientation of intuitive and analytic reasoning processes of HVs follows an integrative operation of the two parts as a whole in making decisions that defines children in relation to their needs as either requiring 'universal' or

'vulnerable' child interventions. When immediate judgement about situations involving child's safety and well-being is indicated, the HV applied intuitive thinking to provide intuitive answers based on rapid and associative mood. However, according to Whittaker (2018), the quality of such reasoning is monitored by the practitioner's analytic thinking, which elicited practice guidelines based on policies, lessons from serious case reviews and other deductive principles to endorse, correct or override their intuitive judgement (Kahneman, 2011; Kahneman and Klein, 2009).

6.7d Applying the Dual-Process Model in Decision-Making

An example is drawn from account in case note 42 demonstrates situation where Dual-Process model was applicable. A HV attended a home visit to review child X's (14 months old) health following notification of discharge from A&E as X was reported to have had a fall at home. The father particularly overtook the conversation, not allowing mother a chance to say anything and from their demeanours, the HV' had an intuitive reasoning that both parents were hiding something about their relationship which might impact on X. At the end of contact, the HV slipped a note and phone number into mother's hand for her to call when alone. In her analytic thought, the HV examined chronology of X's attendances in A&E and parental engagements with services and family dynamics for evidence to generate alternative explanations for what she observed in her visit, evaluating the evidence in a comparative analysis with her initial intuitive judgement. Subsequent contacts revealed that the mother had suffered significant domestic abuse from the father over the years, and few hospital attendances of X were due to violent attack by father whilst mother was carrying X. Given this circumstances, the child who had been under 'universal' services then became 'vulnerable', and such intuitive and analytic processes characterised majority of HVs' thinking in their daily practice, providing them a sense of agency, choice and identity (Kahneman, 2011). Drawing from the argument of Kahneman and Frederick (2004) *'The dual-process theory'* offers a useful explanation about how HVs develop expertise in their decision-making in practice, hence ability to become reflective and reflexive practitioner. This research shows that HVs valued professional-client relationship as a significant useful condition which facilitated their decision-making under the principle of Dual-Process Model and offer of supports to address family needs.

> "… *because you trying to build up relationship with parents in the first place, so what they disclose or don't disclose to you is up to them*" HV 01.

> "*I had to ensure I build up good rapport and relationship with parents and carers to continue working with these vulnerable families*" HV03

Threats to such relationship were regarded as potential obstacles to uptake of health visiting services and achieving the public health role to safeguard and protect children from harm.

6.8 Summary of Chapter

In assessing and identifying child needs for safety, and preventatitive interventions to reduce resk of harm to the child, clinical judgement and decision-making were seen as pivotal in addressing the needs of children and families. This process was facilitated where parent-HV relationship was effective (Chamberlyne and Sudbery, 2001; Sudbery, 2002). The assessment of a child and family within their home remains a preferred practice as it offers opportunity to see the child's interactions with significant others in the home environment, whether the contact involves offer of 'Universal' or 'Targeted' services. However, such contacts or visits lacked consistency and/or clearly-defined purpose, which meant that the contacts were not often 'child-centred' because the focus was more of a top-down, paternalistic orientation rather than client-led or strength-based interactions to deal with family needs in a solution-focused approach (iHV, 2019; Network of Psychosocial Policy and Practice, 2002). Thus was lack of connection with the pervasive characteristics of RBP which reflected the: inseparable nature of the internal and external worlds of HVs when focusing on the integrated and holistic responses to children's needs (Chamberlyne and Sudbery, 2001). This lack of connection epitomises a hinderance in the the mission to restore the balance in promoting public health agenda for early interventions; and to safeguard and protect children in a more effective professional-client relationship (Ruch, et al, 2010; Sudbery, 2002).

However, the concern to develop and sustain practitioner-client relationships has meant that some HVs lost focus on the child as they attempted to contain the needs of parents and in the process became caught in the web of parental issues around complex relationship, financial and other social difficulties within the families. There were instances in the case notes where professional – client relationship hindered assessment, while others could be construed as a shift of focus from the child, which meant potential compromise of preventative principle to safeguard and protect the child from abuse or neglect. In fostering practitioner-client relationships, it was evident that some HVs' emotional projections reflected impacts of the behaviours, internal and external worlds of clients. However, there is ambivalence towards investigating HVS as a relationship-based practice, considering its historical context in relation to contemporary society which it serves. I followed the argument of Yelloly and Henkel (1995) and Stevenson (1999; 1976), from a social work perspective, that the experience encountered in such relationships and the emotional responses of professionals can be challenging. Stevenson (1991) acknowledges that health and social care are emotionally-charged professions and mostly associated with

anxiety, and these emotions can becloud the ability to address the needs of children and family; and this is discussed further in chapters 7 and 8.

Chapter 7 - Discussion of Findings: Child Centredness and Relationship Based Practice

"*Where justice is denied, where poverty is enforced, where ignorance prevails, and where any one class is made to feel that society is an organised conspiracy to oppress, rob and degrade them, neither persons nor property will be safe*". (Frederick Douglass´ speech in 1886 on the 24th anniversary of Emancipation, Washington, D.C)

7.1 Features of Relationship in Health Visiting Practice

In this chapter I focus my discussion on another aspect of the finding of this research in a novel sense within the HVS as the centrality of this thesis, applying psychoanalytic theory in the discussion. This finding resonates with the argument of Winnicott (1956) that there is no such thing as a baby except in relation to a mother; and by extension, there is no health visiting service (HVS) except in relation to child/parent-HV relationship and interactions with family. Paradoxically, the parent-HV relationship appear to be least priority area for HVS organisations as KPIs and outcomes monitor are task-oriented which undermines the very ethos of health visiting principles and child-cetredness. This is built on the awareness drawn from psychosocial principles associated with the early work of Freud who explained that human personality and functioning in terms of conscious and unconscious desires and beliefs, feelings and emotions are grounded on life experiences, especially during early childhood (Freud, 1925). Hence, within the health visiting practice, the HVs demonstrated the need to tune into the emotional world of children and parents and be able to communicate this understanding within their relationship. However, child-centredness moves the concept of relationship beyond an individualistic perspective to incorporate an awareness of contextual and multi-factorial issues affecting families. These include: power, professional role, poverty, social exclusion and political ideology (Dean, 2010; Freud, 1997; 1933; Foucault, 1982). There have been links between the current climate of financial cuts to government services and increasingly 'austere' practice, which involves emotional distancing and 'turning a blind eye' to children and families' experiences and to the impact of diminishing spending on public services (Hingley-Jones and Ruch, 2016).

The emphasis on the centrality of client-HV relationship in practice does not suggest that this, in itself, is sufficient to ensure good practice and enhance outcomes for children.

However, relationships can provide a strong impetus, but they certainly should not be indiscriminate in terms of boundaries and manner practitioners enter into or develop them. They occur in a mandated context, and the HVs form such relationships for specific purposes - towards children achieving certain outcomes or developmental milestones, to prevent potential or actual child abuse or neglect, to achieve positive changes in parental skills or lifestyle (Almond and Cowley, 2008).

> *"Over time we have built trusting relationship, with a good rapport … she thanked me and said "thank you so much for what you did, I really felt supported, I felt there was someone there listening and sort of fighting for me" - Something about that relationship, gave her the confidence to relate. Yeah, she didn't really share so much information initially, as we built up a rapport she began to trust me"* HV 02.

However, this remains a challenge, partially because relationships are complicated, potentially unpredictable and subject to a range of psychodynamic processes – transference and counter-tranference, which require that HVs understand and use themselves centrally, within their practice (Appleton and Cowley, 2004; Preston-Shoot and Agass, 1990). The HVS, as a profession, is premised on a notion of reducing inequalities, improving outcomes for children, promoting positive change in parents' situations; but change comes about through effectiveness of HV-parent relationships (Potter and Brotherton, 2013).

7.2 Professionalism, Relationship-Based Practice and Parents Needs

In a study involving HVs who received training on relationship support, the HVs were able to hold difficult conversations with parents, with positive impact on the way they managed interactions, especially about their relationship difficulties (Audrey and Dahl, 2006). It was also shown that parents experienced a 'good' HV as a 'friend' and an 'equal' (Roche, et al, 2005); and parents looked for 'ordinary friendship' where they meet on equal terms (Reder, et al, 2005). Their conception of friendship identifies qualities of 'containment and reciprocity' (of sharing aspects of oneself, but also straight-talking). Lagerway (2010) suggests that relationships can be developed and nurtured through conflict, genuine engagement and negotiation rather than adopting a paternalistic approach, for instance, in demanding changes in lifestyle or parenting style, or compliance with health advice (Smith, et al, 2012). They identified effective relationship as being central even in work with hard-to-reach or involuntary clients. In all of this, adopting routine acts of 'compassion' and 'sensitivity' to acknowledge parental strength are more important than strict compliance

with policy, formal and bureaucratised standards and procedural requirements in forging relationship in practice (Harold and Leve, 2012)

7.3 Transference and Counter-transference in Parent-HV Relationship

The psychoanalytic concepts of 'transference' and 'counter-transference' can help shed light on our understanding of the impact of unconscious previous and early experiences and emotions at work in parent-HV relationship. As shown in literature, Freud (1925) developed the concepts describe as phenomena where practitioners/parents can unconsciously transfer past feelings and experiences into the present relationship. Menzies Lyth (1960a) describes similar phenomena as 'projections' and 'introjection', where client/professional shows such characteristics as anger, love, feeling of rejection or trust in client-professional relationship. The illustration of Ruch (2010) highlighted an example of prior adverse childhood experiences being transferred by some parents into relationships with their practitioners. It is argued that the dynamic of such interactions in HVS can often be difficult to understand and manage - can manifest as avoidance, dismissive or disguised compliance and HVs, in turn, find themselves reacting unconsciously, in a process known as 'counter-transference' (NSPCC, 2010; Doherty, et al, 2004).

Transference has been a concept of much debate and is possibly one of the most explored subjects in psychoanalysis (Wahl, 2013; Menzies Lyth, 1990; Bion, 1963). According to Freud, the founder of 'transference' is a theoretical phenomenon that is characterised by unconscious redirection or projection of feelings individuals have about their parents or significant others. It mostly generates from emotions developed in a primary relationship during childhood (Freud, 1997; 1984; 1933; 1921). It is a common occurrence to see people transfer feelings about their parents to their spouses or children in what can be described as a cross-generational entanglement, often seen among families where children are exposed to intergenerational domestic abuse (Jaffee, et al, 2013). Within such '*transference',* practitioner and client experience both positive and negative tensions, and it is argued that positive tension allows one to grow and to transform. In some personally or socially harmful contexts, negative transference in the parent-HV relationship can become pathogenic rather than salutogenic due to past experiences of HVs (Bandura, et al, 1961). In practice, '*transference***'** occurs in situations where HV projects and introjects feelings (Menzies, 1960a), particularly from the experiences encountered in practice, influence from society or individual's childhood, onto existing relationship with parents/children, thereby impacting on responses to needs of children (Bion, 2007; 1967). It is further argued that in client-HV relationship, practitioners manifest or experience 'transference' in different ways including defensive transference, paternal/maternal or

sibling transference. However, negative 't*ransference*' that is provoked by anxiety or fear disengages the practitioner from making decisions, and this can result in negative counter-transference (Brown and Ward, 2013; Benbenishty and Chen, 2003).

> "*I can tell you that I struggled as a HV because of my experience of abuse when I was a child. When relating with families I tended to minimise impacts of parental behaviours or actions which could increase risk of harm to their children … because I suffered worst abuse in childhood until I disclosed my feelings and received support through counselling at work. My focus now is the child to make sure that my assessment is about how that child presents, feel, act and think" HV16.*

Klein (1975) expanded this psychoanalytic concept and Joseph (1985) argues that whatever occurred as 'transference', emanates from the internal object relationship rather than actual relationship. Joseph suggests that in situations of anxiety, an individual projects internalised phantasies about relationships as opposed to real relationships from the past (Joseph, 1985). It shows:

> *"the idea of transference as a framework, in which something is always going on, where there is always movement and activity*" (Joseph, 1985, p.156).

Drawing from the arguments of Joseph (1985) and Klein (1975), the relevance of 'transference' in parent-HV relationship reflects projections on what they say, do and rationalise. This perspective on 'transference' during home visits or contacts in clinical settings suggests that the parent-child interactions, actions and conversations of the parent in the session can be meaningful channel in pulling the HV's mind into the parent's unconscious world (Menzies, 1990; 1960). From the argument of Joseph (1975), it is demonstrated that the most efficient way to explore the mind of parents who are vulnerable and "difficult to reach" is for HVs to be sensitive to the possibility of being drawn into the parents' internal drama as an internal object. It requires a conscious moment-to-moment assessment of emerging development about circumstances of the child, what the parents try to convey, the experience of the HV and intended response to address the needs (Barlow, et al, 2007; 2006; 2006). Menzies (1989) recognises that the interplay of projections from patients to nurses can result in 'transference' developing in different forms of expression, some of which can be, positive or negative, defensive or sensual. The argument of Freud, (1925) also suggests that 'transference' in professional practice or family is influenced by past or childhood experiences and events which occur during interactions with individuals or organisations. In health visiting practice the HVs come in contacts with families experiencing diverse needs and difficulties, including relationship, mental health, substance misuse, and domestic abuse with associated parental anxieties which HVs try to contain (Almond and Cowley, 2008). Some of the families are hard-to-reach and unwilling to take up health visiting services

voluntarily (Evangelou, et al, 2913; Doherty, et al, 2004). These developments can provoke anxiety among HVs, especially where there are concerns about the safeguarding and protection of children in the family. Thus, the interactions of HVs and families and outcome of 'transference' and 'counter-transference' develop within the dynamics of parent-HV relationship. There is debate as to whether 'transference' distorts reality, as the current unconscious situation is infused with past experiences, internalisation of the process and possible projection onto interactions with others (Joseph, 1985; 1975).

> *"… some HVs are fearful because families can be intimidating so they don't probe if there is a concern, or sometimes they are not curious about what is happening, they just want to go in, deliver whatever service that they have identified, and document, no real relationship, not very beneficial"* HV14.

Thus the dilemma about 'transference' exists when differentiating phenomena occurring in encounters with children and families assessed HVs identify as having needs under 'universal' services and in parent-HV relationship involving 'vulnerable' children and families. Drawing from the above discourses, it can be inferred that 'transference' in health visiting practice: a) can be traceable to practitioner's projection from past/childhood events, experiences, and relationships; b) exists in all relationships and can generate negative outcome during interactions with 'vulnerable' or 'hard-to-reach' families; and c) can be re-enacted unconsciously in the present in a manner that the present clinical encounter or decision-making of HV is decorated by the past. The dynamics of transference-countertransference in the research process emanate from analysis drawn from practitioner's accounts of their interactions with clients in practice, to make sense about their 'emotions' and 'affect' and impact on outcomes of HV-client relationship on children; with inference from Freud (1925). Thus, as with the nurse-patient relationship examined by Menzies (1989), I explored HV-parent relationship drawing from concepts - 'transference' and 'counter-transference' as psychoanalytic principles to understand HV's interactions with parents and how this relationship impact on their emotions.

7.4 The Primary Task in HVS

In HVS, the process of providing support to parents and families involves a capacity to think about the children and their circumstances which can provoke being emotionally attuned to the situations and experiences of the family. Positive and negative counter-transference under this context generate intense emotions: the HV's own experience of anxiety, fear, sadness, hope, despair and the feelings of rage, hate, love, gratitude and other reactions which are 'transference' from parents and families onto the HV, as explained in the social work literature (Bower, 2005).

These intense emotional experiences are often unavoidable especially when dealing with 'vulnerable' children and families. However, what remains crucial is whether and how these emotions are contained in HV's counter-transference in ways that promote clarity in thinking. The theory of 'containment' by Bion (1962a) provides the basis for the process in which a trusted practitioner, for instance, accepts and takes in the negative and positive transference from parents and families, and allows his/her counter-transference to become discernible. This process mirrors the response of a comforting parent to a very upset infant, which helps the practitioner to think more clearly. In the absence of such an approach in a situation where a child is at risk of harm, it shows the links between thought, feeling and decision-making have been broken and practitioner's response, thus, become defensive as a way of escape from unbearable feelings. These disconnected links resulting in 'defensiveness' reflects the argument advocated in Bion's flight/fight '*basic assumption'* which, in this case, the practitioner's or organisation's anxiety may centre on fear of failure or blame being a danger or an enemy to be: 'either attacked or fled from' (p21). For individual HV the defensiveness may deteriorates further into an experience where the HV becomes detached physically and emotionally and even completely dissociating from the very 'vulnerable' child and family she or he was seeking to help (Steiner, 1993; Menzies Lyth, 1960). In the work of Menzies Lyth (1960; 1960a), the 'primary task' of the hospitals and nurses is to accept and provide continuous care for ill patients who cannot be cared for in their homes; and the full and concentrated impact of this responsibility can generate high level of stress and anxieties among nurses.

The primary task of HVs is to reduce inequalities which could result in different health outcomes and enhance outcomes for children through universal and targeted service offers at home visits, clinics or other settings (Bywaters, 2014; Marmot, et al, 2010). The HVs function in groups, but each individual HV is professionally accountable for his or her actions (NMC, 2018), the influence from basic assumption mentality can reflect in '*transference*' into parent-HV relationship with impact on outcomes for children and families. It is difficult to understand the type of group dynamics which operates in health visiting practice; and impact of organisational mechanisms to defend against lack of achievement of the group objectives. The Local Authorities and National Health Service have developed strategy for monitoring outcomes and effectiveness of local system in providing integrated health visiting services to children and families. However, health visiting service providers are required to adopt national 'Must do' key performance indicators (KPIs), which covers numerous aspects of expected outcomes in Healthy Child Programme. Clearly, Parent-HV relationship does not appear as specific measurable outcomes among the national KPI's (NHS Health Child Programme, 2019). However, the integrated monitoring framework acknowledged the importance of relationship by emphasising that interaction and

decision-making of HVs to promote child-centredness should rest on position of equal partnership:

> "*The relationship between parents and professionals should … move towards working together as equal partners*" (NHS Healthy Child Programme, 2019, p2).

Feedback from parent concerning the parent-HV relationship suggests that an effective outcome from this relationship occurs when professionals and parents engage in conversations and work alongside each other in order to address the needs of children and families. There are said to be three essential ingredients for successful parent-HV engagement which are: open and transparent information, honest consultation and effective participation (NHS England, 2013; DOH, 2012; 2012a).

7.5 Individual Defence Mechanisms and HV-Client relationship

In chapter 3, I highlighted the defensive approaches in practice as described in psychoanalytic terms '*turning a blind eye'* (Steiner, 1985) and '*attacks on linking'* (Bion, 1967) where professionals unconsciously fail to see what is before their eyes because doing so could cause too much anxiety and systematic interruption. The issues Bion (1962a; 1961) raised in his psychoanalytic principles are applicable to health visiting practice, with significant findings about the standards for achieving child-centredness through priority-setting, social interactions and critical judgement. Bion (2007; 1988; 1962a; 1967) suggests that the difficulty practitioners may encounter is inability to think clearly about their clients, to 'hold them in mind', but this can be overcome through the quality of professional-client relationships as seen among the HVs:

> *"It was very chaotic and complex family, poor parenting skills, sometimes the child was in the room watching TV with a bottle in his mouth, so the single mother doesn't know what to do. She rejected the service initially, but I didn't judge her and I didn't give up. Sometimes, it was hand-holding, explaining to her those concerns, giving her everyday examples, and that helped. Eventually, we talked about parenting capacity and skills involving the family support worker through MAT. The child was allocated crèche and nursery, and outcome was good. At the beginning the boy was not talking, walking, and was using bottle at 15 months, had dental problems, but now there was turn around*" HV19.

The account of HV19 shows an '*unconditional positive regard',* a characteristic identified by Rogers (1959) as fundamental in building effective client-HV relationship to enhance child-

centredness. An interesting observation is how professionals have different ways of responding to challenging situations in their practice. Reflecting the principle highlighted by Roger (1959), it means the HV demonstrated '*unconditional positive regard'* whereby the parent was given acceptance without a prejudged history of rejecting the service or previous failure to meet set conditions, standards, parenting advice and/or expectations. With this approach, the HV was able to engage meaningfully with parent, provide interventions which led to useful outcomes for child and family.

"I find it very difficult part of our work and very time-consuming, especially with parents, putting into these families many hours because we know how incredibly intensive with all the missed appointments, follow ups and failed opportunistic visits so if I make these effort and cannot see the child I follow unseen child policy and document" (HV 02).

The dilemma in practice is the danger of using compliance to policy as a disconnection with the reality of circumstances of the child and responses of parents. It is good to follow policy but HVs work with families where there is potential for unpredictability of people's behaviours. Bion's (1961) argument about '*attacks on linking'* is that this concept determines the capacity of individual to focus or divert from what is important. The *attacks on linking'* suppresses individual's ability to manage work tensions, anxieties and relationships, in order to function effectively (Bion, 1961). However, Bion (1961, p.173) also suggests that a practitioner can be over-taken by strong positive or negative emotions – '*anxiety, fear, hate, love, hope, anger, guilt and depression*' (p.166). It is argued that, as a result of these dynamics, the practitioner can become out of touch with the circunstances of the child's experience in the family, with the danger that child become caught up in unconscious collusion, resulting in child suffering significant harm.

> "*A 2-year old child was allocated to me for assessment / support from Children Services following a police report about incident of domestic abuse from father towards mother. The closure summary of Children Services was for family to receive Multi-Agency Team (MAT) Support. Mother did not respond to calls, text/letters and I GP, then made opportunistic home visit. Mother spoke through a letter box: 'I am a good mother you people should leave me alone'. I followed unseen child policy and discharged the family"* HV11.

The accounts of HVs 02 and 11 suggest the bureaucratised focus in practice does not address the needs of children and families. For instance, by discharging unseen children from caseload due to non-engagement by their parents, as HV reported to follow unseen child policy, does not stop the difficulties the children might be experiencing in the care of their parents. Some HVs felt by following the unseen child policy, they are free from blame if a child of non-engaging parent suffers significant harm due to abuse or neglect. Other HVs showed that they were able to manage their emotions differently to develop parent-HV relationship within the challenging

working environment, drawing from different strategies within partnership working, training, supervision, practice wisdom, and team working with colleagues.

> *"As you're aware that as a professional I know that safeguarding is one of the main parts of my responsibility*" HV 05.

> *"It is vital for me as professional to be very careful when dealing with cases where mother has actually fled domestic violence, so I don't put myself or the victim in danger"* HV10

The mechanisms adopted by HVs in their work were influenced by the organisation's culture within the HVS, both personal and societal, which may contribute to raising anxiety; but most HVs reflected these as a positive-transference in parent-HV relationship. In terms of personal factors, HVs took their responsibility seriously and would work to ensure their practice meets high professional standards. The themes developed from discursive context of accounts relating to HVs' experiences showed their coping mechanisms to contain situations of raised anxieties included: partnership working; training, guidance / policies and practice wisdom. Other strategies which were useful were: discussing cases with Child protection Supervisors and / or colleagues, and reflective sessions that offered HVs spaces to discuss issues of concern that were affecting them. Findings showed that these were reflected in the accounts of HVs as some reported triggers of work-related anxieties and coping strategies they adopted to contain the situations in their working relationship with families

7.6 Child-Centredness and Non-Engaging Families

The accounts of HVs and their non-verbal behaviours showed evidence of raised anxiety and other emotions generated in practice, especially in relation to: workload, relationship with parents and some colleagues, influence from the media, families with high level of dysfunctionality and complexity, and differences in threshold for statutory support. These contributed significantly to negative transference from HV into parent-HV relationship.

> *"This parent who has stopped to engage, the child is still in the same sordid condition, the same place, it's not safe for that child to be there. Clearly, you can't even sit down yourself in that house, domestic abuse and the Children Services was happy to close the case. And there are so many other cases where there are referrals, but social workers would say 'they don't meet threshold of need; and you feel like 'Oh, I feel distraught and anxious like am going to hit my head on a wall because this family does need an input, especially when they refuse to engage with MAT or HVS*" HV 10.

The culture and personal experiences of some HVs reflected as professional dilemmas likely to bring bias in their judgements which, in turn, influenced their parent-HV relationship and decision-making to contain the needs of families. The changes in modern society bring unpredictability of behaviours of people in families and HVs having fear of blame if things go wrong and a child suffers significant harm, have resulted in work approach considered as 'box ticking' exercise. The parent-HV interactions and child centredness are influenced by 'fear of broken trust' or breakdown of relationship with families:

> *"… and for some of them it's fear, because some of the families can be intimidatory so they don't probe if there is a concern"* (HV15 CP supervisor)

> "… *even fear of the family the HVs don't want to feel that the families are mistrusting them by them asking various questions or they don't want to spoil that kind of relationship that they have built with the family so they only tick the box*" (HV16 CP Supervisor).

The accounts of some HVs and their perceptions about the HVS showed a culture of paternalism and defensiveness in practice, leading to an emotionally tense environment. There were significantly higher number of referrals to Children Services by HVs who adopted defensive practice approach; whilst HVs who adopted strength-based, child-centred perspectives were more able to support parents – looking at what parenting strategies worked best for these families. HVs that operated in a culture of paternalism came across as persons possessing knowledge and power to make assertions about how parents should conduct 'parenting' of their children within some prescribed norms. Parents who failed to follow these prescriptions were considered non-compliant or 'vulnerable' if they did not 'convince' the HVs that they had the ability to safeguard and protect their children from significant harm. This sort of practice is what Rogers (1959) described as *conditional positive regard,* and the narratives of the HVs' experiences showed high emotions, some of which were provoked by their personal life experiences and work-relationship with families where children had witnessed or suffered trauma, abuse or neglect and the consequences of such circumstances (account of HV 10 and 16 above).

I further argue that the interplay and co-existence of multi demands on HVs – personal. professional, organisational often provoke unavoidable tension or '*conflict*' among HVs, but for most practioners who remain child-centred, such tensions are 'obstructed' or 'diverted' through positive resilience in practice. However the dynamics of such resilience can be 'assisted' or 'furthered' where organisations acknowledge the importance of HV-Client relationship, promote reflection and reflexivity.

7.7 Child-centredness, Reflection and Reflexivity among HVs

Personal reflection has a long and significant role in health visiting education and practice, as trainee and qualified HVs are encouraged to engage in reflective processes, which help unpack the feelings, thoughts and actions seen in practice. In raising the profile of for child-centred practice, the concept of reflexivity takes personal reflection further through consideration of the HVs' 'transference and counter-transference', that is what the HVs themselves bring to parent-client relationship as reflected in each encounter. This includes their own assumptions, anxiety, preconceptions or bias - and also through curious examination of wider determinants, such as power, culture and social exclusion. The act of reflexivity prompts questions about what children, parents and others may feel and think about HVs' actions and decisions. Such ethical and professional curiosity occupies a comfortable position within the discourses of previous discussions about self-knowledge which is crucial elements of the professional infrastructure required in client-HV relationship (Vyvey, et al, 2014; Steele and Steele, 2008).

In this study, reflection is defined as 'thinking about' something after the event. Thus, HVs reflecting on their role helps them to analyse and evaluate their work and performance in order to use the lesson to influence their practice. Reflexivity specifically focuses attention on a phenomenon raised from reflection, as part of a social research which allows analytical investigation of what is observed from reflection (Lives and Legacies, 2010). This need for reflection and reflexivity requires opportunities, relationships and environments that are conducive and safe for HVs to explore the complexities of their practice. The required characteristics for conditions for such environment include: trust, openness and should resist the tendency to rush for clarity and resolution, and O'Donoghue and Tsui (2011) argue that such characteristics mirror those of positive relationship building. The most common forum for such reflection in health visiting is within the supervisory relationship, which often offers a dual function of support and management (Preston-Shoot, 1996b). However, this was seen as a potential tension as the organisational culture within the study setting was managerial or KPI-driven, which meant priorities given to measurable outcomes and certainty over recognition of the more realistic uncertainty and 'unpredictability' of practice (Smith and Smith, 2008). Other opportunities for reflection included came from the informal support of colleagues which HV found to be crucial, as it allowed for prompt, unrecorded explorations of practice with someone likely to have similar experiences and challenges (Ingram, 2015; 2013). This informal structure reflects a

process that, as humans, we engage in, (to a greater or lesser degree) a process to examine our thoughts and actions; and these are key features in child-centredness and RBP.

7.8 Summary of chapter

This chapter examined some of the difficulties and tensions around the delivery of child-centred outcomes and relationship in health visiting practice as a key finding in this research. I have also discussed the concept from one psychoanalytic perspective. Relationships in HVS develop through social interactions and understanding of people, their culture, practices, and the ability of HVs to contain their emotions in parent-HV relationship which is crucial in implementation of HCP (Cowley, et al, 2013). I am arguing that there is a misalignment between policy, research and practice in laying emphasis on client-professional relationship as key structure that promotes 'parent-HV interactions and the potential uptake of services especially for 'vulnerable' children and families (Bidmead and Cowley, 2005a).Two categories of practitioners were identified in practice, and each individual had different approach in recognising and addressing the needs of children both in 'universal' and 'vulnerable' caseloads. Whilst one category of practitioner tended to be defensive, the other category adopted strength-based approach. However, the organisational structure in term of threshold definitions, workload and practice culture tended to stifle achievement of child-centredness.

The foregoing argument highlights the central importance of relationship in health visiting practice; and it is, arguably, the defining characteristic of the profession and its identity. While commissioners, providers and practitioners might agree with this assertion superficially, few, perhaps, have given meticulous thought through its implications. However, client-HV relationship collides with and stands as a fundamental challenge to KPIs-driven management approach in health visiting practice, foregrounding relationships, in all their ambiguity and chaos, above the rigid and seemingly rational bases of contemporary practice. Integrating RBP into contemporary health visiting practice calls for a radical shift in how HV-parent and family relationships are conceived and conducted, opening up potentials for a greater ethical symmetry between HVs and parents (Lynch, 2014), recognising agency and balancing power between human subjects. This might essentially prompt the deconstruction of current terminology in practice (Smith and Smith, 2008), replacing words like boundary, compliance, intervention and outcome with such words as association, help, friendship, love and compassion. The HVs' quest to develop relationships with parents and enhance partnership-working can generate high levels of emotions which may reflect in 'transference', thus the HV may project harmful patterns of

thinking and behaviour into the parent-HV relationship. The primary concern in ‘transference’ is generally the thinking that an individual is not seeking to establish relationship with real persons, but with individuals onto whom they have projected feelings and emotions (Bion, 1961).

Chapter 8 – Emotions from Work Demands and Child-centredness

"*One key issue emerges - can we handle worrying situations by accurately predicting risks of adverse outcomes? … risk and uncertainty are deeply intertwined … How accurate can risk assessment become?"* (Beaumont, 1999, p.69).

8.1 Child-centredness and Perceptions of Risk in Child Abuse

The chapter is a continuation of discussion from previous 2 chapters, but I focus on examining risk perceptions and emotions these generate in practice of HVs within the principle of psychoanalysis. This is based on the premise that definition and classification of children as 'universal' or 'vulnerable' is dependent on how the HV recognises risk and the level of anxiety that influenced their decision-making in preventing children from suffering harm.

8.1a Organisational Policies, Anxieties and Obstacles to Decision- Making

A review of safeguarding and child protection policies in organisations shows the system unintentionally undermines the health and social needs of some children and families. In containing these gaps has generated anxieties among professionals in their practice as a result of unpredictability and complexity of clients' behaviours and other issues in practice (Bilson and Martin, 2016; Gilbert, et al, 2012).

> "*The policies keep changing … so letting all the health visitors know the recent and constant changes of policies or recent studies, and update of things, you know is important. Yeah, because it's constantly changing, sometimes controversial and confusing; I mean one minute they say 'Do this' and the next minute they say 'Don't' so you just follow prescription"* HV 19.

Some management approaches in enforcing systems of accountability and control in HVS sometimes resonate with a predictable organisational response to heightened anxiety similar to reactive management style highlighted by Stevenson (1999). There are fundamental questions about insensitivities in child protection policies and systems of thinking and reflection among commissioners; and these are not viable approaches to address the needs of practitioners in response to the anxiety-provoking nature of health visiting practice. A general recognition in psycho-dynamic thinking shows that lack of social and organisational structures can reduce professionals ability respond positively to work-related anxiety (Menzies-Lyth, 1990; 1989; 1988; 1960a), raising the need to think carefully about work environment that offers reflective space for practitioners to talk about their experiences in practice.

Since the 1990s into the present time, there have been criticisms over recurrent child care tragedies, as featured in recent reports of historical child abuse, despite government's reactionary policies (Brayley, et al, 2014; Department of Health, 2014a; Rush, 1992). The focus on key performance indicators (KPIs) as a means of demonstrating and measuring outcomes for children and families, has shifted emphasis from relationship-based characteristics of health visiting practice to prescriptive, procedural-based practice (Donetto, et al, 2013; Department of Health, 2012). However, prescriptive procedures do not provide a fail-safe response to needs of children and families, nor they offer a guarantee of good practice to prevent child abuse and neglect (Munro, 2011; Preston-Shoot, 1996a; 1996b Preston-Shoot and Agass, 1990). However, reflective space came up as a strong theme that could provide enhanced opportunity for decision-making of HVs.

> "*But clinical supervision and reflective space on top of it are something that I firmly think should be available but it's not currently given regularly, and I think many HVs do not access these; they should be able to go to a practitioner that may not be in the same discipline because then you can fundamentally look at things from a different perspective instead of KPI - driven practice; look at yourself as a reflective and reflexive practitioner. It's something that I feel should be happening"* (HV 20).

This narrative highlights the need to enhance experience of HVs by promoting a therapeutically oriented practice, with underlying and all pervasive relationship-based features to contain the inseparable nature of internal and external worlds of practitioners and the circumstances of their clients (Network of Psychosocial Policy and Practice, 2002). The argument about the need to raise the importance of relationship-based practice can be seen to provoke further epistemological balance in early interventions for children, thereby reducing reactive approach and over-emphasis on child protection and statutory responses to family needs (Adam, et al, 1998; Howe,1998). Findings from this research show the HVS has some understanding about the influences driven by modernisation, and the experience of emotional and psychological impacts on families. However, there is apparent gap in level of support to HVs who are on frontline with commitment to containing difficulties experienced by families as highlighted by HV10.

> *"So yeah, there was pressure because as I said it was really worrying and I took the whole thought home as well. I was just thinking, I couldn't sleep, I was just thinking oh my gosh this poor boy, OK what can I do?"* HV10.

Health visiting practice is predicated on relationship, and lack of attention given to the emotional aspects of HVs' experiences in containing behavioural projections from parents and carers and the adverse experience of children and families in their practice. The HVs offer non-statutory services to clients, and their practice is conducted through the medium of relationship.

8.1b Balancing Work Demands, Parents-HV relationship and Preventing Child Abuse

There were four sub-themes about relationship-based and professional factors which tended to provoke anxiety among HVs. Firstly, synchronising demands between the need to prevent children from suffering potential or actual abuse and neglect, and securing the medium for meaningful working relationship with families was seen as a significant source of anxiety for HVs.

> *"The HVs often have clients that they might feel worried about, especially with broken relationship can add to that anxiety. I think it's realising that different people touch the professionals at different times in their lives, it depends on what resonance or that connection you feel with that family. You work heavily with the family but you actually don't get timely feedback from referral to other professional, making it the more difficult for HVs*" HV11.

Secondly, some HVs had a fear of blame for errors; which is more unproductive rather than accepting errors and mistakes with some degree of inevitability, and as learning opportunities, given the complexity of the task and work environment of HVS. Munro (2011, p61) argues that rather than pursue a blame culture, where practitioners try to conceal difficulties, it is better for professionals to discuss problems so that they can be managed or minimised, an issue which the health visiting management was trying to address:

> *"… we have a duty of candour, so if there's any issues or any incidents that we actually identify and learn from those, so have to embed that learning into practice and also if we have had any error, mistakes that we hold our hands up and discuss it and learn from it, and then also identifying any risk in terms of individual risk and service risk*" (HV 13 manager).

Thirdly, this study also revealed that, among disadvantaged groups, the HVS was wrongly perceived as or experienced by some parents as a service that represented authority, to undertake surveillance and exercise some punitive powers for defective parenting (Burchill and Pevalin, 2012). The HVs in all groups discussed clients who had experienced statutory involvements in their families and the barriers in reception of HVS stemmed from this experience and such difficult relationship contributed in raising anxiety among HVs mostly due to poor parental engagement, disguised compliance and avoidance.

Lastly, following the transfer of HVS commissioning to Local Authorities in 2015, there has been report of diminishing standard and conditions of service for health visiting professionals (Stephenson, 2019; NHS England, 2014). This ambigious position of HVs and their professional identity has brought more anxiety for practitioners who are left to work according to prevailing, sometimes contentious priorities and expectations from management and government health agenda rather than the needs of children and families (Cowley and Adams, 2014). Within the given discourse, the anxiety generated results in professional conflict between efforts by HVs to

achieve relationship-based practice, and to make decision that help define and classify children as ‘universal’ or ‘vulnerable’. A direct consequence of such conflict is the likelihood to undermine or miss opportunity to recognise potential or actual risk of child abuse and neglect in families or other settings. These negate organisational drives and focus on priorities and implementations of policies, lessons from SCRs, even if the priorities are in misalignment with children and family needs, especially given the backdrop of diminishing resources, (NHS England, 2014; Proctor, 1988).

The four sources of anxiety among HVs reflected what Howe (1998) described as the internal and external worlds of practitioners, as they contain projections from families in their complex social circumstances, and can be understood with the application of psychoanalytic concepts (Freud , 1997; 1984; 1909). Among all the theorists, the discourses of risks as expressed by Giddens (2008; 2007; 1998) reflect the implications of varying methods for constructing risks and dangers in relation to the psychological life of an individual - drawing on psychoanalytic theory to locate the basis for ontological security in the infant-mother relationship (Giddens, 1991). He argues that these primary experiences continue to be transferred to the `*environments of trus*t' that mediate the individual's experience of danger. In his first ‘theory of anxiety’, Freud (1997) similarly differentiates between anxiety as: “…*a ‘derivative’ of repressed libidinal wishes' and fear `as a response to ‘external’ danger situations'.* Sandler, et al (2005, p159) elaborated Freud’s `second theory of anxiety', as he rejects the differentiation between an internal position for *anxiety* and an external reference for *fear* “… *arguing instead for a perception of anxiety as a `signal' to the ego of `both external and internal danger situations”* (Sandler, et al, 2005, p160). Furthermore, this indeterminate construction of anxiety shows the variability of psychological processes across different levels of organisation, signifying the potential for dislodgment across different domains and misperception about the source of any subjective experience of anxiety.

In Freud’s words, “… *psychoanalysis is a procedure for the investigation of mental processes which are almost inaccessible in any other way…”* (Sandler, et al, 2005, p1). In this section, the principle of psychoanalysis is applied in examining anxiety and fear, linking the basis for adult experiences relative to infant and mother interactions. This emphasises the significance of this relationship as processes of individuation and for the internalisation of some sense of containment and then capacity for thought. This discourse sheds light on the organisational context and relevance of these ideas to the experience of HVs in defining and classifying children and to address their needs (Scofield, et al, 2014).

The origin of epistemological context of contemporary relationship-based practice can be traced back to the emergence of psychoanalytic theory and practice in the 1920s and 30s when health

and social welfare professionals predominantly conducted casework which were informed by psychoanalytic principles, placing significance on the client-practitioner relationship (Wahl, 2013; Menzies Lyth, 1990; Freud, 1984).

8.1c Triggers of Anxiety and Freudian Psycho-Analytic Theory

Applying the principle of Freudian psychoanalytic theory (Freud, 1997), and the works of Kristeva (1982) and Menzies Lyth (1990), I explore the anxiety of HVs and their resilience within the wider context of their role (Howe, 1998). Kristeva (1982) argues that the psychodynamic principle in constructing and maintaining boundaries between selfhood, other individuals and 'objects' generate emotions, both positive and negative. In her 'object' and 'abject' theory, Kristeva suggests that in infancy the child experiences the body and self as joined with that of the mother – the child has no perceived distinct boundary between 'self' and 'other'. The subsequent process of cognitive and emotional developments allows the child to gradually recognise that its body is separate from the mother. The realisation usually comes with: *"feelings of terror, anger, insecurity, loss and grief, as well as desire to achieve oneness again with the mother's body" (*Lupton, 2013, p190). In a similar epistemological position, Freud (1909) believes that children's experience emotional conflicts, and their future adjustment depends on how well these conflicts are resolved. From a theme in his work, Freud (1909) focuses on the *unconscious mind,* which is the part of our mind we are not aware of; he shares the belief that the unconscious contains unresolved conflicts and has a powerful effect on our behaviours, experience and are so threatening that they appear in disguised forms, shapes and symbols. The subtlety of such inner conflicts in practitioner-client relationship is capable of obscuring decision-making of HVs in their practice:

> *"As a HV, my worry is I don't want the families to mistrust me because I ask them various questions and I don't want to spoil that kind of relationship that I have built with the family"* HV 8.

From the account of HV8, there is a continued conflict between self and others, and this potentially resonates in the professional judgement of the HVs; reflecting the arguments of advocates for *object-relations* theory which suggests the ontological state of selfhood is a process that is constantly in tension with professional-client's relationship as described in the mother's body/self, and later the other objects – people, things, emotions (Sibley, 1995, p7).
The philosophy of Kristeva:

> *"… embraces phenomena such as language, abjection, body, and love, allowing her writings to make a fruitful contribution to nursing philosophy in that they strengthen, expand, and deepen a caring perspective*" (Lindahl, 2011, p12).

She acknowledges that in adulthood the process of self-defence mechanism continues to be an integral experience a relationship; reminiscent of the child's feeling that accompanies the loss of the mother as she or he slips off from the Self. HVs primarily have a role in supporting families to ensure children are safe, whilst they respect the rights of the care giver. However, where difficult conversations cannot be held and practitioners cannot exercise professional curiosity in order not to trample on parental rights, the HVs are left with a feeling of loss of their professional identity, as described in a child-mother relationship (Lupton, 2013). Since the HVs lack statutory powers to enforce interventions, the unpredictability in parental behaviours can, sometimes, trigger feelings of frustration, discontentment and anxiety, with potential of negative outcomes for children and families. This process results in some 'objects' becoming the repositories of very negative emotions – some feelings of: *"hate, anger, frustration, revulsion, disgust*" (Lupton, 2013, p190); other 'objects' experience feelings of: "*love, and desire*" while some have both feelings *"simultaneously*" (ibid). The inexplicable philosophical paradox is: *"That which we most fear, which we construct as 'other', is also often that which we most desire*" (p191). Some HVs came across as having the passions to make differences in the life of children; hence they remained motivated by the notion that they can achieve this in health visiting profession.

> *"I feel like the people that I saw were at the end of their journey so they often were people with really complex needs, poor parenting, chaotic home life, grew up in poverty, so my motivation is being able to get in early and intervene … create positive impact, to change these experience. And from a slightly cynical point of view it saves money, improves society and I just like the idea that we can make an impact now and save problems later on I think".* HV18.

In Kristeva's (1982) argument, this 'Other' is the 'abject' the source of endless 'fascination' as well as 'horror', which disturbs identity, boundaries and 'other' from which we continually seek to escape, but continued to be drawn to and inextricably bound with (Lindahl, 2011), and these triggers anxiety. This anxiety is distinguished from fear; whilst fear is a response to an explicit threat and therefore has a certain object, anxiety, in contrast to fear, does not have or relate to any specific object (Stanford, 2010); so the anxiety of HVs might not relate to a specific reason.
Giddens (1991) comments:

> *"Anxiety is a generalised state of the emotions of the individual. How far anxiety will be felt in any given situation ... depends to a large extent on the person's knowledge and sense of power vis-a-vis the external world"* (pp43-44).

Relating the above quote to the experience of HVs in this research, their assessment of 'risk' is integrally intertwined with subjective experiences of anxiety and fear of unknown, failure and blame as highlighted by HV 01.

> *"Also the changes in risk profiling, before we used to be worried about child contacting infectious diseases, so we checked the home hygiene, immunisations etc. But now I worried about paedophile around the house, drug addicts, child sexual grooming in internet, it just too much these days"* (HV 01).

There are strong indications that HV's needs empowering to respond to risk in modern families as they conduct assessment and develop strategies to promote their health and wellbeing, as fundamental subsets for building a safety culture to prevent child abuse and neglect (Brown and Ward, 2013; Benbenishty and Chen, 2003; Chapman and Sonnenberg, 2000). However, this research findings show significant variability in emotional responses of HVs and their decision-making in practice. It thus raises the argument in this thesis that such decisions can be counter-productive, with potential of errors in definition and classification of children based on wrong conceptualisation of needs and interventions to address them. The dangers are situations of potential lack of appropriate early support to prevent children from suffering significant harm - either where subsequent maltreatment occurs (false negative errors) or resulting in unnecessary separation of children from their parents (false positive errors), as argued by Kaplan and Babad (2011) and Shlonsky and Wagner (2005). When such errors occur, it provokes enormous public outcry with strong condemnation of professionals for ineptitude and poor practice (Munro, 2010; 2010a). Munro (1996) also points out that practitioners are criticised for avoidable mistakes when they fail to make reasonable efforts.

8.2 Analysis of Anxiety and Risk of Child Abuse

Within a psychoanalytic perspective, anxiety is conceived as fundamental to human experience: `*Anxiety is part of the human condition. Traced to their source, the roots of anxiety are to be found in the kind and quality of attachments in early infancy*' (Pengelly and Woodhouse, 1991, p10). The baby, to whom his mother is primarily only an object which satisfies all his desires soon begins to respond to these gratifications and to her care by developing feelings of love towards her as a person; but this first love is already disturbed at its roots by the destructive impulses of love and hate struggling together in the baby's mind (Klein, 1975, pp307-8). The aggressive feelings, fear and anxiety give rise to most painful states, such as breathlessness and other destructive sensations in the child until the immediate and primary relief to this state of hunger is changed when baby derived temporary satisfaction, love and security again by feeding from the mother's breasts. The theory of Klein (1975) shows that:

"…*feeling of security becomes important component of satisfaction … This applies to baby and adult* (p307).

Most HVs showed genuine passions for their jobs, but the negative emotions generated by their work demands have potentials to influence their judgement and decision-making, and responses to the needs of children who might be 'most vulnerable'. The very important part which parents play in the child's emotional life also influences all relationship in later life, feeling attached to gratifying, friendly and protective figures which the child partly models between caregivers (Pettit, 2008).

In similarity to the earliest experiences of an infant, the feelings of some HVs interviewed and their perceptions of risks were dominated by: "*chaos and frustrations*" (Pengelly and Woodhouse, 1991, p1). The Kleinian works highlight these conflicts, though the theory has been attacked and defended with almost the same vehemence in many decades, but at long last, its value continues to remain mostly relevant in contemporary psychoanalysis, and these ideas have been used to help make sense of the dynamics of social work practice (Bower, 2005). Klein developed a theory of the paranoid-schizoid position and the related defence of projective identification; these, together with her theory of the infantile depressive position have provided a strong psychoanalytic basis in developing understanding about 'anxiety' in interactions and activities of the HVs (Klein, 1975; Jaques, 1955). The contrasting thoughts in babies are derived from the conflict between: "two opposing sets of feelings and impulses' - with `libidinal' or `life-giving impulses' competing with `aggressive' or `death-dealing impulses' (Menzies Lyth, 1960, p284). Within this context, the development of the infant and child is dependent on the quality of child-parent attachment, containment offered by the mother or primary caregiver and the reciprocity within these relationship-based encounters. Pengelly and Woodhouse (1991) observe that the: "chaotic and threatening feelings in the infant can be rendered more manageable by the mother's intuitive responses - what Bion (1962,1963) described as mothers ability to function as a "*container*" for the infant's feelings and her contemplative ability to "*reverie*". Winnicott (1956) describes this response as the "*holding function*" of the "good enough mother"' (p10). In the same vein, the HVs were seen to functions as '*containers*' for children who might be experiencing or have been exposed to chaotic life circumstances, and the HVs also have to '*contain'* their personal and work-related anxiety.

"As a HV I work primarily with children and families who are experiencing distress and trauma; and witnessing this situation sometimes has an emotional impact on me; but I must contain and manage the emotions of those families and contain my own emotional responses on a frequent basis" (HV 07).

The processes of projective and introjective identification are key characteristics in the early mother-child relationship (Garland, 1991 p518*).* According to Melanie Klein, high levels of fear

and anxiety trigger the intra-psychic process whereby unwanted feelings, perceptions, attitudes, thoughts and fantasies are projected out of the self and perceived to be situated in the object 'that is, in the other person (Klein, 1975; Klein, et al, 1955). As with the infant, the projective processes experienced by HVs bring to bear the internal fight between good and bad, love and hate, or acceptance and rejection – in such a manner that the HVS, clients and other professionals are rather identified as causing powerful fluctuations in the emotional states that characterise the internal world of the HVs as in the position of an infant. Steiner (1993, p26) remarks: "*The infant hates, and fears the hatred of, the bad object, and a persecutory situation develops as a result"*. In practice, some HVs see social workers as the '*bad object'*, making their role more difficult:

> *"There seems to be quite differences in setting priorities to safeguard children between HVs and Social Worker. The way Social Services work between cases, can be a bit frustrating sometimes which leaves the HVs with complex cases without statutory involvement"* HV 09.

This earliest stage in development is therefore characterised by splitting, projection and persecutory anxiety (ultimately, the fear of extinction) and is what Klein referred to as the `*paranoid-schizoid position*'.

8.3 Paranoid-Schizoid and Depressive States-HVs Containment Strategies

The *paranoid-schizoid position*' reflects a primary anxiety whilst depressive position include some of the defence mechanisms which the infant uses; and in the paranoid-schizoid states, anxieties are about life and death. The characteristics of such position show that: the individual splits people and things into simple categories, depending on whether they will keep him or her alive or become a threat to the individual's life; the life-threatening self-blame is covered up by blaming someone else; other people may be used or manipulated or threatened, as a way of getting rid of terrible anxieties out of self and into others; therefore other people may be seen as: perfect angels or monsters, saviours or the devil himself as inferred from account of HV09 above.

The functions of 'containment' being discharged by the mother are critical to the development of infant; as the infant relies on mother to hold or contain these opposing and uncontrollable feelings – in a complex process to allow reflection and management of the infants feelings. The HV occupies the role of a *'mother'* who is capable of *'containing'* her baby's projection into hers, and whilst holding these projections inside, they are often impelled to act meaningfully (Garland, 1991, p519). The ability of the parents to contain their infant's anxieties without being overwhelmed by them allows the infant to begin to organise and make sense of his own experience (Garland, 1997; 1996; 1991). In situations where maternal containment and the early projective processes fail, the infant is likely to be left with an obsessive sense of what Bion (2007;

1967) refers to as `*nameless dread*', with his remark underscoring the annihilatory anxieties that characterise this stage of development. A normal development follows if the relationship between infant and mother permits the infant to *project* a feeling and *re-introject* into the infant psyche (Bion. 1967, p116). These processes form the basis upon which infant's development depends – the exposure to this continual projection and re-introjection of diverged and inherently ambivalent internal states gradually enhances a clearer and more genuine perception of both oneself and other. Some HVs developed resilience in their practice through defence mechanisms by internalising the real challenges they encounter in the frontline - the fear of error and blame, rejections from care-givers, verbal abuse, racist or derogatory remarks, disguised compliance and avoidance from parents, by focusing on:

> *"the outcomes for children in terms of, you know, some of the achievements, the educational achievements, the school readiness, reducing inequalities, and improvement in life chances of the children as good measure of our long-term success to safeguard children"* HV 11.

Steiner (1993) explains these changes:

> *"The infant comes to recognise that the breast which frustrates him is the same as the one which gratifies him, and the result of such integration over time is that ambivalence - that is, both hatred and love for the same object - is felt"* (p27).

This shift is premised on: "… *feelings of loss and guilt which enable the sequence of experiences we know as mourning*…" (p27), as Halton (1994) observes:

> "*This stage of integration Klein called the depressive position, because facing the complexity of internal and external reality, inevitably stirs up painful feelings of guilt, concern and sadness. These feelings give rise to a desire to make reparation for injuries caused through previous hatred and aggression*" (p14).

The consequences of these developments include a: "…*a symbolic function and emergence of reparative capacities*…" (Steiner, 1993, p27).

The realisation that one and the same person had been both hated and loved thus provokes a depressive anxiety, whilst at the same time permitting the possibility of individuation. A similar conflict is experienced by HVs who, whilst they have passion for their role, are also confronted with their conflicting sources of anxieties in practice. This is what Klein (1975) described as the *paranoid-schizoid position* which antedates the depressive position and remains more primitive developmentally. The shift to a depressive position also enhances the emergence of thought - the HV begins to effectively internalise both the understanding of the contents of previously projected encounters with clients and also the processes by which outcomes were achieved. Thus, the '*internal container'*, is pivotal for the development of a repository known as `thinking apparatus', and described as: "*a space in which thoughts and thinking can happen to make*

sense of experience, using it to learn from, and managing it progressively through symbolisation" (Garland, 1991, p519). In a similar position as a child, the 'internal world' of the HVs is perceived as evolving through these experiences. Likewise, the HVs' ability to contain the anxieties generated in their practitioner-clients relationships and resilience might enable a shift to a more cohesive and realistic perception of both the self and others, although this shift is never fully recognised - instead, it is perpetually subject to failure in the face of external threats. Thus, the behaviours, clinical judgement and decision-making of HVs are perceived as revolving continuously in 'variable states', with the internal states fluctuating between mature and primitive or childish states - a more mature state of mind being constantly threatened by the shift to somewhat more primitive reactions and responses to situations (Garland, 1991).

Garland (1991) suggests that this state is:

> "…*imposed by a massive upheaval in the external environment which is followed by and equally massive upheaval and disruption in the internal world - something unimaginable has happened and a state of extreme helplessness ensues"* (p517).

In his clinical work, Steiner (1993) describes this process as a:

> *"A continuous movement between the two positions takes place so that neither dominates with any degree of completeness of permanence. Indeed, it is these fluctuations which we try to follow clinically as we observe periods of integration leading to depressive position functioning, or disintegration and fragmentation resulting in a paranoid-schizoid state"* (pp27-28).

It is recognised that the experience of containment provides a stabilised basis for integration and greater cohesion in parent-HV relationship; however, such experiences, to a large extent, may not always be available. Thus, the idea of 'good enough parent' by Winnicott (1973) and Bettelheim (1988) could provide adequate stimulation attuned to the needs of the child; and this might only be sufficient to facilitate some aspects of the child's experiences; and invariably not able to address the holistic needs of the child. As a natural response to this absence of containment the child (and later the adult) draws on more primitive defences to resist the anxiety that might otherwise be felt to be devastating (Freud, 1997; 1984). Thus, the responses from some HVs, for instance, to the needs of children and their approaches in interaction with parents can be perceived to reflect '*paranoid-schizoid state'* – which provides likely explanation for *'defensiveness and paternalism'* which emerged from the account of HVs about their practice.

8.4 Individual or Organisational Defensiveness

As seen in earlier chapter psychoanalytic work with both individuals and groups have been applied to team in organisational settings, with applications extending from issues of team functioning to addressing concerns about the nature of authority and leadership:

> "*Despite the fact that there is no distinct parallel between individuals and institutions, psychoanalysis has contributed one way to approach thinking about what goes on in institutions*" (Halton, 1994, p12).

Psychoanalysts like Menzies Lyth (1960; 1960a) and others have developed the notion of socially framed defence mechanisms to describe the way in which work and structures in organisations can be harnessed to defend against anxieties as examined within the HVS. Halton (1994) emphasises the significance of symbolic expressions and interpretations from the unconscious ideas among staff groups. He also argues that staff working in the helping professions – including health visitors, social workers and doctors - frequently experience problems in addressing their angry or rejecting feelings towards their clients:

> *"In the helping professions, there is a tendency to deny feelings of hatred or rejection towards clients"* (p14).

For instance, some HVs have found it irreconcilable for victims of domestic abuse, who continues in relationship with partners despite instances of high risk domestic violence and even threats to their lives perpetrated by their spouses (Hall and Slembrouck, 2001; Henderson, 2001). The poignancy of the situation is explained in infant fears for the impact of destructive forces on the individual he loves and on himself:

> "... *he grieves and mourns over their suffering and experiences, depression and despair about the inadequate ability to put right their wrongs… He fears that his libidinal impulses and those of other people cannot control the aggressive impulses sufficiently to prevent utter chaos and destruction* (Menzies Lyth, 1960a, p98).

Whilst it is acknowledged that early difficulties experienced by parents and carers may lead to poor parenting and potential child abuse, the approaches of some HVs in practice could be construed as they were being placed in positions to act as child abuse intelligence service, sniffing out the bad parents long before they have committed any crime. This situation raised anxiety in the context of experience in HVs-clients relationship and how the HVs worked with other colleagues. Menzies Lyth (1960a, p99) observes that such experience of intense anxiety in nursing profession generates intermixture of objective knowledge, logical deduction, and feelings about clients' circumstances; thus their responses to services and the dynamics of wider family members trigger '*phantasy-situations'* among the practitioners and groups. Menzies Lyth (1960) remarks:

> *"The success and viability of a social structure are intimately connected with the techniques it uses to contain anxiety ...An understanding of this aspect of the functioning of a social institution is an important diagnostic and therapeutic tool in facilitating social change" (*p309).

Similar *phantasy-situations* develop among HVs as they involved with children who are exposed to diverse difficulties including: poverty, parental mental health, substance misuse, gang, criminality, intergenerational domestic abuse, child sexual exploitation, and other forms of abuse and neglect. Menzies Lyth observes that: "*Unconsciously, the nurse associates the patients' and relatives' distress with those experiences by the people in her phantasy-world, which increases her own anxiety and difficulty in handling it"* (1960a, p99).

8.5 Threats to Achievement of Primary Task in HVS

The analysis of case notes suggested that parents had mixed feelings towards HVs, and whilst some parents accepted their supportive role, others could be apprehensive because, as Robinson (2004, p5) argues they felt '*snooped*' and, unfortunately, many HVs spoke '*almost exclusively about parents in a derogatory wa*y'. Menzies Lyth (1960a) identified feelings of both contentment and resentment among patients and relatives in hospitals, with positive and, sometimes, puzzling and distressing emotions often projected particularly and most directly towards nurses in two aspects. Firstly, patients and relatives may express appreciation and respect for nurses in their difficult task. Secondly, the same patients often show anger about their dependence: *"accept grudgingly the discipline imposed by treatment and hospital routine; envy nurses' health and skills; are demanding, possessive, and jealous"* (ibid). Therefore, the patients and relatives, like nurses and HVs, experience strong libidinal and sensual feelings stimulated by the nursing care and HVS, and such erotic feeling can be expressed in ways that triggers *paranoid-schizoid state* (Steiner, 1993). The major responsibility for performing the primary task of caring for patients in the hospital lies with the nursing service, which must provide the service day and night all year round. Furthermore, the nursing service bears the full, immediate and concentrated impact of stresses arising from patient-care (Menzies Lyth, 1960; 1960a). The situations that trigger stress in nursing may not always be predictable, but the obvious reasons: nurses have constant contacts with patients who might have serious physical or psychological illness and the patient is not certain about recovery which is not always complete.

> *"Nursing patients who have incurable disease is one of the nurses' most distressing tasks - nurses are confronted with the threats and reality of suffering and death as few lay people are"* (Menzies Lyth, 1960a, p 98).

The role of a nurse or midwife fundamentally involves invasive and intimate tasks, which ordinarily seem distasteful, disgusting, and frightening. The intimate physical contact with

patients stimulates strong libidinal and erotic wishes and impulses that may be difficult to resist (Menzies Lyth, 1960). This work situation arouses very strong and mixed feelings in the nurse or midwife:

> "*pity, compassion, and love, guilt and anxiety; hatred and resentment of the patients who arouse these strong feelings; envy of the care given the patient* (1960a, p98).

Drawing from (Menzies Lyth, 1960a) analysis, the relationship-based situation confronting the HVs bears a striking resemblance to the phantasy situations that exist in the individual in the deepest and most primitive levels of the mind. The intensity and complexity of difficulties experienced by children and families, the social and economic deprivation, the practitioners fear of making mistakes, unwillingness of parents to access supports or initiate changes to 'improve' their parenting contributed to the HVs' anxieties. These are linked primarily to the capacity of the objective features of their primary task - work situation that stimulate afresh these early situations and their accompanying emotions (Menzies Lyth, 1960a).

In social work, Pengelly and Woodhouse (1991) observe that practitioners are concerned and traumatised by the: "*fear of unacceptable and unmanageable ambivalence towards their clients"* (p180). They remark:

> *"On the one hand, the social workers' concern and commitment was unmistakeable; on the other hand, evidence accumulated (though it could hardly ever be acknowledged) that they also experienced hatred and contempt, especially towards parents who put their own children at risk and who resisted efforts to help them"* (ibid).

The HVs, like nurses and social workers, are predisposed to similar feelings of hatred and contempt, for instance, against a spouse who chooses to remain in violent relationship, exposing their children and themselves to risk of significant harm. I advance another argument in this thesis that rather than apply existing pathogenic approach towards parents who are perceived to have put their children at risk of harm, continue to avoid or resist professional interventions or show disguised compliance; the HVs could adopt saluthogenic approach focusing on positive relationship. Saluthogenic approach, in this context, is a focus on factors that support children's health and well-being, reduce parental stress and enhance coping, rather than focusing on fault-finding on parenting (Nettleton, 2016; Jaffee, et al, 2013). Whilst HVs need to be wary of baseless allegations during their contact with families, they require intense skills in recognising signs of child abuse and neglect, by being professionally curious, corroborating claims about child's health and well-being to differentiate fact from emotions during interactions with children and families as they offer supports under 'universal' and 'enhanced' services (Creighton, 2002).

As Halton (1994) observes the processes of:

"splitting and projection exploit the natural boundary between insiders and outsiders (p15).

Pengelly and Woodhouse (1991) provide further description about the potentially universal nature of such projective processes among professionals:

> *"We found that the social workers tended to make defensive use not only of their procedures and task-definitions, but of their entire institution ... "It" (or "they") became impersonal and monolithic; it could be safely and freely blamed"* (pp185-186).

These types of paranoid-schizoid functioning are in contrast to those dominant in the depressive position. In his argument, Halton (1994), emphasises that the primary task of any practitioner is: "*to identify the projective processes at work and trace the projections to their source*" (p17). However, in making decisions that define and classify children under 'universal' and 'vulnerable' caseloads, some HVs, rather than 'contain' projections from their clients, projected their negative emotions in practice – shifting between paranoid-schizoid state to depressive position. Similar to the position of the mother during early development of an infant, the practitioner becomes a 'container' for unmanageable and disturbing projections, in such a manner that: "… *what was previously unbearable - and therefore projected - (can) be made bearable*" (Halton, 1994, p17).

"When ... some of the projections can be "re-owned", splitting decreases and there is a reduction in the polarisation and antagonism among staff members themselves" (Halton, 1994, p17).

In the long run, for:

> *"a group functioning in the depressive position, every point of view will be valued and a range of emotional responses will be available to it through its members", with Halton theorising that such 'lessening of conflict may then open the way to better working practices and greater job satisfaction*" (p18).

Halton, however, highlights the inherently precarious and unpredictable nature of these individual and group processes: "*The depressive position is never attained once and for all. Whenever survival or self-esteem are threatened, there is a tendency to return to a more Paranoid-schizoid way of functioning'* (ibid).

8.6 The Group Influences and Achieving Organisational Objectives

The HVs are independent practitioners but they also work in teams. Stokes (1994) acknowledges that our experiences of identifying and working in groups or teams are often powerful and overwhelming:

> "… *we experience the tension between the wish to join together and the wish to be separate; between the need for togetherness and belonging and the need for an independent identity*" (p19).

Stokes illustrates the impact of the diverse principles about '*Basic Assumptions'* , processes and modalities upon which the functioning of teams are anchored. Firstly, a group dominated by `*basic assumption dependency*' is susceptible to resistance, defending the interest of its members:

> "*Instead of addressing the difficult items on the agenda. Any attempts to change the organisation are resisted, since this induces a fear of being uncared for"* (Stokes, 1994, p21).

Secondly, whilst there is ongoing demonstration of resistance, employee dynamics and functioning are within a `basic assumption fight-flight' position; showing indifference and passive responses to organisational priorities:

> *"Instead of considering how best to organise its work, a team may spend most of its time in meetings worrying about rumours of organisational change ... Such a group may spend its time protesting angrily, without actually planning any specific action to deal with the perceived threat to its service*" (ibid).

Thirdly, Stokes mentions 'basic assumption pairing', as group characteristics and team functioning within this modality has collective and unconscious belief that the future needs of the group will be solved by whatever the future event is:

> *"There is a conviction that the coming season will be more agreeable. In the case of a work team, this may take the form of an idea that improved premises would provide an answer to the group's problems, or that all will be well after the next annual study day*" (pp2l-22).

This may be similar to the view in HVS that staff training provides panacea to all practice issues, without investigating how information derived from training are embedded in practice to reflect changes. This group does not stimulate foresight, cohesive and pro-active strategies to secure desired improvements, with Stokes highlighting that:

> *"The group is in fact not interested in working practically towards this future, but only in sustaining a vague sense of hope as a way out of its current difficulties"* (p22).

Bion's, and Douglas' and Menzies Lyth's theories highlight the interconnectivity between the nature of anxiety, individual and organisational containment. I drew from the psychoanalytic principles to understand the client-professional relationship, explain the impacts of organisational life by distinguishing between `*defensive or regressive manifestations of group life' and `the sophisticated use of basic assumption mentality*' (Stokes, 1994, p25 with original emphasis). The contention, therefore, is that: *"a group may utilise the basic assumption mentalities in a sophisticated way, by mobilising the emotions of one basic assumption in the constructive pursuit of the primary task*" (ibid). I argue that HVs fundamentally require an awareness of their own unconscious 'transference' and how that may impact on dynamics of relationships they form and potential outcomes for children and families. However, given the level of anxiety

generated in health visiting practice, such dynamics can be powerful but frightening, and it can be hugely helpful for HVs in gaining understanding of the inner worlds of parents and themselves in order to enhance a more positive relationship-building that enhances child-centredness.

Hopper (2003; 1997) added to Bion's theories of 'basic assumption' based on the analysis of 'traumatic experience in the unconscious life of groups' (Hopper, 1997, p439). His argument is that the: "*primary fear of annihilation is a response to the experience of profound helplessness arising from traumatic loss, abandonment and damage"* (p448). Following a traumatic situation:

> *"the individual becomes astounded by emotions that have strong paradoxical undertone of desire for, and envy of, others who are perceived as able but unwilling to help*" (p449 original emphasis).

These `objects of failed dependency' are: "*subjected to annihilating attacks, usually, but not always, in fantasy, and, in turn, they are imagined to retaliate, again usually but not always in fantasy*" (ibid). The imagined retaliation from these processes activates a `*secondary fear of annihilation'* (ibid). The individual develops internal experiences as arising from the convergence of the primary and secondary fears of annihilation, a state described as:

> "*intrapsychic fission and fragmentation ... associated with typical anxieties, for example: fear of disintegration and of dissolution"* (ibid).

As a defence mechanism against these anxieties, the individual may resort to seeking: *"introjective fusion ... with the lost, abandoning and damaging object"* (ibid). However, such regressive merging process provokes 'characteristic anxieties', and this include:

> "… *the `fear of suffocation ... being entrapped ... and becoming petrified', with the individual retreating back into `a state of fission and fragmentation"* (ibid).

Consequently, the traumatic experience is perceived as activating:

> "… *a `pendulum-like, non-dialectical oscillation' between two states of mind -'fission and fragmentation, and fusion and confusion*" (ibid). In a group context, such oscillation provokes: "…. *an unstable and precarious movement between `aggregation' and 'massification'"* (p451).

Similar to Bion's basic assumption modalities:

> "… *the movement between `aggregation' and `massification' involves `characteristic patterns of interaction, normation and communication"* (p453).

Hopper argues that:

> "… *in order to protect against the difficulties and anxieties associated with massification, a social system shifts back towards the state of aggregation and the original anxieties and difficulties re-emerge"* (p456).

The raised anxieties among individual HV and teams in this study reflect the epistemological position of the 'Basic Assumptions' arguments and debates advanced by Stokes (1994), Hopper (1997) and Bion (1955). Four HVs reported they had taken home the thoughts about difficulties faced by children and families in their caseloads and that has resulted in sleep deprivation, anxiety and unhealthy coping mechanisms to deal with the work-related stress, including drinking alcohol, smoking and most fear disclosing their mental health problems – a commonly reported trend among practitioners (MIND, 2016). Whilst there was a general increase in report of long-term sickness among HVs in the organisation, two HVs among the participants reported they had more than 14 days or more off work in the previous one year due to work-related stress. These highlight the needs for actions about stress and other mental health affecting NHS workers both in acute and primary care, and the psychological impact on the lives of staff (Clugston**,** 2019; MIND, 2016).

8.7 Containment Enhanced by Reflective Space and Supervision

In the course of the assessment and information seeking or sharing, HVs liaised with other professionals and undertook 'listening visit' which offered parents opportunity to share their concerns and be part of interventions to address such needs. Whilst majority of parents / care-givers participated voluntarily in such process, few clients needed some encouragement, nudging, at times, or coercion through statutory involvement to access services, where there is need to prevent a child suffering significant harm. However, the HVS remains voluntary to all families; and given this position, the HVs' assessment and interventions would focus on 'routine needs', 'risk' and strategies to prevent significant harm to the child. Thus, from the narratives of HVs about the experiences and circumstances of children, it was evident that 'vulnerability' is entrenched within problems in the families. These included: 'cycle of deprivation', isolation, mental health, domestic abuse and substance misuse. Children who lived in areas of multiple deprivation were identified as 'vulnerable' and mostly described as having 'high-risk' of abuse and neglect; and also likely to experience poor health and developmental outcomes. Thus, these children require additional support relative to their needs and level of vulnerability. There was evidence that the intensity and increased level of involvement of HVs with 'vulnerable' children and families sometimes provoke high level of anxieties among practitioners leading to what could be described as 'over-involvements' in practice, with further impact on clients' uptake of services and outcomes for children. However, interpretive elements of HVs' case notes and themes from accounts describing their work with vulnerable children raise some contradictory or dissonant views, which highlight the determinacy and subjectivity in human behaviours and approaches to assessing these behaviours to define the needs of vulnerable children.

There are arguments that the daily challenge of dealing effectively with emotions is critical to human condition because our brain is hard-wired to give emotions upper hand (Goleman, 2019; Bradberry and Greaves, 2009). Thus defences against the anxieties triggered by `danger and destructiveness' has been described by Giddens and Beck as the '*juggernaut'* and over which practitioners have no control, but remains inevitable component of both individual and professional life (Giddens, 1999; Beck, et al, 1994; Stevenson, 1991). It means, HVs cannot completely exclude potential for a child in their caseload being abused or neglected by their care-giver; and rather than adopt practice of defensiveness and paternalism, a proactive approach to ensure mechanisms are in place to prevent a child suffering significant harm can support outcomes for children. There is a huge organisational difficulty to sustain consistency and professional capacity, as Adams (2015; 2009) argues that the HVS remains a profession in transition. It is also observed that 'deadening' health visiting practice to becoming pathogenic rather than saluthogenic in approach, with less attention to proportionate universalism and early supports may unwittingly exacerbate, rather than reduce, the risk to children and families (Maharaj, et al, 2019; Creedy, et al, 2017; Hunt, 2011; 2005).
Their arguments underlines the critical importance for HVs to be enabled to access and work with these unconscious processes in order to remain 'connected' as they discharge the responsibility in assessing risk, defining and classifying children according to their needs and vulnerability and acting accordingly to safeguard and protect them (Daro, 2002).

There are strong indications that supervision and reflective space were significant protective mechanisms which provided succour to HVs in 'containing' the complex needs of families in their practice. Supervision and reflective space were provided to HVs, but there was lack of consistency and evaluation of quality. Many HVs acknowledged the importance of both supportive mechanisms as reflected in common themes and representative accounts of HVs 1, 5 and 9:

> *"I think the support is quite good sort of child protection supervision, but it's sometimes irregular due to work pressure, I think you get support within your own team"* HV 01.

> "F*or knowledge base, I find regular supervision is helpful and Child Protection Supervision and regular mandatory training are important*" HV05.

> *"We used to have Solihull session in which we had non-directional discussion with the psychologist, but that has stopped. We talked through difficult cases as well and you get feedback and containment from the process"* HV09.

Wallbank and Sue (2011) identified HVs as a particularly vulnerable group to stress given the complex, frontline clinical work that they are involved in, and recent high-profile reviews of safeguarding practices have brought an increased anxiety and pressure on the profession. Supervision, staff support groups and different `reflective spaces' are considered critical for any opportunity to explore professional curiosity and thus being able to utilise the more unconscious processes provoked by work with clients with complex and challenging needs, especially in a High Demand and Low Control work environment as HVS (Featherstone, et al, 2014; Ruch, 2007; Froggett, 1998).

8.8 Promoting Reflective Space in HVS

The provision of various 'reflective spaces' facilitates '*depressive position'* functioning, which involves re-integrating what has been split off, and offer potential for HVs to contain and modify their personal and collective anxieties (Klein, 1975, p14). However, HVs do not fully utilise reflective space or are not consistently given this mechanism to manage their decision-making and professional-ethical tensions in their practice (Greenway, et al, 2013).

The narratives of HVs suggest the desires for reflective modes of knowledge and judgment, are triggered by intense anxieties surrounding this area of work and related appeal (by HVs at all levels) to different socially structured defence mechanisms (Copley and Corryan, 1997).

> "I think a lot of it is communication because obviously my experience has been that social workers are incredibly different and difficult to get hold of, and sometimes you don't necessarily know what they have been doing and they don't necessarily know what you have been doing" HV18.

The inter-professional learning and partnership-working (HM Government, 2018; Machin and Pearson, 2013) to foster reflective practice seems to be under-utilised in practice, especially in relation to some HVs working relationship with social workers. Partnership working offers significant potential for reflective practice as it connects the different expertise that exists in all professionals and creates collaborative and communicative working culture. The synergy created by partnership-working overcomes the isolated and often persecutory nature of individualised approaches to practice and promotes contextual perspective in decision-making of HVs (Firmin, et al, 2016). It is argued in this thesis that for an effective means for helping HVs to develop resilience against difficult work demands, they require an environment that is psychologically containing, intellectually challenging, relationship-sensitive to enhance inter-active and inter-personal processes (Greenway, et al, 2013; Lives and Legacies, 2010; Littlechild, 2008a; 2008b). In some HVs it enhanced what Goleman (2019) and Bradberry and Greaves (2009) described as 'emotional intelligence', creating self-awareness, ability to manage emotions and relationship with families, and self-motivation.

It is acknowledged that the complex circumstances in which vulnerable parents raise their children have links with competing demands of poverty, inequalities and disadvantage, which can result in anger and aggression toward spouses. However, some of these difficulties can be addressed through specific early interventions from HVs provided through public health strategies to reduce inequalities and improve social inclusion (Marmot, et al, 2012a). It is argued that strengths-based support to families is known to build resilience in their relationships, although poverty does not cause poor parenting (Field, 2010), the stress it triggers often affects parents ability to cope with their complex social circumstances. All of these expose children of poor parents to potential experience of poor childhoods and failure in a range of social and health outcomes (Marmot, et al, 2012a). It is perhaps this section of society where HVs have historically been involved and can have positive impact but effectiveness has been limited due to poor organisation of the service (Cowley, et al, 2013), inadequate leadership (Drea, et al, 2014) and poor professional coping mechanisms on which practitioners can draw such strength that can generate compassionate resilience, especially in challenging situations (Adams, 2015). There is further consideration that links this to poor levels of communication in relationship building with families and a product of professional decline (Bailey, 2013). As well as building relationships with families the role of HVs requires them to build effective working relationships with other professionals, for example, midwives, general practitioners, school nurses and social workers to achieve Public Health outcomes. This has been recognised as effective because child – Centeredness can only be achieved where services are more efficient as they co-operate, collaborate and ultimately integrate for the benefit of the clients (Machin and Pearson 2013).

8.9 Promoting Supervision in HVS

A great deal of learning in Health Care settings comprises core features of clinical supervision (Tomlinson, 2015). Child Protection Supervision offers sufficient flexibility for HVs to adapt to their needs, with focus on safeguarding and child protection, good quality clinical care and professional wellbeing (Froggett, 1998). Supervision is varied but usually defined in terms of four main functions adapted from Proctor's Functional Interactive Model: normative (managerial), formative (educational), restorative (supportive) and meditative (introspective) according to Proctor (1988). It is imperative that practitioners have regular access to multi-layered, collective, reflective opportunities, co-working and team meetings, in addition to personal reflective space, to enable them make sense of their own, colleagues and the organisation's contribution to current practice dynamics (Preston-Shoot, 1996b; Hardwick and Woodhead, 1999; Preston-Shoot and Agass, 1990). Evidence from case notes and HVs' account shows child protection supervision was consistent, though there were few cases where HVs did not take some cases for follow-up

supervision. Positive relationships and good communication are fundamental to the effectiveness of supervision , although in practice frictions in practitioner-supervisee relationship were seen to hinder 'container' of uncertainties and complexities to fully explore the psychodynamic understandings of supervision as: an offer of an explicitly reflective and containing space for practitioners (Steele and Steele, 2008; Ruch, 2007).

However, the current state of supervision in HVS does not seem to enhance reflective and professional response to address the anxieties generated by practice which is recognised to be complex, uncertain and ambiguous and insufficiently contained by outcomes driven by KPIs and over-emphasis on lessons from Serious Case Reviews (Greenway, et al, 2013; Gilbert, et al, 2012; Froggett, 1998; Grunwald, 1998). The debate on supervision in HVS highlights different functions by supervisors and the dangers of reductionism in responses to the needs of HVs and the understanding of their responsibilities. There is high need for good and effective communication between all involved in supervisory relationship to reduce potential for splitting as a defensive response, given the primitive and anxiety-provoking nature of health visiting practice (Whittaker and Havard, 2016; Lash, 2007; 2002; 1994; Woodhouse and Pengelly, 1991). Within the care components of supervision, there is growing concern about the qualitative shifts in the nature of supervision (Butler-Sloss, 1988). Thus the ability of supervisors to balance the administrative-inquisitional and restorative-empathic functions lie within understanding:

> *"Which places as much importance on the supervisory relationship and the feelings and development of staff as on the task, regulation and central control functions"* (Browne and Bourne, 1996, p9).

Box 8.1- Summary of Research Contribution to Knowledge

New Knowledge developed from this Research	**Gaps in existing knowledge**
1. Relationship-Based Practice From the analysis of case notes and interviews with HVs, the relationship between HVs and parents, families and other professionals were significant factors that enhanced or hindered child centredness, need identification and uptake of support or interventions by parents to achieve outcomes for children and family. Ironically, the HVS organisation did not acknowledge this concept as integral to addressing the health needs of	The importance of 'relationship' is acknowledged in health visiting and safeguarding policies, government statutes and guidance. However, the inclination of risk policy and society remains within individualised panacea to address

children. Thus, there was no training or other supportive mechanism that could increase HV's confidence in initiating, developing and sustaining relationships with parents and family. There were instances where HVs recorded in case notes and some reported in interviews about the difficulties they encounter in professional relationships with parents including: rejection, accusation, avoidance or disguised engagement, but the HVs felt not well supported by the organisation to ensure the children were ultimately protected from suffering harm. The excessive emphasis on 'risk-assessment', KPIs and surveillance' in safeguarding and child protection is gradually marginalising the relationship-based philosophy in HVS to offer support to 'vulnerable' children and enhance 'child-centredness'	the *"wicked problems"* in child abuse, and practitioners do not seek to apply complex thinking towards possibility for complex solutions within in a relational approach. This requires HVs to examine the context of each child's situation, ask some difficult questions such as: *"…what is happening, why, and what can/should be done?"* (Young et al, 2014, p894). However the importance of relationship in children and family services is highlighted in key health visiting, safeguarding policies and statutory guidance (appendix 13)
2. Risk theory and culture of blame in HVS In defining the needs of children and responding to their needs, the HVs follow the organisational procedure for assessment of needs and risks for potential harm against children. However**,** there were gaps in contextualising the needs of children either as requiring supports under 'universal' or 'vulnerable' services. For instance, some HVs failed to reflect the intra-familial and extra-familial factors that influence vulnerabilities in children and families. The 'Universal' or 'Vulnerable' descriptions were seen as 'fluid state' which could change as circumstances of families altered. Some flaws were identified in HVs' definition and classification, for instance, unseen children were not routinely considered to be 'vulnerable', as 5 children in the sample were unseen but no evidence of processes followed to trace the children.	Various studies by Melhuish, (2013) and Barlow et al (2007; 2006; 2005) acknowledged differences in uptake of Early Year Services among group described as 'hard-to-reach' compared with parents from economic advantaged backgrounds. However, the extent of such dichotomy was not highlighted in their studies, thereby minimising the significance of reflecting the differences and how to address the needs of children and families in policy and practice (Hogg et al, 2013; Katz, 2007; Dhir, 1999).

The study also identified inconsistencies in assessment; parental needs analysis and professionals' understanding of what some parents, such as those from BAME background already do in parenting of their children and how to engage them in improving their practices, with lack of sensitivity to cultural norms and expectations. These sometimes led to misalignment in parenting as parents from certain cultures adopted norms which were considered to be faulty parenting, raising needs for training and changes in HV-family relationships.	
3. Organisational Demands and Proportionate Universalism in decision-making process of HVs There was evidence of disproportionality in uptake of HVS supports and representation in caseloads among families from White and BAME families**.** The finding from this study shows that the needs of children from BAME background require increased priority to address, especially early intervention for children in the Inner London City. The study shows that 7 out of every 10 children identified as having vulnerability came from BAME background. The sample of vulnerable children from BAME comprised 32% Black, 31% Mixed Black and 5% Asian. Moreover, poverty, cultural differences and social disadvantages were common factors militating against access to services within BAME communities due to perceived factors, including lack of trust for professionals and services. There is also concern that Asian parents were less likely to disclose difficulties in the family which might put the child at risk of abuse due to fear of cultural stigma.	The studies focusing on Children and Family Services showed that children from black and mixed ethnic backgrounds were overrepresented among children who were looked after (LAC) and that White children tended to be underrepresented (Owen and Statham, 2009; Owen, 2008; Barn, 1999). These studies were undertaken about a decade ago and focused on Children and Family Services. The evidence of similar pattern in contemporary family services provides a strong call for policy and practice review that reflects the diversity and cultural needs of children from BAME background if they are to achieve their life chances (Biggart et al, 2016; Owen and Statham, 2009; Kendrick, 2007). However, less is known about over- or under-representation of children

	identified to be vulnerable in health visiting services.
4. Emotional impacts of health visiting work: from the lens of psychoanalysis. It is evident in this study that the practice of some HVs reflects a culture of paternalism and defensiveness; and these are associated with raised anxiety among HVs and identity crises. Given these influences, it is argued that sub-optimal decision-making has a potential negative impact on outcomes for children and family outcomes. **Paternalism and defensiveness in practice** The findings showed that HVs were doing extremely good work, but there were cases of involvement with 'vulnerable' children and families that, it is suggested, were conducted in defensiveness and fear of blame. Children under universal services had 185 contacts, which required 45.6 hours of health visiting time to complete; whilst vulnerable children had 1,423 contacts which took 430.5hours for HVs to complete. The average time HV spent with children under Universal services was 54.7mins, compared with 8.6hrs spent on each 'vulnerable' child in the sample (table 5.1). This represents 7-fold increase in time required to support 'vulnerable' children and families compared to those under 'universal' services. The arguments in this research is that such number of contact were more likely to be triggered by various reasons including fear of error and blame rather than children's 'needs', resulting in disproportionately lower level of support for children under 'universal' services. The self-protectionist approach became the driving force with potentials towards cultures of paternalism and defensiveness in practice.	It is known that in social work 'risk society' and blame culture often drive the public toward apportioning blame for injury or harm suffered by a child when such should have been prevented by social workers (Olofssona et al, 2014; Brandon et al, 2015; 2012; 2008; Broadhurst, et al, 2010; Dixon et 2007; 2005a Beck et al, 2007a). Most of the studies focused on social work, and there were no research that highlighted the influence of 'risk culture' on other professions working in partnership with Children and Family Services to safeguard and protect children from harm. The gap raised the importance to undertake study in HVS and explore understanding of how children's needs were assessed and responded to. The extent of mental health problems among health professionals has been an increasing phenomenon. It is known that the risk of suicide among female health professionals was 24% higher than female at national average and this provides explanation for

Raised anxiety among HVs and identity crises. The excessive contacts with 'vulnerable' children had a bearing on the mental health and decision-making of HVs. The reported parents' experience with services and perceived attitudes of HV were more likely to influence the outcome of HVs' interactions with families. The HVs who applied a strength-based, partnership approach in developing relationship-based practice helped in identifying the needs of children and family; they were able to demonstrate the ability to prioritise their work and gain control over their emotions. However, other HVs who were directional, judgemental in their top-down approach in assessing and responding to the needs of children and their families were more likely to report experience of anxiety and fear in their work with 'vulnerable' children and families. Whilst the majority of HVs managed their work-related anxiety very effectively, some required additional support to manage their tensed emotions and these led them into identity crises in the health visiting profession – policing or supporting parents. However, there was similarity in HVs report that they value child protection supervision, reflective space as protective mechanisms that allowed sharing concerns and containing their emotions and their clients' anxieties. The HVs faced complex circumstances that children and families live in, and raised anxiety could further obscure the clarity of their judgement and decision-making, thus impacting on outcomes for children. There was high recorded incidence of long-term sickness among the HVs, high staff turnover and vacancies, resulting in increased cost of recruitment, use of temporary workers and poor retention. These highlighted needs for managers, providers and commissioners to develop policy that acknowledged the complexity of needs for vulnerable children and families and the resources in	high suicide risk among female nurses (Office of National Statistics and University of Bristol, 2017). The work of HVs was not known to be a significant factor that could contribute to mental health problem, where combined work stress and anxiety in addition to stress from personal circumstances could trigger problems when there are no adequate coping strategies in place. Early introduction of mental health support (counselling, restorative reflection) for practitioners had positive impact on their ability to manage work-related stress (British Association of Social Work, 2013). Evidence suggests the high work demand in practice can result in poor decision-making by professionals (Rawlings et al, 2014; Munro,

HVS to address these needs. **Sub-optimal decision making and potential impact on children and family outcomes and HV's identity** Situations where some HVs make decisions with influence of anxiety and fear of blame were associated with defensive practice; and this meant potential of producing sub-optimal results from interventions and negative outcomes for children and families.	2011; Hamm, 1988). However, the gap within this discourse was most in most studies did not include HVS, and failed to recognise factors which could trigger mental health among HVs, coping strategies and potential impacts on their decision-making in practice (James and James, 2012; 2004).

Chapter 9 – Conclusion: Building Resilience in Practice and Policy Development

"Most people are thermometers that record or regulate the temperature of majority opinion, not thermostats that transform or regulate the temperature of society" Martin Luther King.

The argument I put forward in this thesis is that for an effective response to the needs of children and families in Health Visiting Service within contemporary society, there is need to re-conceptualise the 'person in practice' - both the client and the practitioner. This fundamental focus in the core of HVS would involve adopting 'relationship-based' rather than 'forensic-based' ways of working which acknowledge the uniqueness of circumstances of individual child and family (Foucault, 1998; 1995; 1991; Bowlby, 1958). It means breaking the structure of class and social inequalities through engagement with culture, subjectivity and sensitivity of vulnerable children and families who mostly require the HVS with the challenges of our modern society (Gillies, 2007).

9.1 Emotional Impact of Health Visiting Role

Health visitors remain at the forefront of early interventions for children and families, according to public health agenda, involving supports and health surveillance (NHS England, 2014; NICE, 2014; 2014a). However, their increasingly heavy and complex caseloads, dwindling capacity due to funding, inconsistent organisational supports and low work morale has left some HVs overworked and stressed. There was a further concern arising from fear of potential error likely to result in child suffering significant harm, triggered by pressure in a 'risk society' leading to organisational pressures and defensiveness in practice. These have tended to redefine HVS as a profession with a 'high demand and low control' nature which exposes HVs to a higher risk of developing negative mental states such as depression, anxiety, and stress (Maharaj, et al, 2019). Within the period of this study, there were increasing cases of long-term sickness, high staff turnover, and increase in Bank HVs to fill in vacancies in the local HVS. The combination of these factors contributed to an increase in occupational stress likely to impact on mental health, productivity and quality of life of HVs as acknowledged by a manager during the research interview. The traditional role of HVs was focused on promoting health as characterised in such mundane but important activities as checking childhood immunisations, child weight and growth. The HVs also offered additional personal space for parents to discuss their emotional or physical health concerns. These and other encounters between the HVs, parents and children

demonstrated the variety of interventions in different settings, including home, clinics or Children's Centres designed to facilitate clients' access and prevent barriers to engagement with services and HVs. Thus a relationship-based approach in HVS is founded on a public health philosophy to promote child health and development, and positive parenting in a strength-based rather than HVs acting as experts. Whilst some HVs related with parents with respect, building on their strengths and resilience in positive parenting, other adopted approach which stifled the interest and efforts vulnerable parents. The forensic approach in involving with families has been seen as devaluing the complex interpersonal element of the supporting components of HVS; and this pathogenic approach in practice, outcomes-based philosophy, and drive for quantifiable efficiencies have been seen as ultimately threatening the traditional role of HVs in 'supporting' families. The HVs' identity is under further threat by new regimes of economic management, characterised by widespread cuts to services and staff reductions, with potential poor outcomes for children and families. Thus, 'child-centeredness' and interventions under 'universal' services are perceived as threatening the outcomes for children and family.

The research findings showed that support strategies and interventions such as restorative supervision offer HVs safe space to reflect on the needs of children and families in their caseloads, with potential to enhance their decision-making ability and outcomes for children and families. Managers interviewed acknowledged some HVs showed characteristics which were synonymous with psychological indicators for distress, including but not limited to, low self-esteem, fatigue, and sleep/appetite disturbances; with potential for physical impacts including increased risk of cardiovascular disease, high blood pressure, decreased immunity, migraines, muscle aches, and chronic fatigue (Yau and Potenza, 2013; Dyrbye, et al, 2006). There are indications that, high levels of stress and anxiety may be implicated in exacerbation of maladaptive behaviours, such as smoking, over/under eating, excessive alcohol consumption, and substance abuse (Maharaj, et al, 2019), leading to depression. Hence, investigating depression, anxiety, and stress levels among HVs and identifying their emotional predictors and preventive strategies for these mental states are crucial for organisations, providing HVS to secure safer and more amenable workplaces while promoting the well-being of its employees. The concept of changing 'risk culture' in society allows a blaming stance surrounded with atmosphere of criticisms often being adopted when a child suffers significant harm or dies from abuse perpetrated by parents or caregivers. The media and public inquiries set up to investigate these cases are also encapsulated in judgemental tones - with extreme and sometimes horrifying rage heaped on professionals, especially frontline services (Reder, et al, 2001, p1). The sentimentally charged feelings have sometimes overshadowed the psychological aspects of these complex cases, thereby reducing awareness of the emotional factors within families and professional networks likely to dislodge practitioners from 'reflexivity' and 'objectivity'.

The experience of distress and other aspects of poor emotional wellbeing, according to Menzies Lyth (1960), meant HVs had increased potential for error in their judgements and decision-making, with negative impact on outcomes for children and families (Health and Safety Executive and National Statistics, 2017; HSE, 2001).

9.2 Strengthening the Psychosocial Perspectives of HVS

Health visiting is a voluntary service, and its provision is influenced by diverse forms of social behaviours, mostly within the family dynamics and responses from other professionals. The Three-Phased mixed methods research has been developed to explain new and emerging problems confronting professionals in HVS, setting the debate on salutogenic and challenging current pathogenic approaches in responding to the needs of children and families. The psychosocial dimension of contemporary family is influenced by the risk culture; and the State is interested in family in terms of: "how *things were, are and should be done*" (Giddens, 1979, p.200), and other modes, such as the statutory and non-statutory guidance and policies, for legitimising established practices in the family and deviation from such established norms should attract sanctions. The modernisation process and the advent of mass literacy are significant forces in modifying tradition, and therefore, the family are associated with the very risk we are trying to mitigate (Giddens, 1999; Beck, et al, 1994). There are questions about the sort of knowledge humans have about the conditions of their actions, and debate on rationalisation of individual's actions and laws of human conduct does not seem to address this questions. Giddens (1979) adopts the word '*generalisations*' or 'l*aws*' to describe the reason individual agents in family, for instance, act in certain ways, and the modes in which the *reflexive monitoring* of conducts is tied to its '*rationalisation'* (p200). Thus Keynes' social philosophy becomes relevant in developing understanding of socio-political principles that shapes the provision of services, including HVS to children and families (Skidelsky, 2000; Dimsdale, 1988) to correct social norms. However, this study showed variability in perceptions of risk between professionals and services such as: Children Services and HVS.

Health services including HVS are funded and provided by the State free at the point of delivery based on the idea nurtured and supported by Keynes (Dimsdale, 1988), but some of the service boundaries are not well defined. Barr (2004) suggests the Welfare State is used as shorthand for the state's activities in broad areas including: *"cash benefits; health care; education; food, housing, and other welfare services"* (Barr, 2004, p21) to reduce inequalities, improve outcomes for children and enable them make positive contributions to the society (Baldwin, 2012; Barr, 2004; 1988; Beveridge, 1954). I found that some HVs' perception of risk were influenced by their pre-conceived feelings that other professionals, such as social workers, did not understand their

concerns about children and they felt lack of communication and inter-professional learning (IPL) contributed to incongruent definition of risks and threshold criteria for supporting children and families. Within the narratives of HVs and account from discourse developed from case notes, the capacity to tolerate uncertainty and ambiguity inherent in health visiting practice is perceived as dependent on the convergence of intellect and emotion. The constructions of career identity in modern HVS seemed to be shaped by contrasting responses to both the anxieties and dichotomous discourses surrounding public health priorities and forensic undertones in work with children and families. Furthermore, the accounts of practitioners allude to the challenges in sustaining a work approach that combines understanding of both emotional and intellectual realities associated with their health visiting practice. The narratives from three different groups of HVs provide basis for epistemological positions of this research.

Firstly, the accounts from HVs who adopted defensive approach in practice provided description of an intense (and near intolerable) sensitivity to the emotional dynamics connected with the frontline work in HVS, these feelings were (partially) triggered by their inability to influence policy or practice and their associated isolation within the organisational context. Secondly, HVs in this mental category acknowledged the emotional dynamics that underpinned the work they do, but their account described the way in which such anxieties informed an appeal to organisational expectations, processes and KPI-driven outcomes to meet demands of commissioners rather than the needs of children and families. Thirdly, those who follow strength-based approach reasoned at the opposite extremes to the positions of other HVs, as they described a powerful sense of leadership and vision. However, their reasoning and approach were informed by a persistent and characteristic displacement and projection of anxiety into various other professional groups including social workers. The epistemological difficulties in integrating vision and emotion underlines the problematic nature of knowledge in defining the needs of children and offer of appropriate responses to address them under conditions of intense anxiety triggered by fear of error in decision-making and blame if child suffers significant harm. Ultimately, accounts from these three groups lend credence to the unimaginable nature of primary anxieties and the associated appeal to various defensive strategies that resonate in health visiting practice.

At one end of the spectrum, the HVs whose accounts suggested defensiveness showed characteristics analogous to professional response to the repeated lessons from Serious Case Reviews following incidents of child abuse or neglect, with the failure of all risk strategies and pressure from risk aversive society. These left the practitioners overwhelmed by the intense persecutory anxieties associated with fear of error in decision-making about the needs of children and determining the appropriateness of interventions to address these needs. These notions lead to seeking ways in which such level of anxieties could be transformed into an almost obsessional

reliance on defensiveness and paternalism in practice. At the other end of spectrum, HVs whose focus was strength-based and more child-centred, their narratives revealed the potential for such anxieties to be contained; as their account also alluded to the challenging consequences of any disconnection from the emotional realities of their practice. However, whilst their approach clearly provided a more robust and containing space for practice and professional development, they also described the renaissance of intense conflict among HVS, Children Services and interagency contexts. Thus, throughout, these discourses attested to the extreme difficulties in supporting an approach to practice and strategy that encompassed both emotional and intellectual realities. The epistemological position drawn from these account revealed the inherently precarious and inconsistent nature of any pattern of accommodation in clinical practice.

Finally, this research raises fundamental questions about the nature of social and structural concepts required to support an approach to policy and practice that restores some ability to encapsulate both the emotional and intellectual demands of health visiting work. The critical issue here is for commissioners, policy makers and managers to prioritise the emotional demands of the work, as much as rationally framed recommendations, with the kinds of `reflective spaces' advocated by Tomlinson (2015), Greenway, et al (2013), Proctor (1988) and Froggett (1996) being central in any approach to the effective management of risk to safeguard and protect children. Menzies Lyth argues that the primary psychological task for practitioners in any profession that works with people, especially vulnerable families, is to develop adequate professional and emotional '*detachment*' (Menzies Lyth, p102). Drawing from this understanding, I argue in this thesis that practitioners in health and social care need development of capacity to maintain professional independence against manipulation and demands from unprofessional behaviours learn to control their feelings, offer strength-based supports but refrain from getting excessively involved with families. It means HVs should be aware of their 'Transference-Countertransference' dynamics and that of others, to redirect their feelings and emotions towards optimising mutual relationship with clients with the aim of achieving outcomes forchildren and families. In acknowledging the centrality of relationship and in following psychoanalytic understanding about human behaviour, the debates on contemporary health visiting practice shifting towards pathological approach from its fundamental relationship-based approach, embraces both the cognitive-rational and affective-emotional aspects of practitioners' functioning. The psychologist Freud (1997) Klein (1975) and Bowlby (1958) placed emphasis on the relational as opposed to intuitive-driven aspects of primitive human behaviour and their implications in later life as they relate to others or respond to environmental influences. David Howe, a professor of social work, was known as a defender of environmental impacts on intelligence, and the analysis of positive and negative evidence and arguments about talent acquisition suggests that

differences in early experiences, preferences, opportunities, habits, training, and practice are the real determinants of excellence (Howe, 1998). In the same vein, the development in psychology and psychodynamic thinking and research strengthen the understanding about relationship-based practice (Howe, 1997). Thus, the contextual changes in HVS, especially having to offer voluntary services to increasingly involuntary and hard-to-reach parents and care-givers in situations where families experience health, social and economic inequalities are perceived as incompatible with psychoanalytic approaches, emphasising the individual's voluntary engagement in building the therapeutic alliance and focussing on their internal world (Gallagher and Smith**,** 2010; Calder, 2008; Littlechild, 2008a; 2008b).

Furthermore, the HV-Parent relationship as enacted by some practitioners appeared to be paternalistic, showing imbalance in favour of the HVs who presented themselves as 'expert' as they held tenaciously onto their therapeutic positions, thereby raising fundamental questions about what was permissible for HVs to engage with in practice (Condon, 2011; 2008). The parents/care-givers were further placed in a disadvantaged position by the medicalised and pathological approach HVs adopted towards assessment and interventions for their problems which over- emphasised the psychological, individual, rather than socio-ecological causes of these difficulties in families. This approach were seen to be influenced by government's policy, such as *Troubled Families Agenda*, thus reflecting in HVs' definition and classification of children under vulnerable and universal caseloads; and the likelihood of targeting BAME as most 'vulnerable' and most likely to abuse their children; therefore, in needs of '*prescriptive treatment'* to correct their '*faulty*' parenting skills (Department for Communities and Local Government, 2016; Crossley, 2015). Current approaches to practice undermine relational aspects of HVS and, therefore, avoided the emotional implications of health visiting practice. Consequently, this thesis argues for a shift in practice from child protection approach to relationship-based practice with focus on preventative and strength-based work based on early interventions agenda, with less emphasis on reactive and coercive measures followed in statutory child protection agenda (Dumbrill, 2006; Dhir, 1999). It means the emphasis of family support and child welfare is less on procedures, KPIs, and statutory responses and more on uniqueness of the children and their needs, following the contextual strategies to safeguard the children from significant harm (Firmin, et al, 2016); and the family circumstances. There are strong indications that some policy and research adopted by practitioners have forced them to undermine the very fundamental aspects of their relationship-based practice inherent in health visiting. According to Howe, et al (1998) the potential function of relationship-based practice is to contain anxiety for the client which reduces negative projection to practitioners. As clients are empowered to contain their emotional, mental and social states of their internal and external worlds, it is believed that HVs, by so doing, help enhance clients' sense of well-being and reduce their anxiety and its related behaviours, which

can ordinarily lead to child abuse or neglect and are often what bring parents/caregivers to the attention of statutory services (Schofield, et al, 2014; Schofield, 1998). It is acknowledged that the ability of the HVs to hold together the cognitive, emotional and practical aspects of a client's life reduces anxiety as these provide a sense of security and therefore containment and some reciprocity (Douglas and Brennan, 2004). This raises the importance of the debate for the identity of health visiting profession becoming clearer about the nature of the client-practitioner relationship in the context of the shift from prescriptive, top-down approach to relationship-based understandings of practice.

The argument I raised in this thesis, therefore, calls for reconceptualising the organisational acknowledgement and approach for the emotional responses and the emotional impact of practice on HVs. Adopting reflexive-oriented practice can also help HVs contain anxieties which arise from uncertain and risky situations not only for children and their families but for practitioners as well. Reflective practice (Steele and Steele, 2008; Schön, 1991), which has been embraced within health and social care work over the past decades, acknowledges the risk and uncertainty integral to health visiting practice can, I would argue, enhance the capacity of HVs to respond to anxiety inherent in their work. However, there was a significant knowledge gap among HVs in integrating reflective learning and its diverse range of knowledge to inform their practice.

Within the epistemological position of this thesis I embrace reflective space as enabling a 'lived reality' of health visiting practice 'from the inside', as opposed to over-dependence on techno-rational practice which develops from external knowledges - policies, theoretical frameworks, lessons from serious case reviews - imposed from the outside. The integration of both approaches can offer a new insight to inspire practitioners to develop holistic understanding of parents / carers and their family dynamics and consequently to develop into reflective and reflexive, rather than techno-rationally, competent practitioners. If the health visiting profession can follow this path it can develop ways of practising which promote the health, development and wellbeing of children and young people through proactive early interventions and reflective professional practice. This is opposed to rather reactive approach characterised with organisational convenience in response to needs of children and families, sometimes warranted by statutory involvement and its reactive interventions (Schofield, et al, 2014; Ruch, 2007; Schofield, 1998; Preston-Shoot, 1996b).

A further argument I put forward in this thesis is that if the Health visiting Service is to develop capacity for an effective response to the needs of children and families in contemporary society, there is a need for a reconceptualisation of the 'person in practice' - both the child, parent/caregiver, family and the practitioner. This would involve adopting relationship-based

ways of working, acknowledging the uniqueness of each child's circumstances, the centrality of the client-HV relationship and the unpredictability of complex and holistic - rational and emotional - nature of human behaviours. Adopting relationship-based understanding to assess and define the needs of children and families has potential of helping HVs contain the challenges arising from practice in contemporary society, whilst resisting the tendency to resort to the all-pervasive, but ineffective, forensic forms of containment connected with statutory, paternalistic and defensive approaches to practice.

To safeguard and protect children from abuse and neglect a counter-cultural approach embedded in relationship-based practice provides opportunities for practitioners to develop professional responses which appeal strongly towards addressing the complexities of health visiting practice, with focus on the child and promotion of professional well-being of the HVs. The development of emotional intelligence among practitioners is contingent on epistemological perspectives, such as those embraced with reflective practice and clinical supervision. Reflective practice informs relationship-based practice and provides potential for a broad understanding of the circumstances of a child and family, the needs of HVs and the knowledge informing practice. The account of some HVs in this research did not reflect the full benefits of reflective practise and supervision, which raised questions as to the quality and evaluative relevance of HVs' reflective and supervision sessions which should ordinarily contain their anxieties. However, the defensiveness and paternalism seen in accounts of HVs might well show the thinking and intentional approach but a spontaneous response to the dictates of the risk society - anxiety based on the fear of making mistakes and being blamed, potential for collusion to maintain good relationship with parents, thereby undermining parental behaviours which might indicate actual or potential child abuse or neglect. Thus, in part, the conclusion to be drawn from this thesis is that there are potential errors inherent in HV's definition and classifications of children in their caseloads; and errors or failures of practice are grounded - not only on failures of knowledge and procedure - but also on powerful, and principally unconscious, responses to the extreme difficulties associated with work with children and families. From the discussions above, the absence of containment means a likelihood of these unconscious reactions enacting, with the impulse towards `turning a blind eye' which inevitably compound practice difficulties as the practitioners shift between *Paranoid-Schizoid States* and *Depressive Position*. Within this context, there is need for *discursive convergence of* `determinate' and `reflexive' epistemological approaches to risk perceptions and management - with technical direction providing a necessary mechanism to the development of more skilfully structured approaches to practice established in an internalised sense of professional knowledge and authority. Whilst it was evident that the structural frameworks for identified professional development existed in practice, the difficulty observed was the HVs operating in a climate dominated by pressure to meet KPI targets, large

numbers of vulnerable children in individual HV's caseload, these lose the possibility for providing a space for reflection on the emotional realities associated with the work or indeed for acknowledging and addressing the ambiguity and uncertainty inherent in the knowledge of safeguarding and child protection risks and vulnerabilities.

Finally, following the views of Creedy, et al (2017), Dyrbye, et al (2006) and Pengelly and Woodhouse (1991) however, one is tempted to argue the very concept of safeguarding and child protection often involve reductive professional perception of the primary task that has bearing on and complicates the primary anxieties aroused by this work. Thus, the argument that HVs tend to resort to a parochial and paternalistic approaches on preventing child abuse and neglect, as a defence against the ambivalent feelings aroused by the anxiety in this area of work. Pengelly and Woodhouse (1991) observe:

> "*Anxiety fuels an unconscious process in which ... practitioners' defences become aligned with those of their clients, so as to disconnect the presenting problem from other issues, lose sight of a more holistic view and fall back on the narrowest bedrock of primary task activity"* (p179).

Their argument also shows that perceptions that are based on narrow-mindedness about the task have the effect of exacerbating, rather than minimising, the anxieties of practitioners:

> *"For social workers, as soon as they locked onto an exclusive focus of protecting children from bad parents, they became prey to a further anxiety - that they themselves would be bad care-givers"* (ibid).

The HVs' accounts highlighted the difficulties brought about by primary anxieties generated by inquiries in child protection which goes further than influencing practitioners but its processes also infected policy-makers, commissioners and managers, with practice being driven by pressure to meet KPIs requirements, procedures and reductive perception of the primary task observed to have increasingly penetrated structures within the organisational culture. On the one hand, safeguarding and child protection policies have become, not only reactive and proceduralised, but also focused at a narrow and reductive emphasis preventing child suffering actual or potential significant harm or neglect. On the other hand, this discriminatory approach in safeguarding and child protection discourses from contextual and wider perspectives for child health and wellbeing are increasingly strengthened by organisational structures (including the establishment of specialist posts and teams for safeguarding and child protection). However, the accounts of most HVs and analysis of the case notes emphasised the ways in which this reductive perception of task and response to complex needs of children and families tended to exacerbate, rather than diminish, the anxieties of HVs.

Thus, taken from overall perspectives and discursive construction of the roles of HVs, the conclusions drawn from this research reflect the emphasis of Menzies Lyth (1990; 1960) on the need to prioritise interpretation of socially structured defences, as a precursor to any conceptual and structural change. As highlighted in Chapter 9, Menzies Lyth (1960) remarks:

> "*The success and viability of a social structure are intimately connected with the techniques it uses to contain anxiety ... An understanding of this aspect of the functioning of a social institution is an important diagnostic and therapeutic tool in facilitating social change"* (p309).

Further, the psychosocial process of defining and classifying children according to their needs under 'universal' and 'vulnerable' caseload management requires effective social, conceptual and policy changes and focus on 'child-centredness'. I argue that any meaningful change in status quo is likely to require recognising and analysing the common anxieties and unconscious collusions underlying the existing structural defences that determine the phantasy of social relationships to explore the link between instinct and reality. Thus, pursuing this tradition in HVS, the focus for this research has been on exploring the `anxieties' and `unconscious collusions' underpinning decision-making of HVs, policies and practices in relation to safeguarding and protection of children, through the examination and analysis of both documentary and interview of materials. The excessive task-oriented emphasis on 'risk-assessment' and 'surveillance' in safeguarding and child protection must not undermine the relationship-based philosophy. Revisiting the fundamental identity of HVs shows relationship remains a significant factor upon which the profession was conceived to ensure professionals engage emphasis on 'child-centredness, and to stimulate their critical thinking that allows insight into precarious and unpredictable circumstances of families and the needs to keep children safe. My hope is for the findings of this research to have a wider influence on training, policy development, health visiting commissioning and to challenge organisational and practice culture. The position of this study is that although the HVs have low control over their ability to enforce uptake of services, engagement and compliance with additional interventions to safeguard and protect children from harm by their parents and carers, this study does not emphasise statutory powers as a necessary panacea in HVS. There are potentials that HVs can benefit from inter-professional learning and partnership working to increase understanding among HVs and other professionals, especially social workers and professionals in Early Year Services. It is hopeful that these shared understanding and mutual knowledge can bring benefits to children and families in terms of better understanding of threshold of needs and offer of early support options to address their needs. It is also for organisations, service commissioners and healthcare professionals to recognise and prioritise client-professional relationship as pivotal for achieving effective outcomes for children and vulnerable families.

Appendices

Appendix 1 -Vulnerability and 'social risk' factors

Child 'Vulnerability' associated with risk factors from child and family health promotion (Hall and Elliman, 2006)	**'Vulnerability' due to 'new social risk factors' resulting in poor educational and social outcomes of the child (**DOH, 2009**, p15; HM Government, 2015).**
-Lack of bonding or secured attachment between parent and child.	-Poverty, low parental self esteem,
-family has history of violence -History of mental illness, drug or alcohol addiction.	-Parental mental illness, substance misuse, debt, and domestic abuse.
-Mother aged 21 or under at time of childbirth	-Unstable relationship, parent with antisocial behaviour, -family with young parents
-unemployment and other socio-economic disadvantages	-Mother's main language not English -parents not in education, employment or training. -Non-attendance or parent came out of education with low or no qualification, parental Learning difficulties -Poor housing, overcrowding, living in social housing.
	-Low social capital in family.
	-Child Radicalisation, Child Sexual Exploitation, Female Genital Mutilation, Online Grooming and Exploitation.
-Parent who is single, separated or co-parenting	- non-resident partner.
-Late maternity booking, Low birth weight, prematurity or baby separated from mother for more than 24 hours	
-Parental abuse or neglect as a child	- Family where parents grew up in care.
-Unknown male partner in family, step parent, or co-habiting parent.	
-Parental abuse or neglect as a child	- Family where parents grew up in care.
-Child mortality, physical disability, -Less than 18 months gap between child births -Infant never breastfed -Difficult child behaviour	

Appendix 2 - Classification of child's Vulnerability in Inner London Boroughs

London Borough of Hackney (2012) *The Hackney Child Wellbeing Framework*	London Borough of Haringey (2016) Local Threshold Guidance	City of London Corporation (2016) *Thresholds of Need*
Children are defined as 'vulnerable' when there are concerns in the following aspects of social skills, health and developments:		
Physical Health	Physical Health and development	Developmental Needs
Emotional Health, Wellbeing and Behaviour	Social and Emotional Wellbeing	Family and Environmental Factors
Education	Interactive learning	Parenting Capacity
Social and Neighbourhood	Community and Neighbourhood	Parents and Carers
Parents and Parenting	Parental ability	
Family and Environment	Family and voluntary support network	

There are expectations that HVs and other professionals respond to children and family needs based on following levels of 'vulnerability'		
Universal - HVS working individually.	**Level 1 -** The children have no additional needs and any identified needs are met by universal services and children receive consistent child focused care from their parents or carers..	
Universal Plus – HVS working individually but putting in more intensive support.	**Level 2- Universal Plus** – HVS working individually but putting in more intensive support.	
Universal Partnership Plus – HVS and other services coming together with additional intensive support to bring a multi agency partnership plan.	**Universal Partnership Plus** – HVS and other services coming together with additional intensive support to bring a multi agency partnership plan.	
Complex/high risk – HHVS and other high level Specialist Services, often governed by statutory frameworks (Children and Social Care -CSC) to take the lead role.	**Complex/high risk** – HHVS and other high level Specialist Services, often governed by statutory frameworks (Children and Social Care -CSC) to take the lead role.	

Threshold of Needs for children and families

London Borough of Hackney (2012) *The Hackney Child Wellbeing Framework*	City of London Corporation (2016) *Thresholds of Need*
The HVs classify child as 'vulnerable ' when there are concerns in the following category:	
Physical Health	Developmental Needs
Emotional Health, Wellbeing and Behaviour	Family and Environmental Factors
Education	Parenting Capacity
Social and Neighbourhood	Parents and Carers
Parents and Parenting	
Family and Environment	
The HVS respond to children and family needs based on following levels of 'vulnerability':	
Universal - HVS working individually.	**Tier 1** - (Health and Developmental Need met by universal HVS).
Universal Plus – HVS working individually but putting in more intensive support.	**Tier 2**- (Children with additional needs requiring early help from targeted HVS).
Universal Partnership Plus – HVS and other services coming together with additional intensive support to bring a multi agency partnership plan.	**Tier 3**- (Children with complex multiple needs requiring statutory additional needs requiring CSC and specialist services)
Complex/high risk – HHVS and other high level Specialist Services, often governed by statutory frameworks (Children and Social Care -CSC) to	**Tier 4** - (Children in acute need requiring immediate referral to the CSC and/or the police).

take the lead role.	

Appendix 3 - Setting Criteria for Vulnerable Children and Families

Department for Communities and Local Government (2016) (The Conservative Government)	Department for Communities and Local Government (2012) (The Coalition Government)	Levitas et al, (2007); Social Exclusion Task Force (2007. (New Labour Government)
Parents and children involved in crime, gang or anti-social behaviour	Involving in youth crime or anti-social behaviour	Have no parents in work
Children who have not been attending school regularly	Having children who are not in school or truanting	Family living in poor-quality or overcrowded housing
Children who need help: subject to Child In Need (CIN) or Child Protection Plan (CPP)	Having adult not in out of work benefit	No parents has qualifications in the family
Adult out of work or at risk of financial exclusion or young people at risk of worklessness	Costing tax payers high to maintain	Mother has mental health problems
Families affected by domestic violence and abuse		One or both parents have a long standing limiting illness, disability or infirmity
Parents and children with a range of health problems		Family has low income - below 60% of median income
		Family cannot afford a number of basic food or clothing items for the children

Appendix 4 - Research Timeline

The Research Timeline

Research Timeline			Duration (days)
START DATE	END DATE	DESCRIPTION	
11/10/14	1/15/15	Started Writing Research proposal	94
1/30/15	4/20/15	MSU - Research Registration / Scoping literature	80
4/15/15	3/13/16	MSU Research Ethical Committee Approval	328
2/15/16	5/25/16	NHS local Research Ethical Committee Approval	100
6/1/16	9/2/16	Primary Data Collection and Analysis: Case Notes , Review of methodology	91
10/12/16	1/2/17	Mixed Research Method - Interview Data collection and analysis	80
1/12/17	1/30/17	First Attempt Transfer from MPhil to PhD Registration	18
2/12/17	5/15/17	Reviews of mixed method: data sampling, collection, analysis	93
6/5/17	1/2/18	Final Registration - MSU Transfer from MPhil to PhD Registration	207

2/1/18	7/2/18	Writing of Thesis Chapters 1-6, Review of Overall Research	151
7/18/18	10/10/18	Mixed Research Methodology - Case Notes and Interview Data	82
10/20/18	12/30/18	Thesis Chapter 7 - Research Methodology	70
1/2/19	2/12/19	Thesis Chapter 8 - Research Findings	40
2/17/19	3/4/19	Review of Thesis Chapters 1-8	17
3/4/19	6/17/19	Thesis Chapter 9 - Discussion and Contribution to knowledge	103
6/20/19	11/3/19	Thesis Chapter 10 - Conclusion / Thesis Submission	
1/1/20	03/06/20	Review of Thesis Chapters 1-9	
6/7/20	9/20/20	Viva Preparation and Presentation – Pass with minor changes	
10/1/20	12/12/20	Revise Thesis and Re-submit	
		Note: The time for supervision meetings, emails, telephone contacts with the 2 supervisors is integrated within the schedules	

Appendix 5- Combined Coding from interview and Case Notes Data

Themes from Interview transcript	**Themes from Case Notes**	**Global Themes**
The multi-factorial concepts and definition of vulnerability in children.	The HVs apply diverse qualitative and quantitative measures to assess risks and establish vulnerabilities of children.	• Identifying vulnerable children and assessing risk of child abuse and neglect
HVs exercise professional curiosity in response to needs of children in both universal and vulnerable families.	The HVs have leading role in early interventions for universal and vulnerable children and families	
Changing society brings new knowledge, risks; clients challenge of expert knowledge and divergence in definition and conceptualisation of the term 'vulnerable child'.	The culture in risk society reflects in fear of blame, box ticking and over-involvement of HVs with vulnerable children and families; and complexity of cases sometimes show lack of priority and poor insight into children needs.	• The HVs' dichotomous role of surveillance and advocacy for children, young persons and families
HVs are advocates for vulnerable children and their role require integrated working, professional curiosity and information sharing.	HVs advocate for vulnerable children but children's voices are not well-represented in practice to reflect their needs and involvement in decisions about them.	
The HVs rely on quantitative and qualitative approaches to make clinical judgement and decisions to protect vulnerable children from harm	The HVs use professional judgement, clinical tools and other methods to assess risk and plan interventions to support vulnerable children and families	• Decision-making, professional curiosity and paternalism in responding to the needs of vulnerable children
HV'S experience significant stress and anxiety which might	Evidence of excessive actual or attempted contacts with clients;	

impact on their clinical judgement about the risk of harm a child may be facing.	and evidence reflects some pressure and frustration especially with clients who are hard-to reach or difficult to engage. There is high work demand and targets to achieve e.g meeting the 4-5-6 model in practice and child protection plans.	• HVs experience stress and anxiety associated with involvement in vulnerable families and impact on clinical decision-making.
The attitudes of HVs sometimes reflect excessive surveillance, paternalism likely to negatively impact on clients' engagement with HVS and loss of the 'voice of the child'.	HVS explores diverse ways of exercising surveillance and professional curiosity to provide appropriate response to the needs of vulnerable children	

The iterative coding process resulted in the development of four key global themes that capture the nuances of universal and targeted work HVs do to promote health, safeguard and protect children. Therefore the themes which form basis of focus to address the research question are summarised under four broad categories:
Identifying vulnerable children and assessing risk of child abuse and neglect.

The HVs' dichotomous role of surveillance and advocacy for children, young persons and families

Decision-making, professional curiosity and paternalism in responding to the needs of vulnerable children

HVs experience stress and anxiety associated with involvement in vulnerable families and impact on clinical decision-making

Phone Call
Invite Letters
Contact – Home
Healthy Child Clinics
CIN /CP Conference
Professional / CGM
MARAC Attendance/Review
MAT /TAC Meetings
First Assessment and Screening Team – FAST follow up
CP Supervision
Opportunistic Contacts
Liaisons with Other Services /Professional
DNAs / Follow-Up
Transfers /Movement-In
Housing matters

Appendix 6 - The 4-5-6 Model for Health Visiting

Health visiting work with families under 4-5-6 model (The Institute of Health Visiting (2016; Bennett, 2016).

4	5	6
Levels of Service: -Your Community -Universal -Universal Plus -Universal Partnership Plus	**Universal Health Reviews:** -Antenatal -New Baby -6-8 Weeks -12 Months -2 to 2 and half years	**High Impact Areas:** -Transition to parenthood -Maternal mental health -Breastfeeding -Healthy Weight -Managing minor illness and accident prevention -Healthy 2 year old and school readiness

Appendix 7 - SafeLives Domestic Abuse Assessment Tool

Safe Lives Dash risk checklist for use by non-police agencies for identification of risks when domestic abuse, 'honour'- based violence and/or stalking are disclosed.

Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned. **Tick the box if the factor is present. Please use the comment box at the end of the form to expand on any answer.** **It is assumed that your main source of information is the victim. If this is not the case, please indicate in the right hand column**	**YES**	**NO**	**DON'T KNOW**	**State source of info if not the victim** (eg police officer)
Has the current incident resulted in injury? Please state what and whether this is the first injury.	☐	☐	☐	
Are you very frightened? Comment:	☐	☐	☐	
What are you afraid of? Is it further injury or violence? Please give an indication of what you think [name of abuser(s)] might do and to whom, including children. Comment:	☐	☐	☐	
Do you feel isolated from family/friends? Ie, does [name of abuser(s)] try to stop you from seeing friends/family/doctor or others? Comment:	☐	☐	☐	
Are you feeling depressed or having suicidal thoughts?	☐	☐	☐	
Have you separated or tried to separate from [name of abuser(s)] within the past year?	☐	☐	☐	
Is there conflict over child contact?	☐	☐	☐	
Does [name of abuser(s)] constantly text, call, contact, follow, stalk or harass you? Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done.	☐	☐	☐	
Are you pregnant or have you recently had a baby (within the last 18 months)?	☐	☐	☐	
Is the abuse happening more often?	☐	☐	☐	
Is the abuse getting worse?	☐	☐	☐	

Does [name of abuser(s)] try to control everything you do and/or are they excessively jealous? For example: in terms of relationships; who you see; being 'policed' at home; telling you what to wear. Consider 'honour'-based violence (HBV) and specify behaviour.				
Has [name of abuser(s)] ever used weapons or objects to hurt you?	☐	☐	☐	
Has [name of abuser(s)] ever threatened to kill you or someone else and you believed them? If yes, tick who: You ☐ Children ☐ Other (please specify) ☐	☐	☐	☐	
Tick the box if the factor is present. Please use the comment box at the end of the form to expand on any answer.	**YES**	**NO**	**DON'T KNOW**	**State source of info**
Has [name of abuser(s)] ever attempted to strangle / choke / suffocate / drown you?	☐	☐	☐	
Does [name of abuser(s)] do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? If someone else, specify who.	☐	☐	☐	
Is there any other person who has threatened you or who you are afraid of? If yes, please specify whom and why. Consider extended family if HBV.	☐	☐	☐	
Do you know if [name of abuser(s)] has hurt anyone else? Consider HBV. Please specify whom, including the children, siblings or elderly relatives: Children ☐ Another family member ☐ Someone from a previous relationship ☐ Other (please specify) ☐	☐	☐	☐	
Has [name of abuser(s)] ever mistreated an animal or the family pet?	☐	☐	☐	
Are there any financial issues? For example, are you dependent on [name of abuser(s)] for money/have they recently lost their job/other financial issues?	☐	☐	☐	
Has [name of abuser(s)] had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? If yes, please specify which and give relevant details if known. Drugs ☐ Alcohol ☐ Mental health ☐				
Has [name of abuser(s)] ever threatened or attempted suicide?				

Has [name of abuser(s)] ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? You may wish to consider this in relation to an ex-partner of the perpetrator if relevant. Bail conditions ☐ Non Molestation/Occupation Order ☐ Child contact arrangements ☐ Forced Marriage Protection Order ☐ Other ☐				
Do you know if [name of abuser(s)] has ever been in trouble with the police or has a criminal history? If yes, please specify: Domestic abuse ☐ Sexual violence ☐ Other violence ☐ Other ☐	☐	☐	☐	
Total 'yes' responses				

For consideration by professional

Do you believe that there are reasonable grounds for referring this case to Marac?		Yes ☐ No ☐	
If yes, have you made a referral?		Yes ☐ No ☐	
Signed		**Date**	
Do you believe that there are risks facing the children in the family?		Yes ☐ No ☐	
If yes, please confirm if you have made a referral to safeguard the children?	Yes ☐ No ☐	**Date referral made**	
Signed		**Date**	
Name			

Appendix 8a – Sample of Vulnerable Case Note Analysis

Vulnerable Case Note 57
RIO Progress note type: Nursing Progress note sub type: Health Visiting Validation Status: Validated Speciality / Service: Health Visiting HVxxx Date: 21/12/16

Subject: Child XXX. **Age:** 18months **Ethnicity**: Mixed Caribbean **Status**: Child Protection Plan under emotional abuse

***COMPLETED 8-10MONTH REVIEW ***
8-10 month developmental review completed at home on 4/11/16 child was seen with the mother and was well dressed in clean clothes. Using the Assessment Framework principle, the home environment was very unkempt and mother seems to pay little attention. Children remain on CPP. Appears to have difficulties coping due to mental health and relationship difficulties. He current EPDS was 19/30, compared to previous record of 14/30, but I think she is minimising her mental health difficulties which

has deteriorated since she stopped her medications. Child's immunisation is due in two month. No other health or developmental concerns identified. Full details in template.
Plan: Update social worker, GP and other professionals
Discuss with report in CP Conference and Core Group Meeting
Update in supervision
Continue to monitor health and development every 6-8 wks

*****TELEPHONE CONTACT*****
Made a phone contact to arrange home visit but no response from parent.
Plan: Repeat phone contact or opportunistic home visit in 2 days.

*****TELEPHONE CONTACT to review children health and dev following domestic abuse incident*****
Support phone contact to arrange visit, but no response. Sent a text with date for a home visit.
Attended Child Protection Conference see Rio template
*****CP SUPERVISION*****
Child protection supervision with XXX (Named Nurse Safeguarding Children) and XXX - Health Visitor)
Completed CP supervision. HV to continue with previous agreed plans
*****OPPORTUNISTIC HOME VISIT*****
Home visit to conduct assessment following report of domestic abuse incident on **9/7/16.** Seen XX in the family home - 2-bed flat which was well decorated and conducive for children wellbeing. XX was sociable, smiled and gave me high-five cheerfully during visit. XX Sibling … in Primary School.
Health and wellbeing
Mother reported XX has had 1-year immunisation, and all developmental review is up to date as shown in PCHR. Mother reported XX eats all home food and no health issues reported. Weight today was 13.9kg (98th centile). Informed mother about healthy diets, the Henry course and the risk of over weight in children. Children development was age appropriate and no developmental concerns identified or reported by mother.
Voice of the child
Child XX seem to mirror's behaviour of sibling (29month old) who had become disruptive in behaviour, but intervention from psychologist is beginning to bring positive changes and he is making good progress. XX shows parent respond to his needs in a timely manner…. However, he would wish to live is a settled home where father is no longer abusive to my mother and siblings are happy too
DV Incident on 9/7/16
Mother reported partner XXX, not the children's father, had been abusing her to the point that she went to report him to the police, and when the police arrived in the flat they smashed the door and got him arrested. Mother also said she withdrew her statement not because she felt threatened. She said: " I knew I contributed to what happened because he was on non-molestation order but I invited him to my flat then he started controlling behaviours all over again. I don't want to go through the stress I went through before in the court, so I withdrew the statement". Informed mother that she should not blame herself because the perpetrator should have known his restrictions, and no justification for abuse. The children are currently placed on CPP under category emotional abuse. SafeLives Dash risk checklist was completed with a score of 20/24, and referral made to MARAC based on clinical and professional judgements, although mother was hesitant.
*****LIAISON WITH CSC*****
Liaised with CFS for update on ICPC but was informed the case has been allocated to a new social worker. Name: XXX. Spoke with SW XXX who updated that children were placed on CPP under Emotional Abuse on 2/2/16. Mother was also assaulted by ex-partner two weeks when father visited to see the child, police was called and case is in court. Non-molestation order is in place.
*****SUPPORT PHONE CALL TO PARENT*****
Mother responded to voice mail and reported she was with her sister so would not be around until late. However mother reported the social worker would be seeing her and the children today. Mother also confirmed DV incident which happened 2 weeks ago. Mother reported she has a new number: XXX. Mother agreed to bring children to follow up face to face contact on XXX.
Impression:
Mother seems to be minimising the Domestic Abuse and does not understand the impact of abuse on her ability to parent the children. Mother does not also understand the impact of DV on cognitive and emotional development of the children. Mother would benefit from counselling and other DV support

work e.g relationship building and strengthening family.
Plan:
-Continue to provide UPP HV service
-See children as scheduled on xxx at 16:00pm
-Review weight and discuss safety plans / Counselling
-Discuss family with GP, DV Specialist HV
-Referral to MARAC and update CSC

*****CHILD HEALTH CLINIC*****
Seen child in CHC for weight review and health promotion
Attended Core Group Meeting see Rio template
*****Failed phone contact to arrange home visit on 12.6.16*****
Attempted phone contact but no response.
*****DNA OPPORTUNISTIC FACE TO FACE VISIT AT HOME ON 16/5/16*****
Did opportunistic home visit but mother not at home.
*****CP SUPERVISION*****
Child protection supervision with XXX (Named Nurse Safeguarding Children) and XXX - Health Visitor)
Summary
XXX are currently open to access and assessment with XXX children's social care following an incident of domestic abuse in September XX. Abuse between mother XX) and her ex-partner (not the children's father), previously discussed at MARAC (Multi-Agency Risk Assessment Conference) February XXX, following referral by HV and a non-molestation order was put in place. Following another incident of abuse in XXX ex-partner has been sentenced to 10 months in prison
Health
Immunisations up to date
Safety
Mother currently has a safety plan which was created with the police. There is a police alert for the address. The locks have been changed in the home, window alarms are in place and the non-molestation order against father remains
HV XX has discussed with mother her plans when her ex-partner is released from prison; she explained that she currently has no plans to be in contact with him. This is an area of further exploration as mother has contact following previous non-molestation order when it was placed initially.
Plan
-Health visitor to contact social worker to establish the outcome of their assessment
-Health visitor to contact xxx school nursing safeguarding service to provide an update
-Health visitor to continue to provide support to the family
*****SEEN IN CHILD HEALTH CLINIC FOR 6-8WEEKS REVIEW*****
-Health visitor discussed further health eating and referral to HENRY programme for healthy nutrition - 6-8 weeks
Attended Child Protection Conference see Rio template
*****GP LINK MEETING*****
Health visitor discussed family at the GP link meeting
Health visitor to explore support, counselling that mother is receiving and healthy relationships - 6 -8 weeks
*****SENT INVITE FOR 6-4 WEEKS REVIEW*****
DNA 6-8weeks contact. HV to follow up with phone call and opportunistic home visit.
*****NEW BIRTH VISIT - New Birth COMPLETED*****
New birth visit carried out as arranged with father. Mother and partner XX were present. Sibling (XX) went to school. Mother is not working at the moment. Uncomplicated pregnancy and emergency c/section delivery at 41- weeks gestation. Mother reported father has been very supportive and she has good friends around XX. Both parents and children live together in a 3-bedroom privately-rented flat which was spacious, clean and conducive for newborn baby.
Mother reported baby had yellow eyes at day 6. No jaundice noted. Baby opened bowel during consultation - yellow mustard consistency. Mother said baby open bowel 1-3 times a day and wet nappies about 6 a day. Baby cried for feed and mother observed as she fed baby with formula and baby settled. Baby is active and move all limbs. No further concerns from mother.
Mother has history of depression, type 2 diabetes and takes metformin 500mg x3 a day; and on thyroxine due to low thyroid. Mother reported that partner (child's father) has history of bipolar

disorder and has a social worker, XXX. Mother reported that partner lives in a different address in XXX but currently stays in the family home as he is engaging very well with the Mental Health team and he takes his medication regularly. Mother said when partner relapses, she ensures that he gets treatment quickly in the hospital or community treatment team would contact give partner treatment in his home at XXX.
Mother said he has been complying with his medications so no relapse has occurred in the past 12 months. However mother said partner has never been violent to her or the children; and she knows what to do if he becomes ill.
Discussed: Health promotion - Cot death prevention, Vitamin D supplement, Immunisations, Accident prevention, Children Centre activities, HV clinics, 6-week Check with GP, Birth registrations and benefits.
Plan:
-Continue to provide UPP health visiting services
-Update GP
-Child to commence immunisation
-Review in 6-8 weeks

*****TELEPHONE CONTACT to arrange NEW BIRTH VISIT*****
Support phone contact to arrange new birth visit, but no response. Sent a text with date for new birth visit and HV contact details.
. *****FACE TO FACE CONTACT FOR ANTENATAL ASSESSMENT AT HOME*****
Saw mother in the family home on 6/1/18 . EDD: 6/3/16, Gravida 3 Para 2. Mother was in care as a child, she is on benefit. One of her blood test showed diabetes but her repeat test result was negative. Antenatal assessment completed at according to Trust Policy. There were incidents of domestic abuse from partner but mother denied incident and minimised it to be argument. Family live in a 2-bed council flat which is overcrowded with the new baby coming. Assessment using Promotional Guide according to Trust Policy. The family were known to MAT previously but now escalated to tier 4 – the Children services.
Parenting Capacity
Mother appears to minimize incidents of domestic abuse from father which might affect her ability to protect her child from harm.
Perinatal Mental Health
Mother reported she has history of anxiety and depression since her first child, but no history suicidal ideation, but continues on sertraline 50mg OD with reported good effect. Has recently been reviewed by the GP. Completed EPDS and scored 12/30, discussed referral to PMH and counselling but mother reported she already had counselling when she had her first child and has appointment booked to see the PMH team at 36th weeks gestation. Mother was prompted to explore possible triggers of stressful situations which usually lead to her anxiety; and we had strength-based conversations when she mentioned some of the coping strategies she has developed to prevent the situations arising. **Impression:** I have impression that XXX needs insight into her mental health needs and to and the likely impact of this on her parenting abilities. Mother denied report of domestic violence in her relationship.
Health and Development
Discussed breastfeeding and bottle feeding- intends to breastfeed; information given on both and signposted to antenatal class and breastfeeding group. Discussed nutrition, exercise, responsive parenting, children's Centre activities, safe sleeping. Other children are well and adjusting .to routine.
Family and Environment
Mother is on benefit, reported pregnancy was not planned but happy pregnancy .
Other Comment
Mother reported she found her previous health visitor was judgmental and authoritative hence she could not disclose her mental health problems to the HV, and she had to wait for long before she could seek help.
Plan:
-Provide Universal partnership services.
-Review at new birth visit
-Attend professional meeting and provide report
-Mother can make contact as and when required
-Update the GP link HV

*****TELEPHONE CONTACT / INVITE FOR ANTENATAL ASSESSMENT*****

Made 4 telephone contacts, with texts and an invite to mother for antenatal appointment but mother has DNAed twice. Mother has children on CPP and the social worker is aware mother is pregnant again.

Plan:
Arrange a joint visit with social worker as mother is not engaging.
Update the GP and other services including Perinatal Mental Health
Continue to provide Universal Partnership Plus services.

Sample CASE Note 57 Analysis		
Document Analysis Technique	**Analysis by Researcher** **[Contact/interventions (frequency)[**	**Analysis by Inter-coder HV** **Contact/interventions (frequency)]**
What are the reasons, modes, frequency and process for contacting children and families in 'universal' and 'vulnerable' caseloads?	- Vulnerable child on Child protection plan under emotional abuse, child under 5 from mixed Caribbean ethnicity -HV provided universal services / mandated contacts for: antenatal (1), new births (1), 6-8 week reviews (1) and 8-10mts review (1). The child was also seen in Healthy Child clinics (3) -The HV made contacts by telephone and texts (12), appointment invites (4) – Home visits (4) - Additional services due to child vulnerability included: GP link meeting (2), Child protection and Core Group Meetings (4), CP supervision (2).	-Demographics: Vulnerable child. CPP under emotional abuse, Age below 2 from Black Minority Ethnicity -Mandated Universal Contacts: antenatal (1), new births (1), 6-8 week reviews (1) and 8-10mts review (1). Community Health Promotion: Healthy Child clinics (3) -The children and family reached through contacts by telephone and texts (13), appointment invites (4) - - Additional services due to child vulnerability included: GP link meeting (2), Child protection and Core Group Meetings (4), CP supervision (2), Home visits (4).
How did the HV assess and determine level of need for the children?	-Safe Lives Domestic Abuse Assessment for referral to MARAC. -EPDS to determine mothers mental health and guide referral, provide health promotion about possible impact on mental health on parenting -Promotional Guide for antenatal review and Assessment Framework in RIO	-Safe Lives for MARAC referral. -EPDS as mother has mental health issues -Antenatal and Post natal Promotional Guide Evidence of the Trust Assessment Framework
Do HVs routinely involve children and reflect the 'voice of the child' in all decision-making affecting the children - need and risk assessment, planning, interventions/supports and evaluation of outcomes?	Voice of the child was recorded once by the health visitor, and not routinely at every contacts or interventions offered to the child or family. This suggest a possible missed opportunity to listen to the child at every contact and record his view about his future.	The views of the child was expressed in only one contact. It would have been interesting to follow what changes occur with this child: "Child XX seem to mirror's behaviour of sibling…who had become disruptive in behaviour … he

		is making good progress. … he would wish to live is a settled home where father is no longer abusive to my mother and siblings are happy too".
Are there evidence of professional curiosity in seeking/sharing information with other professionals?	-There was evidence of professional curiosity : *"Arrange a joint visit with social worker as mother is not engaging. Update the GP and other services including Perinatal Mental Health"* "*discussed referral to PMH and counselling but mother reported she already had counselling"* Referral to MARAC, Children Services, GP. School Nurses.	-The HV showed professional curiosity reflecting on liaison with social workers, GP and Perinatal Mental Health to support parent and enhance their parental ability. -MARAC.
What organisational, professional and personal support mechanisms do HVs draw upon to enhance their decision-making process?	-CP Supervision (2) -Referral to other services (4) -DV specialist HV -Local policies and Local Work Procedures.	CP Supervision (2) -Referral to Children Service, MARAC, PMH, GP, and Specialist HV (5)
What were the characteristics of vulnerable and universal children?	The key characteristics include: Mixed Race, CPP due to emotional abuse, parental mental health and domestic abuse,	The child was mixed race and vulnerable due to being on: CPP under emotional abuse category. The parental mental health and domestic abuse also put the child at risk of abuse.,
What common factors influenced decision-making of HVs?	There is underlying concerns that parental mental health and domestic abuse impact on the parenting ability of the children, hence HVs increased actual or attempted contacts to engage with parents, to monitor parenting . -Lack of trust and perceived intrusiveness.	There is fear that the children in the family might suffer further significant harm, hence the HV saw or attempted to see he child frequently and monitored health and development. This is associated with 'risk society' and blame culture' -Parent do not seem to have faith in the services or there is avoidance.

Appendix 8b – Sample of Universal Case Note Analysis

RIO Progress note type: Nursing Progress note sub type: Health Visiting Validation Status: Validated Speciality / Service: Health Visiting HVxxx Date: 20/12/16

Subject: Child XXX. **Age:** 14months **Ethnicity**: White British **Status**: Universal Service
*****Child Health Clinic*****
Seen XXX seen at XXX CLINIC on 19/7/16 with her mother. Alert and active. good interaction observed

between mum and baby. Her weight was at 71st centile normal range for the child. No concerns reported regarding health and wellbeing of child.
Plan
Continue to attend clinic 4 weekly for health and weight review
*****ATTENDED XXX HEALTH CENTRE*****
Attended for weight review at XXX Health Centre on the 23rd August 2016 -Mother did not want to see the Health Visitor for consultation.
*****ATTENDED 8-10MONTH REVIEW** ***
8-10 month developmental review completed at XXX clinic on 4/12/16 child was seen with the mother and was well dressed in clean clothes. General health was reported to be good.
Immunisations are all up to date. reminded of the next immunisations at 1 year.
GROSS MOTOR: Grace was observed sitting unaided, reported to be bum shuffling and pulling self up. **FINE MOTOR**- She can hold toys with a firm grip and can pass from hand to hand, reported to be mouthing, shaking and banging toys.
Social & Emotional:. A good level of interaction was observed between her and her mother. She was observed to babble. Mother states that she is able to say "dada"". Encouraged the mother to read to her to gain an early interest in reading books.
Vision & Hearing: no concerns with vision or hearing. XXX was able to follow an item with her eyes when it was moved from the front of her. she is able to respond to sounds clearly and turns to her name when called.
Diet: child is breast fed, fully weaned and eats a varied diet 3x a day plus snacks, she is able to drink water from a sippie cup. No concerns in regards to her diet.
SLEEP- Reported to sleep well, wakes up 2x at night for feeds.
Dental Care: Dental care discussed and advised brushing teeth twice daily.
Plan
For continued universal services
Invited to attend 8-10 months health review on 4th December, 2016 at XXX Health Centre at 9.30am
*****SEEN IN Child Health Clinic *****
Seen child and siblings in CHC today. He was well presented, active and alert. Fully breastfeeding and attended today for weight review. Weight today was 7.53kg (at 75th centile). Discussed immunisations and Vitamin D supplement. No concerns reported.
Plan:
Continue to provide Universal Services
*****SEEN AT HOME FOR 6-8 weeks Review *****
Seen child in 6-8 weeks review at home at 9.30.
*****Telephone contact to confirm appointment for 6-8week review*****
Spoke to mother who reported they were ding well and would be available for today appointment at home.

*****SEEN AT HOME FOR New birth review on 20/2/16*****
Baby XXX seen at home with mother xx and father xx. Baby is 10days old, was alert and responsive during the visit.
CHILD DEVELOPMENTAL NEEDS:
Health:
Baby was born at 39 weeks at Homerton Hospital through Spontaneous Vaginal delivery Baby's birth weight was 3.0kg, head circumference 34cm and current weight today was 3.50kg. Baby has regained birth weight, mother said she is seeing midwife again on Friday at XXX health centre. Baby was given vitamin K-IM and blood spot taken by midwife on.
Baby is exclusively breastfeeding. Mother reported baby to be feeding well and having regular wet and dirty nappies. Urine is said to be clear and stools yellow. Umbilical cord off, area clean and dry. Skin intact and moist. No jaundice noted. Mother praised for doing a good job..
Immunizations, 6 weeks GP check and registration discussed.
PARENTING CAPACITY:
During the visit baby XXX was clean and appropriately dressed. Parents seen to be responding appropriately to their baby's cues and a caring interaction was also observed. Both mother and father are second time parent – they appears to be bonding well with their baby.
Parents said baby sleeps in a cot. Correct sleeping position for baby were explained together with increased risk of cot death when bed sharing. Parents advised to place baby on her back while sleeping. Tummy time and baby massage were discussed.
Mother encouraged to attend postnatal groups at the local children's centre
Smoking and implications relating to passive smoking were also discussed. Family non- smokers.

FAMILY & ENVIRONMENT FACTORS:
Mother and baby's father XX living together. The couple appear to be happy together, No DV reported or suspected.
Family live in a 2 bedroom flat. The flat was said to have all basic amenities and appears clean and appropriately furnished. Mother reports to be well supported by her partner. Mother said her family lives outside London and they visited for few days to support her with her baby.
Mother worked as a Massage Therapist- she is currently on maternity leave. Baby's father is also employed full time – he reports to be earning regular income. No family history of ill health reported. Mother encouraged to attend local drop in clinic within 2weeks to weigh her baby and also speak to HVs as needed.
All relevant health promotion material discussed during the visit. This includes the child health record, clinics and clinic times, breastfeeding support and nutrition, vitamin D, cot death prevention and child safety, immunisation, children centres, pelvic floor exercise, contraception and maternal mental health.
OUTCOME OF VISIT:
New birth visit completed- satisfactory-
PLAN
- Weight review in 2weeks at GP drop in clinic
- 6weeks GP check /registration/BCG
- 8weeks immunisation
- Mother to contact HVs for further support and advice as

*****Telephone contact by mother*****
Mother called the HV team to report that she has not been visited by a HV according to previous plan in antenatal. The called was handed over to HV who informed her that she was about to call mother and book home visit. Mother reported she and baby are doing well and have agreed to home visit on 20.2.16 at 10:30 for New Birth review appointment.
Plan: Attend New Birth Review as scheduled.
*****ANTENATAL REVIEW COMPLETED*****
Seem mother on 3/1/16 at XXX health for antenatal review according to Trust policy and promotional guide questions used. Second pregnancy which was planned first male child is in nursery and mother and father are working (Father works in Investment Bank in City) and very supportive. Both parents attend antenatal class at NCT. No report of depression or low mood, NICE questions asked and no concerns reported, No DV reported in relation. Antenatal review template completed.
Plan:
See Family during new birth

Sample Analysis of Universal Case Note 3		
Document Analysis Technique	**Analysis by Researcher** **[Contact/interventions (frequency)]**	**Analysis by Inter-coder HV** **Contact/interventions (frequency)]**
What are the reasons, modes, frequency and process for contacting children and families in 'universal' and 'vulnerable' caseloads?	- Child receiving Universal services, child under 5 from White British ethnicity -HV provided universal services / mandated contacts for: antenatal (1), new births (1), 6-8 week reviews (1) and 8-10mts review (1) The child was also seen in Healthy Child clinics (4) -The HV made contacts by telephone (2), appointment invites (1) - Home visits (2), No additional services provided as child was not at risk of abuse or	-Demographics: Universal child age under 2yrs from White British Ethnicity -Mandated Universal Contacts: antenatal (1), new births (1), 6-8 week reviews (1) and 8-10mts review. Child brought to voluntary health clinic: Healthy Child clinics (4) -The children and family reached through contacts by telephone (2), appointment invites (1) and Home visits (1).

	neglect	Parents were proactive by contacting the HV to request services and also attending antenatal classes to improve their parenting ability
How did the HV assess and determine level of need for the children?	-NICE Guideline to determine mothers mental health and guide referral, - Routine health promotion parenting -Promotional Guide for antenatal review and -Assessment Framework in RIO	-NICE Guideline, Trust policy and Antenatal Promotional Guide
Do HVs routinely involve children and reflect the 'voice of the child' in all decision-making affecting the children - need and risk assessment, planning, interventions/supports and evaluation of outcomes?	Voice of the child was not recorded in this case note, suggesting another missed opportunity to listen to the child at every contact and record his view in decision-making concerning her future.	The views of the child was not expressed at any of the contacts
Are there evidence of professional curiosity in seeking/sharing information with other professionals?	-The HV seems to have identified no concerns to provoke curiosity as the child's health and development were within 'normal' parameters for the child and no concerns with parenting	-There was no apparent indication for curiosity or doubting the parenting ability of the parents, beside the routine questions about DV in the family.
What organisational, professional and personal support mechanisms do HVs draw upon to enhance their decision-making process?	-The HV demonstrated ability to provide routine services and health promotions to contain the needs of this children and parents.	The universal family receiving basis routine services and quite aware of local services and able to access.
What were the characteristics of vulnerable and universal children?	Voluntary parental engagement with services and willingness to access local services, stable base for children and mostly from White British ethnicity	-Parents were proactive in accessing services -Health and developmental checks up to date - White ethnicity
What common factors influenced decision-making of HVs?	-The parental health belief and information about services. -Willingness to work in partnership with professionals. -Trust and confidence is HVs and the services	-'Partnership between parents and HVs and trusting relationship -Strength-based support to parents and respect of parental views where there is no safeguarding or child protection concerns.

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Appendix 9 - Semi-structured interview questions

Research Title - Addressing the Needs of Children under 'Universal' and 'Vulnerable' Caseloads - Psychosocial Case Study of Health Visitors within an Inner London Borough

SEMI-STRUCTURED INTERVIEW

Assessment of risk of abuse and neglect.

How do you recognise vulnerability in children?

Child Health and well being surveillance

In safeguarding and child protection, how do you determine 'risk' and 'protective factors' for children?

How do you respond to the needs of 'vulnerable' children and family?

Do you have an instance of a case you can say went well in respect of your support and engagement with the 'vulnerable' child and family?

What made you considered this a 'good case'?

Early interventions
Can you give me an example of a case with 'vulnerable' child and family that did not really go well?
What were the things that made you feel this case did not go well?
What early help do you offer 'vulnerable' parents

How do you perceive working with parents / carers of 'vulnerable' children?

How do you prepare for a typical visit or contact to a 'vulnerable' family?
What training and development opportunities are available for you concerning your work with 'vulnerable' children and family?

What other general comments, observations or concerns do you have regarding your work with 'vulnerable' children and family in practice?

Demographic information:

a) Sex b) Years of experience in health visiting:

Other Registration: d) Age

Appendix 10 – Research: Invitation Letter and Information

Ethics Application number:

PARTICIPANT INFORMATION SHEET (PIS)

1. Study title

Addressing the Needs of Children under 'Universal' and 'Vulnerable' Caseloads - Psychosocial Case Study of Health Visitors within an Inner London Borough

2. Invitation paragraph

You are being invited to take part in a research study which is concerned with looking at the work you do as a health visitor to safeguard and protect children in your caseload. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. You may contact me for further information if there is anything that is not clear. Take time to decide whether or not you wish to take part.

Thank you for reading this.

3. What is the purpose of the study?

The evolving role of health visiting practice has impacted on the health and wellbeing of children, parents/caregivers, families and communities as acknowledged by various governments, individuals and researchers. Two of the main roles of health visitors are safeguarding and child protection and this filters through all the six high impact and other areas identified in health visiting practice by NHS England and the Department of Health. Although research has been undertaken into the leading role of Children and Social Care in child protection, very few researchers explore health visiting practice. This is particularly clear especially in the area of health visitor's early interventions role to support struggling parents and families in order to prevent difficulties they may be having with parenting to escalate to levels that require statutory interventions. This research, therefore, intends to fill this gap and attempt to bring in-depth understanding of what health visitors do in practice to safeguard and protect children suffering or likely to suffer significant harm.
The research aims to provide opportunity to gain insight into the decision-making work of health visitors regarding safeguarding and protection of children within a cross-section of universal, universal plus and universal-partnership plus cases. The study will focus on the local health visiting caseloads. The study will last for 12 months ending June, 2017.

4. Why have I been chosen?

You have been chosen because you are a health visitor working for Homerton University Hospital NHS Foundation Trust and have experience of working with families with children where safeguarding issues have been identified.

5. Do I have to take part?

Taking part in the study is entirely voluntary, and is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

6. What will happen to me if I take part?

You will be asked to take part in one interview lasting not more than 60 minutes. Your responses to the questions in this interview will be used for the purpose of this project only. You can be assured that if you

take part in the project you will remain anonymous. No identifying details will be included in any report of this research.

7. What do I have to do?

Taking part entails completing one interview with the researcher. The interview will be audio-recorded to enable the researcher transcribe the content of the interview. However, if you do not want the interview recorded, your decision will be respected and that need not stop you from having the interview.

8. What are the possible disadvantages and risks of taking part?

There is no known disadvantage in taking part in this study. However, in an interview, discussing cases about children and families may possibly be distressing, especially when there was an unexpected outcome for the child and family. To reduce psychological and emotional distress on the participants, the researcher will terminate the interview if participant shows any sign of distress arising from the discussion or reflection on practice or wishes to terminate the interview. All participants who require debriefing will be given leaflets on Restorative Session run by Clinical Psychologist and available to health visitors in the trust, or participants can have debrief session with their Child protection supervisor/manager, as required.

9. What are the possible benefits of taking part?

There may be no direct benefits to you in taking part; however, the intended benefits for this study include the contribution from practitioners with diverse skills, experience and knowledge towards development of understanding regarding safeguarding and child protection role in health visiting practice. It will also enhance future policy, health visiting curriculum, training and continued professional development to benefit current and future practitioners. It will offer opportunity to reflect on cases in order to gain deeper insight that can inform future practice. Furthermore, reflection over past actions and decision-making about a child and family may highlight a situation when a child might have been at risk of harm. In this event, necessary procedure will be followed to assess and escalate the current situation to ensure that adequate protective factors are in place for the child and family.

10. Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential, to the extent of the requirements in NMC code of professional conduct and the mandatory reporting regulation. Any information about you which is used will have your name and address removed so that you cannot be recognised from it. All data collected will be stored, analysed and reported in compliance with the local trust Data Protection Policy. However, if a child is identified to be at risk of harm, this will be escalated according to the trust safeguarding policy.

11. What will happen to the results of the research study?

This research forms part of a PhD Thesis registered with Middlesex University and a copy of the findings can be obtained from the researcher. Participants can also contact the researcher for the result. Please note that participants will not be identified in any report or publication.

12. Where will the interview take place?

To maintain confidentiality and reduce interruption, the interview will take place in a private office booked for the time of the interview, with a sign on the door to prevent, distraction. This will be either at the participant's place of work or the researcher's, whichever the participant prefers.

13. Who funds this research?

This study is funded by the following institutions:

A 2-year PhD Scholarship Award from Middlesex University covering tuition fees and £14,000 grant.

One year tuition fee from Homerton University Teaching Hospital NHS Foundation Trust for 2014/15 academic year.

A £2000 student-of-the-year award from Health Education England to support study expenses.

14. Who has reviewed the study?

This study has been reviewed by two Ethics Committees:
The Middlesex University, School of Health and Education, Health and Social Care Ethics Sub-committee, and

Homerton University Hospital NHS Foundation Trust Research Ethics Committee.

15. Thank you for taking part in the study.

16. Contact for further information
For further information about this study, please see the contacts below:

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Appendix 11 - Appendix Consent Form

Homerton University Hospital NHS
NHS Foundation Trust

Middlesex University London

Ethics Application number: MH44

Participant Identification Number: 000

CONSENT FORM

Title of Project: Investigating Safeguarding and Child Protection roles in health visiting practice.

Name of Researcher: Mfon ARCHIBONG Please initial box

I confirm that I have read and understood the information sheet Version 1.3 dated 14/4/16 for the above study and have had the opportunity to ask questions.

1

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. 2

I agree that this form that bears my name and signature may be seen by a designated auditor. 3

I agree that my non-identifiable research data may be stored in National Archives and be used anonymously by others for future research. I am assured that the confidentiality of my data will be upheld through the removal of any personal identifiers. 4

I understand that my interview may be taped and subsequently transcribed. 5

I agree to take part in the above study. 6

I agree that quotes from me may be used in publications and conferences relating to this research, and I understand that such quotes will be strictly anonymous. 7

_____ _____ _____

Name of participant Date Signature

_____ _____ _____

Researcher Date Signature

Distribution: 1 copy for participant; 1 copy for researcher

Appendix 12 - Sample Interview Coding and Themes Development from 2 HVs

Codes	**Basic Themes**	**Organising Themes**	**Themes from Interview transcript**
-Families with domestic violence1[32, 33]24[11,30]42[32]43[6,12,13,31,32]44[5]48[7,8,14,25] -Substance abuse1[32, 33]24[31]42[32] -Physical abuse1[32, 33] - Be isolated3[17] - Mental health8[25]17[1] 24[12,31]39[2]41[3,10]45[29,34]46[14] - Depression2[1]3[11]6[24]8[25,32]11[10,11]39[14]45[29,33]46[11,28]39[14,26,27] -Poor housing / Untidy house 8[24,25].10[27]15[22]16[2] 36[11,22,,26,23,]37[33,14] 39[7] -Ex-offender /Criminality38[6] 26[3,4,6,] -Child protection plan3[30]5[15]6[24]12[28] -Poor emotional states1[32, 33] -Low self-esteem1[33] - -Mood swings6[25] - Child in Need plans12[25]36[9,17] -Did not engage 3[30,32]5[17,18]6[12]16[18]17[2]42[25]44[13,19] -Doesn't want to contact 6[27,29]	-The physical, environmental, emotional and economic factors of clients can place children in vulnerable states. -The HVs' definition of 'vulnerability' has socio-political connotations, and draw influences from public and media reports - HVs' description of internal and external parental stress; and	- The HVs' definition of a 'vulnerable' child remains ambiguous, but parental mental health, domestic abuse and substance misuse are key vulnerability factors.	The multi-factorial concepts and definition of vulnerability in children.

-Children that are vulnerable 1[29,30] 14[17,18] - At risk 1[32]28[26] -Was being difficult7[22,23] -Poor parenting skills 8[16,17] -Struggling8[24] -Relationship difficulties 9[28,33] -Troubled Families 10[5] -Safeguarding issues 12[1]27[17,18,20,26,29]31[24]47[28]49[26] - Lots of concerns12[26,27]14[19,20] - No recourse to public funds20[19] -Parent is struggling31[20] -Harming self/others39[22]46[1,11]40[2,3,4] -Lots of stories 38[3,11] -Anger management48[17] -Parents abused as children42[31] -Feeding Problems8[27]	personal factors causing vulnerability. -HVs classify children already identified as having needs for protection due to sexual, physical or emotional abuse and neglect are vulnerable. -HV's description of vulnerability reflects characteristics of a non-permanent state relating to broad circumstances of individual child, parents/carers and family	-The HV has diverse and complex concepts for classifying vulnerabilities in children - Child abuse and neglect are likely to occur in families where there is resistant to service, lack of insight into parental needs and care for the children - HVs view vulnerability is dependent on individual's perception of risk for actual or potential significant harm to the child	
-Routine checks11[30] -Opportunistic visits 7[10]11[7]16[13,14,15,17,18] -Calls 5[28]16[13,14]27[33]31[5] - Texts 5[28]16[13,14] -Appointments16[13,14] -Sent invitations7[14]28[10]	-The HV applies different strategies to reach universal and vulnerable clients. -The HVs spend more time and efforts on vulnerable children, leaving less time for universal services.	-The health visiting approach is concerned with assessment or signposting clients to other services -The HV promotes evidence based parenting and child development	HVs exercise professional curiosity in response to needs of children in both universal and vulnerable families.
-Do assessment 8[23,25,31]14 [21,22,23]24[5,6,10,17]28[33]36[9]43[8,11,20]44[5]48[21,32] 2 [30,31]28[17] 2[8,9]11[24]14[7,8,10,1115] - I observe 2[26,26]28[17] 2[28] 2[28] -- weaning3[19]9[8] - Review development 3[25] -Support 3[26]8[28]17[2122]31[22,25] -Encourage 8[26]	- The HV carry out assessment of all children all children to identify needs, risk factors, protective factors, strengths and vulnerabilities.	-The HVs under-represent the 'voice of the child' in assessment and decision-making.	

-Parenting support 8[17] -Managing behaviour9[3,5] -Managing sleep problem 9[4] -Advice and leaflets 9 [16,17,23] -Weighing regularly9[22] -Monitoring17[5,15] - Counsel them9[34] -Do more home visits11[19,21,22] - Early intervention8[30] -Home visits28[6,10,11,12,14] -Baby massage41[4,14] -Listening Visit 45[11,12,15,19] -To find problem31[6]	-Healthcare workers are not well supported by managers, are worried about meeting care needs of their patients. -Health promotion remains an integral role of health visiting for both universal and vulnerable children and families. -Implementing the Healthy Child Programme in integrated 4-5-6 models.	-The HV's interventions may be excessive or practice considered defensive due to fear of error or blame. -The HV provides a good listening skills, offers timely guidance, advice and visits	
-Liaising17[4]25[3]26[18,26]17[4]41[7]44[21]44[21] -Referral to specialists5[5]6[31]8[30, 32]9[4,34] -Child protection conference3[27]5[15] -Escalating to Social Services 8[7,17]28[25]30[12]31[12,14,16]37[32]40[15,17,25,30]41[1,2]43[2]50[32] -Background check25[4]26[18,26]45[31]47[23,24,29] -Children centres20[18]	- The HVs work in partnership with other professionals to supports vulnerable children and families	The HV-client relationship and resonance of paternalism reflect practice of fear of making wrong-decision if incidents occur. -Generally, clients value the work of HVs but some seek other sources of support when there is relationship breakdown and they do not trust or value the HV service - HVs feel achieved when there is evidence parents are accessing early help, child is healthy and develop well, protected from harm; there is positive resilience and not disadvantaged by parental economic circumstances.	-Changing society brings new knowledge, risks; clients challenge of expert knowledge and divergence in definition and conceptualisation of the term – 'vulnerable child'.
- Much happier3[14] -Very grateful 3[15,18] - It makes you happy 4[14] -Attending activities3[16] -To come to clinic3[19] -Build up relationship25[18]27[34] - Thanks very much26[34] -Changes brought to family38[18] -I was pleased38[27] -Keep eyes open48[4] -Passion 49[5] - Lots of positive things11[16] - Being stable10[9] -Bring up a stable child10[9] -If you do it 4[2,4] -Try and do these things5[4,5] -She's done things we expected4[4,5,9] - Doing really well11[14] -Good bonding 11[15] -Good attachment 11[15] -Done parenting course11[15] --Support groups20[18] -Behaviour change30[19]	- The HVs description of what they perceive as outcome for vulnerable children whose parents are engaging with services -Clients are perceived to be responsive to advice and view HV service as supportive resource -Clients attend health and developmental appointments and access parenting services		

-Parenting change30[19,20]45[22] - We need to have a plan 1[30]50[3,4,16] -Needed do things for the family 3 [24,25] -Keeping doing those plans3[28] -Plans put in place3 [26,27]4[1] - Help us to decide3[28] - Come off the plan or not 3[29] - We have to do 5[19,20] -You will have to4[30,31]5[1,2] -Just do these few things5[3,4] - She had been told not to 3[4] - Stop using those things3[7] - Begin to put child on the floor3[7] - You need to encourage the child3[8] - You're staying on register for longer3[32,33] - You need to engage3[34] - It's for your own good4[1] -It's best for the children4[11] - I would explain why28[12] -Duty of care49[26]	-Clients can communicate needs, request help and information in a timely manner -The HV's expectation from clients to follow all 'expert' health advice and instructions given to them -The HV chose unconventional approach to secure compliance - use threat to keep or remove child from CP register as a means of securing client's compliance with health advice. -The HV do not seen to recognise or build on strengths of clients	-The Clients responses to service offer and attitudes towards HVs suggest the HVs come across as authoritative and directional in their relationship and support. -Some HVs use a top-down approach rather than routinely negotiated methods to provide meaningful engagement and support to clients.	- The attitudes of HVs sometimes reflect excessive surveillance, paternalism likely to negatively impact on clients' engagement with HVS and loss of the 'voice of the child'
-Feel I am being monitored5[29], -Somebody is watching 5[30] -Don't want to see HV6[34] -Feel she didn't do anything6[34]7[1] -Broken trust 25[30,31]27[2,3]30[30]48[30] -Sick of you43[21] -Judging me43[22] -Pushing and picking negatives36[36] - Picking up strengths37[7,8,9]40[18] -He was there 46[5,6,14,15,22,26,27]47[1,5] -Working forum51[18,19]	-Clients' encounter of difficulty to access services -Clients' concerns with issue of confidentiality, respect and lack of trusting relationship with HVs.	- Clients description of their perception of HVs' attitudes -The HVs suffer rejection when there is breakdown of trust and relationship with clients and presence of perceived 'failure of expertise'	
- It's very hard10[20,]11[22] -It's very difficult10[20]12[13] - Its complicated10[11] - Not being open11[3] - Nothing has changed12[12,27,28] -Quite a difference12[18] (threshold) - Frustrating sometimes12[19]25[21]	- HVs have high work demand, low control -The HV feelings about the burden of excessive	-The work environment is severely stressful, threatening and unpredictable	

-No improvement 12[28] - Feel there's an issue13[10] -Difficult workload13[16,17] -Combining vulnerable with universal13[18,19,25] -I do struggle13[25] -I do find it hard13[31] -Refusing access16[21] -Going into unknown18[4,5] - Seem defensive7[30,31] -What am I achieving?12[10] -Hard to communicate19[25,33,34]25[19]30[29]36[33] -Awake at night worrying20[30] -Feel anxious21[2] -Worry/pressure49[16,33] -No capacity 11[19]13[17,25]21[10] -Universal visits pick up problems22[17]25[21,23] - Very broad27[17] -Tiring50[1]	involvement with vulnerable children and families. -Poor engagement or disguised compliance impacting on children outcome and increasing anxiety of health visitors -HVs. Description of barriers and facilitators to early interventions for vulnerable children and families	-HVs' perceptions of barriers to effective engagement with vulnerable children and barrier to their access to early support and services - The HV attitudes can be enhancer or barrier for clients' engagement with or disengagements from the HVS, thereby increasing vulnerabilities of the children further.	- HV'S experience significant stress and anxiety n their clinical judgement to meet the work demand and targets in practice.
-I wasn't good for her3 [22,23] -Angry face 7[13,17,19] -'Who sent you?7[13] - Quite resisting3[22] -Lodge complaint against me7[19]44[10] - Said I was rude7[20] -Not everybody wants to hear17[25] -Refused to see me44 [9,10] -	-HV feeling of rejection from highly resistant and hard-to reach families -Attitudes of clients' partly reflecting dissatisfaction and discontentment with the HVS and individual's HVs' attitude		
- NICE depression guidelines 14[26,27] -Domestic Violence risk DASH Assessment14[27]15[14] -Use CAF model 15 [9,10]42[1] CAF for MAT: which is multi-agency24[23]50[30] -Healthy Child Programme24[8] -Universal/Universal Plus /Universal Partnership24[18,19,] -Assessment triangle / framework28[7,8] -Edinburgh Postnatal Depression Scale:EPDS46[10]	- HVs apply expert and scientific assessment of risk and resilience, including tools, approaches and thresholds for interventions. -The HVs routinely apply different tools although they do not rely solely on the tools for decision-making e.g. EPDS score is related to physical presentation of mother.	- The HVs apply diverse strategies to recognise triggers for concerns, early signs of abuse and neglect or other vulnerability factors children may be facing; and how to address these needs.	-The HVs rely on quantitative and qualitative approaches to make clinical judgement and decisions to protect vulnerable children from harm -HVs are advocates for vulnerable children and their role require integrated working, professional
-Have a plan 2[8,9,10] -Have a supervisor 2[10]16[30]18[23] -Contact / share information with professionals 13[22,23] -Family, environmental, social, housing,15[9,10]37[20]	- The support mechanisms for HVs to guide their decision-making process.	- The HVs strive to ensure child safety and clients' relationship are	

-Shouldn't be judging[15][21,22]42[2,4,9,11,14,27]48[26] -Follow me31[15] -Speak to GP 16[21,22] 39[19] -Child protection supervision16[21]20[22,24]21[22]50[15]51[22] -Contact Social Services16[24] -The policy16[14,25]21[24] - Colleagues/Managers17[24,26]20[22,25]49[9] - Training20[1315,16]29[6,9,7,10] -Safeguarding team20[25]50[34] -News media21[4] - Partnership working24[26] -Studies/Research29[14,15,23,24,] -Clinical supervision19[9] -Serious Case Reviews42[13] -Read records47[26,27] -Making note50[4]	-The HVs use wide range of policies, guidance and tools for decision-making. -The HVs definition of vulnerability, their responses to the needs, early intervention work and other decision-making are expected to reflect frequent changes in government policies and directives in relation to safeguarding and protections of children	maintained; showing respect and dignity of clients, especially as HVS is predicated on home visits. -The HVs feel empowered to function in their role by organisations that have adequate training and professional development facilities, good safety culture and effective support from colleagues and managers. -Some HVs do struggle to maintain work-life balance and be detached from complex emotions and circumstances of some vulnerable children and families	curiosity and information sharing.
-Professional wisdom / judgement13[12]29[17] -Intuition/ Instinct 69[21]80[22,25]49[7] -Review and reflect 2[10] **Key**: -Interview transcripts for HVs Jane and Ekaette -Coded by: (Page Number [Line Number])	-The HVs require evidence-based clinical judgement, reflective and reflexive reasoning to proactively make decision.		

Appendix 13 – Narrative of Child Protection Statutes, Policies and Guidance

Year	Type	Title / Description	Narrative
2016	Independent Review by Care Quality Commission	Not Seen, Not Heard - A review of the arrangements for child safeguarding	It highlights that listening to children improves their emotional, mental and physical health. Practitioners do not routinely listen to and respond to the needs of children. And: *"… children and young people in care, and those with safeguarding concerns, remain some of the most vulnerable in our society. Yet not all get the*

		and health care for looked after children in England	*help they need when and where they need it"*. (Care Quality Commission, 2016, p3).
2015	Statutory Guidance	Working Together to safeguard children – WTSC	The WTSC emphasises that safeguarding children is everyone's responsibility. It provides the legislative requirements and expectations on individual services to safeguard and promote the welfare of children; and a clear framework for Local Safeguarding Children Boards (LSCBs) to monitor the effectiveness of local services. A child is anyone: *"… who has not yet reached their 18th birthday*" (HM Government, 2015, p92). Training should cover: *"how to identify and respond early to the needs of all vulnerable children, including: unborn children; babies; … young carers; disabled children; and those who are in secure settings*" (p13).
2015	Advisory	Information sharing Advice for practitioners providing safeguarding services to children, young people, parents and carers	Advice on confidentiality and information share, with emphasis on distinguishing fact from opinion about 'vulnerable' child. Ensure that you are: *"… giving the right information to the right individual …sharing the information securely … inform the individual that the information has been shared if they were not aware of this, as long as this would not create or increase risk of harm to the child*" (HM Government, 2015, pp10-11 with emphasis).
2015	Advisory	Care Quality Commission and Ofsted	Highlights the availability and impact of Early Help for vulnerable children became part of CQC and Ofsted inspections. "*Inspectors should evaluate how well the local area engages with children and young people in the identification, assessment and provision of their needs … decisions that affect how their needs are met*" (Care Quality Commission and Ofsted, 2016, p25)
2015-2020 2012-2015	Government Programme	Troubled Family	Introduced payment by Results (PbR) for provision of services to meet the needs of 'vulnerable' children and families (Troubled Families), featuring use of pre-agreed results (KPIs) between commissioner and provider of services. Considered a modernisation processes to achieve value for money, promote improvement in health and social care by aligning incentives to desired outcomes (House of Common, 2017). Criticised as lacking research evidence of criteria for troubled families and measure of outcomes, politically motivated model (Levitas, 2012).
2014	Statutory Act	Children and Families Act 2014	Provides legal framework on Children and Families including: Adoption, Family Justice, Welfare of children, Special Educational Needs and Disabilities (SEND), parents' rights and clarity on the role of Children's Commissioner, increasing it from simply representing the 'views and interests' of children to focusing on, and 'promoting and protecting' the rights of children. (HM Government, 2010).
2011	Dr Eileen Munro: Independent Review	A review of Child Protection	Focus was on: A Child-Centred Approach: emphasises a statutory duty placed on Local Authorities to ensure enough provision of early intervention services and to make every child and family who fell beneath child protection thresholds an "early help offer" of tailored services and resources (Munro, 2011, p12).

2011	Graham Allen (MP): Independent Review	Early Intervention: The Next Steps	Allen's review shows early intervention is the answer: a range of well tested programmes, low in cost, high in results, can have a lasting impact on all children, especially the most vulnerable (Graham Allen – MP, 2011). Early Intervention: Next Steps *"a rebalancing of the current culture of 'late reaction' to social problems towards an Early Intervention culture …. a primary prevention strategy….To raise educational achievement and employability, improve social mobility, reduce crime, support parents and improve mental and physical health" (p27).*
2010	Guidance	Grasping the nettle: early intervention for children, families and communities	Focus on early intervention as a force for transforming the lives of children, families and communities, particularly the most disadvantaged and vulnerable. (Centre for Excellence and Outcomes - C4EO, 2010; 2010a).
2010	Independent Review	Fair Society, Healthy Lives	Focus on reducing inequalities, improving health determinants and outcomes for children. Emphasis on health status in relation to early year, education, work, income, housing and communities in which children live. (Marmot, et al, 2012; 2012a; 2010).
2009	Policy	Healthy Child Programme (HCP) - Pregnancy and first five years	The HCP led to focus on preventive services and early support for children and family, with emphasis on: parenting support; child development; changed in public health priorities; integrated services; and vulnerable children and families. (DOH, 2009)
2007	Public Enquiry	Death of Peter Connelly	Led to Laming's second report: "*The Protection of Children in England: A Progress Report*" in 2009. Criticism: Many Authorities failed to adopt reforms following lessons after death of Victoria Climbié. (Lord Laming, 2009)
2004	Statutory Act	Children Act 2004	The statute incorporates changes introduced in ECM including the importance to capture the 'voice of the child' especially the 'vulnerable'. It established local safeguarding children board (LSCB), with emphasis on the partnership working and improvement of outcomes for children and young people to: stay safe be healthy enjoy and achieve achieve economic well-being make a positive contribution - SHEEP – (H M Government, 2004)
2003	Policy	Every Child Matter (ECM)	The ECM led to a new framework of integrated working to change the way services are delivered (SHEEP). (H M Government, 2003)
2004	Public Enquiry	Bichard inquiry into Soham murders	Led to radical change in system of enhanced vetting for anyone working with children (House of Commons, 2004)
2003	Public Enquiry	Lord Laming Report on Victoria Climbié	Victoria Climbié died in 2000. Enquiry led to a radical overhaul of child protection services and policies (Lord Laming, 2003)

		enquiry	
1989	Statutory Act	Children Act 1989	- A single legislation that brought together all regulations about child protection and welfare in UK. - The Child is paramount - Duty of local authority under section 17 Child in Need, Section 47 assessment and protection of child from significant harm - Parental Responsibility - Care Orders, Supervision orders and Protection orders - Private law orders known as 'section 8' orders Child Protection (H M Government, 1989)

Appendix 14 - Research Field Notes

RESEARCH FIELD NOTES 1.pdf

Appendix 15 – Rochdale Child Sex Ring - Perpetrators

The child sexual exploitation ring targeted underage teenage girls in Rochdale, Greater Manchester, England. Twenty–one men were convicted of sex trafficking , rape, trafficking girls for sex and conspiracy to engage in sexual activity with a child between 2012 and 2015. Offenders included British Pakistanis, asylum seekers and forty-seven girls were identified as victims of child sexual exploitation during the police investigation.

Source: BBC News 19th October, 2018

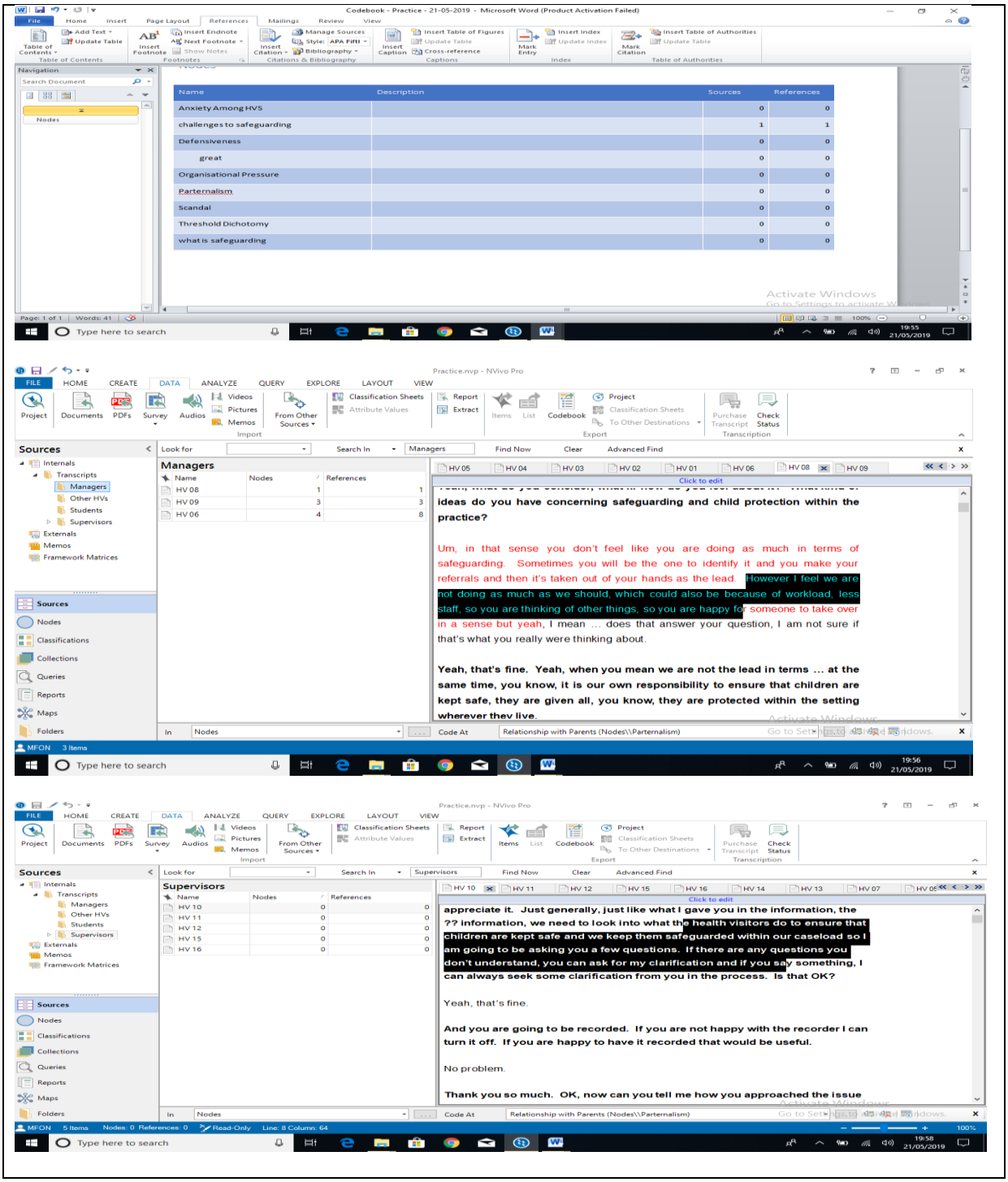
Appendix 16 - HV contacts / interventions for the period 1/1/16 to 31/12/16

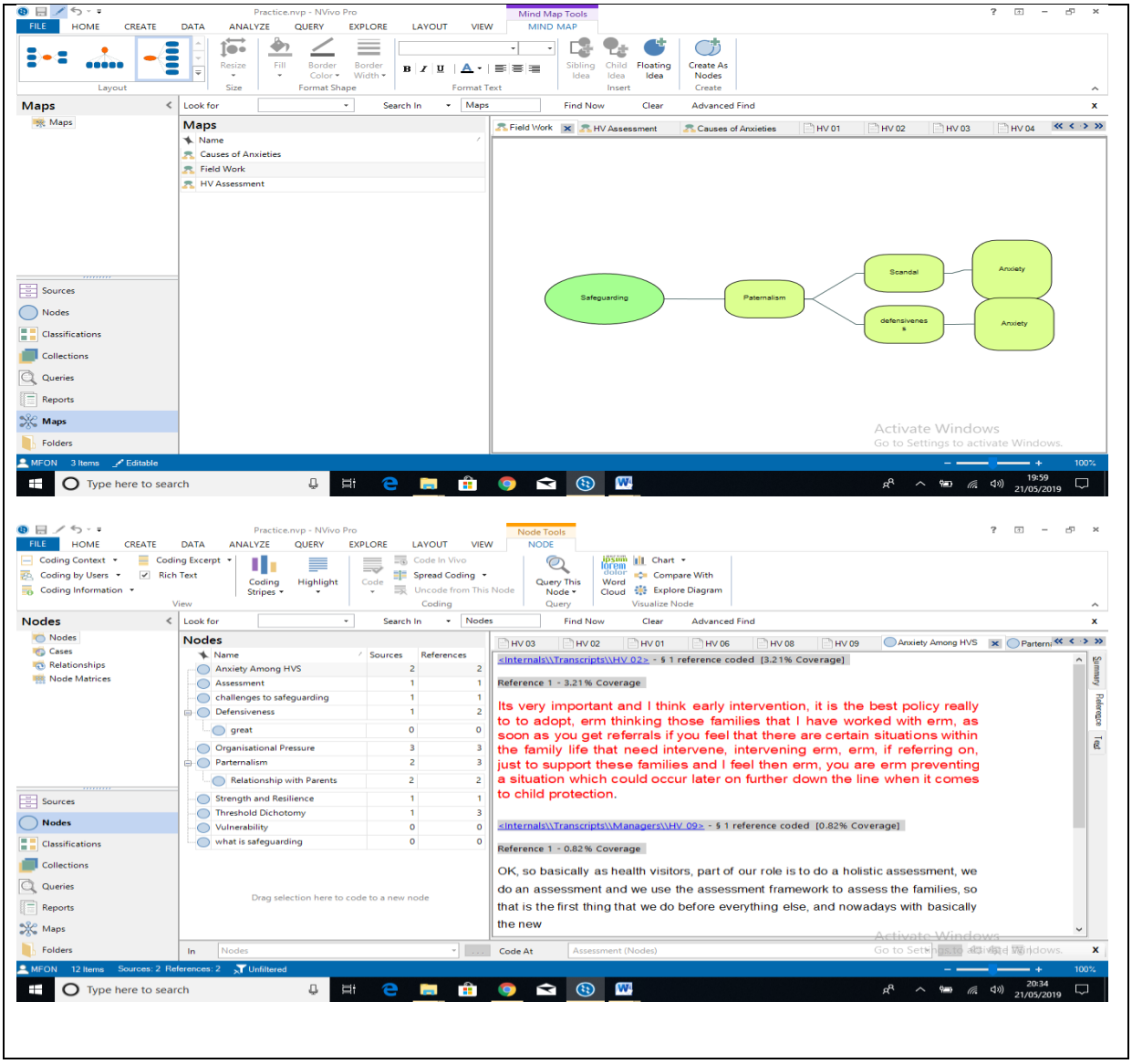
Activities /Interventions	**Code / (activity time in minutes)**	**Frequency of contacts (universal)**	**Frequency of contacts (universal) *in minutes***	**Frequency of contacts (vulnerable)**	**Frequency of contacts (vulnerable) *In minutes***
Phone Call	R1 - 3min	58	174	368	1104
Invite Letters	R2 - 10min	14	140	26	260
Contact – Home	R4 - 60min	25	1500	123	7380
Healthy Child Clinics	R4 - 10min	57	570	134	1340
CIN /CP Conference	E4 - 120min	0	0	30	3600
Professional / CGM	E4 - 45min	0	0	43	1935
MARAC Attendance/Review	E4 - 35min	0	0	5	175
MAT /TAC Meetings	E3 - 20min	7	140	43	860
First Assessment and Screening Team – FAST follow up	E3 - 30min	0	0	14	420
CP Supervision	E3 - 25min	1	25	108	2700
Opportunistic Contacts	E2 - 30min	1	30	43	1290
Liaisons with Other Services /Professional	E2 - 10min	5	50	395	3950
DNAs / Follow-Up	E1 - 5min	6	30	30	150
Transfers /Movement-In	R3 - 10min	4	40	24	240
Housing matters	E2 - 19min	2	38	22	418
No Contacts	R0	5	0	0	0
			2737		**25822**
Total in hrs Average per HV (Total 75 WTE)			**45.6hrs** **0.6hrs**		**430.5hrs** **5.7hrs**

Note: Appendix 16 provides a summary of HVs' interventions and contacts with children under Universal services and for those receiving enhanced or targeted services; highlighting the frequency and duration based on '*time and motion'* estimates for these activities. I found these descriptive data very crucial as it provided the useful tool for the interpretive component of the study, with a clearer insight into the work of

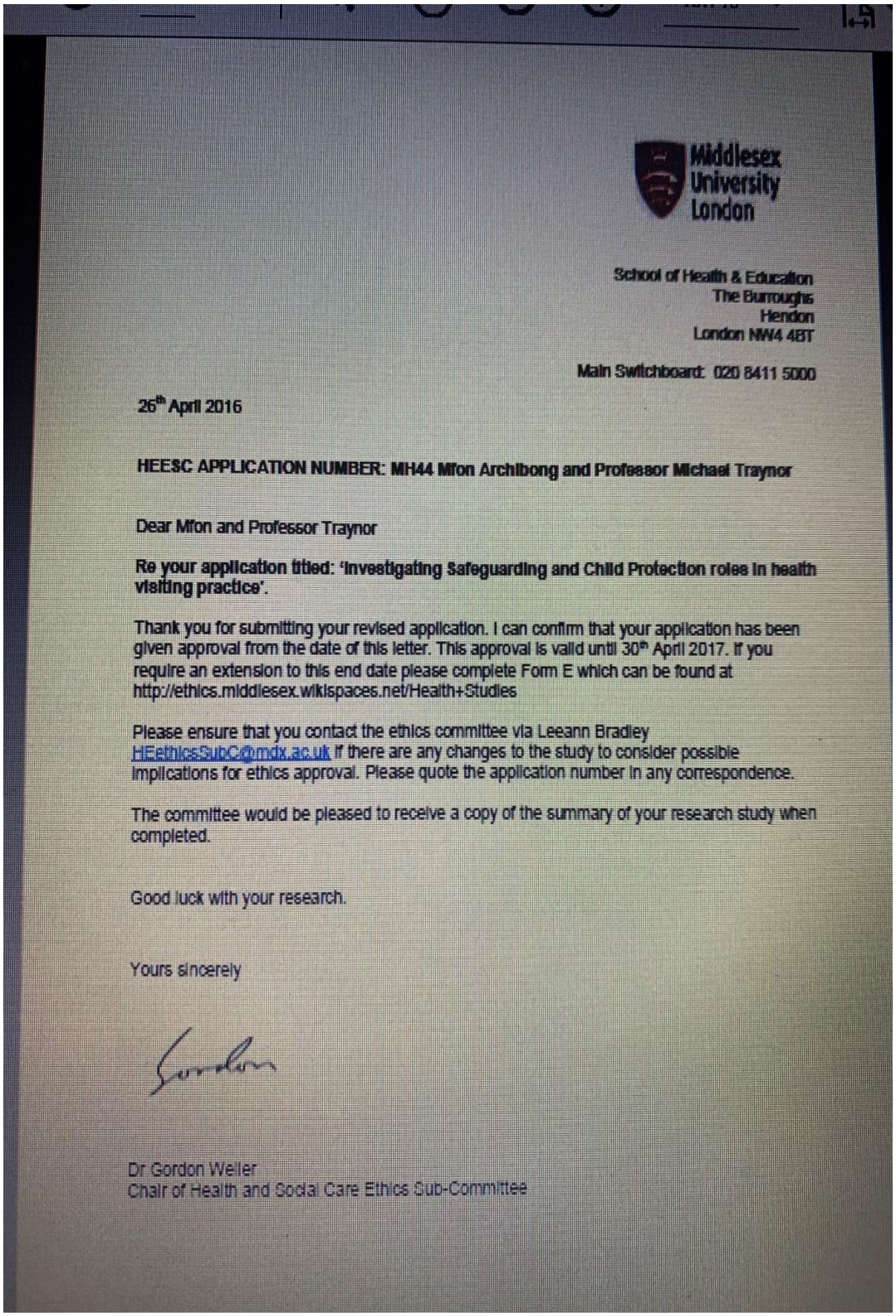
HVs, especially with vulnerable families. It shows a significant amount of their time is focused on supporting children and families with additional needs, leaving less time to offer universal public health services such as engagement with other health promotion activities in the community. The activities are differentiated with prefix ‘R’ and ‘E’, representing ‘routine’ and ‘enhanced’ supports or intervention offered according to needs of the child and family.

Appendix 17 – Screenshots NvIVO Worksheet




Maps
Safeguarding
Paternalism
Scandal
Anxiety
defensiveness
Anxiety
Nodes
Anxiety Among HVS
Assessment
challenges to safeguarding
Defensiveness
great
Organisational Pressure
Paternalism
Relationship with Parents
Strength and Resilience
Threshold Dichotomy
Vulnerability
what is safeguarding
Its very important and I think early intervention, it is the best policy really to to adopt, erm thinking those families that I have worked with erm, as soon as you get referrals if you feel that there are certain situations within the family life that need intervene, intervening erm, erm, if referring on, just to support these families and I feel then erm, you are erm preventing a situation which could occur later on further down the line when it comes to child protection.
OK, so basically as health visitors, part of our role is to do a holistic assessment, we do an assessment and we use the assessment framework to assess the families, so that is the first thing that we do before everything else, and nowadays with basically the new

Appendix 18 – Middlesex University Ethics Committee Approval Letter



Middlesex University London

School of Health & Education
The Burroughs
Hendon
London NW4 4BT

Main Switchboard: 020 8411 5000

26th April 2016

HEESC APPLICATION NUMBER: MH44 Mfon Archibong and Professor Michael Traynor

Dear Mfon and Professor Traynor

Re your application titled: 'Investigating Safeguarding and Child Protection roles in health visiting practice'.

Thank you for submitting your revised application. I can confirm that your application has been given approval from the date of this letter. This approval is valid until 30th April 2017. If you require an extension to this end date please complete Form E which can be found at http://ethics.middlesex.wikispaces.net/Health+Studies

Please ensure that you contact the ethics committee via Leeann Bradley HEethicsSubC@mdx.ac.uk if there are any changes to the study to consider possible implications for ethics approval. Please quote the application number in any correspondence.

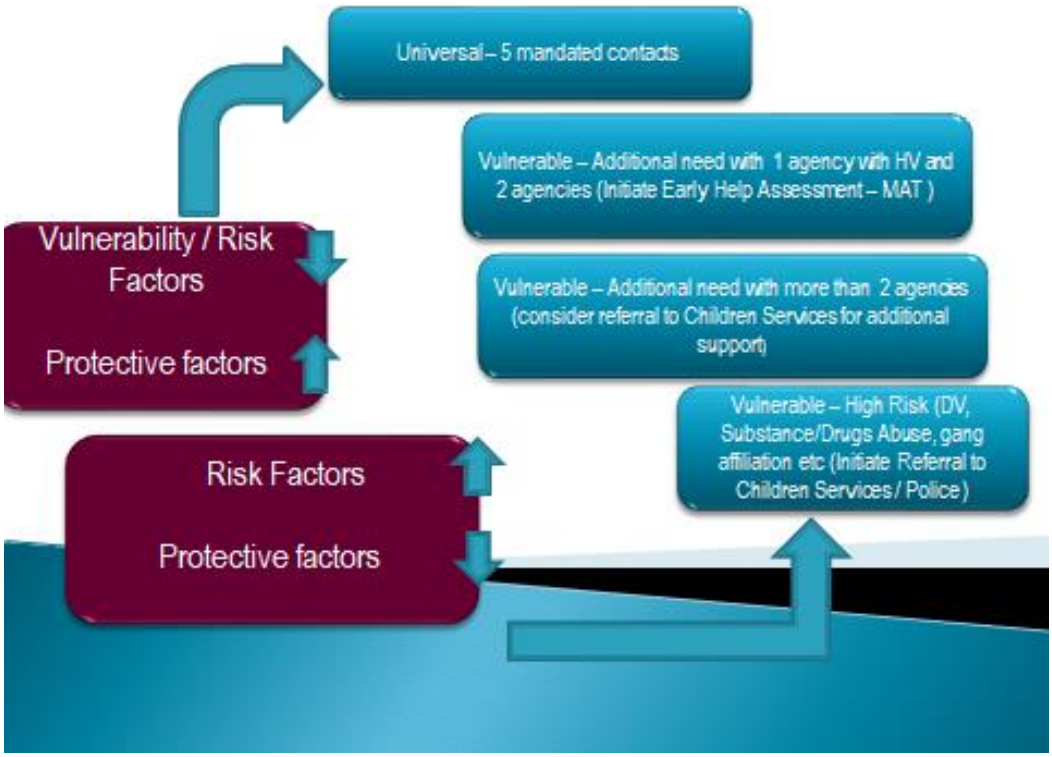
The committee would be pleased to receive a copy of the summary of your research study when completed.

Good luck with your research.

Yours sincerely

Dr Gordon Weller
Chair of Health and Social Care Ethics Sub-Committee

Appendix 19 – Threshold of Needs / HVS Offers



Note: The case notes showed that children with more protective factors and less risk factors were classified under universal caseload, and those with more risk factors and less protective factors, as determined by the HVs, tended to be classified under 'vulnerable' caseload.

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