

## **Health visiting and safeguarding children: a perfect storm?**

PECKOVER, Susan <<http://orcid.org/0000-0001-9766-9330>> and  
APPLETON, Jane

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# **Health visiting and safeguarding children: a perfect storm?**

## **Abstract**

Health visitors play an important role in safeguarding and protecting children. In this paper we review current research evidence and professional literature about this aspect of health visiting and highlight some of the practice challenges in undertaking this work. Three critical issues are discussed. The invisibility and unquestioned nature of much health visiting safeguarding work; that health visitors with their clinical expertise and accepted home visiting role are well placed to undertake this type of work; and the challenges of ensuring effective safeguarding within the context of economic austerity. The paper highlights the important contribution of contemporary health visiting to safeguarding children and child protection. It is important that this role is made explicit to those commissioning health visiting services for children in the early years.

**Keywords:** Health visiting; child protection; public health; safeguarding; policy;

## **Key Points**

- The longstanding role of health visitors in safeguarding and protecting children is largely unquestioned, and has been subject to limited contemporary debate.
- This paper provides a contemporary overview of health visitors' work in safeguarding and protecting children.
- There are particular challenges in ensuring effective health visiting safeguarding practice within the context of social and welfare austerity and significant change to commissioning arrangements.

## **Introduction**

Health visitors are public health nurses who provide a universal, largely preventative home visiting service to families with babies and pre-school aged children. The safeguarding and child protection role of British health visitors was empirically examined in depth more than 30 years ago (now republished as Dingwall et al, 2014), yet since then the policy and practice landscape in this field has changed considerably. The aim of this paper is to critically examine the contribution of contemporary health visiting to safeguarding children and child protection work drawing upon recent research and scholarship and to identify the key issues and practice challenges relating to this area of work.

## **Background**

Established in the late nineteenth century health visiting has developed as a community based public health nursing service that works mainly with families with babies and young children. Health visitors have a preventative orientation to their work with universal home visiting, needs assessment and the health visitor-client relationship the core practices underpinning service delivery (Cowley et al, 2013). Health visitors' work mainly with families with under 5's and their role involves assessing children's developmental needs, their family and home situation and supporting parenting skills They are able to provide a range of practical help and advice to promote positive health and prevent illness and can advise on aspects of parenting such as infant feeding, sleeping, child safety, immunisation, and promoting children's physical and emotional development.

Whilst health visitors have contact with all families with babies and children aged

between 0-5 years, the pattern and intensity of contacts is shaped by a progressive universal model which targets additional support to children and families with higher levels of identified need (Public Health England, 2016). The safeguarding and protection of children is a core feature of health visitors' work within this progressive universal model (Department of Health, 2012). Indeed health visitors have

‘a crucial role in the early identification of needs and providing tailored support. The offer of early help is essential to ensure issues are addressed in a timely manner and the appropriate support is provided’ (Department of Health, 2012:1).

Health visitors also work with children and families where formal child protection actions are required. This includes for example, making referrals to children’s social care because of concerns about abuse and neglect and contributing to multi-agency assessments and meetings in order to develop and implement plans to protect children (Department of Health, 2012). Thus the health visiting role in safeguarding and protecting children is broad, encompassing a range of activities which includes work with children and families displaying different levels of need and risk. This is however an area of practice that is largely policy driven, creates professional anxieties and surprisingly has been subject to less empirical research than other areas of health visiting (Lines et al, 2017; Taylor et al, 2017). Before critically examining the literature on this aspect of the health visiting role we discuss the current legislative and policy framework for safeguarding and child protection.

### **The Safeguarding and Protection of Children**

In England the child protection system is underpinned legally by the Children Acts

(1989 and 2004) and a wide range of government guidance that shapes multi-agency policy and practice (e.g. HM Government, 2018). This area of work is constructed in terms of safeguarding and promoting the welfare of children. This is defined as

‘protecting children from maltreatment; preventing impairment of children's health or development; ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and taking action to enable all children to have the best outcomes’ (HM Government, 2018: 5-6).

The focus is on early help with additional support to children and families as soon as a problem arises. Child protection is a part of safeguarding and promoting welfare and refers to the activity undertaken to protect children who are suffering, or are likely to suffer, significant harm (HM Government, 2018). A similar legislative and policy context shapes the safeguarding and protection of children in the other three countries of the United Kingdom. Professionals such as health visitors who work with children and families are required to be aware of their responsibilities and work collaboratively in order to safeguard and protect children (HM Government, 2018; Nursing and Midwifery Council, 2018).

Over recent years different forms of abuse such as child sexual exploitation, forced marriage, female genital mutilation and dangers associated with social media and the internet have become more widely recognised. The shifting nature of this social problem helps explain why, despite a policy preoccupation with protecting children, cases of child abuse and neglect continue to hit the headlines (Parton, 2014). Indeed a key feature of the British child protection system is policy reform and change; this is often driven by child abuse tragedies, wider political and media pressures and ideological differences in how the state

should intervene in family life (Parton, 2014). Current developments emphasise a child-centred approach, early help and intervention (HM Government, 2018). This has particularly focused attention upon ‘parenting’ and the importance of emotional nurturing and attachment during the first 1001 ‘Critical Days’ (All Party Parliamentary Group, 2015). As the health visiting role is focused upon families with young children and has a preventative orientation, the profession is very well placed to deliver this safeguarding and early intervention policy agenda.

## **Design and Methods**

Our starting point for this critical review of the health visiting role in safeguarding and protecting children is the current research evidence and professional literature in this field. Following this we draw upon wider health visiting literature to discuss some critical issues and practice challenges relating to this area of work.

In order to identify current evidence we conducted systematic searches of the electronic databases, CINAHL, Sociological Abstracts and Social Care Online, using the search terms ‘health visit\*’, ‘child safeguarding’, ‘child protection’, ‘child welfare’, and ‘child abuse’ and ‘abuse’. Inclusion criteria were articles published in English within the last 10 years (from January 2008-April 2018) and related to the health visiting role in safeguarding and protecting children in the United Kingdom (Aveyard, 2014). A total of 54 articles were retrieved. The abstracts were read and those that did not specifically discuss health visitors or their role in safeguarding and/or protecting children from abuse or neglect were excluded. The final 27 articles, included empirical research, literature reviews and

discussion papers; these were analysed to extract key themes and summarise the current state of knowledge on this topic area (Aveyard, 2014).

### **State of Knowledge: The health visiting role in safeguarding and protecting children**

Existing research evidence on the health visiting role in safeguarding and protecting children largely derives from small scale qualitative studies (Appleton and Cowley, 2008; Selbie, 2009; Burchill, 2011; Taylor et al, 2013; Bradbury-Jones et al, 2015; Taylor et al, 2017; Rooke, 2015) and literature reviews (Litherland, 2012; Botham 2013; Akehurst, 2015; Perryman and Appleton, 2016). We also found evidence generated from larger studies that included health visitors alongside other professionals concerned with safeguarding and protecting children (Whiting, Scammell and Bifulco, 2008; Fifield and Blake, 2011; Reeves et al, 2015; Whittaker et al., 2016; Luckock et al, 2017).

#### *Assessment of needs and risks*

The identification and assessment of needs and risks facing children is a key theme in many of the research papers. Drawing upon the findings of a wider study Appleton and Cowley (2008) discuss how health visitors assess the needs of vulnerable children. Selbie (2009) focuses upon risks to children exploring how health visitors identify, analyse and manage these. Burchill (2011) focuses specifically upon the work of health visitors in safeguarding asylum seekers and refugees finding considerable practice challenges in assessing needs, identifying risk and engaging other services particularly children's social care. Burchill (2011) concludes that the quality and effectiveness of health visiting safeguarding work with this population could be improved. Other studies focus upon the recognition by health visitors of specific child safeguarding concerns such as domestic abuse

(Litherland, 2012; Taylor et al, 2013; Bradbury-Jones et al, 2015; Perryman and Appleton, 2016). Again challenges in this field include safeguarding knowledge as well as professional skills in assessment. Indeed both Akehurst (2015), in a literature review of child neglect risk factors, and Selbie (2009) highlight the importance of safeguarding knowledge for effective health visiting practice. An example of the breadth of knowledge required for effective safeguarding practice is provided by the results of the literature review conducted by Perryman and Appleton (2016) who draw attention to male victims of domestic violence arguing that health visitors have an important role in recognizing this problem and supporting victims and their families in practice.

### *Support for Practitioners*

Running throughout all these papers is discussion of the practice complexities associated with the identification and assessment of safeguarding risks. Taylor and colleagues (2017) draw upon evidence from their study to highlight the emotional aspects of child protection work for health visitors. One important way to support staff is through supervision. Although Botham (2013) identified a lack of consensus about the supervision models and frameworks being used in practice, her review highlighted the benefits for health visitors of supervision; these included stress reduction, the provision of support, and opportunities for personal learning and development including enhanced critical thinking skills. The benefit of supervision was also confirmed in a small qualitative study reported by Rooke (2015), which also identified the importance for health visitors of support from colleagues. In this study health visitors also discussed the need to manage emotions associated with child protection work, and the importance of having time to reflect and evaluate casework (Rooke, 2015).



### *Inter-agency collaboration*

A number of studies have examined health visiting safeguarding practice within the wider context of inter-agency collaboration or working. These have focused upon integrated models of practice which enable health visitors to work alongside other safeguarding professionals, most notably children's social workers (Whiting et al., 2008; Fifield and Blake, 2011; Luckock et al, 2017). There has also been research examining joint training initiatives that address health visiting and social work practice in relation to child neglect (Reeves et al, 2015). Evidence from these studies suggest that working and learning together has benefits for safeguarding practice including improved communication and assessment, and better understanding of different professionals' roles and supports the acquisition of more specialist knowledge.

Whittaker et al (2016) report on a Scottish study that examined the views of health care professionals about parenting support for drug-dependent parents. The views of public health nurses, general practitioners, midwives and addiction staff who work with vulnerable families were collected. The findings identified challenges in providing care to these clients; these included professional ambivalence about this parenting support role, anxiety about intervening with this 'hard-to-engage' population, and concern about lack of resources and organisational support. A key message from the paper is the important role played by universal service providers such as public health nurses in safeguarding children living in complex family situations.

### *Safeguarding issues facing health visitors*

Papers discussing the health visiting role in safeguarding or protecting children were mainly topic focused and largely concerned with enhancing or exploring professional practice (Appleton, 2011; Peckover, 2013; Middleton and Hardy, 2014; Plastow and Lowenhoff, 2014; Allen, 2015; Richards, 2015; Bradbury-Jones et al., 2016; Morton, 2016; Dobson, 2017; Moseley, 2017; McGarry and Ali, 2018). These focused for example upon the role of health visitors in recognising and addressing specific safeguarding topics such as domestic abuse (Bradbury-Jones et al., 2016; Moseley, 2017; McGarry and Ali, 2018) and female genital mutilation (Allen, 2015). Drawing upon evidence from Serious Case Reviews Middleton and Hardy (2014) discuss the interrelated issues of domestic violence, mental health and alcohol or substance misuse; they argue that children in families affected by these issues are particularly vulnerable and explain the legal frameworks relevant to ensuring appropriate safeguarding practice.

Training and education to support effective safeguarding practice is advocated by Morton (2016) and Plastow and Lowenhoff (2014). Morton (2016) discusses the advantages of undertaking inter-professional training –describing an initiative which involved health visitors learning about safeguarding and child protection with other professionals such as school nurses and social workers. Plastow and Lowenhoff (2014) describe the development of a safeguarding game designed to enable student health visitors to learn lessons from serious case reviews in a fun and innovative way. This is part of a set of training resources they developed for practice educators to use to support the practice learning of student health visitors in an alternative and enjoyable way.

Both Appleton (2011) and Peckover (2013) discuss the health visiting role in safeguarding and protecting children within the wider changing policy, practice and organisational context. Appleton (2011) outlines health visitors' work with children and families, and reviews the profession's track record in safeguarding and protecting children work. While Peckover (2013) traces how British health visiting has become focused upon both public health and safeguarding children. A key theme running throughout both papers are concerns about the profession's continued ability to protect children given current workforce constraints and fiscal and organisational changes which have eroded this (Appleton, 2011; Peckover, 2013).

### *Practitioner perspectives*

Another insight into this area of practice comes from Dobson (2017), a newly qualified health visitor who reflects upon the challenges in 'treading the tightrope of safeguarding' (p. 219). In this discussion piece Dobson (2017) highlights the tensions inherent in health visiting between their work directed at building 'trusting, open and honest relationships with families, to be non-judgemental and to take a strength-based approach' (p. 219) and their surveillance role in relation to identifying abusive situations and protecting children. She illustrates these tensions by drawing upon practice examples of working with families where mental health and domestic abuse are issues and refers to the challenges in these situations of decision making and having difficult conversations with parents about child welfare. Dobson (2017) reflects upon the importance of supervision which provides a safe space to explore these practice issues and the need to keep the child at the centre of all decision making. Another piece written by Richards (2015) focuses particularly upon the manner in which assessments and interventions are carried out, drawing attention to the complex power dynamics evident in multi-agency child protection work. This author argues

that health visitors could be more aware of how these discourses operate and suggests that challenging these would enable a more holistic, child centred and reflexive approach to child protection work (Richards, 2015).

Our review of the current literature about the health visiting role in safeguarding and protecting children has enabled us to identify and discuss the current state of knowledge on this topic. The available research evidence is limited and has been generated from mainly small scale qualitative studies or literature reviews. This reflects the findings of an earlier extensive review of health visiting research which also found limited literature specifically about the safeguarding and child protection role of health visitors (Cowley et al, 2013). In discussing this aspect of practice Cowley et al (2013) emphasised the role of health visitors as ‘case finders’, approaches to assessment and work with vulnerable groups such as asylum seekers and refugees. There are some gaps in knowledge; for example we identified no recent research examining service user views of the health visiting role in safeguarding and protecting children. Contemporary critical debate is lacking. This overall lack of evidence may reflect the relatively weak position of the profession within universities as well as the universal, broad remit of the health visiting role which may obscure safeguarding work (Peckover, 2013). The relative invisibility of the safeguarding role has been identified by Taylor et al (2017) who argue the visibility of the nursing and health visiting contribution to safeguarding children needs to be enhanced. In the next section we discuss some critical issues and practice challenges relating to this area of work.

### **Critical issues and practice challenges.**

Health visitors are the only professional group who undertake home visiting on a universal basis enabling them to access all families with babies and young children. The significance of this unique home visiting role was recognised by Lord Laming (2009) in his report published following the death of Baby Peter Connolly in 2007:

‘Health visitors play a key role in child protection, particularly for very young children who are unable to raise the alarm when suffering from abuse or neglect.... In this context, the role of health visitors as a universal service seeing all children in their home environment with the potential to develop strong relationships with families is crucially important. A robust health visiting service delivered by highly trained skilled professionals who are alert to potentially vulnerable children can save lives’ (Laming, 2009: 57–58).

The age and therefore vulnerability of health visiting’s primary client group – the under 5’s is significant. Evidence from Serious Case Reviews draws attention towards the increased risks facing babies under 1 who die or are seriously injured at the hands of carers or parents. It also highlights the important role of effective universal health visitor home visiting provision, as many of these infants never come to the attention of children’s social care (Sidebotham et al, 2016). Home visiting by skilled health visitors provides an opportunity to observe the environment in which children and their parents live, to assess complex needs and consider the impact of these on the child’s health, development and wellbeing. Health visitors are particularly skilled in relationship building, having difficult conversations with clients, and are able to identify abuse or neglect and take appropriate action. They also have the skills to work with families and the multi-disciplinary team, when children are subject to

more formal child protection processes and interventions such as having a Child Protection Plan (HM Government, 2018).

Although there is no doubt that health visitors are very well placed to make an important contribution to safeguarding and protecting babies and young children they are also facing a number of challenges in undertaking this aspect of their role. Public policy concerned with children and families is very much focused upon parenting and early intervention (All Party Parliamentary Group, 2015) but welfare reforms and austerity measures including cuts to public spending, welfare entitlements and service provision are impacting adversely upon both children and families and service providers (Smith, 2015). Levels of need faced by children and families are rising; child poverty is increasing, and health and social inequalities are widening (Bradshaw, 2016).

There are also changes to the organisational and commissioning landscape for health visiting. This is particularly evident in England where in 2015 responsibility for commissioning of the health visiting service transferred from the National Health Service to local government. Health visitors are now being employed by a range of provider organisations - and with many different employers clarity is required about the health visitors' role in safeguarding. Overall evidence suggests service priorities are changing, workforce numbers have reduced and services are being organised and delivered differently across the country (Royal College of Nursing, 2017). In some areas this has resulted in cutbacks in universal provision and less health visiting contacts with under 5's and their families, resulting in families sometimes not even knowing who their health visitor is. Cuts to home visiting and general erosion of the universal service means there is a potential for

some vulnerable children to be ‘missed’. Additionally developments in information technology are leading to a more flexible and mobile approach to working (Abdu and Cooper, 2016). These have led to the displacement of health visitors initially from general practices but more recently from local community based centres such as the Sure Start centres, to geographically dispersed office spaces. This means that health visitors are becoming less visible in the community they serve.

Although not specifically writing about the health visiting role in safeguarding and protecting children two studies undertaken in Scotland provide useful empirical insights into this area of practice (Hogg et al, 2013; King, 2015). Reporting a qualitative study which examined how a policy shift towards a more targeted child health service impacted upon health visiting work King found that reductions in routine contact with all children and families coincided with an increase in focus and time spent on child protection work (King, 2015). The need to prioritise families with child protection issues was also identified by Hogg et al (2013) in their study which explored parents’ and professionals’ experience of family assessment.

For the health visitors’ safeguarding role these changes are creating a perfect storm. Public sector cuts and demographic changes are leading to a reduction in the size of the health visiting workforce, leaving less health visitors to assess and respond to need and deliver services to children and families. Limited contact with clients will make the health visitor—client relationship harder to establish and maintain. Furthermore cuts to wider services- particularly voluntary and non-statutory support services- are also increasing the levels of need faced by children and families (Ball, 2014). All of these developments make a

preventative approach to ‘safeguarding’ difficult to achieve as there is less child and family contact, and less time, resources or services available to address early needs. Moreover as Bywaters and colleagues (2017) have demonstrated child welfare services and intervention rates reflect wider inequalities making those children living in poverty and deprivation more likely to experience child protection interventions.

## **Conclusions**

This paper has provided insight into the health visiting’ safeguarding and child protection role. We have drawn upon research and wider literature to discuss the available evidence in this field and to raise some critical issues for practice. Our review highlights the skills and expertise health visitors have in safeguarding and child protection work. Through their universal home visiting role health visitors’ have unique access to babies and preschool children. Their public health orientation makes them ideally placed to deliver a policy agenda focused upon early intervention. Health visitors have the clinical expertise and are well placed to conduct this work and have an important responsibility to safeguard children. They also have the knowledge and skills to respond to situations where abuse or neglect is suspected or evident.

We have also highlighted a number of challenges facing health visitors in relation to their safeguarding children role. Of particular concern is the impact of austerity and public sector reforms that have led to service reconfigurations, changes in the organisations employing health visitors and general cutbacks in public sector services for children and their families. These measures may be putting the healthvisiting safeguarding role at risk.



Another challenge is the relative low visibility of the health visiting role in safeguarding children which, beyond the worlds of professional practice and unlike social work, is relatively unrecognised in the mind of the public or the media (Dingwall et al, 2014; Taylor et al, 2017). Dingwall and colleagues writing in 1983 (republished 2014) noted the lack of visibility and public accountability of health visitors in relation to the child protection aspect of their role. This lack of visibility is reflected in the limited contemporary critical debate or available research evidence about the safeguarding and child protection role of the health visitor identified in this paper. With the exception of a short Department of Health (2012) publication there is also a lack of policy detail about the health visiting role in safeguarding children work. And as Parton (2014) has pointed out reviews of child protection failures often draw attention towards social work shortcomings and system failures whilst the contribution of services such as health visiting is less visible. With the current shifts in organisational and commissioning arrangements for health visiting - which see the profession once again more closely aligned to local authorities - it remains to be seen if this low profile will continue.

The issues discussed in this paper shed light both on the important role of health visiting in safeguarding children – and also some of the challenges inherent in this role. At a time of child welfare policy reform and fiscal austerity, this paper has aimed to fill this discursive gap. It has provided an overview of the contemporary legal and policy frameworks shaping health visiting and safeguarding children and discussed some of the critical issues relating to this role. We hope this paper stimulates further discussion and debate about this important area of practice.

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