AIMS For a better birth...

Health Visitors or Health Police?

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Jean Robinson reports on how health visiting is increasingly being dominated by surveillance, not support, with all mothers being assessed for risk of child abuse at the first meeting

"Although health visitors have no legal right of entry, they do not make a habit of pointing this out to clients"1

A young woman, expecting her first baby, hears a knock at the door. She opens it, and the woman standing there says she is a health visitor, and can she come in? The woman asks why, and the health visitor says, "Just to see how you are". The woman says she's fine and doesn't need a health visitor, thank you. The health visitor replies, "If you don't let me in, I shall report you to Social Services."

The young woman is the daughter of an AIMS member, and an official complaint has been made. We've also suggested that she access her records - the health visitor has very likely put something on them - and this will almost certainly be recorded as a 'non-access' visit, a red flag for potential risk to children.

An offer you can't refuse?

Health visitors are "not to cross the threshold unless an invitation is given to enter, not to sit down unless a seat is offered, to remember that every room of a cottage has as much right to privacy as any lady's drawing room". - Instructions for visiting scheme, Huddersfield, 19331

In Cornwall, a couple who had given birth to their second bonny child without the attendance of a midwife did not take up an offer of health visiting by the midwife who did the postnatal check. They said they would call for medical help if they needed it. Staff at the Primary Healthcare Trust believed that refusal of health visiting was an automatic cause for referral to Social Services and acted on that assumption - although the Trust has since denied that this is their official policy.

This was the last straw for us. We have been receiving an increasing number of complaints about health visitors, and we think the time has come to put our members in the picture.

A health visitor has no right of access to your house - she cannot come in unless she is invited. Also, you are not obliged to use the services offered by a health visitor and you can refuse to see any of them at any time. This information is not given to you by the health service but, we think, in view of the increasingly authoritarian behaviour we are seeing, every mother in the country needs to know these facts.

The health visiting service has been universal because most mothers accepted it, and many found it

helpful (though sometimes, like the curate's egg, it's only good in parts). But health visiting has changed, and parents need to know what it has become before they make their choices as to whether they wish to use all or part of the service.

A balancing act

Ever since health visiting first began, the job has had two aspects that sit uneasily with each other: giving advice and support to mothers on baby and childcare, and operating a 'surveillance' system for faulty or dangerous care.

Surveys of mothers' views reveal many criticisms of health visitors. Their opinion of the service depended on the health visitors' behaviour. Cold-calling, or dropping in, was simply not acceptable - women regarded it as discourteous at best, snooping at worst - as was asking to use the loo so they could look around. As one nursing academic told us, "It has been considered bad practice not to visit by appointment for at least 25 years." Something is slipping.

Showing who's boss

Another of our clients - separated from her husband, breastfeeding a small child and pregnant again - was desperate for advice on weaning. Health visitors repeatedly failed to keep appointments, so she complained and got an apology from the Primary Care Trust. But she, too, was reported to Social Services as a risk to her children "because she could not get on with professionals". The health visitor had this vulnerable and needy mother struck off the GP's list - a GP with whom she got on perfectly well.

And she's not the only one. This illustrates another lesson. Although health visitors have no legal power - it is social workers who have that - they can use powerful punitive strategies, and our helpline suggests they are using them more often. We are now getting accounts of health visitors behaving in a manner we have never seen before.

One factor may be a result of the government's campaign for allowing no aggression towards NHS staff. We can understand this, and none of us would condone aggressive behaviour towards a nurse in casualty who is doing her best. But there are always at least two sides in communication.

Indeed, health visitors are likely to feel vulnerable going alone into family homes of all sorts. However, there was no discussion with patient groups about this 'aggression' campaign, and a high percentage of the potentially dangerous are likely to suffer from a mental illness, or drug or alcohol addiction. Black people are also more likely to be perceived as aggressive than white people by police and health services.

The campaign has simply encouraged health staff (and social workers) to label clients as 'aggressive' when they have felt threatened, and such a label is seen as adding to the risk of future child abuse.

Recently, we have been receiving a growing number of reports from indignant clients who say this has happened to them, and their detailed stories cause us concern. Two black clients we know well, whose

homes we've visited, have been so labelled (we've also noticed an escalation of unwarranted child - protection actions against black families after the Victoria Climbie report) as was a Romany mother, who has a white-collar job and lives in a settled home, and is quiet, gentle and sensitive. But it's now happening to mothers who are not from ethnic minorities.

In one home, the health visitors came in pairs - as if they needed support - in spite of a detailed investigation showing no evidence of a problem. When AIMS as supporting a mixed-race mother, both we and the NCT found it was the baby's white middle-class grandparents who were aggressive in manner, as reported by the mother, although the social workers did not believe any of us.

Breastfeeding complaints

At AIMS, because of our frequent contacts with mothers throughout the UK, we get early warnings of problems that often surface much later in the official literature. When complaints take a new direction, we try to put them in the context of what we already know and the research available. We usually ask depressed mums what support they had locally and whom they found helpful. We were surprised at how few mentioned the health visitor, and the many who dismissed the idea when we suggested it.

The most common complaint was bout health visitors' ignorance and misinformation about breastfeeding - and it's getting worse. Invariably, mothers told us that any hiccup was met with firm advice to put the baby on the bottle immediately. "They only care about getting increasing weight to look good on the chart" said one despairing mother. We wonder how this affects the poor continuation rates of breastfeeding. Given all the data showing longterm benefits to the child through to adulthood, this is a major public-health issue.

Alternative lifestyles or 'non-compliance' of any kind may be regarded with suspicion - including breastfeeding toddlers, use of alternative practitioners and alternative lifestyles, and rejection of immunisation.

The undertrained visitor?

"A few of the health visitors stood out from the rest in that they were not judgmental. That is, they offered few comments that blamed mothers. There was, unfortunately, a large group who spoke almost exclusively about mothers in a derogatory way."[2]

One reason for growing consumer dissatisfaction could be the reduction of health-visiting training - down from a year to 36 weeks - while breastfeeding and nutrition don't appear to be prominent in the courses offered at training centres. Oddly, none of the research on health visiting sees this as a problem, though "conflicting advice" appears in much of the breastfeeding literature. Of course, health visitors have already trained as nurses, some as midwives. But some researchers have questioned whether using nurses is a good thing, as they might be overly dogmatic in their approach. So, what about direct-entry health visitors?

Indeed, one criticism is that health visitors have an educational agenda (on feeding, sterilising, etc) that is delivered 'from the top down' - so parents are not their equal and don't have any subjects or questions they raise dealt with properly. The democratic health visitor seems to be a minority.

Research shows that mothers like, and find helpful, health visitors who treat them as equals, respect their knowledge and experience, and exchange ideas rather than impose their own agenda.

It seems to us that the health visiting culture varies from place to place. We know of super health visitors who are supportive of parents and cooperative, but we also know an ex-health visitor who left in despair because she could not live with the derogatory way her colleagues talked about their clients.

Screening for child abuse

"We cannot ask our Health and Social Services to act as a kind of anti-abuse intelligence service, smelling out the bad parents long before they have committed any crime. Parents deserve better than that. The more problems they face ... the more they need caring support."[3]

But new developments are reducing the chances of old-style supportive health visiting continuing. Health visitors are now required by the Primary Care Trusts that employ them to screen all new parents for any likely risk of child abuse. In some areas, they even visit mothers before the birth to do so. No wonder we're seeing more and more cases of babies targeted for adoption while still in the womb.

Health visitors don't tell mothers what they are doing, or why, and parents don't know, from their first encounter with the health visitor, that a record is set up. This means that, if a labelled-mother's toddler has an accident and is taken to A & E, the injury is looked upon more suspiciously than the same injury to the child next door.

The screening looks at risk factors such as the mother's age, marital status, education, whether the baby was premature or in special care, or whether the parents have a history of mental illness, violence or criminality. Many of these 'risk factors' are related to poverty, so just being poor makes labelling more likely. On screening over 14,000 births, 964 (7 per cent) were identified as being potentially higher risk; 106 of these families - 7 per 1000 births, higher than the 5 per 1000 national average - had attended a case conference for suspected or actual maltreatment.[4] This begs the question of whether there was real risk, or intervention because health and social workers now saw these families differently.

At many case conferences, false allegations have been spread like Chinese whispers to so many agencies that they are believed simply because of repetition, not good-quality investigation. Other researchers have pointed out that risk-assessment measures are increasingly used to pass judgments, and used retrospectively to justify past decisions and actions.[5] The worker's personality also affects assessments - and that, too, is clear from AIMS' case histories. As Dr Walter Barker, director of the Child Development Programme at Bristol University, pointed out: "The very fact of suspicion that someone may abuse their child creates subconscious barriers and hostile feelings for most people who work with such families. To

see families as being in need of support is very different from seeing them as potential abusing monsters[3]

Only one in 13 of the 'high-risk' families went on to abuse their children within five years, and 6 per cent of non-abusing families were incorrectly identified as 'high risk' for child abuse. In the 964 cases labelled 'high risk', there were 892 false positives. What's more, one-third of the families who did abuse children had been classified as 'low risk'. Are health visitors merely preparing the ground for the harvesting of babies for adoption?

The spy with the smile

"In most instances ... the visit was conducted without the clients' knowledge that her needs were being assessed ... The risk of child abuse ... was not mentioned to clients."[6]

Most alarming is the parents' lack of knowledge and consent as to what is being done and why. In one study, the health visitors were unhappy about having to use a highly structured questionnaire. In another, health visitors screened before the births used a different assessment - an 'early intervention strategy'. Recordings of conversations revealed the use of phrases like "a bit of a longer visit really to sort of get to know you and your family before baby arrives" and "We have to ask some quite deep questions, and the reasons we ask those questions is not because we're nosy, not because we're prying - it's because the more we know about strains within the family, then the more we can help". The purpose of the interview is disguised and fudged.

While going through the formal checklist, the health visitors repeatedly cut off mothers' attempts to raise their own concerns or questions - from the first, negating the type of informal conversation that research has repeatedly shown works best for health visiting. The mothers' responses to, for example, being asked what kind of mother she had could also be misinterpreted.

Give a dog a bad name ...

When assessments are done before birth, what is then passed on to the maternity services? Are 'high-risk' mothers treated differently and, if so, how? Are social workers already hovering in the background? How are these mothers perceived and treated thereafter by GPs and paediatricians?

Other health-service interventions require informed consent. Yet, with what may be one of the most dangerous interventions for you and your child, parents don't know what's being done.

The insistence that detecting potential abusing parents have high priority may be having another effect. We now get reports that mothers with physical problems (including one with a birth injury) were reported by health visitors to Social Services instead.

Access to records

Health visitors are amazed when our clients try to use the Data Protection Act to obtain their records as the process is often unnecessarily difficult. It is often not clear who the health visitor's employer is, and

who holds the records - the GP? Primary Care Trust? Sure Start? Some, including those in care proceedings, have tried and failed to get the records they are entitled to see.

Labelling - and then what?

In all discussions of health screening, experts agree it is unethical to seek out and identify risks that you cannot effectively treat. Where is the evidence that (a) this screening results in effective preventative treatment; and (b) the level of serious harm to parents and children is outweighed by the good? It all depends on what interventions follow the identification of a potential risk.

Help mothers, protect babies

One study is often quoted as showing that home visits by health visitors can reduce risk to children - but, in fact, it doesn't.[7]

In this American study, randomisedand with a long-term follow-up, yes, the intervention worked (although it lacks the crucial element of assessing parents' views). It reduced reports of child abuse as well as drug, alcohol and criminal problems, numbers of future births and use of food stamps.

What was the intervention? An interdisciplinary developmental agency offered a personal life development programme for each mother. It helped mothers to work on their own goals, build up confidence, and helped them obtain access to education and employment. And the authors warn, "It is incorrect to assume that our results can be applied to home-visitation programmes that are not based on this model."[7]

It was interesting to see how much this research corroborated the underlying theme bubbling through much health-visitor research - mothers' disappointment that the health visitor was largely there for the baby, not for them. And, as we see from our clients, sometimes requests for help with their own problems are met with irritation.

A report from Lambeth, in South London, gives hope.[8] Alas, they are assessing antenatally, and there is norandomised trial - nor do we know what parents think of it. But they are offering a creative programme. They start from the concept "that every parent wants and tries to do their best for their child", and offer many strategies, including baby massage workshops, and special clinics to deal with problems like sleep, crying, feeding and child behaviour. Parents are seen as vulnerable, rather than potentially abusive, and the aim of visits is to strengthen the parent-child relationship.

The end of health visiting?

Will health visitors continue to exist and, if so, in what form? So far, they have been a separate 'profession', with their own registration with the Nursing and Midwifery Council. That separate registration has gone. They will now be included in Specialist Community Public Health Nursing. Will the 'good' traditions of the old, experienced health visitors go with it? They are colluding in their own demise,

and their acceptance of unethical practices means that consumers won't be fighting for them. The bell tolls not just for us, but for them, too.

Many health visitors feel overworked and overstretched, their pattern of work now dominated by what their employer (and the government) wants them to do. Some have bravely resisted, but are helpless. One experienced and respected health visitor has refused to administer the abuse-assessment tool, declaring it is unethical. But, as we know from our contacts with midwives, it is hard for the vulnerable lone employee to hold out when their profession does not have a strong, supportive ethical framework.

The forerunner of the Nursing and Midwifery Council used to have an influential and effective ethics committee, where debates were of a higher standard than those of the equivalent committee in the GMC. I know. I used to sit on both. But it was disbanded. When AIMS protested, we were told that ethical issues would be tacked on to other work and be covered in other committees.

We think it is their lack of ethical perception that has led health visitors into this morass. As the state gave "a nudge here and a prod there",1 the ethical ground eroded beneath them, and they didn't notice; they were so busy not admitting even to themselves, let alone their clients, how uneasy was the compromise between support and surveillance.

In France, the equivalent of health-visitor and child-protection work is done by separate groups. To maintain a fiction of reluctance, health visitors insist on subpoenas before giving evidence in family courts. But they had previously given out information on clients openly at case conferences.

Now the surveillance role has tipped too far towards policing to fit in with the traditional health-visiting role. Some have adopted it with alacrity, some with reluctance and others with despair.

The time has come for everyone to put their cards on the table and have an open debate (see the box on page 22 for a recent case received).

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