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Home level bureaucracy: moving beyond the 'street' to uncover the ways that place shapes the

ways that community public health nurses implement domestic abuse policy

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Abstract: Street-level bureaucracy is an increasingly useful way to understand how strategic policy is implemented in day-to-day practice. This approach has uncovered the ways that individual health and social care practitioners work within institutional constraints to influence policy implementation at the micro-level. Nonetheless, despite the diversity of settings where these street-level bureaucrats (SLBs) work, little attention has been focused on the impact of place on policy delivery. This paper draws on empirical research to examine the ways that delivering government domestic abuse policy in the intimate space of the family home shapes the delivery of strategic policy in the everyday. Drawing on qualitative research with Health Visitors (HVs) in the UK in 2016, the study findings illuminate the ways that the material, socio-spatial and idealised boundaries of the family home shape the implementation of policy. Key themes in the HV's narratives emerged as they described themselves as both a danger and in danger in the family home. In challenging the ontological security of the home (Giddens, 1990) - privacy, security and control are key concepts here - HVs described how they shape their actions to achieve policy outcomes while simultaneously managing threats to the home, to professional identity and to self.

1. Introduction

Since the seminal work of Pressman and Wildavsky (1973), examining the

implementation of an economic development programme in the USA, policy

implementation researchers have examined the complex and dynamic processes that

operate between the decisions of policy makers and the final implementation of the

policy at 'grass roots' level. With the exception of Bardach (1977), the focus of much of

the work in the 1970s was on failed federally funded programmes in the USA and the

complexities faced by multiple decision makers throughout the implementation process

(Sætren and Hupe 2018). A shift came in the 1980s with the work of Lipsky (1980), who,

taking a political theory approach to policy implementation, theorised that 'street-level

bureaucrats' (SLBs) operate at the interface between bureaucracy and the population,

exerting a high degree of power and control over how policies are implemented in the

everyday. Contrary to the literature that asserts that policy is decided by politicians and

delivered by civil servants (Hudson and Lowe 2004), the basis of Lipsky's (1980)

argument is that, 'the decision of street-level bureaucrats, the routines they establish,

and the devices they invent to cope with uncertainties and work pressures, effectively

become the public policies they carry out' (Lipsky 1980 p. xii).

The core tension at the heart of the implementation debate has been on how to

develop theoretical understandings of the relationship between many different actors in

complex governance systems: political decision makers at nation level; local-level

administrative units; and, the practices of 'front-line' public sector workers (Sætren and

Hupe 2018). As the research focus has shifted from the USA to Europe, it has become

clearer that the implementation of policy involves a negotiation and bargaining process

that exists within formal and informal networks of different actors and implementers

(Fudge and Barrett 1981, Hill and Hupe 2014), rather than a linear 'top-down' model of

the past.

While acknowledging the complexities of the debates in the policy implementation

literature, there has been a resurgence in interdisciplinary empirical research exploring

the ways that front-line workers such as teachers, health care personnel, social workers

and police officers work as 'street-level bureaucrats' (Maynard-Moody and Musheno

2003). Drawing on the work of Lipsky (1980), this body of research explores the ways

that public employees use, implement and subvert policy directives in response to day-

to-day pressures of working in a resource limited environment (Erasmus 2014, Hughes

and Condon 2016). A focus on discretion has emerged as a prominent discourse in

health and social care scholarship: student nurses (Hughes and Condon 2016),

experienced Health Visitors (Bergen and White 2005), social workers (Evans 2010,

Scourfield 2015) and primary care physicians (Cooper, Sornalingam *et al.* 2015) have all

been shown to use discretion to reconcile professional values with institutional

constraints and limited resources.

While this growing body of scholarly work has been focused predominantly in the field

of social work, it has illuminated the ways that individual actions - particularly the moral

judgments and agency of individual practitioners - work in conjunction with institutional

constraints to influence the ways that policy is made reality at the micro-level (Erasmus

2014). Nonetheless, little attention to date has been focused on the *place* of policy

delivery. The concept of the 'street' in SLB theory has been weakly problematised and

normalised discourses of SLB position the 'street' as a neutral, agendered and public

space. As Crossely (2016) and others have pointed out, while the implicit assumption –

and focus of much empirical research - is that street-level encounters happen at an

office desk in a government building (Fletcher 2011), increasingly the site of government

intervention into the lives of the disadvantaged families is in the home (Wacquant 2009,

Crossley 2016, Upton 2016). Taking a Foucauldian approach and widening the lens

beyond disadvantaged families, Winter and Cree (2016) likewise track over time the

historical progression of the state into the intimate space of family homes through the

practice of social work.

2. Health Visiting in context

It has long been recognised that while nurses represent the largest professional group in

the health care workforce, they remain largely invisible within the policy arena (Davies

1995, Hughes 2010, Traynor 2013). The work of community public health nurses has

global reach and universal coverage in many countries, including Australia, Canada and

Northern Europe (Schmied *et al.* 2011). Delivering global health care policy in the most

intimate of spaces of family life, these SLBs work in the most diverse settings from the

slums of global mega-cities to the rural planes. The United Kingdom (UK) has a long-

established provision of child family health services through the health visiting service

(Peckover 2013) and the devolved countries of the UK deliver similar health visiting

services but in different ways.

Health Visitors (HVs) have, and always have had, a central role to play in relation to

families as the only service to offer a universal health needs assessment to all children

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under five years of age in the UK. In 2014, the Scottish Government introduced the

Children and Young People (Scotland) Act 2014, which identified health professionals as

pivotal to delivering policies relating to the act. Despite a policy context of otherwise

extensive cuts to public services and the implementation of austerity measures across

Europe (Karanikolos *et al.* 2013), policy reform in the UK has led to an unprecedented

investment in health visiting services in recent years (Department of Health 2011) and in

2014, the Scottish Government released funding for an additional 400 HVs. In addition,

the number of statutory home visits HVs are required to make following the birth of a

baby has increased from 4 to 11 over the first five years of life. The details of these

home visits are clearly set out in the new Universal Health Visiting Pathway

(UHVP)(Scottish Government 2015), which prescribes both the timing, and requirement,

of each home visit.

Assessing and intervening in domestic abuse (DA) is not new for HVs, but until now, it

has been located at the 'fringe' of health visiting work (De La Cuesta 1993), peripheral to

the 'core' work of monitoring child development, public health and safeguarding

(Peckover 2013). While assessing and intervening in DA has long been a part of the role

of HVs, the safeguarding of children is the priority duty for all health and social care

professionals and has been the primary focus for policy and practice (RCPCH, 2014).

Nonetheless, the new UHVP (Scottish Government 2015) mandates that HVs increase

home visits and include questions in their routine assessment following the birth of a

baby and ask mothers about current DA, with a particular focus on the wellbeing and

safety of the mother. Discretion has been given to HVs to ask about DA as a 'routine

enquiry' at any of the first 4 home visits post birth: 11-14 days old; 3-5 weeks; 6-8

weeks; 3 months; or, 4 months old. The policy also states that this should happen while

HVs 'build on and strengthen therapeutic relationship between practitioner and

mother/family' (Scottish Government, 2015, p.8-12). NHS Scotland has also rolled out a

programme of training to educate key health care professionals, including HVs, to the

issues of gender-based violence (Nursing in Practice 2010) and the Scottish Government

(2015) and Department for Health and Social Care (2017) has produced guidance on

what health workers need to know about gender-based violence.

Increasingly domestic abuse[1] is recognised as a global issue (WHO 2009), and despite

the intense level of scholarly attention directed towards DA, there has been limited

success in intervening as a public health concern. Scotland's National Strategy to

Address Domestic Abuse (Scottish Executive 2003) defines DA and states that

'gendered-based violence, can be perpetrated by partners or ex partners and can

include physical abuse (assault and physical attack involving a range of behaviour),

sexual abuse (acts which degrade and humiliate women and are perpetrated against

their will, including rape) and mental and emotional abuse (such as threats, verbal

abuse, racial abuse, with holding money and other types of controlling behaviour such

as isolation from family and friends' (p. 1). In recent years, scholars working from a

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[1] It is recognised that different terms are used in different countries and contexts to describe domestic abuse, including intimate family violence, domestic violence and gender based violence. In this study, the term domestic abuse is used throughout to maintain consistency with the terminology used by the Scottish Government policy documentation.

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nursing and feminist poststructuralist perspective have raised concerns that HVs do not

know how to identify and intervene in DA (Bacchus *et al.* 2012, Taylor *et al.* 2013).

Detailed guidance continues to be developed to help health professionals to identify

and respond to DA (NHS Scotland 2009, Scottish Government, 2017). Nonetheless, as

policy makers increasingly recognise the need to intervene in this public health concern,

they struggle to align macro national policies with actions that occur in the most

intimate of family spaces.

It is timely then to explore the experiences of HVs as SLBs: the professional focus of

their day-to-day work on universal service provision to all families with children under 5

years old, family support, screening and prevention has the potential to illuminate areas

of practice that might have been obscured by studies that prioritise the work of SLBs

such as the police and social workers, who operate with a more targeted, acute and

crisis intervention focus in relation to family work.

This paper draws on empirical research to examine the ways that HVs in the UK describe

their subjective experiences of asking as part of a mandatory 'routine enquiry' about DA

while working in the home with new mothers. Informed by theoretical and empirical

work on professional identity (Traynor 2013); ontological security (Giddens 1990); and

gender scholarship on the home (Peckover 2002, Young 2005), prior work is extended,

generating more nuanced understandings of the impact of the material and spatial

confines of the family 'home' as a place of policy delivery.

The theoretical focus of this paper locates HV practice as predicated on classic

sociological conceptualisations of home as much more than a house or a roof over one's

head: it is a place of 'shelter, hearth, privacy, roots, abode and (possibly) paradise'

(Somerville 1992 p.332). It is a place where identity is developed, and a sense of family

and belonging is nurtured (Saunders and Williams 1988). Despite the strong symbolic

power of home (Mallett 2004), the nursing literature has been slow to interrogate the

socio-political dimensions of home as a site for policy delivery. While the scholarly

literature identifies the ways that men and women recognise and ascribe meanings to

home in different ways (Gurney 1997, Gorman-Murray 2013), a plethora of studies

exploring home as a therapeutic landscape have identified the psychosocial benefits of

'home' as providing privacy, security and control in a complex and changing world

(Ahmet 2013, Alaazi *et al.* 2015, Kidd and Evans 2010, Smith *et al.* 2015). Ontological

security is a key concept here (Giddens 1990) and this paper explores the ways that

home becomes a site that amplifies contradictions in the HV role when asking about DA

and uncovers the ways that discretion is used to manage these tensions.

3. Aim of the study

The aim of this study was to explore the day-to-day experiences of HVs using a 'routine

enquiry' approach to domestic abuse with women following childbirth.

4. Methodology

4.1 Study context and sampling

The data presented in this study involved in-depth individual interviews (n=17) with HVs, aimed at eliciting their subjective experiences working in communities with women following childbirth. Respondents were all sampled from NHS community health services in Scotland. The nurses interviewed were all qualified HVs working in primary and community care with a minimum of 6 months to a maximum of 30+ years post-qualification experience. All seventeen participants were female and described themselves as white British. They were aged between 27 and 65 years. All of the HVs had undergone a wide range of different DA training programmes delivered by a range of different providers (NHS, Women's Aid etc.) in the last 5 years as part of their continuing professional development.

Information on the study, and invitations to participate, were sent via managers to all HVs in the area inviting them to be involved in the study. The study was undertaken at a time of acute staff shortages amongst the HV workforce in Scotland and it was extremely difficult to recruit HVs to this study. A convenience sample was eventually reached of HVs who replied to the invitation sent by their mangers to participate in the study and participants were sampled because they were able to shed light on the research question (Coffey and Atkinson 1996).

4.2 *Individual interviews*

Following signed consent by each participant, interviews were conducted in a range of

different health centres, and during working hours, in one Health Board area in Scotland

between September 2015 and March 2016. Semi-structured interviews were conducted

in English, based on a topic guide devised from the literature on the experiences of HVs

working with women who had experienced DA. Interviews lasted from 30-90 minutes

(mean length of interview = 50 minutes). Questions asked participants to describe their

day-to-day experiences of working with women following childbirth and their

experiences of asking women about DA as part of the requirements of the forthcoming

UHVP. They were also asked to share their experiences of working with women who had

experienced domestic violence, disclosed DA and/or been referred to them by the police

following a reported incident relating to DA. The HVs gave rich interviews, sharing

stories of their day-to-day work, the values that drove their actions and detailed

reflections on their role. Interviews were tape recorded and transcribed verbatim. A

pseudonym was used to identify the transcript of each participation and identifiable

data removed from the transcript to ensure anonymity.

4.3 Ethical considerations

The University of X and the local NHS research governance authority granted ethical

approval for the study. All participants were given written information prior to obtaining

written consent for the study. Participants were informed that they could withdraw

from the study at any time without explanation and were reassured that whilst data

collected from the interviews might be published, anonymity and confidentiality would

be adhered to at all times. Following data analysis, all participants were given an

electronic copy of the research briefing findings and invited to comment or to ask for

clarity; no participants formally responded.

4.3 Data analysis

The analytic process was multi-layered and iterative throughout the research (Coffey

and Atkinson 1996). The analytic process operated at two levels; first, analysis of each

interview as a whole was carried out; descriptive codes and categories were developed

by remaining close to the data (Braun and Clarke 2006, Ritchie *et al.* 2013). This

provided detailed, in depth explanations that inductively derived patterned meanings

from the data and also identified the implications of themes related to the experiences

of the HVs in working with women to discuss issues of DA. Analysing the descriptive

codes and themes, and their relationship to each other, and to theories led to the

development of second, analytical codes. The rigour of the research was maximised in

two important ways; memo writing was used to consider analytic decision and themes

were also shared with a qualitative research colleague to allow for exploration of

counter themes. A reflexive account of the role of the principal investigator was central

to the research process; issues of positionality and bias were considered, as the principal

investigator is a former community nurse. She has over 15 years of working in a wide

range of community settings, including the home, and her 'insider' status brought

sensitivity and closeness to the data. While aware of the dangers of 'insider' status

(*author*), she was also able to bring insight into the wider context of health visiting

practice.

5. Findings

The study findings illuminate the ways that the physical, gendered and idealised

boundaries of the family home shaped the ways that the HVs exercised discretion to

negotiate, adapt and resist elements of the policy to identify and to intervene in DA.

Initial study findings confirmed that although knowledge of DA was high amongst the

participants, many struggled to implement 'routine enquiry' and used discretion in

asking about DA in a range of different ways: 1) by deciding on the most appropriate

visit to ask about DA; 2) by asking vague questions about 'feeling safe' at home; and, 3)

by not asking directly at all. Interestingly, length of time as a qualified HV did not lessen

these concerns: two HVs had been qualified for over 20 years and said that they had not

had one disclosure of DA, whereas other, more newly qualified HVs, reported several

disclosures of DA. Nonetheless, exposure to DA cases over time did appear to increase

HV confidence in dealing with DA.

The notion of 'home' arose as a major finding in this study and although interest in

'home' was not an *a priori* concern, it emerged during the data analysis and collection.

Key themes in the HVs' narratives emerged as they described their work in the family

home as amplifying their role as 'surveillance' in a private space, as materially and socio-

spatially porous and as a dangerous place to work: somewhere beyond, and more

intimate than, the 'street'. In entering the home, the HVs used discretion in their day-to-day work because they were aware that to ask questions about DA positioned them as both *a* danger and *in* danger in the family home.

5.1 Invading the privacy of the family home: being *a* danger

5.1.1 Maintaining safety and minimising disruption

When the participants began to talk about their day-to-day work as HVs, they recognised that they were given access to the most intimate of family spaces, somewhere that is usually private and hidden from public view. The HVs all described themselves in different ways as 'invited guests' in the home and, as such, engaged in building a therapeutic relationship with the mother. This was central to the work of HVs and to justify their observation of the intimate physical, social and relational aspects of the family home, they asserted that this was necessary in order to build up a more 'complete picture' of the family. This reflects the UHVP (Scottish Government 2015), which emphasises the 'core and wider role [that HVs play] through home visiting which focuses on relationship building with the family; ensuring that families' needs are appropriately assessed and responded to in a person-centred and supportive way' (p.3).

Nonetheless, the HVs understood that the reality of working in the home was much more complex than assessment and providing support: repeatedly the HVs expressed concern that a consequence of their assessment could potentially lead to disruption.

Examples of this included the mother and child(ren) having to leave the family home, or the removal of child(ren) from the home in response to child safeguarding duties. Home was clearly understood as a space of unavoidable 'tensions surrounding the use of domestic spaces' (Sibley 1995p. 94) and these tensions were evident as the HVs described the ways that they held the tensions of ensuring safety was maintained for the child(ren) and the harm that disruption to the family home could bring from disclosure of DA. Amy was clearly angry that the new UHVP mandated that HVs screen for DA and yet did not resolve the inherent contradiction of how to support the mother while also prioritising child safeguarding duties.

> *What is not clear is how we are supposed to support the mother but if she*
>
> *tells us she wants to stay with a violent man, and I've had that situation,*
>
> *then we have to safeguard the child first and foremost and then that means*
>
> *protecting the child, and maybe being part of the whole sorry process of*
>
> *removing the child and then how can you support both the mother and the*
>
> *child at the same time? I don't get that, I really don't' [Amy]*

In this context, HVs asserted that many families did not want to have health care professionals in their home, resenting the intimate scrutiny that working in the home brought, and the HVs knew they only had right of entry to the home if the family granted it. Building a positive relationship with the mother became pivotal in order for HVs to undertake a needs assessment, to plan subsequent interventions and to fulfil child safeguarding duties. To achieve this, the HVs seemed to engage in a discursive

'dance' with families, where 'probing' and 'hiding' emerged as a constant thread in the

HV narratives: the HVs probed for detailed information of family life; the families

disclosed some information and hid other aspects of their lives from public scrutiny.

I spent a long time at that visit and doing as much probing as I could but she

[the new mother] would not open up, so that's very difficult…Yeah you know,

I will always ask, you know, be aware of the relationship, you know and how

supportive the person is and I will do a lot of probing type things, you know,

about domestic safety but you can only go so far before the mum becomes

defensive and backs off [sic]. [Sarah]

'Playing it carefully', 'going cautiously' and 'leaving the door open' became the

modus operandi for the majority of the HVs: at once asking challenging questions

in relation to intimate family life and yet only probing as far as maintaining a

therapeutic relationship and trust would allow. In this context, where the daily

work of HVs became a delicate and fragile relational endeavor, the HVs found it

very difficult to ask about DA as they felt this type of questioning risked fracturing

what could be a very fragile and fledgling relationship of trust. Sarah further

describes it below:

Yeah, you know, because you're coming in and meeting someone for the very

first time. You're asking them lots of questions anyway, and then you're

being really pressing asking them, well, you know, what's your relationship

like? I think that can destroy what can be a positive relationship straight

away if they think you're [pause] and they don't trust you. A lot of people

don't trust professionals…you need to play it carefully [sic]. [Sarah]

Running through the narratives of the HVs was the recognition that the reality of

DA was far from the notion of the idealised home as being a safe and nurturing

space. Within this reality, the HVs saw their role as complex: supporting the

woman to maintain the home as a safe space for the children, while also ensuring

that children were protected under safeguarding duties.

Our role is to make sure that the children are protected and are living in a

safe environment. That's what I learned from our training, is that women

really can protect their children, even if they're having coercive control

[Margaret]

I'm not sure why I find it so difficult to ask about domestic abuse but I think I

tend to focus on making sure the home is a safe place for the baby to

develop and form attachment bonds with mum. You're there in the house

with the mum and new baby and it's all very intimate and they're

vulnerable…I focus on the positives, although I know safety can be an issue

[Sinead].

While Margaret and Sinead understood the dangers that women faced while in

abusive relationships, the safety and development of the children were clearly the

priority. Nonetheless, the participants were aware that to uncover DA required

them to take action that could potentially have high-risk consequences for the

woman and her children, including leaving the home, living in temporary or

unsuitable accommodation and experiencing homelessness. Several participants

talked about the disruption to family lives that moving to a refuge could bring.

There was anger and frustration that the result of the actions of violent or

coercive men would result in unstable housing for the woman and children. Sarah

described her awareness of the impact of leaving the family home:

> It's really hard when you're out there in the community because you really
>
> realise how disruptive it is to move these women. It means moving school for
>
> the kids and social support for the woman. I know that safety is really
>
> important but it's huge to have to lose your home and move out [Sarah].

In this context, discretion in asking about DA was used as a means of managing the

tensions inherent in the HV role: to maintain a therapeutic relationship to ensure

that health needs could be adequately assessed and safety maintained, yet not

'probing' as far as to threaten the safety the woman might struggling to maintain

for child(ren) within an abusive relationship. In ensuring safety was maintained

while minimising disruption, the HVs held together the contradictory tensions

embodied in their role as both support and surveillance.

5.1.2 Amplifying surveillance

While government policy documents are replete with normalised discourses of the home as a positive site for HV work (Scottish Government 2015), it was clear from the narratives that participants understood the precarious nature of their work and that to ask 'challenging questions' in relation to DA amplified their role as 'surveillance' in the family home. With a few notable exceptions (Peckover 2013, Peckover and Aston 2018), little is written about the 'policing' role of HVs and the wider nursing literature primarily focuses on the support roles HVs hold. Peckover and Aston (2018) highlight the inherent tension in the HV role where nursing discourses of therapeutic support are simultaneously held with the wider public health surveillance and child safeguarding roles: one working against the other but embodied in the same person. Jane articulated the contradictions inherent in the HV role, as did of many of the participants, when she explained how she would ask about DA but emphasised that her role was primarily to support the mother:

> *Em, so yeah, I don't really push it you know, but if I really was quite*
>
> *concerned about someone then I wouldn't be put off kind of discussing it*
>
> *[domestic abuse], because I feel that I need to be there to support that*
>
> *woman [sic]. [Helen]*

This narrative of 'support' is consistent with nursing identity and a long-standing discourse of caring and compassion as a foundation to the professional role but the

requirement for HVs to routinely ask about DA appeared to amplify their role as

'surveillance' and this made them very uncomfortable. Several of the participants

admitted to 'skirting around the issue' or seemed to avoid asking about DA altogether.

Recent research by Bradbury-Jones (2015) underscores the 'dynamic of silence' that can

exist between health professionals and women who have been abused: despite research

that states that women want to be asked by health professionals about DA (Bradbury-

Jones *et al.* 2014, women are reluctant to disclose DA (Feder *et al.* 2009) and do not

necessarily recognise the abuse as such (Bradbury-Jones *et al.* 2014).

The participants in this study described the way that working in the family home as

being in 'their territory', which intensified feelings of 'invading' an intimate and private

space. Jane described the importance of 'their territory' clearly:

> *There's always something about people being in their own home that makes*
>
> *it more difficult to ask that sort of question [about potential domestic abuse]*
>
> *because you're on their territory. It feels like you're sort of invading their*
>
> *personal lives [Jane].*

This idea of 'invading their personal lives' was a strong narrative thread running through

the accounts the HVs gave of their daily work in the family home. This was sharply

contrasted with the way several of the participants described their work with parents in

the health clinic, where the medicalized environment and a desk enabled HVs to

distance themselves from the intimacy of family life:

In the clinic, you're sitting behind a desk and there's the computer and the woman is coming in to our space, so it is much more clinical you know, and you can be much more matter-of-fact about asking questions about domestic violence, you know what I mean? At home, it's really different – you're more just like two women sitting talking about children and families. It's the relationship you have to get right and to build up trust or you always think you might not be allowed back in to the house, and that would be a disaster [Janet].

The clinic was framed by several of the participants as a medical space, less personal the family home and as a space that protected HVs from getting 'tangled up' in the complexity of family lives. The HVs contrasted their work in the clinic with their work in the family home: the clinic was described as a space where it was easier to focus on medical discourses of immunisations and developmental milestones, whereas the family home was identified as a space that intensified gender relations and idealised notions of 'home', making it easier to identify DA but harder to ask about it.

5.1.3 Intensifying gendered notions of 'home'

Picking up on the themes of therapeutic relationships and gendered notions of the home, the participants were asked to describe the ways that they developed

relationships in the home. Several of the HVs clearly drew on their personal

experiences as women and mothers to develop a more intimate bond with their

clients. Morag described the way that she lowered professional/client barriers by

drawing on traditional gendered notions of women as mothers in the private

space of the home:

> Yeh, I do chat sometimes about what it was like for me as a new mum and
>
> some things with my children. I don't give too much away but it helps the
>
> mum to relax and to see me as less of a threat. When you're in the house and
>
> chatting it's easier to be like that than in the clinic. It's more formal there
>
> [Morag].

Nonetheless, it was clear that Morag also felt some personal vulnerability and

protected herself from emotional harm by 'not giving too much away'. When

Miriam described her work in the family home, she described letting go of

professional power and considerable effort in order to build up a therapeutic

relationship:

> I don't know but it strikes me that when we're working in the home, we're,
>
> em, I don't really know how to put it, em, what should I say, bending over
>
> backwards to try to build up a relationship with the mum. Less in-charge of
>
> things because we have to make sure they let us back in the next time [she
>
> laughs]. It's a bit more just one woman talking to another woman. That's
>
> how I build up the relationship anyway [sic][Miriam].

In both of these accounts, the HVs removed professional barriers while working in the space of the home, were less in control and more open with the women they worked with. Home in this context was repeatedly reinforced as an intimate private and feminine space, especially following the birth of a new baby where the mother was positioned as particularly vulnerable.

Gendered notions of the private and public space were evident in a different way as several HVs expressed anger that policy often appeared to be ungendered and yet asserted that the 'locus of the problem' is always on the woman, while the male perpetrators are free to come and go from the family home (Hearn and McKie 2010). The role of women as the 'protector of the home' – even when there was a violent partner in the home - were strong throughout many of the stories told by participants and this narrative was exemplified by Mary:

> *You notice that the guys just come and go whenever they feel like it, but it makes me so angry, the woman has to stay, to make sure that the children have somewhere safe to live and develop. She can't just take off with a tiny baby and children. She's the one keeping the home together and the guys just come and go. Where's the justice in that*? [Mary].

The HVs in this study used discretion in asking women as part of a 'routine enquiry' about DA as they understood themselves to be *a* danger in the family

home and, as such, uncovering DA could damage the relationship they had built

with the mother and trigger a range of consequences that could lead to

homelessness and further vulnerabilities for the mother, which all challenged their

professional ability to support the mother and newborn baby. In addition,

working in the intimate space of the family home seemed to intensify and amplify

gender roles. In not asking about DA within this space, some of the HVs were able

to diminish their role as 'surveillance' and accentuated their empathy and support

for the woman, protecting identity and self.

5.2 Negotiating porous boundaries: being in danger

During the interviews about 'routine enquiry', the HVs also talked about their

experiences of working with families who had been referred to their service following a

police report – usually a physical assault on the woman the previous night – and in these

accounts, the narratives were predominantly of being *in* danger in the family home,

rather than being *a* danger. Contrary to previous literature that has highlighted a lack of

knowledge about DA and resulting lack of confidence in dealing with the issue

(Lazenbatt *et al*. 2009, Bacchus *et al.* 2012), this study found high levels of knowledge

about DA. The HVs seemed reluctant to be involved in cases of DA not because of a lack

of confidence in dealing with the issues, but because they were anxious that they would

become mixed up in the complexity of family lives.

5.2.1 Tangled up in the complexities of family lives

Being *in* danger was articulated in the multiple ways that the HVs became 'tangled up in

the complexity' of family lives: the complexities for women of negotiating safety with

fear; the complexities of family relationships; the complexities of harmful substance use

and mental ill health; and, the complexities of intersectional lives.

> *I just feel that I am a Health Visitor and I'm not an expert in domestic*
>
> *violence, neither am I an expert in drug use or substance…you just get*
>
> *tangled up in it all. It can be just so complicated. [Janice]*

While working in the family home, the HVs described how they encountered

extended family members, with their opinions, needs and wants. They negotiated

different cultural norms and values as diverse families lived out their religious and

traditional values, observed neglect and poverty as they sat in homes where basic

physical and emotional needs were clearly not being met and, they absorbed the

physical and emotional fear that women experience when subject to violent men.

This feeling of being 'tangled up in the complexities of family lives' was bounded

by the physical and emotional 'walls' of the home environment.

> *You get caught up in Asian families where there are extended families and*
>
> *the mother-in-law rules-the-roost and the daughter-in-law is unhappy and*
>
> *then there's a controlling male in the family and it's so hard to work out*
>
> *what is normal and cultural for them and what is controlling behaviour*
>
> *[sic][Amy].*

In addition, 'feeling afraid' within the physical walls of the family home were at the

forefront of several of the accounts the HVs gave of their experiences when they had

felt unsafe within the family home. HVs gave accounts of feeling afraid by a male family

member and 'trapped' within the family home. This had clearly influenced the questions

they were able to ask women and their willingness to re-visit the family home:

> *Some of my families for instance where the male is always present and he's*
>
> *the one who talks, so you would be trying to make opportunities then to see*
>
> *that woman on her own, outside the home or in the clinic. You can feel*
>
> *scared when there is a threatening male in the house and you can't do your*
>
> *job. You just want to get out! [sic][Eva].*

While some of the HVs clearly felt trapped within physical and emotional

boundaries of the family home, experiencing the fear of a male perpetrator in a

confined space, they also simultaneously felt professionally exposed as

professional barriers were dissolved and gender politics of the public sphere

leaked into the private space of the home.

5.2.2 Universal provision and unprotected boundaries

The findings of this study concur with several other studies revealing weakened

screening processes for DA because health professionals were hampered by heavy

workloads, a lack of time and lack of privacy away from a male perpetrator (Feder *et al.*

2009, Hooker *et al.* 2012, Hooker *et al.* 2015). In addition, this study identified the

'universality' of the HV service and increased provision of home visits as a key area of

concern.

The HVs described themselves as always 'universally available' as part of the

universal health visiting service, which was accentuated with the introduction of

the UHVP (Scottish Government 2015). In working regularly in a support role in the

home, and in building up a relationship with the mother, the HVs felt that the

private/public boundaries of home had become porous and, unlike other

professional colleagues, they were unable to say 'no' to a home visit. The HVs

argued that social workers and police had 'thresholds' that had to be reached

before they would visit a family, but as a HV, they were always expected to be

available and to visit a family in need. A visit to the home brought the public into

the private domain, and dissolved the professional and personal self, resulting in

the transfer of the responsibility for the health and wellbeing of the woman to the

HV. This brought increased professional responsibility, to ensure the woman's

wellbeing and safety, and responsibility if anything happened to the woman. Many

of the HVs said that they felt anxious that if a serious incident occurred - such as

serious violence or murder - and they would be exposed as negligent by the press.

They were placed in a very precarious position if they'd asked about DA, or had

been called following an incidence of violence, and felt in part responsible if

something subsequently happened to the woman. It seemed to be that to be a

'universal service' was to carry 'universal responsibility'. The HVs also suggested

that this would be exacerbated by the introduction of the 'Named Person' in

Scotland (Scottish Government 2014). Jan clearly described the feeling of 'never

being off duty' and always carrying responsibility if something goes seriously

wrong:

> *You do go home with that anxiety of what if something terrible happens and*
>
> *um somebody is really badly hurt which I think probably for a few of these*
>
> *families actually there is a real potential for that, that to happen. Um, which,*
>
> *but all we can do is just kind of regular visiting…but there's a lot of risks. It's*
>
> *a dangerous business for us all. [Jan]*

Working within the intimate space of the family home appeared to dissolve

protective professional barriers, such as the desk, clinic and medicalized

discourses. The 'home' is understood as a private and intimate space where

gender roles are amplified, professional identity challenged, professional

responsibilities increased and a context created where HVs must maintain a

therapeutic relationship with the mother, while asking challenging questions that

threaten to endanger these relationships and self.

4. Discussion

As street-level encounters for disadvantaged families move increasingly from the desk,

clinic and office to the family home (Wacquant 2009, Corssley 2016, Winter and Cree

2016), this study illuminates the ways that working in this intimate space shapes the

work of HVs as they deliver a 'routine enquiry' into DA. The use of discretion is clearly

evident in the extent to which the policy mandate is implemented and yet this study

suggests that the 'decision' of HVs to use discretion is much more nuanced than the

existing literature would suggest. Professional discretion is frequently framed as either a

negative professional attribute impeding policy implementation or as the result of wider

structural constraints, such as a highly managerialised and marketised health care arena

(Howe 1991), resource limitations (Evans and Harris 2004) and/or stakeholder

constraints (Newman 2009, Evans 2010, Scourfield 2015). Examples where discretion is

framed as a negative attribute include: ignoring policy guidelines (Kamuzora and Gilson

2007); making moral judgments on the implementation of services (Mullet *et al.* 2016);

and, advancing personal interests (Kaler and Watkins 2001). In this study, discretion

operated as the outcome of a complex interplay of social, economic and political

tensions that exist beyond the boundaries of home and yet permeate the home

environment (Somerville 1989).

The work of HVs within the home goes beyond the private/public binary of home and

work. While HV work has been shaped by the intersecting discourses of the idealised

'home as hearth' thesis of earlier decades, the reality of the day-to-day work of HV

opens up 'home' as a site of contradictory tensions: maintaining safety and security

while simultaneously managing a therapeutic relationships that can be imbued with

fear, anxiety and violence (Blunt and Dowling 2006). Gendered identities are reinforced

through home (Dupuis and Thorns 1998) and normative and universal discourses of

home (Somerville 1989) are disrupted through DA. In addition, structural issues of race

(Chase 2013) and gender (Gorman-Murray 2013) are challenged as mothers seek to

maintain safety for themselves and their children within dangerous spaces. Within this

intimate space, the idealized presentation of home and material representations of self

are challenged (Dunn 2013) to foreground the multiple ways that home can be a site of

conflict, interpersonal violence and distress (Saunders and Williams 1988).   Working in

the intimate space of the family home, HVs are not protected by the desk or the

medicalization of the clinic, but are exposed to (re)conceptualization of the boundaries

of home as porous: not only a 'socio-spatial system' (Giddens 1984) where the social

and physical unit of home and household come together, but as a much more

problematic entity.

HVs are at once constrained by the physical boundaries of the bricks-and-mortal of the

house to make it a place of containment and fear if a male perpetrator is at home, and

yet simultaneously exposed to porous socio-spatial boundaries: mechanisms that

usually protect professionals from emotional distress, such as the desk, clinic and

medicalised discourses of professional knowledge, are dissolved as the HVs give of

themselves as women, mothers and within the intimate space of the family home .

Health visiting is based on a strong history of being 'mother's helper' (Cowley *et al.*

2015) and while this has been strongly critiqued over the last two decades (Peckover

and Aston 2018), discourses of 'support' clearly remain an underlying premise of health

visiting work. As the UHVP mandates that HVs ask about DA as a means to support the

mother, this glosses over the emotional investment that HVs make in building up a

therapeutic relationship with women, only to know that to uncover DA could also result

in disruption through moving to a refuge or the removal of children.

In being both *a* danger in the home and *in* danger, the role of the HV as 'agent of the

state' is accentuated and juxtaposed against that as 'agent of the citizen' (Rowe, 2014).

Nursing identity is predicated on notions of care, compassion and empathy (Richardson

et al. 2015), notions antithetical to their role in surveillance. This is particularly

emphasised following childbirth and the early days of life when the material, socio-

spatial and idealised dimensions of home are intensified.

It is within this socio-spatial and material environment that 'ontological security' has

been identified as an essential psychological need in order to establish a place in the

world to enable identity construction and self-actualization (Giddens 1990) away from

outside scrutiny. Dupuis and Thorns (1998) assert that 'much of the work that goes into

maintaining or restoring a sense of ontological security takes place in the private realm,

where tensions built up from the constant surveillance in other setting of daily life can

be relieved' (p. 27). While ontological security has been identified as particularly

important for people experiencing mental illness (Laing 1965, Padgett 2007), Giddens

(1990) argues that ontological security is a deep psychological requirement of all people:

it is established in early childhood; it is an emotional need in all societies; and, gives a

sense of 'being-in-the-world' (p. 92). While earlier work attached the concept of

ontological security to home ownership (Dupuis and Thorns 1998), more recent studies

have identified the importance of home for ontological security in people who are living

in conflict zones (Sousa 2014), those who are homeless (Padgett 2007, Smith *et al.* 2015)

and indigenous people (Alaazi *et al.* 2015).

For women who experience DA, ontological security is related to having a house and

also the emotional stability of having a home that offers safety, comfort and community

(Woodhall-Melnik *et al.* 2017). When HVs ask about DA in the home, they become a

potential danger to the fragile security that many women work to provide for their

children. This is particularly damaging at a time when a woman might be struggling to

maintain ontological security against threats from an abusive partner.

In asking about DA, HVs clearly saw their actions as potentially threatening to the

ontological security of the home (Giddens, 1990) - privacy, security and control are key

concepts here. As a consequence of this heightened awareness of the contradiction of

home as a site of safety and of violence, HVs shape their actions to achieve policy

outcomes while simultaneously managing threats to the family home, to professional

identity and to self. Study findings illuminate the impact of the home as a site for

intense emotional tension and contradiction in policy delivery and highlight the

importance of attention to *place* in shaping delivery of policy beyond the actions of

individual 'street' level bureaucrats.

Conclusion and implications for research and practice

As critical debate in the literature increasingly focuses on the ways that health and social care professionals work as SLBs and use discretion to 'subvert' the implementation of government policy, there is also a growing body of work highlighting the macro-structures that constrain policy implementation at the 'street' level. Nonetheless, the 'street' has been largely conceptualised in these discussions as the desk, clinical and/or office environment and is weakly problematized. Concurring with previous studies, the HVs in this study used discretion in different ways to choose if, and when, they asked about DA, and yet discretion is not conceptualised as 'subversion', but as a strategy to manage the complex relational dynamics that exist, and are intensified, in the intimate space of the family home. In this space, the intention of the HVs was not to 'subvert' the policy mandate to ask new mothers about DA but rather to manage threats to the home and to self. In entering the family home, the HVs clearly understood that space to be somewhere more intimate than the 'street', and somewhere that simultaneously reinforced gendered and physical boundaries while dissolving professional and socio-spatial boundaries. This was very different to when they described their work in the clinic, where they were protected by the desk and computer and were more able to frame their work within medicalised discourses.

In conceptualizing the work of HVs in the family home as both *a* danger and being *in* danger, this paper highlights the importance of attention to place to understand the

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ways that home shapes the actions of SLBs to exercise discretion beyond the space of

the desk, the office or the 'street'. As HVs increasingly become key SLBs, professional

education and policy directives must acknowledge the impact of the family home on

health visiting practice and address issues of ontological security, surveillance and

professional identity in order to equip HVs to work more effectively with women who

are experiencing DA.

There were several limitations to this study: it was specific to one geographical location

in Scotland and one group of health professionals and it was only possible to obtain a

convenience sample, which may not have gleaned data from a representative sample

and opened the research up to dissenting voices. The study did not explore the

experiences of women who invite HVs into their homes and further research is needed

to explore whether 'ontological security' also has meaning for new mothers, including

those who have experienced DA. In addition, all of the HVs in this study were women

and it would be interesting to more fully understand gendered identities in relation to

the home and male HVs. Finally, comparative research between different types of

'street' - beyond the home/clinic - would be welcome, as well as between different

health and social care professionals working in the space of the family home.

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