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Citation for published version:
Cuthill, F & Johnston, L 2019, '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', *Sociology of Health & Illness*, vol. 41, no. 7, pp. 1426-1443. https://doi.org/10.1111/1467-9566.12968

Digital Object Identifier (DOI):
10.1111/1467-9566.12968

Link:
Link to publication record in Edinburgh Research Explorer

Document Version:
Peer reviewed version

Published In:
Sociology of Health & Illness

Publisher Rights Statement:
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Download date: 02. Dec. 2021

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Journal:	*Sociology of Health and Illness*
Manuscript ID	SHI-00002-2018.R2
Manuscript Type:	Original Article
Subject Area:	Community care < RESEARCH AREAS, Domestic violence < RESEARCH AREAS, Gender < RESEARCH AREAS, Giddens < RESEARCH AREAS, Health Policy < RESEARCH AREAS, Health visiting < RESEARCH AREAS
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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.

Keywords: Community care, Domestic violence, Gender, Giddens, Health Policy, Health visiting

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.

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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 –

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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

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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

[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.

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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.

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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*

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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.

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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

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(*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

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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.

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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

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'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*

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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].

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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.

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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

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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:

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> *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

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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].*

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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

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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

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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].*

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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

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'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

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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

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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

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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

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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

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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.

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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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