Fifty years on: reflections on research on the role of the health visitor

by June Clark (FRCN 1982)

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The 1960s and 1970s were exciting times for me on a personal and professional level. My personal and professional lives became inextricably intertwined. In 1962, I graduated with a degree in classics from University College London. I had already decided, much against my parents' wishes, that I wanted to be a nurse.

As a student nurse I was already regarded as 'a bit of a troublemaker' and I became active in the RCN. In 1966 I got married and our children were born in 1969 and 1972. In 1967, I qualified as a health visitor and went to work in Berkshire, where my husband held a university post and we lived on the campus in a university flat. These seemingly irrelevant factors determined the next ten years of my career including, in particular, the development of my research into health visiting.

This study of health visiting in Berkshire was my first attempt at research and was also one of the earliest studies undertaken by any nurse in England. This early study is the focus of my contribution to this RCN Fellow's 2020 publication, nearly 50 years later.

The role of the health visitor: a study conducted in Berkshire, England

Abstract
A study of 1057 home visits undertaken by health visitors in Berkshire in 1969 showed that the range of the health visitor's work was much wider than the stereotype which portrays health visiting as an activity limited to maternal and child welfare and concerned mainly with physical care. The sample was the population of health visitors, 82 in all, employed by Berkshire County Council. The health visitors completed a questionnaire, were interviewed, and recorded their home visits for one week. Seventy per cent of the visits were to households containing a young child, 18% were to the elderly, and 12% to other households. The content of the visits was recorded in terms of the topics discussed. Some topics were essentially medical, and some were within the scope of the stereotype, but many were topics not traditionally associated with health visiting and there was a considerable psychosocial content. Differences were found between visits recorded by younger and recently qualified health visitors and visits recorded by other health visitors.

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Introduction and background

The 1970s were turbulent or exciting times, whichever way you looked at them. The National Health Service (NHS) was embroiled in preparations for its major reorganisation in 1974 which involved the transfer of community health services, including health visiting, from local government to the newly created health authorities. I was appointed as the nurse member of the Berkshire Area Health Authority, which enabled me to become deeply involved in the development of health and social policy, working with many of the leaders in health care of the day. In 1962, the Health Visiting and Social Work (Training) Act had established the Council for the Training

of Health Visitors (CTHV), later extended to include education (CETHV) as the new regulatory body for health visiting. The council established several working parties that attempted to define the future role of the health visitor, and in 1966 a training programme with a new curriculum had been introduced, designed to produce a 'new breed' of health visitor with a much broader role (Clark 1968).

I was one of the first to qualify under the new regime. The decade also included the Committee on Nursing (Briggs report) (HMSO 1972) and the 1979 Nursing, Midwives and Health Visitors Act, which replaced the General Nursing Council with the UKCC and abolished the CETHV. The NHS, nursing, and nursing education were turned upside down. Other issues of the day were the development of the primary care team and the attachment of health visitors to general practice, both of which were controversial and were seen by some as a challenge to the autonomy of health visitors. There was tension between health visitors and social workers and the role and status of health visiting was continually challenged.

Already active in the RCN, I found myself involved in numerous working parties and a speaker at numerous conferences. At home with two babies I had the flexibility to serve on lots of committees and task groups. I published articles in the professional press with titles such as That uncertain knock on the door, No new type of visitor, What do health visitors do? The dilemma of identity in health visiting. I became the health visiting consultant to a popular newsstand publication called Mother and Baby, even acting for several years as the magazine's 'agony aunt'. I often thought that I did more and better health visiting in this role than I ever did by knocking on doors – it certainly shattered my complacency about how wonderful health visitors were. I was becoming well known as a 'champion' of health visiting.

The trigger for action was the publication of the Report of the Committee on Local Authority and Allied Personal Social Services, The Seebohm Report, in July 1968 (HMSO 1968). The report specifically excluded health visitors from its membership and considerations and stated: 'In our view the notion that health visitors might further become all-purpose social workers in general practice is misconceived'. It recommended that a new Social Services Department should be set up in each local authority which would undertake the existing work of the children's department, the welfare department, and parts of the health department. Functions that health visitors had traditionally regarded as theirs were transferred to social workers who would exercise a central role in the new system.

Social workers were delighted but health visitors were furious. They complained that they had been misunderstood, misrepresented, and undervalued. I agreed and stood up on several conference platforms to say so. But I argued that if people did not understand what health visitors did, it was probably because health visitors had not told them. There was a plethora of opinions and recommendations about what the role of the health visitor should be, but a dearth of factual information and evidence about their actual practice. What was needed, I argued, was some proper research.

But who could do the research? At the time, nursing research in the UK was embryonic. There were a few studies using work study methods undertaken by researchers who were not health visitors, which health visitors rejected as contributing to the misunderstandings. Very few nurses or health visitors had a first degree, which was the normal university requirement for undertaking post graduate research.

Almost none had a doctorate, which meant it was very difficult to find nurses who could supervise nursing doctoral students. My husband's job precluded a move to one of the developing epicentres of academic nursing such as Manchester University. I knew nothing about research methods, and I searched in vain for some kind of course that my family commitments would allow. The mantra of the Briggs Committee on Nursing that 'Nursing should become a research-based profession' was still four years in the future (HMSO 1972).

But I did have a first degree, I was living on a university campus, and I was 'unemployed' because I was pregnant or occupied with babies. My RCN involvement brought support and mentorship from some wonderful nurse leaders such as Marjorie Simpson, Jean McFarlane, and Grace Owen, who were planting the 'little acorns' of nursing research which later grew into oaks. I obtained a grant from the King's Fund – the first one ever awarded to an individual nurse. I joined the fledgling RCN Research Discussion Group. Professor Peter Campbell, Professor of Politics, and Dr Viola Klein from the sociology department at Reading University agreed to take on the formalities of my registration for

a MPhil. At the time, most master's degrees were research-based degrees rather than taught programmes.

I was introduced to Professor Margot Jefferys, one of the founders of the developing discipline of medical sociology, who encouraged me and became my external examiner. And there were other benefits. I had tremendous goodwill from the health visitor interviewees, and I discovered that being accompanied by a breast-fed baby established an immediate rapport in interviews! I sent a questionnaire to every health visitor in Berkshire, achieving a response rate of 89%; I interviewed 79 health visitors and persuaded 72 to record all their home visits for a week using a recording form that I devised, amounting to 2,057 visits in all.

The interviews were recorded on a reel to reel tape recorder the size of a suitcase. The data was analysed using the (then) new Reading University computer which filled a whole building. The thesis was typed on an old-style typewriter with carbon copies – it was more than a decade before computers and word processing came into common use. In 1972 I graduated with the degree of MPhil. The thesis, suitably edited, was published in book form in 1973 under the title A Family Visitor (Clark 1973) – the first in the series of research monographs published through the 1970s by the RCN in conjunction with the Department of Health and Social Security (DHSS). I participated in a BBC series of television programmes about primary health care (Bloomfield et al 1974), and I spoke at many conferences at which my study was referred to. The study was also published as a series of three occasional papers in the Nursing Times, the newest outlet at the time for academic articles about nursing. The 1976 paper revisited for this article was published in the first issue of the Journal of Advanced Nursing.

Impact and influence

This study was undertaken nearly 50 years ago. The health visitor of the 1960s would hardly recognise health visiting as it is today. The 'family visitor' with a caseload that includes people of all ages appears to have become nowadays largely a protocol-driven system of developmental checks on young children – an important function, but not the only one. Health visitors no longer visit older people, and family support is seen as the function of the social worker.

In 1999, I was commissioned by the Welsh government to undertake a review of health visiting in Wales The review found that the number of health visitors in Wales had declined dramatically during the previous decade, that the introduction of general management following the 1983 Griffiths report had diminished the position of the heath visitor in the organisational structure and led to the loss of professional leadership (Clark et al 2000).

The review contained several recommendations, but the report was quietly shelved. The good news, however, was that some of the local directors of nursing supported the report and quietly implemented several of the recommendations within their own management arrangements. Fortunately, during the past decade, perhaps as a result of the renewed importance of public health in government policies, health visiting appears to be experiencing something of a resurgence.

My increasing profile in health visiting and primary health care during the 1970s led directly to my representing the UK in work with the International Council of Nurses and the World Health Organization (WHO) following the WHO Declaration of Alma Ata on Primary Health Care in 1978 and the WHO Global Strategy for Health for All by the Year 2000. My search for others who were researching in the same field led me to Professor Sirkka Lauri in Finland, which I visited on a Council of Europe Fellowship in 1981 and several times subsequently. What I saw in Finland revolutionised my ideas about health visiting and primary health care. I published more articles and spoke at more conferences, but sadly, my proposals – such as visiting by appointment, structured documentation, sharing records with clients, seemed ahead of their time. At that time, they were not popular with UK health visitors. Now, they are recognised as central to good practice. The Department of Health's continuing search to understand health visiting practice (Clark 1982) led to a new research project to develop a model for explaining health visiting practice which eventually became my PhD (Clark 1985), and a project to identify the outcomes of health visiting practice (Clark and Mooney 2001). Citations in other people's work continued well into the 1990s. In 1982, when I was elected Fellow of the Royal College of Nursing, the citation said, 'for her contribution to the art and science of nursing in the field of health visiting'.

But I can hardly claim that the study itself had any influence on the developments in health visiting in the 1970s, which were largely

determined by the introduction of legislation and other external events over which the profession could exercise little control. In particular, the absorption of health visiting into the new framework of the 1979 Nurses, Midwives and Health Visitors Act moved health visitors from having a unique title and professional registration which was mandatory for practice, to recordable with the Nursing and Midwifery Council as 'specialist community public health nurses' alongside a variety of other nurses with no such requirements. Midwives retained their specialist identity; health visitors lost theirs. With hindsight, the legislation of the 1970s could be considered as marking the beginning of the demise of health visiting as I had known it.

Current and future relevance

It is hard to think that my research of some 50 years ago might have relevance to current and future researchers or practitioners, but it continues to be cited from time to time. Perhaps, however, any influence I might have had applies more to individuals than to big changes in policy. The outcome of which I am most proud is the number of individuals whose careers I was able to help, many of whom are now the leaders of the profession, just as the great nursing leaders of the 1960s and 1970s supported me. Health visitors I meet at conferences and other meetings often recognise me, and the older ones, that is, my contemporaries in health visiting, who are now, like me, approaching their eighties, often refer to my work in health visiting and in particular to this study. I did not know whether to be flattered or horrified when I discovered quite recently that A Family Visitor was still included in some students' reading lists!

As my children grew up, I expanded my interests into other fields of nursing – care of older people, nursing education, and standardised nursing terminology for electronic patient records. I am no longer directly involved in health visiting, but with hindsight I can see some relevance of this study to my and others' later work in other fields. I have been fortunate to be able to combine practice, research, and teaching in my long career (Clark 2016). With hindsight I can see that the methodological approach of trying to capture the essence of health visiting practice through identification and recording of the topics discussed in the home visit, as described in this paper, led directly to my work on the development of a standardised terminology to capture the essence of nursing, the International Classification for Nursing Practice (Clark and Lang 1992), and to make nursing and health visiting visible in electronic patient records. Only now in 2020 do I see the beginnings of understanding among nurses why the use of standardised terminology and structured documentation for nursing practice is important.

Fifty years later I still carry and promote the attitudes and ideas that were born in my health visiting days – the focus on prevention and early intervention, the social determinants of health, public health as opposed to individualised 'treatment'. The principles of health visiting which were set out in the 1970s (CETHV 1977) apply equally today and to every field of nursing:

- The search for health needs
- Stimulation of awareness of health needs
- Influence on policies affecting health
- Facilitate health enhancing activities.

Health visiting still has much to offer in meeting society's health needs.

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