Influences that affect health visitor's ability to work with fathers who are perpetrators of domestic abuse

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Abstract

This study explores the factors influencing health visitors' engagement with fathers known to be domestic abuse perpetrators. This qualitative study recruited seven health visitors who participated in semi-structured interviews. Collection of data was between February - March 2018. Findings showed that the health visiting service mainly focused on the mother and children without including fathers who were often 'invisible' to services. Other professional groups, alongside the 'gatekeeping' of mothers', appeared to influence the health visitors' perceptions of the perpetrators' ability to be effective fathers. Due to feelings of anxiety and a lack of confidence, health visitors often avoided contact with fathers. Avoidance reduced the opportunity for health visitors to promote healthy relationships with fathers and their children.

INTRODUCTION

The Office of National Statistics (2017) repFrted 1.9 million incidences of known domestic abuse and 228,385 child protection referrals following domestic abuse-related incidents. Evidence suggests the impact of domestic abuse on children includes emotional and physical harm that may lead to significant cognitive and psychological developmental delay (Humphreys 2006; Cleaver 2015; Thornton 2014). The law clearly states that children must be protected from the potential

risk of harm and from witnessing domestic abuse (The Adoption and Children Act, 2002: section 120).

Health visitors have an essential role in ensuring that children have the best start in life. By supporting them during their early years, health visitor interventions impact their lifelong health and wellbeing (National Health Service (NHS) England 2014). Early intervention ensures 'that our children get the best possible start in life' (Allen 2011:14). Within the early intervention framework, there is a recommendation that health visitors need to promote the inclusion of fathers in their practice (NHS England 2014). The National Institute for Health and Care Excellence (NICE 2012) promotes the inclusion of fathers and recommends that the health visitors' role supports the development of the father/child relationship. While there is much evidence to indicate that early intervention positively impacts long-term outcomes for children (Munro 2011), when fathers are perpetrators within violent and abusive relationships, their engagement with health professionals' is inconsistent and problematic.

BACKGROUND

Fathers impact the psychological, social, cognitive and behavioural outcomes for children, with supportive and engaging fathering having a positive influence on children's mental health (Sarkadi *et al.* 2008). Despite the positive aspects of fathers' involvement, professionals emphasise the mother's parenting role (Rivett 2010). Peckover (2014) highlighted the focus on women and children within health visiting practice, based on the traditional understandings of attachment theory (Ainsworth 1989). The attachment theory emphasises the importance of a mother who can provide a secure base from which the child can explore the world, with their social and emotional development directly influenced by this attachment (Ainsworth 1989). However, recent advances in the attachment theory have challenged this assumption when posing that fathers provide a

parallel attachment figure, which equally predicts children's outcomes (Zanoni *et al.,* 2013). Fathers can encourage while developing the child's exploratory skills mainly through physical play (John and Halliburton 2010). This positive role of fathers impacts children's social and emotional development (Dumont and Paquette, 2013). However, a father's presence alone is not enough to promote a child's wellbeing. An abusive or distant relationship may lead to poor outcomes for children (Amato and Gilbreth 1999).

Some practitioners appear to consider the fathers input in their children's lives as less effective than the mother's (O'Donnell *et al.* 2005). At the same time, Humphries and Nolan (2014) found little importance placed in fathers' inclusion in practitioners' clinical practice. Serious Case Reviews (DH 2011-2014) continues to highlight the lack of engagement with fathers (Sidebottom *et al.* 2016), where there can be 'deficit' views of fathers who are abusive with suspicions of them as carers (Rivett 2010). In practice, professionals ignored the fathers' role when carrying out a holistic assessment of families, rarely addressing their behaviour or the impact this may have on their children (Ashley *et al.,* 2011). Brandon *et al.* (2010) explored this concept within safeguarding children and found some professionals had 'fixed thinking', labelling fathers as bad or good. Professionals may pre-judge and view that fathers are dangerous, resulting in fathers' exclusion based on these perceptions. Health services appear to perpetuate the mindset of bad fathers, often geared towards working with the non-abusive parent, in most cases the mother, assuming that fathers are not 'safe' parents (Rivett 2010). However, Featherstone and Peckover's (2007:181) study highlighted the need 'to take violent men seriously as fathers and father figures.' When professionals focus on the perpetrator's crime, such as domestic abuse, they become invisible as fathers (Featherstone and Peckover 2007).

Ferguson and Hogan (2004) recognised that when fathers had restricted legal access to their children, they could not be active fathers, and services could not work with them. These legal restrictions have perpetuated the professional culture of avoidance towards abusive fathers and an increased focus on the mother to protect the children from harm.

Peckover (2002) found that some health visitors felt a potential threat and highlighted their perceived vulnerability that led them to avoid contact with fathers. Bateson *et al.* (2017) and Swann (2015) suggest that there are pervasive difficulties for health visitors to engage with men exacerbated by personal fears when abuse is known. Ferguson and Hogan (2004) found that family members and other professionals' views influenced health visitors judgement of fathers. However, Brandon *et al.* (2017) suggested that multi-agency teams should be curious about the father's role, considering the potential benefits and assessing the child's possible risk of harm.

Study aim

The study aimed to explore current health visiting practice around the context of fathers known as domestic abuse perpetrators. Research question:

'*What are the challenges and opportunities for health visitors to engage with fathers who are known perpetrators of domestic violence and abuse?'*

METHODS

Setting and sample

The study took place in a large NHS Trust in the South of England. Purposive sampling recruited health visitors who would share their working experiences with families where the fathers were known to have perpetrated domestic abuse.

Ethical considerations

The University Research Ethics Committee approved the study to take place. Ethical approval ensured that both the researcher and participants rights were protected (Bell 2014).

Data Collection

This exploratory qualitative study used semi-structured interviews to collect data between February - March 2018. An interview guide (Table 1) was used based on the research question. Seven participants were interviewed, with each interview lasting, on average, 45 minutes. The interviews were audio-recorded as this was the most accurate and reliable way of collecting the data (Green and Thorogood 2005).

[insert] Table 1

Data analysis

The interviews were transcribed verbatim to thoroughly familiarize the researcher with the data (Green and Thorogood 2005). A review of the data involved systematically reading through each interview script and highlighting quotes, following an inductive approach to derive an initial set of ideas (Braun and Clark 2012). The data were thematically analysed by coding and clustering the concepts using a constant comparative method to identify categories to sort the data into a connection of themes.

FINDINGS

Three key themes were identified as follows:

Theme 1: Engagement with fathers

Participants had experienced difficulties engaging with fathers who had perpetrated domestic abuse during universal client contacts. For example, out of seven participants, four indicated that they only saw the fathers at the new birth, 6-8-week check or not at all:

You only really meet them at the new birth if they're off. (P6)

[In] some of the cases we don't even know who the father is. (P3)

We're so focused on the mum and the children, regardless of whether there is domestic abuse. The dad is always on the outside. (P4)

There were limited opportunities for health visitors to build up a relationship with fathers. When fathers were not living with the children, it appeared that there was no role for the health visitor to reach out and include fathers:

You are sort of stuck in a situation where there's no remit for me to contact dad, my role is around the children in the home. (P1)

But, if anything happens again, I haven't built up the relationship. (P1)

Participants also suggested that health visitors may not be the only agency that does not engage with fathers:

I don't think anybody has approached him to say that this is an abusive relationship. He does what he does but its only mum that's voicing this. (P6)

Participants relied on mothers to describe the behaviour of fathers. Therefore, mothers were able to influence participants' perceptions of fathers and were able to obstruct opportunities for their engagement:

I'd formulated a kind of picture in my mind of what he was like, because mum had explained things about what he did or had done. (P6)

I don't think I've even seen them, the men, the perpetrators they're not there. (P5)

I know cases where the dad wanted to be involved, but the mum was quite obstructive. (P3)

At times, mothers denied or minimised the abuse, therefore, avoiding interventions for both parents. Participants highlighted that as they worked Monday to Friday between the hours of 9-5 pm, this did not allow the inclusion of fathers who may be at work during the day and prevented engagement with working fathers:

She completely denied everything. She denied telling me anything and said she was in a fantastic relationship. (P1)

They work full time, and we work 9-5. (P7)

Participants expressed frustration regarding limitations imposed by services which reduced their ability for early intervention. One participant expressed frustration that she could barely find the time to work with mothers, never mind the additional challenge of working with fathers:

Because you only see people briefly and you don't have time to do interventions, follow up or make contact with dads. (P4)

I think it's difficult to do specific work with anyone let alone trying to get dads in. (P4)

However, two participants were able to share some positive experiences of connecting with fathers who were perpetrators:

He was very engaging with the health visiting service, quite open and honest about things. (P3)

He is getting the support he needs; he is moving forward, being able to engage with me. (P1)

While there was evidence that participants did not engage with fathers, this was often due to a lack of opportunity or mothers obstructing contact by underplaying the abuse. It is also evident that other agencies failed to engage with fathers.

Theme 2: Personal feelings

All participants reflected on their personal feelings about perpetrators and how this impacted their practice. Participants raised the issue of having a predominantly female workforce and the possible impact this had on engaging with fathers:

The majority of health visitors are women. I find that men probably don't want to be opening up to you, talking about their feelings. (P1)

The [fathers] don't think it's relevant to them because it's always a woman [health visitor] sitting with a woman. (P1)

Nearly all the participants shared concerns about the potential risk of intimidation from the perpetrator, which influenced their practice:

You have to be very careful about the statements you are making, we live in the areas we work generally, I don't want to be walloped! (P5)

I don't feel it is safe for me as a practitioner. (P2)

Quite intimidated, sometimes you're sitting there going 'woo' [concerned look on face]. (P1)

The participants also expressed concern that their interventions could pose an increased risk to the victim of abuse:

You might be aggravating the problem, you might leave, and that will result in a further incident of abuse. (P2)

You don't want to put your foot in it and make it worse for her. (P4)

There was the recognition that participants personal views may conflict with their professional roles:

It's really hard to work with fathers, you have your own ideas, have feelings, and have professional views about them. It gets confusing and blurred. (P5)

All participants suggested they may not have the skills or confidence to work with perpetrators of abuse:

It's quite a skilled job to work with perpetrators, we're not the right people. (P5)

I might not necessarily have the skills. (P2)

It would be a big leap to do more work with dads. (P4)

This theme identified how participants acknowledged a conflict between their personal views and professional roles. Participants made assumptions about fathers with some feeling that it was a waste of time trying to engage. Others had concerns about the safety of their clients and for their

own safety. It was evident that a perceived lack of skills to engage with fathers directly impacted participants' confidence to work with them.

Theme 3: Professional barriers

The multi-agency child protection plans often restricted opportunities to engage with fathers:

The Chair [of the committee meeting] said you can't do that as he's not allowed in the family home… I got shut down by the Chair. (P1).

Information shared by social care via multi-agency child protection plans was said to impact the participant's perception of the fathers. This perception often raised anxiety before participants conducted home visits and often led to negative and biased views:

You basically pick up things they are saying to you through reports, through things the social worker says, rather than having direct contact with that father. (P1)

Some participants highlighted the legal restraining orders, which prevented fathers from being allowed in the home:

I didn't have any contact with him before as he had an order that he couldn't see the children. (P1)

This theme highlighted how other professionals' verbal and written reports influenced participants, which instilled an unfavorable view and anxiety about meeting the fathers. At the same time, court rulings meant that the fathers could not always access the family to protect them from harm.

DISCUSSION

Health visitors in the study focused on maternal and child welfare and were less likely to include fathers during home visits. Findings from O'Donnell *et al.* (2005) suggested that female-focused services may stereotype fathers, resulting in practitioners not considering the father's role or the importance of including and supporting them (Zanoni *et al.*, 2013). St George and Fletcher (2011) agreed that fathers felt overlooked during the postnatal period, with Taylor & Daniels (2000) finding that fathers expected exclusion when the health visitor came to the home. This lack of involvement and engagement minimised the importance of working with fathers known to be perpetrators (Gilligan *et al*., 2012). Having limited contact with fathers reduced the opportunity of building positive relationships and more so when identified as perpetrators.

Deave and Johnstone (2008) endorsed fathers' inclusion and emphasised their value in supporting their children. However, health visitors had a minimal direct or indirect engagement with fathers. When health visitors were able to see fathers during home contacts, this was often for brief interventions such as the new birth visit, leaving limited opportunities to build positive relationships.

Once the health visitor was aware that the father was a domestic abuse perpetrator, fathers became more invisible. The invisibility of fathers increased when they lived apart from their children, particularly when restraining orders were in place. This study found that when fathers were perpetrators of abuse, some health visitors' felt fearful and intimidated. Fathers were labelled as 'too risky' to engage with during home visits. This finding echoes Peckover (2002) and Hatton's (2011) study that found fear led to practitioners who avoided working with abusive fathers.

Health visitors were also concerned that discussing the abuse during home contacts could increase the mother's risk of harm. As a result of this concern, health visitors arranged home visits at

specific times when fathers were less likely to be in the home. Health visitors focused on the mother and child's wellbeing with little or no engagement with the fathers.

When considering fathers' engagement, some mothers could influence the health visitor's perception of the father. Health visitors explained how some mothers acted as 'gatekeepers', preventing their direct contact with fathers. An earlier study by Miam *et al.* (2006) suggested that health and social care systems often relied on mothers as being the 'gatekeepers' to fathers' access. Also, health visitors gave examples of social workers advising them not to work directly with the fathers who were known perpetrators of abuse. Health visitors found the information provided by social workers to be a key influence, which resulted in fathers seen as dangerous or threatening before meeting them. Ferguson and Hogan (2004) suggested that a range of external influences informed their practice and that fathers may be excluded based on these perceptions. The 'gatekeeping' of mothers and influences from other health professionals has led to some health visitors avoiding fathers' engagement.

Limitations

The was a purposive sample of health visitors recruited from one NHS Trust. As a result of the small sample size, the participants may not have represented other health visitors' experiences and views on how they engage with fathers known as domestic abuse perpetrators. Therefore, caution will be applied in not claiming generalizability to other areas in the UK. The researcher is also a safeguarding lead for the NHS Trust, which may have influenced participants' responses. However, participants were asked to 'member check' a copy of their transcripts and invited to comment on the accuracy (Cresswell 2017).

CONCLUSION

This study found little evidence of health visitors working with fathers who were perpetrators of domestic abuse. The health visitors' limited involvement of fathers' contrasts with recommendations by the Healthy Child Programme (2009). The Healthy Child Programme (2009) advocates the inclusion of resident and non-resident fathers to participate in child health reviews.

There were clear challenges found in the engagement of health visitors and fathers with few opportunities to develop and support positive father/child relationships within the context of domestic abuse. The Healthy Child Programme (2009) identified that services do not do enough to include and support fathers. Services must develop creative ways to include fathers to support their children's health and wellbeing (Plaintin *et al.,* 2011). Recommendations are for health visitors to have a strong focus on fathers (NHS England 2014; NICE 2012), emphasizing the development of father and child relationships.

There is evidence in this study to suggest that health visitors limit opportunities to build positive family relationships when they do not engage with fathers. Given this evidence, how can health visitors be supported to increase their engagement with fathers who are known perpetrators of domestic abuse? To build confidence and competence in this important area of practice, education and training that focuses on working with abusive fathers may promote this engagement. Also, policymakers need to develop processes and structures that support father-inclusive practice. Further research is needed to explore the role of health visitors to gain a wider perspective on how non-engagement of fathers impacts the child and family.

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