'Walking my baby back home' - Policy and Practice in Health Services and Single Parent Families

by Cathy Boland

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The position of single parent families in Australia is examined from a historical perspective, and this is a prelude to a discussion of service provision in maternity hospitals and Baby Health Centres in New South Wales, which are now staffed under the auspices of the Community Health Program. The paper is concerned with issues raised by criteria used to predict child abuse. These criteria are examined from two methodological perspectives; the first applies to the welfare critiques of social control to health service delivery, and the second is an epidemiological critique that notes an extremely high error rate in predicting child abuse at one maternity hospital.

Some data from the New South Wales Maternal/Perinatal Statistics Collection on low birthweight and hospital status is used to discuss some implications of this critique related to service delivery and social class of both providers and recipients of health services.

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INTRODUCTION

In terms of social policy the position of single parent families in Australia has always been one of ambivalence. This paper explores the historical nature of this ambivalence and its historical continuity and then illustrates this issue with a recent example of maternity services provisions for unmarried mothers. The purpose of this paper is to search for contemporary perceptions of unmarried mothers, and their historical sources, and the influence of demography and economy on this aspect of family life.

In past years, the surveillance of single mothers was the prerogative of welfare departments, however, some of the studies reviewed herein suggest that maternity hospitals and other community health services appear to have been drawn into the surveillance of this group of women. A proposition is put forward that when health services had incorporated aspects of welfare services provision, there was a failure to take into account the problematic nature of the role of welfare services which has been discussed in the theoretical critiques of social control

The paper is set out in five sections. The first section looks at the history of single parents from 1788 up until the turn of the twentieth century and at the foundations of the maternity hospitals which were primarily established for single mothers. The perspective of this section is set in a broader aspect of access to paid employment and the position of the family. Section 2 continues the historical perspective, and emphasises the role of the Commonwealth in direct maternity services provision which began in 1912 with the £5 Baby Bonus/ Maternity Benefit. This benefit was the only direct Commonwealth provision of maternity services for three decades.

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The Commonwealth's next appearance on the stage, so to speak, was in 1941 with the provision of Child Endowment (introduced first by the New South Wales State Government in 1927). Section 3 examines four

recent studies of maternity hospitals, the first of which was a survey of patients in 1979. It is argued that a methodological perspective of observation of individual clients, in this case single mothers, has led to a narrow focus on the clients themselves, rather than to a broader analysis of the social conditions and policies within which the whole community is enmeshed, and from which concepts of social life are created. Section 4 raises the issue of poverty and its relationship to social class and service provision as described in these studies. This issue is discussed with reference to some data from the New South Wales Maternal/Perinatal Statistics Collection. The final section aims to explore issue raised in this paper and their relation to social policy, and continuity and change in the ideological construction of the single parent family.

SINGLE PARENTHOOD IN COLONIAL AUSTRALIA

The structure of the "family" which was the basis of white settlement in Australia was concerned with, inter alia, issues of social class, access to financial resources and marital status. The founding mother of white Australia was predominantly a single-parent mother, and a vulnerable one at that, with little access to the workforce, other than domestic service. As there were very few wives and children who accompanied the marines and officials of the First Fleet, opportunities for even that type of work were limited because the demand for servants was minimal (Summers, 1975). Convict women who became pregnant were confined at the Female Factory, where they and their offspring were kept and provided for by the state/colony.

Summers describes the lot of the female convicts as follows:

> Since there was virtually no escape from the colony which required women to be whores, there was no escaping whoredom... They had been transported to service the sexual needs of the males of the Colony and they were condemned for their behaviour (Summers, 1975:270,272).

The upper classes were distressed by the depraved behaviour of the often drunken women whose sentences were actually for life because of no access to the labour market, which at that time was based on barter. Indeed, Alford argues that, apart from domestic service, there was no real alternative work for women until the late nineteenth century when service industries, commerce, and manufacturing were established (Alford, 1988:47).

There was a change in social policy during the governorship of Macquarie when issues of access to the "labour market", the structure of the family, and social policy generally received some attention. Macquarie was concerned about the "immorality and vice so present among the lower classes" (Alford, 1988:43). He substantiated his concern with a policy of promoting emancipated convicts and the promotion of education. Under Macquarie, by 1820, one-fifth of local official public spending was on education.

The lack of a family as the basic social institution was noted by the colonial 'intelligentsia' in the 1850s, and the interplay of capital, labour and the family was once again of concern. Wakefield argued "that the presence of wives and children would have economic benefits by making men both industrious and stable, and less militant ... marriage produces greater anxiety for the future"

Macquarie's policy of promoting emancipated convicts, Summers notes, "was bitterly resented by the exclusivist and anti-emancipist "Pure Merinos" who wanted a pastoral industry resting on convict labour to form the foundation of the new colony" (Summers, 1975:279). Following Macquarie's departure, his idealism was soon overturned by a policy based on "profit and punishment". Instrumental in this reversal of policy was Commissioner Bigge who was sent to report on the Colony at the end of Macquarie's governorship. The Bigge Report of 1831 represented, in retrospect, a swing in policy from the left to the right. Land grants which had previously been allocated to emancipated convicts were, from 1831, allocated to the respected capitalists who received land grants in proportion to the capital they had to develop the land. "The price set for land had to be a 'sufficient' price, high enough, that is, to stop labourers from becoming land owners quickly" (Martin, 1988:71). Under this policy, women were "a supply of whores who could keep their men [the employed male convicts 'with no encumbrances'] from becoming too restless" (Summers, 1975:279).

The lack of a family as the basic social institution was noted by the colonial 'intelligentsia' in the 1850s, and the interplay of capital, labour and the family was once again of concern. Wakefield argued "that the presence of wives and children would have economic benefits by making men both industrious and stable, and less militant...marriage produces greater anxiety for the future" (Alford, 1988:43). It was not, according to Alford, until the immigration of middle and upper class families that a "feminine ideal" of motherhood replaced the images of "damned whores" but middle class women were at an economic advantage, being held safely out of the workforce in the arms of marriage (Alford, 1988).

The interaction of marital status and class is exemplified in the following analysis from O'Farrell's *The Irish in Australia*

> The Irish had no comprehension of the convenient English double standard practice in regard to morality which affirmed the highest theoretical public standards but tolerated private moral anarchy... Certainly colonial laxity in sexual matters, as in many others, was a challenge which no zealous reformer - indeed no civilised person - could ignore, but the drive to suppress the sexual went much further than that. How much it was a reaction to English criticism is unclear, but that contempt and snobbery always had a sexual edge (O'Farrell, 1987:153).

COMMONWEALTH GOVERNMENT POLICIES

By the late nineteenth and early twentieth centuries, the ideology of Australian assistance to "deserted wives" was established, following the depression of the 1890s, in the boarding-out allowance of 1986 which was given to deserving mothers who did not drink or gamble, and were not promiscuous. These mothers were kept under surveillance by charity workers in the city and the constabulary in rural areas (O'Brien, 1988).

At about this time, public maternity hospitals were established, mainly as charitable institutions for single mothers. In 1908 the Platform Committee of the Political Labor League had produced a programme calling for the provision of maternity wards in all hospitals ("Worker" in Dickey, 1976:60). Place of birth did change from home to hospital and the service also began to be used by married mothers. By 1929, 54 per cent of births took place in public hospitals, compared to only 7 per cent in 1920.

From the time of Federation until the 1970s, the only measures introduced by the Commonwealth which benefited single mothers were the maternity benefit of 1912, child endowment in 1941 and the widows' pension in 1942. The next appearance of the Commonwealth was in 1973 with the supporting mothers' benefit. Prior to this, State welfare departments had held the responsibility for supervision, registration and visiting single mothers in receipt of a pension. Even in 1974, women were eligible for supporting mothers' benefits only after being on State benefits for six months. The Commonwealth took over the first six months of payment of this benefit in 1980, thus terminating reimbursements to the States under the States Grants (Deserted Wives) Act. The Act itself was repealed in June 1982.

SINGLE MOTHERS IN A CLINICAL PERSPECTIVE

The previous two sections of this paper briefly considered the position of the single parent family in a broad social context and the ambivalent attitude towards it which has been evident in government policies from the earliest colonial days. This section narrows the focus to four papers from maternity hospitals in Australia, which give an indication of professional perspectives on single motherhood and the effect of these perceptions in a clinical setting. The four papers discuss practices at four different hospitals in Australia. The first two papers are referred to here as Hospital 1 (Rothfield, 1981) and Hospital 2 (Normoyle, 1983) and are from New South Wales. Both these papers report results of studies conducted at these two hospitals. The two other papers are from Brisbane (Hospital 3, Tudehope, 1983) and Melbourne (Hospital 4, Yu, 1983) and discuss issues related to parent-infant attachment. In an attempt to place these studies in a wider social framework, some results from an analysis of the New South Wales Maternal/Perinatal Statistics Collection are included in the discussion in section 5 on service provision and social class.

The following discussion is a methodological and social critique of the four studies, three of which attempted to predict at birth "abnormal parenting practices, likely to lead to child abuse or neglect" (Normoyle, 1983:73). These three studies aimed to identify parents who at some time in the future might abuse their child, and were conducted as an attempt to develop preventive measures by creating an "at risk" profile, and then targeting those "at risk" with some type of "support" services. Rothfield (1981) and Normoyle (1983) refer to the Kempe studies, the authors of which are well known for the identification of the "battered child syndrome". All three studies refer to Kempe et al. as the source of this methodology. For example,

> Kempe's studies suggest that the observation of parents by doctors or other staff, during antenatal consultations, observation in the

TABLE 1: OBSERVATIONAL DATA COVERING PERIOD OF CONFINEMENT, HOSPITAL 1

Name: Primp/Multip Partner: Present/Not present *(Tick paternal response in red if different from maternal)*				Medical Officer: ..... Type of delivery: ..... Sister I/C delivery: ..... Date of delivery: ..... Sister I/C postnatal ward: ..... Date of Discharge: .....
Parental Reaction at Deliverty	Accepting	Passive	Rejecting	Post Partum Interaction Maternal/Infant contact: Continuous/Interupted Reason for interruption: Chosen Feeding Method: Breast/Artifical formula
Visual Response				Reaction to infant: (a) Concerned/Unconcerned (b) Eager to touch/reluctant (c) Eye contact sought Yes/No (d) Talks to baby Yes/No (e) Infant named Yes/No
Active Response				Handling of Infant: (a) Confident (b) Initial lack of confidence (c) Persistent lack of confidence
Infant	Apgar score	Sex	Gestation	Infant Photographed: Yes/No General Impression on Discharge: Parent/Infant Relate Well / Fairly / Poorly /

Source: Rothfield (1981, p.9)

TABLE 2: DATA SOUGHT FROM PARENTS IN THE 'INCREASED RISK' AND CONTROL GROUPS IN FORM OF FOUR PART QUESTIONNAIRE, HOSPITAL 1

Antenatal	Delivery	Post Natal Ward	At Home
Attendance at: Physiotherapy class Mothercraft class Birth film	Understanding of the stages of labour	Method of feeding chosen	Who, or what provided most adequate assistance at the time
Partner participation in this preparation	Differences between eventuality and expectation of the birth	Reasons for choice	Paternity leave available
Ability to find and understand information related to pregnancy	The hardest part of the birth experience	Problems encountered with that method	Paternity support
Cause for particular anxiety	Feelings on first receiving infant	Degree of confidence felt in handling infant	Other support sources sought
Particular hopes or expectations related to infant	Who, or what had offered most useful support during labour	Who, or what provided most useful support at that time	Assistance not available that would have been appreciated
Understanding of the word 'motherly'		Name of infant	Action of baby's causing most concern
Books read on the subject of childbirth and/or infant care		Feelings for infant How they differed from expectation	Greatest fear to infant
		Understanding of the word 'bonding'	Time to feel confidence in ability to interpret and meet needs of infant
			Use of baby-carrying sling and its effectiveness
			Hoped for adjustment at any future birth experience

Source: Rothfield (1981, p.9)

labour ward and particularly within a maternity unit can be used in the identification process (Normoyle, 1983:73).

These three studies are directly or indirectly focused on single parent families. The studies are analysed here from a sociological perspective, and are compared and contrasted for the possibility of class, gender and ethnic bias. Because of similarities in the methodologies of the first two studies at Hospital 1 (Rothfield, 1981) and Hospital 2 (Normoyle, 1983) they are discussed together.

In 1979, International Year of the Child, the first of these four studies (at Hospital 1) began a six-months' survey of all obstetric patients at that hospital. The intent of that survey was the "identification of behavioural characteristics that appear to inhibit the development of an early and secure parental/infant attachment" (Rothfield, 1981:6) which "is accompanied by an increased risk of the occurrence of physical or emotional abuse" (Rothfield, 1981:8). The intent of research at Hospital 2 was similarly expressed (Normoyle, 1983).

The method used at the two hospitals consisted of observation of the mothers in the labour ward; so, the entire obstetric population at those hospitals came under what Rothfield describes as "routine surveillance" (Rothfield, 1981:8). The information obtained in Hospital 1, (Rothfield, 1981:9) indicates that, at the birth of their child, the parents' visual, verbal and active responses were assessed as accepting, passive or rejecting in order to predict who would be "at risk" (see Table 1). In the second study, Hospital 2, Normoyle also refers to direct observation in the labour ward of the "mother's visual response, verbal response, and her actions" (Normoyle, 1983:75). At Hospital 1, further information was sought on the mother's reaction to, and handling of, the infant, and whether the staff at discharge considered the parent related well, fairly or poorly to the infant.

Although it could be reasonably argued that there are indeed mothers who do have difficulty in establishing an immediate bond with their infant, the question arises of how appropriate are such methodologies to predict child abuse? It appears that the nature of the project determined that observation was carried out and recorded without the parents' consent. Informed consent is technically part of the legal basis of the contractual relationship between recipients and professionals providing health care. The welfare model enters the hospital and the right to informed consent departs.

In addition to observation of the parents in the labour ward, other risk factors were identified. At Hospital 1, antenatal factors included consideration of adoption/abortion; denial of pregnancy; depression; lack of support from partner/family and isolation; over-concern with infant's future performance; and excessive concern with small problems.

Post-natal factors included, inter alia, failure to name child or inappropriate name chosen; relinquishing control readily to staff concerning baby's needs; expectations developmentally beyond infant's capabilities; and negative response from partner and/or relatives to mother and/or infant. So, indirectly, single mothers are on the agenda. As for the social construction of maternity, the mothers come under

surveillance and are indirectly held responsible for the actions of other adults, ie. their partners and families.

Within this research methodology there is no room for the uncertainty that can surround parenting, or for the fact that it is a far more arduous task for those who are poor and unsupported, or that parents, too, can learn how to cope with their offspring.

At Hospital 2, the author identified the "at risk" group as follows:

> The most significant factors used to identify the "at risk" group are the mother's age, marital/de facto status, socioeconomic disadvantage, social and geographical isolation, and nursing staff's concern at the mother's attitude towards her infant (Normoyle, 1983:73).

This list was extended to include mothers who "openly discuss their anxiety about financial difficulties and marital problems... the career orientated, may be more vulnerable" and those who experienced "complicated deliveries and separation of the mother and infant soon after birth" (Normoyle, 1983:74). Once again, it appears that the mother comes under surveillance for circumstances beyond her control; neither the families that rejected them, nor the staff who initiated the complicated interventions who come under surveillance; rather, it is the mothers who "must be initially counselled within the maternity unit" (Normoyle, 1983:75) and followed up by community agencies including Baby Health Centres and child assessment clinics.

The author (Normoyle) appears to be in an ambivalent position. On the one hand, it is hoped to provide support for women to express their "doubts and fears" (Normoyle, 1983:79). Yet at the same time such a revelation deems that the client is "at risk". Rothfield (1981) and Normoyle (1983) appear to be reluctant to point out that community agencies include State welfare agencies which have legislative obligations to provide surveillance in which children are considered to be "at risk". Single parent families, almost by definition, have traditionally been placed in that category.

By identifying anyone who experiences "marital/de facto breakdowns, socioeconomic disadvantage and isolation" (Normoyle, 1983:75) as "at risk", certain methodological assumptions are implied, mainly that these risk factors are reliable predictors of child abuse. A review of similar research methodologies in Britain notes that the scientific validity "of any self-styled predictive checklist is negligible" (Dingwall, forthcoming: 51), as it is statistically unlikely that everyone who is poor will abuse their children. In other words, there is likely to be a large number of what is referred to in epidemiological literature as "false positive" identifications; that is, the method/tool of analysis incorrectly identifies subjects as having a condition, when, in fact, they do not have that condition. A research methodology of this kind also may omit some "true negative" cases, those people who do abuse their children, but do not have the characteristics that the methodology is searching for. Dingwall refers to this as the "proportion of abusers that lie outside that population" (Dingwall, forthcoming:48).

"Most studies support the opinion that any single woman under 20 years of age is in the 'at risk' category" ...It is of some concern that a research methodology should actively seek out single parents, an activity which should technically be in breach of the marital status provisions of the Anti Discrimination Act.

How the two studies related to or created a philosophy of general patient "care" at these hospitals is not discussed in the research reports. The model of surveillance set up at these hospitals could be deemed a welfare model, built on knowledge accumulated in welfare agencies that children at risk of physical abuse or "neglect" have historically been from poor families (Sweeney, 1989). Such a model ensures that service providers' concerns about appropriate/inappropriate behaviour determine the outcome, as was similarly the practice concerning the recipients of the boarding-out-allowance at the turn of the century (O'Brien,1988).

The first study indicated that those deemed to be "at risk" could be identified and targeted, to "bridge the gap between the hospital and community based welfare services", provided the clients exhibited a "readiness... to seek ongoing support from a less familiar welfare source" (Rothfield, 1981:6).

Table 2 presents the type of information sought from the mothers at Hospital 1. This included, inter alia, information concerning attendance at physiotherapy classes and films, causes for anxiety, understanding of the word "motherly", understanding of the stages of delivery, feelings on first receiving infant, understanding of the word "bonding", name of infant, availability of paternity leave, time to feel confidence in interpreting and meeting the needs of the infant. On first analysis, how do these criteria relate to issues associated with ethnic diversity in Australia? It is a well established knowledge that attitudes, norms and professional practices in these matters differ considerably among ethnic groups. Therefore, if the data in Table 2, from Hospital 1 (Rothfield, 1981:9) is analysed with this knowledge in mind, that is, in a multicultural perspective, possibly five of the seven Antenatal Categories, one of the five Delivery Categories, two of the eight Post-natal Categories and three of the nine At Home Categories seem unable to incorporate a population non-literate in English that may not have access to paternity leave. There is no consideration that these criteria may not have access to paternity leave. There is no consideration that these criteria may not be relevant or critical cross-culturally. The approach assumes literacy, availability and knowledge of classes and written material in many languages, which the recent review of

obstetric services indicates does not exist (The Ministerial Task Force on obstetric Services in NSW, 1989). The data in Table 2 could also be analysed from a class perspective. The data sought at that hospital appears to have ethnic and class bias, as the information appears to be directed towards middle-class users of physiotherapy classes, books and baby slings. (Perhaps baby slings and the large number of "How to Birth" books should be sold with the warning, "failure to use these devices will lead to prosecution under the child welfare act"). How these factors were related to the mothers' "actions" as recorded earlier in Table 1 is unstated. Using observation of the mother as a key criterion for establishing those "at risk", the two studies note somewhat divergent findings. The first relied on a psychological profile, and the second on a social class continuum. Study one (Hospital 1) identified 77 women out of 1,1006 live births or 7.6 per cent of that hospitals population as being "at risk"; nine mothers were at risk as they had experienced prolonged social disadvantage, fifteen mothers' infants had been in Intensive Care Units for longer than 48 hours, and fifty-two mothers were thought by the researcher to display an "inability to reconcile reality" with the researcher's vision of it. The author relies on a psychological profile. The damned if you do and damned if you don't analogy applies here, as presence of what the author implies are psychosomatic symptoms represents ill-adjustment, as does absence of psychosomatic symptoms. The author suggests that the ill-adjusted were:

> Those whose pregnancies were viewed as an illness, or were accompanied by many relatively minor complaints, or who expressed "never felt so well" sentiments appeared to show unexplored feelings and preoccupations (Rothfield, 1981:7).

The "ill-adjusted" mothers were further described as those who listed ideal maternal qualities which they did not see themselves as having. As there does not appear to be any allowance in the research method for parenting experience, or for the number of previous births, it is tempting to ask, who really had the idealised view of maternity, the researcher or the researched? Within this research methodology there is no room for the uncertainty that can surround parenting, or for the fact that it is a far more arduous task for those who are poor and unsupported, or that parents, too, can learn how to cope with their offspring. In this analysis, the focus of "deviance" has broadened out to include not only those experiencing prolonged social disadvantage but possibly a wider section of the previously "perceived as normal" population.

The author continues her observations about the group categorised in this analysis as "ill-adjusted" by stating that; "they illustrate the vulnerability of the parents who lack both the models and the support of an extended family" (Rothfield, 1981:7) In reading the analysis of the results of this study, the lack of an extended family could be interpreted as the fault of the "ill-adjusted", as subjects who are socially isolated are described in the study as belonging to the ill-adjusted group (Rothfield, 1981:7) Thus, it appears, if lack of an extended family is not the fault of the individual, at the least, lack of an extended family is interpreted as "ill-adjustment".

The second study, relying on the same method of observing the mother at birth, proposed additional and different criteria for identifying those "at risk". These additional indicators could be summarised as class-related; mother's age, marital status, socio-economic disadvantage and social isolation. The researchers at Hospital 2 followed up 54 "at risk" mothers - and noted three recorded cases of abuse out of a population of 844, despite some kind of community follow-up, which included community health and baby health services, social welfare agencies and voluntary child care groups. In this study, noting that what was termed abuse is undefined, the abuse rate was 5.5 per cent, and 94.5 per cent were incorrectly identified. The rate of "false positives", that is subjects who the methodology incorrectly identified as "at risk" was 94.5 per cent. Commenting on a similar study, Dingwall notes:

> Arguably the 74 per cent of children about whom there was no real concern were false positives who had been wrongly stigmatised (Dingwall, forthcoming:39).

TABLE 3: BIRTH OUTCOMES AND CLASS

	Birthweight		Apgar Score	Respiration	Congenital Abnormality
	Very low ≤1500 grams %	Low ≤2500 grams %	≤ 7 %	Time ≥ 5 mins %	%
Private Hospitals	0.5	3.8	2.8	0.8	2.5
All Married Women	1.1	5.4	4.5	1.7	3.7
All Women (NSW)	1.1	5.8	4.8	1.9	3.7
Single Parents (SP)	1.4	8.1	6.7	2.7	3.7
NESB Single Parents	1.6	9.2	7.3	2.7	5.5
Aboriginal Women	1.6	9.2	7.9	2.8	3.2*

* Indicates where the trend was not followed.

Apgar is a score given to neweborn infants, usually at one and five minutes after birth. It is derived from three possible scores 0, 1, or 2 for heart rate, colour, respiratory effort and signs of adequate oxygenation of the nervous system such as reflex response to a nasal catheter (e.g. none, grimace or sneeze/cough) and muscle tone (e.g. limp, some flexion of the extremities, or the infanct is active). The maximum score is ten (Berkow & Fletcher, 1987, p. 1856).

TABLE 4: COMPARISON OF TYPE OF DELIVERY AND CLASS

	Low Forceps %		Mid Forceps %		Spontaneous %		Caesarean %	
	<25yr	All	<25yr	All	<25yr	All	<25yr	All
Private Hospitals	16.3	11.5	13.8	11.5	51.3	57.0	16.9	18.4
Married	8.7	8.0	7.1	7.0	67.8	65.8	13.7	16.1
All State	8.4	7.9	6.9	6.9	69.0	66.5	13.1	15.8
Single Parent (non-Aboriginal)	8.2	8.2*	6.8	6.9	71.0	69.2	11.6	13.0
Single Parent (NESB)	6.1	6.6	7.6	8.5*	71.4	66.1*	11.4	15.9*
Aboriginal Women	5.0	4.9	4.0	4.1	74.5	73.1	13.6*	14.8*

* indicates where the trend was not followed.

A further explanation of issues related to false positives and false negative identifications has been examined elsewhere (Boland, 1989:100-102).

The third study, at Hospital 3 had similar intentions, the identification of the mother and infant "at risk". The methodology differed from the previous two studies in that notification and follow-through to community services was not discussed, other than referral to hospital social worker. The five criteria at this hospital for identifying those "at risk" were the hesitant, clumsy mother, the anxious depressed mother, the mother who thought "the baby belongs to the hospital", mothers who had feelings of inadequacy about themselves, and mothers who claimed the baby "didn't bond to them" (Tudehope, 1983).

It would be rather unfortunate if, in retrospect, some of the mothers who claimed that the baby "didn't bond to them" had been trying to explain the effects of epidural anaesthesia. Research on this aspect of the practices in birth services shows that:

> On tests at 24 hours, babies from both epidural groups performed poorly on motor, state control and physiological responses. At five days, the Bupivacaine (epidural) neonates still had poor state control and cried more. By 1 month there were few differences between the groups in neonatal behaviour (Murray, in Bennett et al., 1987:15).

Muhlen-Schulte and Wade (1988) also noted significant differences in motor performance at one month of age of infants delivered by epidural Caesarean section. Problems in the child were low-birth weight infants and infants with feeding problems.

The final paper, from Hospital 4 was published in the same year, in the same journal and in the same month (Yu, 1983). In this paper, the author is very concerned with the social trauma associated with the admission of an infant to neonatal intensive care. The author suggests:

> Preterm or sick newborn infants... were considered, in the past, to be at particular risk for later child abuse or neglect. These observations were made in an era when the psychosocial needs of the parents were neglected in the hostile environment of the early neonatal units. It is not surprising that parent-infant relationships and subsequently the quality of parenting were adversely affected (Yu, 1983:58).

Yu comments that:

> even the perceived competence of the neonatal unit staff can enhance the parents' sense of failure and increase their lack of confidence in assuming caretaking responsibility (Yu, 1983:52).

A recommendation of this paper from Hospital 4 is that "parents are allowed to develop a relationship at their own pace" (Yu, 1983:56). Of the hospitals reviewed, Hospital 4 appears to have the clearest idea of how to support a vulnerable parent.

SERVICE PROVISION AND SOCIAL CLASS

These four studies appear to indicate variability in the way clients are perceived at different hospitals, although all hospitals recommended social work or counselling intervention. As one author commented "Most studies support the opinion that any single woman under 20 years of age is in the `at risk' category" (Normoyle, 1983:79). It is of some concern that a research methodology should actively seek out single parents, an activity which should technically be in breach of the marital status provisions of the Anti Discrimination Act.

In retrospect, the outcome of such procedures was the identification and control of deviance, and by accepting referrals based on these methods other health and welfare organisations were prepared to accept the criteria of "risk" developed at these hospitals. It is possible, for example, that the relationship between low birth weight and social class may be a confounding factor in the interpretation of the "at risk" mother and infant.

Table 3 is derived from the New South Wales Maternal/Perinatal Statistics Collection in 1986, and relates socio-economic status or class, as defined here, to very low birth weight (less than 1500 grams) low

birth weight (less than 2300 grams), congenital abnormalities and Apgar score at five minutes. An Apgar score is derived from three possible scores: 0,1,or 2 for infant heart rate, colour, respiratory effort and signs of adequate oxygenation of the nervous system such as reflex response to a nasal catheter (e.g. none, grimace or sneeze/cough) and muscle tone (e.g. limp, some flexion of the extremities, or the infant is active). The maximum score is ten. It is usually recorded at one and five minutes after birth (Berkow and Fletcher, 1987).

...if you play with your infant or use this baby sling, I will be less likely to notify your child as being "at risk" to the State welfare department, a pyrrhic progress perhaps.

As there are no clear indicators of socio-economic status in this data base, the following six indicators are used for preliminary purposes.

1. Births at private hospitals.
2. Births to all married women (this includes all private and public hospitals).
3. Births to all mothers in the State.
4. Births to all single non-Aboriginal mothers.
5. Births to all single mothers from a non-English speaking background.
6. Births to all Aboriginal women.

These categories are not mutually exclusive. Table 3 indicates that, generally, those from more disadvantaged social classes have proportionally more very low and low birthweight infants, lower Apgar scores, longer times to establish respirations and more congenital abnormalities. To set this information (Table 3), which could be said to indicate risk status into a social context, the following table (Table 4) indicates the percentage of interventions, forceps delivery and Caesarian sections incurred by the same groups of women. Tables 3 & 4 indicate that, generally, those with the highest risk status receive the least forceps deliveries and Caesarean sections, and are most likely to have their births commence spontaneously. Those women with the lowest risk status were the most likely to receive Caesarian sections and forceps deliveries and were least likely to have their births commence spontaneously. The results suggest that there is a relationship between low social class, and poorer infant outcomes, including low birthweight. This information may have led to confounding factors in the first three studies, as the authors may not have been aware of low social class, its relation to low birthweight, as well as its relationship to notification to child welfare agencies. if these factors are considered, it may not be so surprising to find in the Tudehope study that, "Approximately 30 per cent of battered children are premature yet the overall incidence of prematurity is 6.5 per cent" (Tudehope, 1983:69).

The final table (Table 4) raises a number of questions about risk status and interventions at birth, not the least of these being: why does the "most well" population receive the most forceps and Caesarian sections? These interventions are related to poor patient outcomes, as forceps deliveries are associated with, at the least, soft tissue trauma; as well, the effect of epidural anaesthesia on foetal heart rate has not been assessed with appropriate clinical trials (Bennett et al., 1987). A number of other questions arise: how appropriately are the interventions being used; how does the funding of the health care system contribute to their use; and is prevention more appropriate than "treatment"?

RELEVANCE OF THESE STUDIES TO SOCIAL POLICY

Within health services, there appears to be a certain ambivalence in service delivery, with informal notification to the social worker of "at risk" parents, noting that risk is defined variously, and that certain practices develop where some mothers are under surveillance, and where the criteria for the detection of "deviance" appear to be normatively created. The hospitals' perception of the "at risk" mother appears to have created a scenario far removed from the broader perspective of access to resources which was created in the initial analysis of the single mother and her relationship to class, capital, work and family. The methods of intervention used by the service providers, which they believe to be a form of prevention, focus on the "at risk" mother and detract attention from a broader perspective where the provision of adequate resources and children's services would be much more effective in reducing any such "risk". The data in Table 4 also suggests that the variability in the levels of interventions in obstetric practices has a class bias as well. In that aspect, too, the possibility of redirecting resources towards other children's services does not appear to be considered.

The practices described herein appear at times precarious and at least ambivalent and will no doubt continue to remain so at the health and welfare interface unless the value positions of service providers are carefully examined. Service providers have a considerable access to the creation of issues and problems associated with deviance, its perception and control.

The methodologies used might appear to be scientific but the unstated assumptions on which the methodologies are developed are normative, with an historically culturally inherited bias against single parenthood, cultural diversity and, above all, poverty. Thus, in retrospect, the arbitrary "scientific" methodology is frail and fragile, dancing out the worn steps of inequality.

There could be a variable interchange at this health and welfare interface, and conferring on welfare clients the rights of informed consent, such as, if you play with your infant or use this baby sling, I will be less likely to notify your child as being "at risk" to the State welfare department, a pyrrhic progress perhaps.

However, studies that promote the identification of the "at risk" mother, due to their methodological failures,

contribute to the confusion and stigmatisation of such women. Yet, this idea appears to maintain a current fascination, as identifying the "at risk" mother in the labour ward and the maternity hospital is a recommendation of the review in Maternity Services in New South Wales and early intervention teams have already been established by some Area Health Services (The Ministerial Task Force on Obstetric Services in New South Wales, 1989:216-222, Appendices 5.5 and 5.6, 1989:89-93). The role of science, as it is perceived in a number of these maternity hospitals from the studies conducted in them, takes on a new form which ethnomethodologists might describe as science as enchantment, dominating, defining and classificatory in action.

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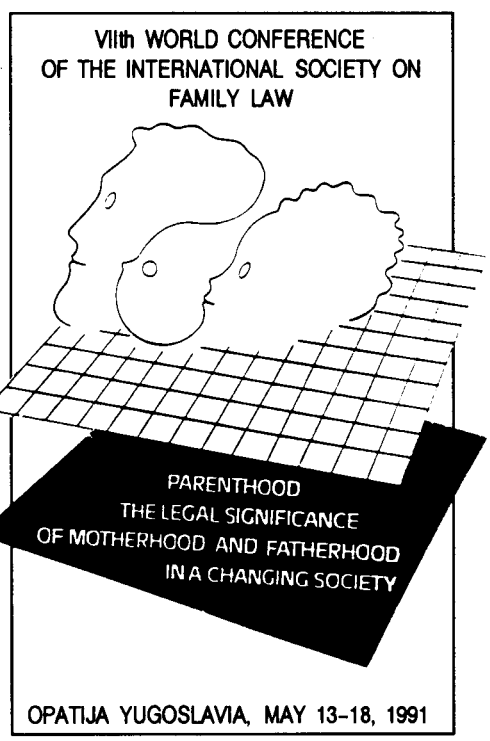

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