Written evidence submitted by Dr Jenny Woodman,[1,2] Professor Ruth Gilbert,[1,2,3] Rachel Pearson,[1,3] Dr Louise Mc Grath-Lone,[1,3] Matthew Jay,[1,3] Claire Grant,[1,3] Claire Powell,[1,3] Katie Harron[1,3] Professor Gene Feder[4] 19th March 2021

[1]University College London
[2]NIHR Children and Families Policy Research Unit
[3]UCL Child Health Informatics Group (CHIG)
[4]University of Bristol

Inquiry: Call for evidence on the role of public services in addressing child vulnerability

A. Executive Summary

A1. Definitions of child vulnerability and policies to address child vulnerability should reflect the evidence that very large proportions of the child population and their family members will likely need additional services at some point over childhood to 'level-up' child outcomes.

A.2. Responding to the needs of vulnerable children and their parents or carers should be embedded and supported more widely as part of the everyday interactions between healthcare professionals and families, as part of a 'No Wrong Door' approach. This approach needs to be properly resourced, properly supported via advice from specialist services and underpinned by clear referral pathways across child and adult services within and beyond health services.

A.3. There are opportunities for health services to intervene early and prevent child vulnerability in the years before a child is conceived through supporting the health, wellbeing and living conditions of the future-mother.

A.4. A critical role for central government is to ensure good quality, de-identified administrative data is collated at the national level. Such data can be used by government departments and researchers to monitor variations in 'place-based' approaches, identify possible inequities or worrying trends and evaluate different policy and service approaches using robust methods. This data should be linked across public services so researchers can evaluate how interventions in one sector (e.g. schools) influence outcomes in another (e.g. health).

A.5 There is a need for further consideration of best practices for local authorities linking data on individuals for operational purposes.

A.6. Inaccurate measures of income deprivation underestimate the steep inequity gradients between income and health, education, and wellbeing. DWP and HMRC can address this measurement bias by providing anonymised measures of income level and benefit receipt by household for de-identified data analysis

B. Introduction

B.1. We are a group of academic researchers at University College London and University of Bristol, leading a portfolio of studies investigating responses to 'vulnerable' children and their families within the public services of health, education, family justice and children's social care in England and beyond.

B.2. Our research is policy facing and we generate recommendations to support policy and practice. Our responses reflect the views of the authors named above, based on our own research and the wider research landscape and not the views of our funders or collaborating institutions.

C. How is child vulnerability best defined?

C.1. The Children Commissioner's report on defining child vulnerability[1] and Public Health England's report on supporting vulnerable children in the context of COVID-19[2] conceive 'child vulnerability' as groups of children who experience outcomes that are systematically different from those experienced by the average population and that affect their wellbeing and life chances.

C.2 Vulnerability is not a value-neutral concept. Critics argue that it is a stigmatising label used to control and oppress certain groups[3]. In a workshop in September 2020, young people told us that they disliked the term 'vulnerable' and preferred to speak about 'additional needs'[4].

Recommendation: We suggest framing the concept of 'vulnerability' as: families who are likely to need additional support from public services to improve their children's outcomes and life chances.

C.3. Two of our studies have found that GPs face challenges in appropriately recording child vulnerability in a child's electronic health record, especially when the professional concern has been prompted by a contact with the parent-as-patient[5][6]. In our workshop with GPs, there was consensus that a generic 'cause for concern' code in a child's electronic health record could allow GPs to flag possible problems but avoid the level of certainty required for recording child safeguarding issues which require statutory intervention 5.

Recommendation: Health care professionals could use 'catch-all' codes such as 'cause for concern' in health care records to make vulnerable children 'findable' and facilitate proactive management and follow-up.

C.4. We have found that there is a strong association between prevalence of parental health need related to violence, mental health or substance misuse and child entry into care in local authorities (LAs) in England and this association has increased with time, particularly since the introduction of austerity measures[7].

Recommendation: A holistic focus on '**families** who are likely to need additional support,' reflects the many instances of child need related to challenges faced by the whole family or household.

C.5. In our recent study, we estimate that 25% of all children in England have been classified as a 'child in need' by Children's Social Care services at some point before the age of 16 years and 43% of all children are referred to Children's Social Care services before their 16th birthday[8]. In another study, we found that 37% of all children in England will have received Special Education Needs (SEN) provision by the time they are 16 years old[9]. This same study found that children are likely to have multiple additional needs, with 83% of Looked After children and 65% of children classified as 'in need' by children's social care having received SEN provision by age 169.

Recommendation: Policies to address child vulnerability should take account of the very large proportions of the total child population and their families who will need input from specialist public services at some point over their childhood and recognise that some children will need multiple specialist services.

D. How well do public services address underlying causes of child vulnerability within families, such as domestic abuse, mental ill health and addiction?

D.1. Large numbers of mothers whose children are the subject of care proceedings in the family courts experience mental health problems. Our research in South London found that two thirds of women in family court proceedings between 2007-2019 had ever accessed specialist mental health services or 'improving

[1] The Children's Commissioner Report (2017) https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/07/CCO-TP2-Defining-Vulnerability-Cordis-Bright-2.pdf
[2] Public Health England (2020) https://publichealthmatters.blog.gov.uk/2020/09/02/no-child-left-behind-a-public-health-informed-approach-to-improving-outcomes-for-vulnerable-children/
[3] Brown (2011) https://doi.org/10.1080/17496535.2011.597165
[4] https://www.ucl.ac.uk/child-health/research/population-policy-and-practice-research-and-teaching-department/cenb-clinical-23
[5] Woodman et al (2012) https://doi.org/10.3399/bjgp12X652346
[6] Drinkwater et al (2017) https://doi.org/10.3399/bjgp17X689353
[7] Pearson (2020) http://dx.doi.org/10.1136/bmjopen-2019-036564
[8] Jay (pre-publication) https://osf.io/6ecrz/
[9] Jay (2020) http://dx.doi.org/10.1136/archdischild-2019-317985

access to psychological therapies' (IAPT)[10]. However, parents are often not entitled to accelerated access to mental health services, unless acutely unwell, and there is underprovision of mother-baby units and other specialist perinatal mental health services.

D.2. Benefits of multi-disciplinary teams carrying out intensive assessment and therapeutic work with families at-risk of child entry into care has been demonstrated in Family Drug and Alcohol Courts (FDAC).[11]

Recommendation: It is vital that parents/carers and parents-to-be can access effective and timely mental health care, especially when these parents are involved in care proceedings.

D.3. Our research identified three approaches for responding to parental mental health, domestic violence or addiction within healthcare settings which have been embedded into health care services[12]

1) **Routine enquiry:** In some emergency departments**,** health care professionals routinely ask all adults who present with problems relating to violence, mental health (including self-harm) or addiction if they have dependent children and provide clear referral pathways for the parents and children to access support[12]. Alternatively, HCPs can routinely ask all parents and carers about their own experiences of violence, mental health problems and addiction when they bring their children in for check-ups[12].

2) **Health promotion**: In-patient hospital admissions, including in maternity units, have been used as an opportunity to provide educational material designed to help parents better manage stressful events or situations, such as crying babies or intensive care stays[12].

3) **Using relationships:** The most common way of health professionals helping the child living with parental health problems, mental health problems or addiction is to build and leverage a strong parent-professional relationship to encourage readiness to change and/or behaviour change in the parent[12].

D.4. Our research has found that GPs and health visitors use 'direct responses' to families in order to respond to parental mental health, alcohol misuse, violence in the household and wider determinants such as poor housing[1314]. Direct responses include proactive review, monitoring and follow-up of 'vulnerable' families, offering opportune healthcare to children and coaching parents to recognise and address, for example, the impact of alcohol or substance misuse on their children[1314]. Direct responses are likely safest and most feasible when health professionals have access to support from other services, such as in IRIS which provides GPs with on-going advice from an 'IRIS advocate educator' as part of an intervention to improve the healthcare response for women (including mothers) experiencing domestic violence and abuse.[15]

Recommendation: Direct responses to 'vulnerable' families should be properly resourced and embedded in primary health care services, with health care professionals able to access support from other specialist services and clear referral pathways across child and adult services within and beyond healthcare.

D.5. Our research has shown that if a woman is admitted to hospital with adversity (drug or alcohol abuse, violence, and self-harm) in the three years before giving birth, it can act a signal that her future child is at higher risk of poor outcomes. We found that:

- Women in England who were admitted to hospital in the two years before a pregnancy with adversity were more likely to have a child who had a serious injury or who died in the first year of life[16].
- Local rates of hospital admissions for substance misuse, domestic violence and abuse, and mental health problems in women in the three years before birth accounted for 24% of local area differences in rates of infants taken into out-of-home care in England.[17]

[10] Pearson et al (2021) https://doi.org/10.23889/ijpds.v6i1.1385
[11] https://www.cfj-lancaster.org.uk/projects/fdac
[12] Woodman et al (2019) https://doi.org/10.1093/pubmed/fdy210
[13] Woodman et al (2014) https://www.ehcap.co.uk/content/sites/ehcap/uploads/NewsDocuments/219/RCGP-GP-Role-responding-to-child-maltreatment-July-2014-ashx.PDF
[14] Woodman et al (2013) http://dx.doi.org/10.1136/bmjopen-2013-003894
[15] Lewis et al (2019) https://doi.org/10.1111/hsc.12733
[16] Harron et al (2021) https://doi.org/10.1016/S2468-2667(20)30210-3
[17] Pearson et al (2020) http://dx.doi.org/10.1136/bmjopen-2019-036564

D.6 Our research has shown that adolescents admitted to hospital with adversity were more likely (61% more likely for girls and 113% more likely for boys) to have died within 10 years than peers hospitalised with accidental injuries[18].

Recommendation: Hospital admissions for adversity, including in the years before a pregnancy, offer opportunities for intervention to prevent poor child/young person outcomes related to vulnerability. This represents a 'No Wrong Door' approach, which means that means that children and families can get help regardless of which service or agency they connect with and at whatever point in their lives.

E. How should central Government coordinate public services to support vulnerable children to recover from the effects of the COVID-19 pandemic?

E.1. By collating high quality administrative data from across public services in England, central government can facilitate monitoring of variations in practice and outcomes between local areas and over time in order to identify good practice which can be shared and form the basis of robust evidence to evaluate what works for whom. For example, the Children Looked After (CLA) return is an administrative dataset that has been collated at a national level by government for more than 25 years, with standardised data submitted by LAs. This dataset has been vital to understanding how out-of-home care is used: we have found that 1 in 30 children (3.3%) in England are placed in care during childhood, but for children of black ethnicity this figure is 1 in 10 (9.5%) and for children in Manchester it is 1 in 15 (6.9%).

Recommendation: Central government should ensure monitoring and evaluation of local 'place-based' approaches to commissioning and service delivery. This requires high quality, de-identified administrative data to be collected at a local level and collated at the national level.

F. Do vulnerable children, parents, guardians and families receive sufficient support from early intervention and preventative services? If not, how might such support be improved? Can early intervention and prevention deliver more efficient and effective public services?

F.1. Many vulnerable children and their parents/families do not currently receive sufficient support from early intervention. For example, the Family Nurse Partnership is one of the only interventions recommended for families at higher risk within the Healthy Child Programme, but in local authorities that offer the programme, <25% of the eligible population (first time, teenage mothers) are enrolled[19].

Recommendation: The development of effective interventions for vulnerable families before, during, and after pregnancy should be prioritised Evidence is needed on how to provide specific interventions with complete coverage of the population they are targeting.

Embedding direct responses to parents, children and young people within healthcare services (see **D.4.**) would facilitate early intervention and prevention by allowing universal healthcare services to safely 'hold' families below the high thresholds needed to access children's social care services and specialist mental health service. This requires:

- Proper resource to allow health care professionals to see and proactively follow-up families
- Referral pathways so primary care, hospitals and children's social care can refer for early mental health and other interventions for parents, without resorting to statutory safeguarding procedures.**Error! Bookmark not defined.**

F.3. Opportunities for early intervention to level-up the health and opportunities for a vulnerable child exist in the years *before* conception as well as during pregnancy and after the child is born. Foetal development can be affected by stress, health conditions and hazards in the maternal environment[20]. The impact may be manifested by being born too early or too small or in the child's development[2016], which are early problems that have life-long effects on health (see **D.5** and **D.6.**).

G. At the local level, where does responsibility rest for addressing cross-cutting issues that affect children's vulnerability, such as parental mental health, addiction and domestic abuse issues? How are those who are responsible for such issues held to account, and how might such accountability be improved?

[18] Herbert et al (2015) https://doi.org/10.1371/journal.pmed.1001931
[19] https://www.fundingawards.nihr.ac.uk/award/17/99/19
[20] Bekkhus et al (2020) http://dx.doi.org/10.22541/au.159682259.93390668

G.1. Primary care professionals such as GPs and health visitors can provide a family health service, which can address the health and wellbeing of children and their parents or carers, especially mental health, which is critical to parents' capacity to care for their children[21]. But pressures on primary care and erosion of continuity of care undermine a family approach.

Recommendation: The Government needs to address low levels of funding for primary care and the erosion of the GP and health visitor work force.[22]

H. What practical steps can the Government and providers of public services take to encourage different agencies – such as NHS bodies, councils, schools and the police – to share data that helps keep vulnerable children safe, and to support early intervention and preventative services?

H.1. Using data recorded for one purpose without consent for another purpose or service to keep vulnerable children safe can threaten wider public support for the use of data and the right to privacy:

- Firstly, vulnerable children constitute a substantial proportion of children and families with over 40% of children estimated to have been referred to children's social care (see **C.5**).
- Secondly, data used to identify vulnerable children could involve data on all children (i.e. data combined from schools, social care and police, and may involve other household members as well as children). Legal clauses that waive the right to privacy for vulnerable groups may not have been intended to be used for whole populations in this way.

Recommendation: Limiting access for approved individuals and roles may be more acceptable but there is a need for a 'best practice' guide that local authorities and other organisations can use to justify and safely undertake linkages for operational purposes.

H.2. Linking up de-identified data, where individuals cannot be identified, can provide valuable information about service provision and inequities at a population level while maintaining trust and support for wider use of data. If access to data and outputs are controlled, there is minimal risk to privacy and use can be restricted to purposes with clear public benefits. The data can provide powerful evidence to reduce inequities and to target interventions to improve health, education and social care services. For example, the ECHILD database links de-identified data from all hospitals, schools and social care services in England for 15 million children followed over two decades[23].

Recommendation: Linking de-identified data across public services would allow researchers to provide policy-makers with answers about how children and families use multiple public services across their lives and investigate how interventions in one sector (e.g. schools) influence outcomes in another (e.g. health).

I. The Government has stated its ambition to 'level-up' underperforming regions. How could the Government's 'levelling-up' agenda address regional and local disparities in children's education, health and wellbeing outcomes?

I.1. Although poverty is a key driver of disparities in children's education, health and wellbeing outcomes, it is measured inaccurately in most administrative data resulting in the underestimation of inequities. Income deprivation is a commonly used measure at lower super output level (LSOA). On average, a LSOA includes 500-600 households and 1500 individuals in England. This measure is insufficient because the lowest tenth (decile) of income deprivation could contain between 26% and 64% of income deprived households households[24]. This measure will blunt any associations between poverty and health outcomes.

Recommendation: The levelling-up agenda should be leveraged to achieve a step change in the quality of some administrative data, such measures of poverty and mental health services and health visiting data (**F.1.**).

[21] Dreyer et al (2018) http://dx.doi.org/10.1136/bmjpo-2018-000266
[22] Ruzangi (2020) http://dx.doi.org/10.1136/bmjopen-2019-033761
[23] ECHILD Project https://www.ucl.ac.uk/child-health/research/population-policy-and-practice-research-and-teaching-department/cenb-clinical-20
[24] https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

Acknowledgements This response was drafted by Dr Jenny Woodman, with input from all listed authors, oversight from Professor Ruth Gilbert and editorial support from Audrey Tan, UCL Public Policy.