

26: 3 Editorial

Was Not Brought - Take Note! Think Child! Take Action!

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Guidance on *When to Suspect Child Maltreatment* from the National Institute for Health and Clinical Excellence (NICE, 2009; National Collaborating Centre for Women's and Children's Health, 2009, p.23) reminds health professionals to consider neglect 'if parents or carers repeatedly fail to attend essential follow-up appointments that are necessary for their child's health and wellbeing'. National analyses and summary analyses of Serious Case Reviews have consistently raised the issue of children's missed health care appointments as a feature in cases (Brandon *et al.*, 2010; Brandon *et al.*, 2012; Sidebotham *et al.*, 2016).

The most recent triennial analysis highlighted how difficult it can be for agencies to share information about children's missed appointments and that such policies are not always consistently applied in organisations (Sidebotham *et al.*, 2016). While there are many reasons why children and young people miss health care appointments (Arai *et al.*, 2014), rethinking the concept of 'Did not Attend' (DNA) to one of 'Was not Brought' (WNB) should encourage health professionals to take a child-centred approach (Roe, 2010; Powell and Appleton, 2012; Roe *et al.*, 2015). Importantly a 'Was not Brought' policy should lead to consideration of the consequences for the child or young person of the missed appointment (Appleton *et al.*, 2016). This is the central message of an excellent YouTube video animation produced by Nottingham City Council, NHS Nottingham City Clinical Commissioning Group and the Nottingham City Safeguarding Children Board available at <https://www.youtube.com/watch?v=dAdNL6d4lpk>. It also reinforces a series of questions raised by Appleton *et al.* (2016, p.6) in a study of professional and organisational response to children's missed healthcare appointments namely:

- 'What are the consequences of these missed appointments for the child/young person?
- What is known already about the family?

- Why have there been previous missed appointments?
- Has the clinician spoken directly to the parent about what's happening?
- Does the parent understand the need to get the child to the appointment?

Missed dental appointments

In the first paper in this issue Jennifer Harris and colleagues (2017) explore the issue of missed dental appointments for children as an alerting feature of possible dental neglect. These authors report on a clinical audit of children and young people's missed dental care appointments conducted across Community and Special Care Dentistry in Sheffield, as part of a quality improvement exercise. Audit standards were developed against the NICE (2009) guidance on *When to Suspect Child Maltreatment* (National Collaborating Centre for Women's and Children's Health, 2009) and set out to determine (1) the frequency of communication with the family following a missed appointment, (2) frequency of communication with other professionals in cases of significant unresolved dental outcomes and (3) referral to children's social care for child protection concerns. This well conducted audit study collected data from a random sample of 100 electronic clinical dental records in Cycle 1. Using an October 2009 reference appointment, the authors examined all communication and the dental outcome within six months for those who missed the appointment. The first audit cycle was very helpful in identifying that there was no consistent method for identifying children whose appointments had been cancelled by parents/carers and not rebooked. Following this baseline data collection, an action plan was developed including staff training, the introduction of new procedures for rebooking cancelled appointments, and text messaging appointment reminder systems. Two further cycles of the audit were conducted in October 2010/April 2011 and October 2011/April 2012.

The audit results revealed a low rate of children's missed health care appointments across the dental care service (11-12% in all cycles), with single missed appointments predominating in the first audit, and in cycles 2 and 3 'a greater proportion of children not brought for the second or subsequent time' (Harris *et al.*, 2017, p. XX). While small improvements were made in interprofessional communications and dental outcomes for children, the authors also revealed lapses in their action plan which they note 'might indicate children at risk of neglect who could 'slip through the net'' (Harris *et al.*, 2017, p. XX). The paper's discussion considers a number of reasons why their action plan was only partly effective including the problem of undeveloped communication pathways with other professionals or the fact that while dentists may consider child abuse and neglect as a reason

for a missed appointment, they focus on the dental impact for the child and overlook 'the more general indication of risk' (Harris, 2017, p. XX). Harris *et al.* (2017) conclude their paper by arguing that 'novel solutions will be required to achieve consistent standards of communication between dentistry and other healthcare disciplines and children's social care'.

Supporting adolescent mothers

The second paper in this issue reports on a study from New York by Margaret McHugh and colleagues (2017) evaluating a parenting programme developed by hospital staff for adolescent mothers. The Bellevue Hospital adolescent parenting programme involves a combination of medical care for the teenage parents and their babies, alongside support provided in group sessions from the wider multidisciplinary team, to help teenage parents develop their parenting skills. Partners of the pregnant teenagers are encouraged to participate in the programme, and as the time of delivery approaches teenage parents are taken on tours of the hospital's labour and delivery wards.

While teenage pregnancy is a major public health issue globally, it is worth noting that the rates of teenage pregnancy across the UK have declined to their lowest levels since records began (Office of National Statistics, 2016; Information Services Division/National Statistics Scotland, 2016; Northern Ireland Statistics and Research Agency, 2016). Yet there are strong links between deprivation and teenage pregnancy; and despite these figures there are potential adverse outcomes for the children of teenage mothers. These include: a higher incidence of adverse perinatal outcomes, such as preterm birth and low birth weight (Althabe *et al.*, 2015); developmental delays, behavioural and cognitive deficits in infancy and childhood; and, in some cases, child abuse and neglect. However, the Bellevue Hospital programme is based on the premise that while there is a long list of risk factors and potential negative outcomes for adolescents and their children, these 'are by no means inevitable' and that 'meeting a core set of fundamental needs for parenting support for this vulnerable population would improve long term child outcomes' (McHugh *et al.*, 2017, p. XX).

McHugh *et al.*'s (2017) evaluation focussed on health outcomes of 29 mother-infant dyads that started attending the parenting group in 2011 compared to the general clinic and New York City populations. Data were collated from hospital records (including labour and delivery records), community providers and the governmental registry and stratified according to whether or not the mothers attended the parenting programme until their child's first birthday. The results showed that teenage mothers who attend the full one-year programme had more well baby visits and emergency department visits, higher uptake of infant immunisation (exceeding New York City's infant immunisation uptake rate) and earlier identification of infant developmental delay.

Despite this being a very small study with no control group, in the group that attended the parenting programme for the full year, no infants were reported for suspected child abuse/neglect, and, during the study, none were known to be placed in foster care. The authors conclude their paper by talking about some of the difficulties associated with working with vulnerable teenage parents, including their frequent moves and long distances needed to travel to attend the programme as well as the challenge facing many researchers of unpicking which aspects of the intervention are most suited to teenagers, young fathers and their babies.

Research and intervention with vulnerable young people

Picking up on the issue of collecting data from vulnerable groups, the next paper in this issue by Rachael Cox and colleagues (2017a) from Victoria, Australia, describe a randomised trial of the Healthy Eating, Active Living (HEAL) programme for young people in Australia living in residential out-of-home care (OOHC) and their carers. HEAL is a 12-month programme intervention which aims to help young people (independent of their weight status) to make positive choices in relation to their physical activity and eating, and provides resources for 'their professional carers to model, encourage and support this change' (Cox *et al.*, 2017a, p. XX). The study was offered during 2012 to 2014 and recruited 70 young people and 177 carers from 48 residential care units across Melbourne and Victoria. Using a waiting list control group, data were collected at baseline, 6 and 12 months post the intervention using a range of quantitative measure of behavioural, psychosocial and motivational outcomes. Measures for children included the 'Children's Eating and Physical Activity Questionnaire' (EPQ) and the Depression Anxiety Stress Scale 21 (DASS21), measures of height and weight and questions developed specifically for the HEAL study to measure motivation. For carers the study included measures of physical activity, including screen time at work, height and weight, DASS 21 and measures around encouraging healthy lifestyle behaviours, supporting young people to eat healthily and carer knowledge about national recommendations for adolescent diet, physical activity and screen time. 'Only participants with baseline data and at least one follow-up were included in statistical analyses' (Cox *et al.*, 2017a, p. XX).

Disappointingly, the study results showed no evidence of effectiveness of the HEAL intervention for either young people or their carers. There was a high drop out from the study (with 118 carers and 51 young people) lost to follow up, so limiting the statistical power of the study to detect significant differences. The authors suggest that the high dropout reflected both the young people's vulnerability as well as their movements around the care system with many having different OOHC

placements alongside the high turnovers of staff working in care environments. The HEAL study highlights some of the difficulties of recruiting vulnerable young people to take part in intervention trials as well as their implementation in complex environments. In a refreshing analysis, Cox *et al.* (2017a) conclude their paper with a summary of important lessons they learned from the work that will be invaluable for others planning similar research in out-of-home care environments.

This paper reports on the first stage of a mixed-methods analysis of the HEAL programme. A qualitative analysis based on semi-structured interviews with carers and programme coordinators explores further some of the reasons for the lack of objective improvements found in the quantitative study (Cox *et al.*, 2017b). It does highlight, however, that the programme 'was considered a valuable adjunct to the residential care programme, and was successful in raising awareness about the importance of leading a healthy lifestyle' (Cox *et al.*, 2017b, p. XX) and that the carers did observe 'positive behaviour change among the young people and carers' dietary, physical activity and sleeping habits, and the development of independent living skills' (Cox *et al.*, 2017b, p. XX). These findings emphasise the importance of different research methods in fully understanding the impact of interventions, the need for careful research design, and the challenges faced in implementing appropriate interventions.

Using digital technologies to prevent violence

In the introduction to the 2016 special issue of *Child Abuse Review* - 'Digital Technology, Child Abuse and Child Protection' (Volume 25 Issue 5) - guest editor Bernard Gallagher reflected on a piece of his published over ten years earlier on the extent to which technology was 'helping or harming children' (Gallagher, 2005, p.367; Gallagher, 2016, p. 327). The paper in this issue by Carmen Cronin and colleagues (2017) from Philadelphia, Pennsylvania focusses on the use of digital technologies and their potential to contribute significantly to the prevention of violence against children and young people. This is a well-conducted systematic review of social and behaviour change interventions addressing violence against children, which sought to address three questions: '(1) What is the nature and scope of interventions using digital technology to address violence? (2) How are digital technologies being adapted for use in interventions dealing with violence? [and] (3) Do digital technologies work to address violence?' (Cronin *et al.*, 2017, p. XX). However, despite reviewing 18 intervention studies using digital technology to address violence and classifying efforts to bring about social and behaviour change as either 'innovation, fusion or transcreation, depending on how the technology was incorporated into the intervention' (Cronin *et al.*, 2017, p. XX), the authors were unable to draw any solid conclusions about the effectiveness of digital media technologies. These

authors conclude their work by arguing that 'successful violence prevention programmes are not taking full advantage of digital technologies' (Cronin *et al.*, 2017, p. xx) and recommend more investment in research and evaluation is required. This systematic review provides a good starting point for future research work.

Accidental and abusive ano-genital injuries

Our final paper of this issue is an extremely interesting report by Neil McIntosh and Jacqueline Mok (2017) from Edinburgh who have collated and compared three datasets of accidental and abusive ano-genital injury in children under 16 years across Scotland. 'Ano-genital (AG) injuries in children may be accidental or secondary to sexual abuse' (McIntosh and Mok, 2017, p. xx). The datasets were reviewed and collected for the years 2009-2010 and included (1) children (n=146) with ano-genital injuries attending a regional children's emergency department in South East Scotland – data collected retrospectively, (2) all children admitted to hospital in Scotland with straddle injury (n=56) collected prospectively, and (3) all children (n = 98) attending a child abuse and neglect regional service for assessment of suspected child sexual abuse – data collected retrospectively. The authors used the Royal College of Paediatrics and Child Health's (RCPCH, 2015) criteria in *The Physical Signs of Child Sexual Abuse* for the diagnosis of accident or abuse in their datasets. The two injury types (abusive injury and accidental injury) were compared.

The results of this study make very interesting reading, with the authors reporting that 'exclusion of abuse was variable' with the child's explanation usually accepted if they were over 6 years of age and under this age 'accidental injury was accepted if a reliable witness gave a consistent story' (McIntosh and Mok, 2017, p. xx). The authors also report that 'relatively few sets of notes stated that CSA was considered and even fewer that this diagnosis was explored...' (McIntosh and Mok, 2017, p. xx). It is worth reading the whole study and reviewing their findings which cover injuries to the female genitalia, injuries to the male genitalia and perineal, perianal and anal injuries. McIntosh and Mok (2017, p. xx) found that in boys 'penile and scrotal injuries were only seen following accidents; anal injury was more frequent following suspected abuse (36%) than after accidents (5%); while 'in girls, injuries to the perineum and labia were more frequent after accidental trauma (32% and 74%, respectively, compared to 2% and 11% following suspected abuse), while hymenal injuries were more frequent after sexual abuse (19% compared to 1% in the accident group)' (p. xx). This paper concludes by providing a very helpful way to document clinical findings in cases of ano-genital injuries, which includes the mechanism, cause and injury type.

Evidence-informed approaches

The somewhat eclectic collection of papers in this issue serve to highlight one of the central tenets of evidence-informed practice in health and social care. A previous editorial in *Child Abuse Review* spoke of authoritative practice requiring ‘the application of appropriate evidence, combined with the experience of the practitioner and their responsiveness to the current context’ (Sidebotham, 2013, p. 1). That, of course, is dependent on a careful analysis of current best evidence, high quality research to promote and extend our evidence base, and practitioners who retain a focus on the child, recognising and responding to vulnerability in a supportive but challenging manner.

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