Editorial [30:2]

Vulnerable Children and Early Intervention – What about health visiting?

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Several of the papers in this issue have a focus on vulnerable children and early help and intervention with children, young people and their families. Early help and support given as soon as needs are identified is widely accepted as being much more effective in promoting children's health and welfare than responding later (HM Government, 2018). We know from research evidence that early identification of problems and early help can protect children and young people from harm, it can help to improve their long-term outcomes, reduce involvement of child protection services and is more cost-effective (Haynes *et al.*, 2015; Early Intervention Foundation, 2018). Many professionals and services are involved in providing early help to children and their families, but what struck me as I was organising the papers for this issue, was the lack of mention of health visiting services within these papers. Health visitors lead the delivery of the UK child health promotion programmes and they are trained to have a key role in promoting the health and wellbeing of preschool children and their families, as well as identifying and working with vulnerable children. Health visitors are notified about the birth of all new babies and should (if services are properly resourced) have continued contact with a child and family until children start school (Appleton and Whittaker, 2019). They are the only professional group who undertake home visiting on a universal basis and are therefore in a unique position to access all families with babies and young children and identify those in need of early help and support [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN, i.e. [Health visitors] are… in a unique position to access all families with babies and young children and identify those in need of early help and support'] (Appleton, 2015; Peckover and Appleton, 2019).

During the COVID-19 pandemic there was widespread redeployment of health visitors with 53 per cent of local authorities in England redeploying staff away from front line health visiting duties (Conti and Dow, 2020). Across the country health visitor numbers are dwindling. There is also variation in the number of core health contacts with children and families across the four UK countries (Appleton and Whitaker, 2019). In England, NHS Workforce Statistics show that in December there were 6653 fulltime equivalent health visitors working in the NHS, a reduction of 3.6 per cent from December 2019 (NHS Digital, 2020). In the 1990s, the movement of the majority of health visitors out of general practice, and more recently from local community-based centres such as the Sure Start centres, to geographically dispersed offices, has undoubtedly impacted on their visibility to the public (Peckover and Appleton, 2019). There has been an increase in home working since the pandemic (Barlow *et al*., 2020) which may have added to this reduced visibility. At the same time, 'the retraction of universal services' and reduced face-to-face contacts have affected the ability of professionals to identify ''new' or increased need, and safeguarding issues' (Barlow *et al*., 2020, p. 5), despite health visitors adopting some new and innovative ways of working during the pandemic (see Institute of Health Visiting, 2020).

The reduced opportunities for preventative work by health visitors with children and families is a significant concern [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN]. In 2015, responsibility for commissioning health visiting services in England transferred to local authorities (LAs) and while the majority of health visitors are still employed by the NHS some now work for private companies, local authorities and small to medium enterprises (SMEs), which has led to services being

delivered and organised very differently across the country (Royal College of Nursing, 2017; Conti and Dow, 2020; Whittaker *et al*., 2021). As Sue Peckover and I recently observed:

> 'in some areas this has resulted in cutbacks in universal provision and less health visiting contacts with under 5s and their families, resulting in families sometimes not even knowing who their health visitor is. Cuts to home visiting and general erosion of the universal service means there is a potential for some vulnerable children to be 'missed'.' (Peckover and Appleton, 2019, p. 236)

It is this latter point, and the increasing number of vulnerable children since the start of the COVID-19 pandemic who do have access to public services that has prompted the attention of the House of Lords to launch a new inquiry in February, chaired by Baroness Armstrong into vulnerable children and how well public services tackle underlying causes of vulnerability and keep children safe (see UK Parliament (2021) for the call for evidence). There is a lot of valuable information and expertise that readers of *Child Abuse Review* can contribute to this important inquiry on vulnerable children and we urge you to do so.

Turning now to this issue's content, our first paper by Helena Mc Elhinney and colleagues (2021) from Ulster University reports on a research study which sought to examine the perceptions and experiences of midwives and child protection social workers in Northern Ireland around the protection of unborn babies when pre-birth risks are identified. A newborn infant may be vulnerable to abuse and/or neglect and professional pre-birth risk assessment involves understanding the impact of risks to the unborn infant when concerns arise during pregnancy [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN]. This topic will also be addressed in *Child Abuse Review*'s Special Issue in 2022 which is being guest edited by Jane Barlow and Harriet Ward from the University of Oxford.

In this study, Mc Elhinney *et al*. (2021) gathered data through four focus groups involving 14 midwives and 16 child protection social workers in one of the five Health and Social Care Trusts in Northern Ireland. Focus group discussion centred around identifying risk factors around referrals of unborn babies, risk assessment approaches and decisions to refer. Data were analysed thematically and sought to understand risk factors and how professional judgments are formed. Key risk factors discussed by participants included the mental wellbeing of the pregnant woman, her childhood experiences, the woman's age and feelings about the pregnancy, drug and alcohol use, domestic violence, gestation period and attendance for antenatal care. Participants also reported that some pregnant women were not able to 'see the risks in their behaviour' (Mc Elhinney *et al*., 2021, p. XX) and were unable to 'recognise the dangers in misusing illegal or prescription drugs, excessive alcohol consumption and initiating/maintaining relationships with sex offenders' (Mc Elhinney *et al*., 2021, p. XX). Midwives also described finding it difficult to discuss both current and historical mental health issues with pregnant women and reported they were not trained or equipped to deal with the deteriorating mental health of a pregnant woman (Mc Elhinney *et al*., 2021, p. XX).

In forming professional judgments three issues appeared key for the participants: professional experiences, the professional's skills and ability in engaging pregnant women, and the use of 'soft intelligence' described as the 'thoughts, feelings and feedback shared between professionals in child protection cases' (Mc Elhinney *et al*., 2021, p. XX). Participants highlighted 'the importance of continuity of care, building rapport and developing and maintaining transparent relationships with pregnant women to inform decision making' (Mc Elhinney *et al*., 2021, p. XX). Such relationship building strategies are central to needs assessment practices for many public health professionals, including school nurses and health visitors (Cowley *et al*., 2015). The Continuing Professional Development paper in this issue by Chris Mills and colleagues (2021) also highlights the importance of human factors knowledge in the development of three non-technical skills areas involved in child protection work: situation awareness, decision making and communication, and a brief summary of the evidence base for each is presented in the paper.

Early help or early intervention can promote resilience and reduce risks and is increasingly being recommended to safeguard children [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN]. The next paper in this issue by Melanie McCarry from the University of Strathclyde and colleagues from the University of Central Lancashire (McCarry *et al*., 2021) reports on an evaluation of early intervention services running in the North West of England for women and children suffering domestic violence (DV). The new early help services were part of the *Safer Together* consortium that involved eight organisations providing a range of specialist DV services including a refuge, helpline, outreach and a DV advocacy service. DV risk and children's needs were assessed through use of the Common Assessment Framework (CAF). 'The early help service was designed to be part of a holistic care response for children and mothers across this continuum of need' (McCarry *et al*., 2021, p. XX) and operated in the context of a range of multi-agency services for children and their families. The DV early help services were targeted at those families who were either 'just coping' or 'struggling to cope' as assessed by the CAF, with domestic violence generally being in a 'medium' risk level and they were offered 12 weeks of support. During the study period (1 January 2014 to 31 March 2015), 473 families with 541 children were referred to the early intervention services, although sources of referral are not outlined in this paper.

The research study adopted a participatory approach and involved a range of standard measures for child and maternal wellbeing at entry and exit of the service. Data were also collected through focus groups with four children and young people, telephone interviews with 13 mothers and five children and through two focus groups and one-to-one interviews with staff from *Safer Together*, with all eight early intervention services being represented. Use of thematic analysis resulted in three themes being identified including:

> 'the benefits of having any service at all for children living with DV who slip off the agendas of professionals working with child protection and high risk DV; the importance of flexibility of key worker led service delivery; and the suitability of current group work and therapeutic models for meeting the varied needs of families affected by DV.' (McCarry *et al*., 2021, p. XX)

Interviews with mothers and *Safer Together* staff emphasised the positive impact on children of their receipt of early intervention services, with changes being observed in children and young people's physical health, self-confidence, their relationships, risk-taking, school attendance and school work. The importance of service flexibility and key workers being able to respond to a child and family's needs without delay was an important finding. The authors describe how trust in the workers and confidentially were highly valued by mothers and children, alongside support and reliability. However, in contrast, 'the timing, accessibility and location of group work for children and young people and mothers in paid work meant that some missed out and/or there were long waiting lists before they could run' (McCarry *et al.*, 2021, p. XX). There thus appeared to be gaps in what early intervention services could offer and what families also needed and or wanted, especially in situations where a victim/survivor was still living with the perpetrator or when the child or young person was having post-separation contact with the perpetrator. Holt (2020) and Katz *et al.* (2020) have previously highlighted the ongoing risks of significant harm in domestic abuse cases following separation. In such cases, while high risk domestic violence support services might have been withdrawn, family needs were ongoing, with different risks being faced by the children and their mothers. There were also situations where a child or young person might want early help but their mother does not agree to it [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN, i.e. 'There were… situations where a child or young person might want early help but their mother does not agree to it']. Furthermore, the 'time-limited approach' of the 12-week intervention was identified as a problem, when it often took a long time for abusive experiences or needs to be disclosed by participants.

It was interesting to note that in this study the focus of the early intervention services were entirely on support to the mother and their children, with a lack of work with the perpetrators. The authors conclude that 'further work is needed to develop and evaluate more holistic approaches to that include engagement and parallel work with the perpetrator as part of improving safety and wellbeing for adult and children victims/survivors' (McCarry *et al.*, 2021, p. XX). The paper offers some useful insights for others planning evaluations of early intervention services as it highlights some of the challenges of gathering evidence on the effectiveness of early interventions for children and adult victims/survivors living with DV, for example, addressing attrition rates, issues of engagement and balancing the requirement for programme fidelity with a family's needs for flexibility.

The next paper by Rosemaria Flaherty from the Northern NSW Local Health District and colleagues from the University of South Australia (Flaherty *et al.*, 2021) also has a DV theme, and reports on a systematic review of the literature on child protection and DV alerts used in electronic medical records (eMR). The authors sought to identify from the existing literature the extent to which eMR alerts exist and have been evaluated for flagging up concerns around DV and child abuse and neglect. Flaherty *et al.* (2021, p. XX) point out that eMR are increasingly being used in some countries 'as a policy response to information sharing about interpersonal violence, abuse and neglect concerns'. Such alerts on a linked eMR system are able to:

> 'convey standardised, current, clinically significant information to a multitude of clinicians across several health services at once, for example to child and family health nursing, medical officers, mental health services, paediatric therapists (e.g. speech therapy, occupational therapy) and social work, who may all be providing services to the same patient or family.' (Flaherty *et al*., 2021, p. XX)

While the search period for the review covered January 2000 to April 2019 and 751 records were screened, only four articles met the inclusion criteria for the review, thus suggesting an evidence gap. Two papers related to a clinical decision support alert for Child Physical Abuse used in the emergency department of Pittsburgh Children's Hospital, Pennsylvania, USA and the extent to which it acted as a cue to clinicians to consult endorsed clinical guidelines. The other two papers concerned the Child Protection – Information Sharing (CP-IS) system operating in England, which allows specified data sets to be shared between unscheduled health and NHS settings and children's social care. No studies were found that used DV alerts, which was surprising given the Identification and Referral to Improve Safety (IRIS) study (Feder *et al.*, 2011) based in general practice of women experiencing DV, did include a prompt to ask about abuse within the electronic medical record. In discussing the evidence gap highlighted by the paper, Flaherty *et al.* (2021, p. XX) note that neither of the systems using linked data to trigger a child protection alert had 'evaluated the child protection and wellbeing outcomes of the system for children and families over time'. The authors make the case that these types of eMR alert systems are important in facilitating 'a more comprehensive assessment of and response to the care and protection of children in line with clinical practice guidelines' (Flaherty *et al.*, 2021, p. XX).

We return to a focus on professional practice in our next paper by Alyson Rees and colleagues (2011) from Cardiff University in a paper reporting on findings from a qualitative multi-disciplinary analysis of 20 Child Practice Reviews (CPRs) in Wales. The CPRs were reviewed, thematically coded and analysed by the research team from the disciplinary perspectives of law, criminology and social work practice. The four themes were then discussed in two focus groups with 12 participants from practice, managerial or strategic roles within social services, health, the police and probation. The four key themes emerging from the review included:

> '(i) hierarchy of knowledge, where certain sources of knowledge were privileged over others; (ii) information sharing/recording, where deficiencies of sharing or recording of information were evident; (iii) partial assessment, where certain assessments were not always holistic, and …, (iv) voice of the child, where the experience or perspective of the child was not always considered.' (Rees *et al.*, 2021, p. XX)

An additional theme around 'challenges to effective practice and the CPR process' was also identified. For health services in particular further complexities were identified around service disengagement and children not being brought for appointments [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN, i.e. 'For health services… complexities were identified around service disengagement and children not being brought for appointments'].

The authors note that while many of these themes have been highlighted in previous reviews, they are 'inherently contextually, temporarily and culturally bounded' and should not therefore be regarded as either 'static in nature' nor 'intractable' (Rees *et al.*, 2021, p. XX). The paper describes how the Welsh repository for CPRs is currently under development to facilitate broader learning from reviews, as is the case with the NSPCC national repository of Serious Case Reviews in England (see https://learning.nspcc.org.uk/case-reviews/national-case-review-repository). This thematic review highlights the considerable confusion around GDPR (General Data Protection Regulation) and the authors call for more multi-disciplinary training on this. They also briefly highlight that greater consideration needs to be given to the difficulties faced by large families. The authors also draw attention to the support needs of staff managing large caseloads in practice, but apart from mentioning 'possibly via supervision', they offer no further insights on this.

The topic of caseloads in child protection services is addressed in the Short Report in this issue by Joyce Lee (2021) from the University of Michigan. The paper provides a useful overview of definitions of caseloads and what it means in practice to have a 'high caseload' [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN], as well as some of the research evidence underpinning caseload size and job retention. Lee (2021, p. XX) outlines that caseload size is 'closely related to the time a child welfare worker needs to complete case-related paperwork, administrative duties and coordination of services for each client' and argues throughout the paper that 'reasonable caseload sizes are understood to promote worker retention, wellbeing and effective service delivery'. In a secondary analysis of existing documents available in the public domain from child welfare systems in the States of Michigan, New Jersey and Tennessee, Lee (2021, p. XX) investigates the following research questions:

> '(1) What do states' individual class action lawsuits say about the state of child welfare workers' caseloads?; and (2) What do states' individual consent decrees suggest with respect to the type of settlements the states and courts have made regarding child welfare workers' caseloads?'

The study highlights variation in caseloads sizes across the states and impacts on staffing levels, practice standards, legal actions and settlements and the caseload related outcomes achieved. Lee (2021) concludes from her analyses of the three States, that legal measures in the form of class action lawsuits and consent decrees are potentially effective in reducing the size of child protection service workers' caseloads as part of systematic change. However, this interesting paper also discusses their limitations as policy reform tools and concludes by calling for frontline child welfare workers to be increasingly involved in such policy planning in future.

The second Short Report in this issue by Julie Taylor and colleagues from the University of Birmingham and the NSPCC reports on a qualitative study of child protection practitioners' perspectives and experiences of working with British Army Families. The aim was to develop an understanding of the needs of military children 'in the context of child welfare and protection concerns' (Taylor *et al*., 2021, p. XX). 'The UK Armed Forces are committed to co-operating with statutory agencies in supporting military families, and have internal procedures to help safeguard and promote the welfare of children' (Taylor *et al.*, 2021, p. XX). This study involved interviews and focus groups with 18 health, education and social work professionals working in two large army garrison towns in England, and although small, does make a useful contribution to the limited literature in this area. The interviews highlighted

that while 'closed tight-knit army communities provide protective factors for children' it was perceived that these environments could make it hard for children and adults to seek help or speak out if there are concerns about a child's safety or wellbeing [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN] 'for fear of being judged or marginalised by peers' (Taylor *et al.*, 2021, p. XX). Interviews highlighted that non-serving partners (often women) 'were not very visible in army life and that there were few services dedicated to them' (Taylor *et al.*, 2021, p. XX). It is clear that health care professionals such a midwives, health visitors and school nurses working with early years, education and social care have a unique and important role in identifying children of military families and to work with their parents to improve children's health and wellbeing outcome (Public Health England and Department of Health, 2015). However, while children of British military families access both army and civilian health, education and welfare services, Taylor *et al.* (2021, p. XX) stress that 'transitions and communications between these services need to be improved' to ensure children's safety and wellbeing and that in responding to children at risk of harm 'child protection practitioners [must] understand the different cultural and social context in which army family and parental life is shaped'.

This issue concludes with a review by Sally Shillaker, a health visitor from Solent NHS Trust, of Russell Wate and Nigel Boulton's 2019 book *Multi-agency Safeguarding in a Public Protection World: A Handbook for Protecting Children and Vulnerable Adults* (2nd edition). Shillaker's (2021) review is very complementary and highlights that this updated edition reflecting changes in legislation and statutory guidance, offers its readers new ways of thinking and delivering safeguarding practice today.

We have seen that early help and intervention is key to improving outcomes for children and young people, across a number of the papers in this issue. So, to return to the original question 'what about health visiting?', health visitors, if funded to do so, have the clinical expertise to work with babies, preschool children and their parents in early help and support. Through a model of 'proportionate universalism' (Marmot *et al*., 2010, p.16), with their unique home visiting role, health visitors should be well placed to provide additional offers of help or a more intensive level of service involvement alongside other professionals and agencies depending on need. But health visitor numbers must be increased, they must not be redeployed from their work with children, and heath visiting teams must regain their visibility in all local communities [PUBLISHER – THE PRECEDING UNDERLINED TEXT IS FOR THE MARGIN]. These professionals have the knowledge and skills to respond to situations where abuse or neglect is suspected or evident and have an important responsibility to safeguard and promote the welfare of all children, but particularly the most vulnerable children in society.

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