Health Inequalities in the Early Years

CHILDREN 1ST

For 130 years, as the RSSPCC and now as CHILDREN 1ST, we have campaigned for every child in Scotland to enjoy a better start in life and for no child to grow up in fear of abuse and violence. We will continue to be a strong public voice for vulnerable children and young people in Scotland, listening to them, to influence public policy and attitudes. Then, now and for another 130 years, as long as Scotland’s children need us.

CHILDREN 1ST has 52 local services and four national services across Scotland, and we work closely with many local authorities as well as working in partnership with other organisations. All our services are child centred and the children, young people and families we support are key partners in all aspects of our work.

1. How effective are early years interventions in addressing health inequalities?

There is now a much wider understanding about the impact of the early years on a child’s life; we know the relationship between a child and his or her family can have an impact on brain development, emotional wellbeing, relationships with others, and ability to learn, as discussed in the WAVE trust’s ‘Conception to 2 – the age of opportunity’1. All of these will in turn have an impact on health. The links between early years and health are therefore clear.

Despite this and developments such as the Early Years Change Fund, there are still clear health inequalities between the least and most deprived areas in Scotland.

- In 2010, 31% babies who were born with very low birth weight were born to mothers living in the most deprived areas, compared to 13% of babies born to mothers in the least deprived areas (% of low birth weight babies more than twice as high in most deprived areas)2.
- Rates of exclusive breastfeeding at 6-8 weeks are almost 3 times lower in most deprived areas3.
- Children in the least deprived areas are still more likely to suffer from tooth decay (54% children in most deprived areas had no dental decay, compared to 81% in least deprived areas)4.
- In 2010, 25% children in most deprived areas were classified as overweight, compared with 18% children in least deprived areas5.
- Teenage pregnancy (under 16) is 5 times more common in most deprived areas (14 per 1,000 in most deprived areas compared to 3 per 1,000 in least deprived areas)6.

---

2 http://www.audit-scotland.gov.uk/docs/health/2012/nr_121213_health_inequalities.pdf
3 Ibid
4 Ibid
5 Ibid
Moreover, we need to look at whole health inequalities and the links between deprivation and the impact on the whole child. This includes “less obvious health issues” such as physical injury and its impact on children’s well-being. The Scotland PHO profiles highlight data on the number of young people per 100,000 population admitted to hospital following an assault in Scotland. This provides an indicator of violence, which is relevant to physical health, crime, and mental health and wellbeing with the data showing "a more than four-fold difference between CHPs with Glasgow North East and North Ayrshire having the highest rates. There may be an association between our measure of child poverty and admission to hospital following assault, although the pattern is not consistent." In the health board area of Arran and Ayrshire, a number of indicators are significantly worse than the Scottish average, including the numbers of children admitted to hospital because they have been assaulted, as a result of an emergency, or who were victims of road traffic accidents, or experienced unintentional injuries in the home. In Greater Glasgow and Clyde health board area, indicators which are significantly worse than the Scottish average include unintentional injuries in the home, children admitted to hospital as a result of assault and residence in “crime deprived” areas.

It is also vital that we not only consider the health inequalities of children but those of their parents and carers. We cannot get it right for every child if we are not getting it right for their parents and carers. With regard to the latter group, CHILDREN 1ST has a specific interest in the health inequalities experienced by kinship carers and the impact that has on the children they care for in their early years.

There is a “toxic combination” of health issues which result in inequalities and poor outcomes for parents and carers – domestic abuse/violence in the home; mental health issues and substance misuse. Between October and December 2013, in CHILDREN 1ST’s East of Scotland service region (covering all the Lothians, Scottish Borders areas), over one third of individuals (including 66 children under the age of 11) had been impacted by domestic abuse, over one in five families had been referred into our services because of the impact of substance misuse and over one in five because of mental health issues in the family, affecting 44 children under the age of 11. Failure to address these issues effectively and timeously in parents and carers severely impacts on their ability and capacity to care for and respond to their child or children’s

---

6 ibid
9 P 22
needs. Thus, direct health inequalities for adults can and do result in indirect health inequalities and a poorer start in life for young children.

Preventing this from happening and enabling more vulnerable children to thrive safely within their families is at the heart of what CHILDREN 1ST does. We work with families at the earliest opportunity to prevent escalation of need, providing low-level, early interventions through non-statutory services which building and strengthening parents and carers’ capacity to parent effectively and safely, so that they are better able to respond to and meet their children’s needs. Part of this includes developing strong, trusting relationships with families to empower them and give them confidence to access universal services such as GPs and health visitors. This non-engagement with universal services often prevents early interventions by statutory agencies reaching and impacting positively on the health inequalities of parents, carers and children whose well-being is compromised by health-related issues, such as the three listed above. When CHILDREN 1ST consulted parents we work with in North Ayrshire who have substance misuse issues to inform the development of the Scottish Government’s National Parenting Strategy in 2012, they told us that some of the biggest challenges they face as parents include: “when you go to the GP too much and are feeling judged”, “Feeling scrutinised all the time” and “you worry people are judging you when they have never been affected by drugs so they do not know the impact this has on you as a parent”. Few expressed confidence in their parenting skills and this lack of confidence, often caused or exacerbated by health issues and inequalities, then impacts on their capacity to parent and parent well.

There is considerable evidence from the National Performance Framework and HEAT targets about which interventions are impacting positively on children’s health inequalities. For example, the largest reduction in the last ten years in the percentage of women smoking while pregnant was in the most deprived areas, and significant reductions have been recorded in dental caries in children below the age of five (though the reduction is less significant in some deprived communities). Yet, this data also points up where early interventions are not having an impact. Despite the significant resources invested in improving breastfeeding, breastfeeding rates in Scotland have not increased, particularly in health board areas with high levels of deprivation. These poor outcomes warrant closer scrutiny and strongly suggest that a change of approach is needed.

CHILDREN 1ST services: supporting children and families

As stated above, CHILDREN 1ST’s approach is about preventing the escalation of need and about intervening to support families at the earliest opportunity. The aim is to invest in parents’, carers’ and families’ capacity, building and strengthening their assets so they are more confident and competent in responding to their children’s needs. It is about providing the right support at the right time, and increasingly, we are applying a trauma-

\[\text{Ibid}\]
informed approach to everything that we do. Moreover, much of our service growth in the last two years has been in working with families with children under the age of eight and very often, with children under five, including with pregnant mothers.

CHILDREN 1ST provides services that support families across Scotland. We provide services in Aberdeenshire, East Lothian, Edinburgh, North Ayrshire and South Ayrshire that support families with children in the early years, as well as pregnant mothers. Much of the work we do with children is far more effective when carried out in partnership with parents and so some of our projects work with the family both individually and in groups. Our services work to a GIRFEC focused outcomes framework, and seek to achieve outcomes for children which include; children are living in a safer environment; children's health needs are adequately met; the parent/carers' parenting skills have improved and; the families' relationships have improved. All these outcomes positively impact the child’s health and wellbeing.

CHILDREN 1ST has recently developed a number of public sector partnership (PSP) services that support families with children aged 0 – 5 years. In Glasgow we are working with the health board and the council to provide intensive, flexible support to families with children aged 0-5. In East Lothian we are working with CIRCLE to support families. In Banff and Buchan we are working together with Home Start to reach families who are not accessing local health and education services. We are also working in the Helensburgh and Lomond area to support families with children aged 0-5, including unborn children. Partnership working can mean that the best possible service is available to those who need it at the time they need it; it makes use of existing expertise and services which are already locally available. It also, crucially, means that resources are not wasted on duplicated work due to different departments not talking to each other. These saved resources can be re-invested in the communities where they are most needed.

These partnership services aim to help families to cope better, build stronger relationships in their families, to feel less marginalised and more included by, for example, making use of community facilities and to help them make better use of local services, such as attending local parents groups. The services support parents and carers to help their children have fun, to enjoy the opportunity of new experiences through family led support groups and to ultimately have happier, safer homes with happier, safer children. Families are also encouraged to use ParentLine Scotland, our national confidential helpline for anyone caring for or concerned about a child. The helpline is open seven days a week, 365 days a year and can provide support, advice and information in evenings and at weekends, when local workers and volunteers might not be available.

The impact of our public social partnership projects is being evaluated by Stirling University, focusing on Safe, Healthy, Active and Nurtured from SHANARRI well-being indicators. The evaluation will use data from our outcomes-focused management information on the impact of the services and the support provided to families, as well as the families’ experiences, to create
a picture of what works in terms of early intervention with families with pre-

school age children. An interim report should be available in September and
CHILDREN 1ST would be happy to share this and final findings with the
committee.

Communities putting children first
CHILDREN 1ST believes that to improve outcomes for children in the early
years and tackle social problems, it is crucial to involve the local community at
every stage of the process. Quite simply, we believe it is everyone’s
responsibility to protect children and that by involving and engaging
communities in keeping children safe, they and families who live there are
better able to meet the whole needs of children’s well-being. Children, young
people and their families should be an integral part of the design and delivery
of any service that affects them. Our community engagement services13 train
volunteers to empower and enable the local community to protect its children.
Outcomes include, communities collectively taking responsibility for children
and young people, an increased capacity to support children, and attendees
feeling more confident in taking action to protect children, and knowing what
to do, or who to contact. This makes it is possible to bring about positive
changes in communities while also improving the self esteem, confidence and
work-readiness of those involved in the project.

Family Group Conferencing
Family Group Conferencing (FGC)14 is another way in which CHILDREN 1ST
has been working with local authorities to help families build on existing
networks and to work together in a solution-focused way. FGC gets the wider
family together to participate in the decision making process regarding the
care of their child. Our data shows that between 2012 – 2013 77% of
CHILDREN 1ST FGCs that identified ‘child/ young person is at reduced risk of
being accommodated’ as a potential outcome, fully or partially achieved this.
We know that supporting families in this way can have positive outcomes for
children in their earliest years, and subsequently positive benefits for children
throughout their life.

We continue to develop an innovative approach to the role of FGC, for
example, we have piloted the provision of FGC in Highland and South
Lanarkshire working with families where children are not yet born or are newly
born to keep them safe and put in place appropriate family “circles of support”
to parents where these children are at risk of becoming accommodated. We
are also working in Midlothian with Surestart providing FGC to all families with
children in the very early years and there is parental substance misuse to
encourage families to meet and plan how they might be more involved in
caring for children at risk of becoming accommodated.

The effectiveness of CHILDREN 1ST services

13 http://www.children1st.org.uk/what-we-do/our-services/search-our-services/community-

engagement/
14 http://www.children1st.org.uk/what-we-do/our-services/search-our-services/family-group-

conferences/
Our IMMS data shows successful health related outcomes for 0 – 5 year old children, who attend our services. The following data was collected from 01/04/2012 to 31/03/2013 we worked with 305 0 – 5 year old service users in this period. When a case is opened a work plan is agreed between the family and the project worker, and the outcomes are agreed, along with a review date. At the review it is decided whether each outcome has been met, partially met or unmet.

- There was a 93% success rate for children who had the outcome “health needs more adequately met” in their work plan.
- There was a 76% success rate for children who had the outcome “improved emotional health” in their work plan
- There was a 100% success rate for children who had the outcome “increased resilience” in their work plan
- There was a 95% success rate for children who had the outcome “Parent/carer has improved emotion health” in their work plan
- There was a 100% success rate for children who had the outcome “Parent/ carer is happier” in their work plan.
- There was a 77% success rate for children who had the outcome “Parent/ Carer has increased resilience” in their work plan.

2. What are your views on current early years policy in Scotland in terms of addressing health inequalities?
CHILDREN 1ST is a co-signatory to “Putting the Baby IN the Bath Water”; a collective briefing aimed at influencing the Children and Young People bill. We welcome the additional provisions added to the Children and Young People bill as a result of our joint influencing. Action on primary prevention and the earliest possible intervention must now be included in all children's services plans and a variety of relevant services and support must now be made available, starting during pregnancy, to the mothers, fathers, and carers of children who are at risk of eventually becoming 'looked after'. It is vital that guidance now reflects the policy intention of the recommendations made through Putting the Baby IN the Bath Water, and ensures that primary prevention is embedded in service delivery and planning.

The definition of health inequalities needs to be holistic and to be about wellbeing and the health of the whole family, not just the child. With this focus in mind, it is important to address parental substance misuse, and mental health issues to improve children’s earliest years. Currently, the national early years indicators are overly focused on primary health issues. There needs to be consistent adaption of early years indicators to provide robust data on what works to improve health and wellbeing for all babies and young children.

In order to support children in their earliest years, we also need to support and educate parents, ideally before they become parents. It is vital that there is education for children and young people at school, so that informed choices can be made around parenthood. It is also important to ensure there is appropriate support and advice for both young mums and young dads throughout the pregnancy and beyond. We believe that there are clear
indications that it would help to listen to young people and their experiences to establish what could really make a difference.

We would reiterate too our belief that we cannot get it right for children, and particularly vulnerable children in Scotland, unless we get it right for their parents and carers. Their health inequalities must be addressed through early intervention as much as focusing solely on children’s health inequalities in the early years.

CHILDREN 1ST also believes that while sex education should include information about correct use of contraception and STI’s, this on its own is not enough, and sex education needs to involve young people in discussions around building and sustaining healthy relationships, and the importance of communication within trusting respectful relationships. Appropriate and accessible support services should be available to all young people across Scotland, in a confidential environment where they feel comfortable and not judged. A society that is better prepared, informed and supported regarding parenting will lead to better outcomes, including health outcomes, for children.

3. What role can the health service play in addressing health inequalities through interventions in the early years?

Health visitors are a vital support network for parents and their young children. One of the largest barriers is the consequences of health visitor caseloads and vacant posts. Health visitors provide an important support and advice resource to many parents and pregnant mothers, and it is important that they are adequately supported and invested in.

Our response to the National Parenting Strategy consultation in 2012, found that parents and carers accessed other forms of support, than just from the health service. We consulted with 137 parents, carers and young people and many respondents felt confident about seeking help, and felt they knew where to find it, and satisfied with the help received. Rather than services, family and friends were the most frequent sources of help and advice. Many other respondents felt certain forms of support were difficult to acquire, such as support for single parents, or parenting support or advice for children between the ages of 2-3, or advice for step-parents.

Parents and carers should be able to access treatments other than medication from G.P.s for mild to moderate mental health difficulties, most commonly depression, anxiety, and agoraphobia. Our services tell us that these difficulties often appear to be linked to trauma experienced in their own childhoods, for instance, sexual abuse, neglect, traumatic early separations through bereavement, domestic violence or acrimonious parental separation. The introduction of the 24-30 month health review by Health Visitors will no doubt identify more parents with mental health difficulties and children with additional support needs. The NHS Health Scotland resource, Ready Steady Baby, and Ready Steady Toddler are also important and useful resources. They are provided to families by health visitors, and also are available online.
While the health service has a primary and key role to play in addressing health inequalities in children’s early years, the key to achieving better outcomes for children is rooted in the GIRFEC approach which puts the child at the centre, considers the needs of the whole child and involves all agencies and organisations which can and should play a role in working with families to meet these.

4. What barriers and challenges do early years services face when working to reduce health inequalities?

Current law allows a defence for adults of ‘justifiable’ assault when they hit children of any age – including in the earliest years – as a punishment. Despite promises to mount a public information campaign and to monitor the use of the law, there has been little activity on this matter in the last ten years. The current law in Scotland is confusing for parents, creates loopholes and undermines the ability of professionals and concerned family and friends to protect children from harm. By removing the current legal ambiguity about what constitutes physical harm to a child, we can keep children safe.

The Scottish Government’s ambition for ‘Scotland to be the best place in the world for children to grow up’ is unrealistic as long as the law justifies the assault of children and they are treated differently in law and in practice from adults. Simple legal reform will send a clear message that hitting children is as unacceptable and unlawful as hitting anyone else. The Growing Up in Scotland research shows that high levels of parent–child conflict are associated with social, emotional and behavioural difficulties for the child.

Neglect is another area in which the law can be a barrier to improving health outcomes. We are concerned that the current law on neglect does not enable professionals, including the police, to adequately protect children. Professionals across Scotland tell us that it is currently difficult to access appropriate interventions to support children who are suffering from neglect; those working in services can recognise when neglect is happening but are not always able to do anything about it. As a society we now understand much more about the impact of neglect; we now know that children who are emotionally neglected are more likely to experience mental health problems, be involved in the criminal justice system, and struggle to build relationships. We also know from our work with children, and from research, that neglect can be one of the most harmful forms of abuse. Yet because the current law does not make any non-physical neglect a criminal act, it can be difficult to secure a prosecution, even when police recognise neglect within the household.

Evidence of this is that although 9664 children were referred to the children’s reporter on lack of parental care grounds, in 2012/13 prosecutions

16 [http://growingupinscotland.org.uk/about-gus/key-findings/](http://growingupinscotland.org.uk/about-gus/key-findings/)
connected to cruelty and neglect of children were far fewer than this number.\textsuperscript{18}

The current law does not fit well with modern understanding of the harm caused by neglect. If we are to protect Scotland's children it is important that those working with families are operating within a shared definition of neglect. This is currently not possible, as the definition outlined in the National Guidelines for Child Protection, ‘Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development’, varies greatly from the definition in the legislation.

Access to assessment and treatment for young children from Speech & Language Therapy, Occupational Health is often held up by waiting times. Timely help is vital for children to achieve their developmental milestones. Additionally, we know that cheap access to local leisure centres and facilities is of significant value to many children and families, however we understand now that the £1 membership that is available in some local authorities, is now time limited to only 3 months. Current budget cuts are removing concessionary rates, and access to free swimming for families. These cuts impact the poorest families, the most, and mean that many families can not afford to use these leisure facilities.

Finally, the current challenging financial climate presents a significant challenge and barrier to early years’ services, particularly those which are provided by third sector organisations like CHILDREN 1\textsuperscript{ST} and especially where those services are non-statutory ones. Local authorities in particular are cutting the sort of services advocated as a key part of public sector reform by the Christie Commission, which de-formalise the state's role in intervention and which are largely preventative in nature. These cuts mean that the focus is being withdrawn to “just in time” interventions and services – as many feared and as CHILDREN 1\textsuperscript{ST} has commented in a number of recent Scottish budget processes – and which mean that the sort of early intervention work needed with parents, carers, families and children in the early years will be compromised. This may have an impact on society’s ability to address the short, medium and long-term effects of health inequalities on Scotland’s vulnerable children and deliver a better start in life and better life chances for them.

5. Are there any specific initiatives or research evidence from Scotland, UK or internationally that you would wish to highlight to the committee?

As part of the National Parenting Strategy, the Scottish Government commissioned CHILDREN 1\textsuperscript{ST} to undertake a mapping exercise of current parenting information resources.\textsuperscript{19} The research mapped physical parenting resources, such as leaflets, booklets and websites from 119 organisations. The research found a wealth of parenting resources, especially aimed at

\textsuperscript{18} http://www.nspcc.org.uk/Inform/research/findings/how safe/indicator05_wdf95543.pdf
\textsuperscript{19} http://www.children1st.org.uk/parenting-resources
children in their earliest years including many different information resources on pregnancy from a variety of providers. For ages 0 – 1 years, the research found that a high number of resources on breastfeeding/feeding and nutrition, as well as sleeping, play, toilet training, and child development. For 1 – 3 year olds, the research found that most resources were about feeding/nutrition, breastfeeding, general health/wellbeing information and play/reading. For ages 3 – 5 years, most of the mapped resources included information about nursery/preschool and play and reading. These findings are positive, however the research also found that most information resources are mainly available online, and it was not clear if parents and carer are able to access these information resources in other, more accessible ways. The research found only a small number of parenting information resources specifically targeted at teenage or young parents. The research also found that many resources, while claiming to be for a universal audience, were more targeted at mothers, than fathers and that some resources could alienate fathers due to the language, wording and photos used to illustrate the resource. It is important that accessible and inclusive parenting resources are available to all parents, to ensure that, where necessary, parents and carers are supported and feel confident in any parenting challenges they may face.

CHILDREN 1ST in partnership with Scottish Child Law Centre and One Parent Families Scotland (OPFS) will be delivering a new service - Family Decision Making. The service will combine the expertise of the three organisations to create a seamless national online, phone and face to face service for separated and separating parents. It aims to reduce conflict and improve collaboration between separated and separating parents by helping them deal with issues such as contact, maintenance and residence using family group decision making. This will help to improve family relationships, and by consequence, help to improve family life and outcomes for children in their early years.

CHILDREN 1ST led a research study conducted by the University of Strathclyde in 2010, about the experiences of fathers of children born to teenage mothers in Scotland. The research found that some young fathers experienced exclusion when interaction with maternity and health services with their partner. The perceived experiences of exclusion also appear to deter some young men from attending further appointments with their partner, discouraging them from being as involved in the pregnancy as they would like to be. The young men discussed ways in which they learnt to be a hands on dad. Their partner, and their own and their partners parents provided advice and support to them in this respect. However, a few young men discussed not having confidence in their own abilities to undertake everyday childcare tasks in the early days of fatherhood, and other’s perceptions of them sometimes reinforced this. “Bathing babies was a task that many of the dads felt afraid of initially, in case the baby slipped under the water, and making bottles to the

right mix was also a scary task for some. Some also had a fear of hurting their baby whilst they tried to dress them.²¹

Few young parents who took part in the research provided complaints about the follow up support after the birth of their child, regarding their interactions with community midwives and health visitors. Some of the young men did express concerns about basic childcare activities, such as bathing, handling etc. and in the early days of parenting some would have benefited from further guidance and support in the lead up of the birth and immediately after, giving them the confidence in caring for their child’s basic needs. The research highlighted the importance of looking at the wider support networks within families, which often provide buffers for young parents and new families. In conclusion, just as all services dealing with parents should give more recognition to men as parents, so services supporting pregnant women and families in the early years ought to develop attitudes and models that are inclusive of fathers.²² Practical changes can also help young fathers engage more with services to help them parent children in the early years, such as the times of meetings, the availability of men only sessions, or mixed gender groups, and explicit recognition of fathers in leaflets and web-based information, something that the Mapping report 2013, also found.

CHILDREN 1ST
March 2014 CHILDREN 1ST