Why Should Vulnerable Families Be a Concern For Deep End General Practices?

Do We Need a New Set of Skills?

Defining Vulnerable Families

- Abstract, interpretive, often obvious in practice: families with low incomes, young parent families, sole parent families, families from culturally and linguistically diverse communities, families with a parent who has a disability, and families experiencing problems with housing, domestic violence, substance abuse, mental health or child protection can be particularly vulnerable. Vulnerability can be transient, depending on the needs of the individual or family (Deep End Paper 17c:21.3).
- Broad concept definitions when recording in notes ‘cause for concern’ (Woodman et al, 2012).
- Vulnerable Child Syndrome The “vulnerable child” can be defined as a child who has an unusual or exaggerated susceptibility to disease or disorder (Pearson & Boyce, 2004).
- There is no single approach to a definition of vulnerability. In fact, there is no purposeful categorisation at all (Morawa, 2003 p.150).

Relevance to General Practice?

- Contact with vulnerable families is an everyday aspect of general practice in deprived areas.
- GPs see pre-school children six times a year and school age children two or three times a year (DH, 2004).
- However, since the demise of CHS the opportunity for preventative health care has diminished (Woods & Wilson, 2012).
- Inequalities in health are cumulative over the life course — combination of biological insults and psychosocial factors (Kowenke, 2008).
- Child protection and children's wellbeing linked to the provision of an adequate child health service. The GP has access to extensive privileged information about families and almost universal contact with children and their families (Gunn, Lumley & Young, 1996).
- But... this is not often acknowledged and poorly understood (Wilson & Mullin, 2010).
What Exactly Is a Vulnerable Child?

- **Framework:** ecological model of childhood development incorporates community and neighbourhood factors (Belsky, 1993; Cicchetti & Lynch, 1993; Bronfenbrenner, 1979, 1993).
- **Child characteristics** e.g. low birth weight and poor health (Sidebotham & Heron, 2003; Jaudes & Mackey-Bilaver, 2008) behavioural and educational difficulties, language delay (Gilbert et al., 2009; Spinhowen et al., 2010).
- **Parental factors** e.g. education status, parenting styles (Bifulco et al., 2009; Maughan & Moore, 2010; Wilson et al., 2008). Parental addiction and mental health issues (Dunn et al., 2002; Kirisci et al., 2001).

The Measurement Challenge

- Vulnerability has to be grasped conceptually before it can be measured—consider attributes of functioning—resilience and capability (health, education, income).
- "Short of following an individual child throughout the course of his or her entire life, no one has been able to determine a way to make this assessment accurately" (Widom et al, 2004 p.717).
- Inherent difficulties in health relate to ‘diagnosing’ vulnerability and its ‘downstream’ effects within a traditional biomedical model (Chaffin et al., 2006).

Poverty—An Old Dilemma

- "wretched conditions of overcrowding under which the poorest families live and particularly the absence of open spaces in the neighbourhood, do produce the potential criminal...in the cases of delinquency...over one-half were found in homes that were poor or very poor" (Cowan, 1933)
- "Poverty either real or relative presents problems...Relative poverty is often caused by sheer selfishness and irresponsibility in the parents who put their own indulgences before the needs of their children" (BMA, 1956).
Inheriting Poverty/Poverty's Inheritance.

- Higher reported levels of childhood physical and educational neglect in socioeconomically deprived households (Chasaide & Crittenden, 1995; Fonseheater et al., 2000).
- Dimensions of poverty include income consumption and deprivation of capabilities linked to health, education, and participation in social activities (Sandberg, 2001).
- Determinant of health inequalities from pregnancy through to childhood (Haas et al., 2011).
- Poor outcomes are maintained throughout life (Clayton-Saunders et al., 2011; Hovekawa et al., 2012) through direct and complex influences of adverse family and neighborhood poverty (Mucka et al., 2010; Schuck & Widom, 2005) and reduced social capital (Boskerson et al., 2004).
- There is a clear association between disadvantage with social class and adverse effects on child health in the first 5 years of life (Preuss et al., 2006) with increased mortality (see: Collins et al., 2007). The "basic effects" of poverty on child health (Micha, 2002).
- Persist into adulthood with increased likelihood of co-morbidity and dying from CVD disease and diabetes (Raphael, 2011) on "endless struggle." (O'Brien et al., 2011).
- Requires a proportionate rate response to unravel the effect of poverty at adverse childhood outcomes (Gassman-Poore & Yoshikawa, 2006).

Vulnerable Children Become Vulnerable Adults

- Worsening physical health (Dube et al., 2003; Wickrama, Conger, Wallace & Elder, 2003)
- Increased rates alcohol and substance misuse (Dube et al., 2003, 2006; Wilson & Widom, 2009; Widom et al., 2007).
- Adverse psychological outcomes (Tomalski & Johnson, 2010) e.g. depressive disorders, anxiety and somatic symptoms (Johnson et al., 1999; Johnson et al., 2000).

The Politicisation of Vulnerability

- Socio-economic challenge of sustained 'gap social structures' that continue to exacerbate the social and economic consequences of ill-health (Bresan & Gudnall, 2009a, 2009b).
- The UK scores particularly poorly across health and education despite its national wealth in comparison with other countries (Bradshaw, 2007; Bradshaw & Richardson, 2009). In terms of child well-being the UK emerges as "a serious contender for the title of the worst place in Europe to be a child." (Middleweight & Stewart, 2007 p.23).
- Burden of decreased human capital through childhood vulnerability that is "biologically unnecessary" (Sherwood et al., 2010); A negative impact on adult socioeconomic status (Zwolak, 2009).
- Time lost at work through illness and injury, absent school attendance in the short and long term, indirect costs of special education, adult mental health, other healthcare services and the costs to the judicial system (Cumie & Widom, 2010).
It’s A Costly Business

- £735 million annually in the UK attributed to child maltreatment (NICE, 2009).
- Child poverty costs society in a broader sense upwards of £25 billion a year (Hirsch, 2008).
- Intangible costs of human suffering: mental anguish, stigma.
- 21,000 of Scotland’s one million children live in poverty. These have been little progress since 2004/5 in the rates of child poverty (The Scottish Government, 2010).
- 3.6 million or 27% of children live in poverty in the UK (DWP, 2012).
- Child poverty in the UK is expected to increase by 300,000 more in 2012/13 and is predicted that 4.2 million children will be living in poverty by 2020 (Brewer et al., 2011).

Working At The Deep End

- GPs are well placed to understand the specific challenges that result in the vulnerable family and the vulnerable child (Hertzman & Bertrand, 2007).
- Our unique contribution is a holistic relationship between the family and physician that is built up often over many years from numerous consultations (Dubowitz, 2002).
- GPs do have an intuitive grasp of identifying children ‘in need’ which they invoke in clinical contacts with vulnerable families (Lykke et al, 2008; 2011).
- GPs contribute to the process of ongoing family assessment and support (Levine, 2006; Scribano, 2010).
- Access to healthcare and an empathetic doctor are aspects of what children consider a ‘good life’ (Andresen & Fegter, 2011).

The Deep End Working

- Policy regimes can impact positively on child well-being (Engster & Stensota, 2011) and health inequalities (Beckfield & Kreiger, 2000). Deep End 17c paper on health inequalities.
- Directing strategic policy within universally accessible child services to improve childhood outcomes (Farah et al., 2006; Hertzman et al., 2010).
- Promoting collaborative, interagency approaches to improve child welfare (Horwath, & Morrison, 2007).
A Visionary General Practice

- **Support the child in the family unit** from early years through to young adulthood. Develop understanding of subjective child well-being (Bradshaw et al, 2010) there is no ‘universal’ childhood but many ‘childhoods’ (Ridge, 2002 p.136).
- **Understand the protective and detrimental influences** that impact on child well-being (Inman et al, 2011). Promote the role of general practice within a collaborative systems approach to support childhood resilience underpinned by robust policy initiatives (McNeill, 2010; Tompsett et al, 2010) that are relevant to regional and local challenges (Ben-Ariah, 2010).
- **Retain altruistic goals** and look beyond immediate working practices to negate the constraints of exercising our ethical beliefs (Sieghart, 1985).
- **A progressive approach** to connect the science of the individual mind and the consequences of social behaviour (Posner, Rothbart & Gerardi-Caulton, 2001).

Finally...

- ‘**Listen carefully, judge slowly**’ (Gallagher et al, 2012)
- This ‘requires professional barriers to be broken down, clear communication that questions assumptions and a genuine commitment by the individuals and organisations involved to work together collaboratively’ (Sen & Green Lister, 2011).
- **We’ve always worked like that!**

- **Thankyou**

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References


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