

GPS IN AT THE DEEP END – SUPPORTING SCOTLAND’S FAMILIES. RIGHTS, RESPECT, RELATIONSHIPS

SLIDE 1

Thank you for asking me to speak at this very timely conference –I’m delighted to be here. Timely because it is the ‘Year of Young People in Scotland’ and a good opportunity to take stock of the status of young people in our society. My talk is about parents and how parenting might be supported by my own profession General Practice. I am a GP in Govan and currently chair the DE GPs steering group.

GPs at the DE have a particular interest in the welfare of children and families which isn’t a surprise when you imagine us in our traditional role as family doctors. I was asked to discuss parenting through several lenses -children’s rights, the social determinants of health, inequality and the wider welfare and state support for parents. My challenge was to try to pull these all together in a discussion about how GPs make a difference to parenting in Scotland. I don’t see this as a challenge because working in general practice is holding a mirror up to society and all of these issues can filter into the consultation.

There is no such thing as a formulaic family- the make-up of families is varied depending on social and cultural circumstances but that is a cause in many ways to celebrate. In my practice for example we have single parent families (who often have very good support), many kinship carers who are effective parents, same sex parents, the ‘traditional nuclear’ family and ethnic minority families. My practice in Govan reflects the diversity of a modern society and I have seen many changes to the demographics of our population over the years- Govan is a very interesting place to be a GP.

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Article 1 of the Universal Declaration of Human Rights states ‘All human beings are born free and equal in dignity and rights’ (United Nations, 1948). The status of the child has been given specific recognition through the UNCRC that was ratified in 1989.196 countries including every member of the United Nations ratified the treatise except the United States (The US has signed it but not ratified it). The UN revisited the UNCRC in 2005 with a specific focus on early childhood acknowledging the understanding across many research domains that early childhood requires specific attention. Young children’s needs should be incorporated in all aspects of government policies. The EU is also an important institution in upholding children’s rights and this is of relevance to us in Scotland if we leave the EU.

We know that children from the age of 5 are linguistically competent and therefore we should encourage them to give their own views about childhood. They are the primary source of knowledge about their own experiences. It is important to acknowledge their views to formulate ‘child impact’ statements that can profoundly influence child centred policy in a progressive agenda. Scotland is being ambitious in that respect and advocating for children rights impact statements across many policy areas.

We should have no difficulty in our society in Scotland in accepting a rights based approach that’s focused on children. The difficulty seems to be the intertwining of rights with the way we communicate with one another in complex societies about all manner of concerns and then act on

those concerns. If we were all on the same page regarding children's rights there would be no military conflicts, poverty, hunger, inequity of health, welfare and education provision, and so on.

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The early campaigners of child welfare recognised that to make progress in the notion of children having a childhood that they had to move away from conflating deprivation in childhood with depravity and challenge societal attitudes. Many children and impoverished parents were imprisoned in the 19th century for essentially being poor, homeless and destitute. We are now in our 3rd century of sustained child welfare reform which is connected to many other policy areas- housing, health, education, parental employment but the state structure is fragile and vulnerable to rationalisation (a proxy term for dismantling). Current UK welfare policies are reversing decades of progressive child welfare reforms. General practice and the medical profession are not peripheral to this debate and are inextricably linked to the politics of child welfare and child poverty.

It is concerning that child poverty in the UK is increasing and forecast to reach 37% by 2022 which is clearly a blatant breach of the UNCRC. In Scotland there is no local authority with child poverty rates in single figures.

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We should also be aware of how we fit into a global agenda to reduce inequality in child well-being in rich countries – this does echo the UNCRC treatise – no poverty, zero hunger and so on- recommendations that focus on the individual, the family unit, the community and the state and are achievable with appropriate political will.

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The RCGP believes that GP should have an important role in child health matters and has written their own strategy document which I fully support .

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Scotland has been given number of recommendations for improving child health from 'The State of Child Health' report. I have highlighted those recommendations which are relevant for everyday general practice wherever that practice is.

I want to now say something about the historic and current role of GP in supporting parents and families. I will also spend a bit of time discussing the impact of child poverty on family health and well-being and why it is important to keep focusing on this issue.

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Historically GPs specifically the early female GPs pre NHS were very involved in the care of children and women. Before the NHS came into existence there was no payment attached to child and maternal health. Working men were covered by payments to GPs and encouraged to join the practice list as they were profitable patients. The early female GPs were the pioneers of their day, they worked very long hours, were embedded and valued members of their communities. The feminisation of general practice has been a good thing I would argue that its legacy with regards to child and maternal health is the normalisation of the profession.

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This is a photo of Possilpark in Glasgow where I did my GP training in the early 90s. It was at height of a heroin epidemic with young people dying from fatal overdoses, the Hep C rates were climbing, and the area had been devastated by de-industrialisation. It was not yet on the political radar as having a major public health disaster. It really was as grim as that photo suggests although there was and remains a long established, strong community spirit.

In my training practice my GP trainers were described to me as 'medical missionaries' when I applied for my training post. They were also the pioneers of their day. They were holistic practitioners who were responding to a public health calamity by prescribing Methadone for opiate addiction (before shared care was established) that reduced drug related deaths and the local crime rates. They were not content to sit back, do nothing and wait for someone to direct them.

They worked alongside this woman Mary Hepburn a consultant obstetrician who ran her outreach clinic in Possilpark Health Centre with her main base within the Royal Maternity Hospital. Pretty amazing as a young GP to have access to their professional wisdom and experience, to be part of joined up working with models of integrated care firmly embedded in a community they had so many unmet needs. She and my GP trainers were inverting the 'Inverse Care Law'.

The anthropologist Margaret Mead wrote 'Never doubt that a small group of thoughtful, committed, citizens can change the world. Indeed, it is the only thing that ever has'

We should hold that thought when we think about children's rights not just in Scotland but around the globe.

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How does one learn to be a parent or 'good enough parent'? Despite all the supportive reading material and guidebooks and online resource (which for my patients may be difficult to access) parenting is a difficult job (as the Simpsons will tell you) and even more challenging when parents have physical or mental health issues, their child has learning difficulties or refuses to attend school or the family is overburdened with home-based or external stresses. GPs regularly see adult patients with mental health problems, addictions or other health-harming behaviours which seem to be rooted in their own unhappy childhood and increase the burden of stress in the family home. All of these factors are connected with strong but complex associations between parental mental health, parenting behaviours, children's brain development and ultimately adult health.

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To understand the factors that impact on family life and parents we should also understand the importance of strong social supports.

Today we have a plethora of evidence of the impact of widening inequalities across a range of health and well-being indicators. These are the result of political choices they are not random occurrences or inexplicable routes to an unequal society.

The UK is lagging behind many EU countries in its GDP spend on health and is lower down the league tables in happiness and well being indicators in children. It is not a surprise that many Nordic countries who have higher taxes to support state infrastructure to tackle inequality are consistently outperforming the UK.

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Progress is slow in terms of child health and welfare and it could be argued that in the current political climate that we are going backwards.

The report 'Born to Fail' was published in 1969 and was a landmark report of inequality in childhood in Britain. Its follow up report in 2013 'Greater Expectations' has gloomy conclusions. Therefore it is pertinent to ask how does government get away with policies that seem to deliver the opposite outcomes to that which we would expect of an advanced democracy. Or is it possible that as a society we are comfortable with the levels of child poverty that children experience today. Are we willing voyeurs to disadvantage and social injustice – as this report says we are sleepwalking into a world of inequality and disadvantage ?

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To emphasise significant challenges remain – the negative social determinants of health and rising child poverty, although it is important to stress that there is not linear relationship between financial status and dysfunction in families.

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It doesn't matter where you look in Scotland no local authority has child poverty levels in single figures. In Glasgow City almost one in 2 children are being brought up in poverty and you can zoom in on this rather depressing interactive map to locate the areas of highest deprivation across Britain – Glasgow is number 12 on the list. In Scotland there are pockets of child poverty, blanket child poverty and hidden child poverty (particularly in remote and rural areas).It is a ubiquitous problem.

'Poverty Safari' is worth reading for an account of growing up in a household with multiple stress and dysfunction. I recognise this author and his story- I've heard similar stories of distress in my surgeries over the years.

McGarvey is correct to argue that 'beneath all the discussion and tortuous terminology about politics and economics , these problems of mind , body and spirit and what we do to manage them as individuals , families and communities are the unglamorous , cyclical dilemmas that many people are really struggling with'.

It seems we continue to struggle with the unglamorous cyclical nature of child poverty.

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Often frontline professional accounts are an effective way of communicating adversity and worrying health trends in affected populations. The Royal College of Paediatrics and Child Health did just that. Their important report, another memo to government should be read widely. Children attending health facilities are under-nourished, living in inadequate housing, families struggling with the endless cycle of poverty related issues and the impact on their physical and mental health – this is 21st century child health.

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The other very important professional body that is also witness to the impact of policies that adversely affect children are teachers.

They reported their experiences of teaching hungry children in the 2013 Kelloggs 'Lost Education' Report. You cannot teach hungry mal nourished children. Their physical health impacts on their educational performance- schoolchildren lose over eight weeks of their primary education due to hunger in the classroom. The solutions are the responsibility of local and national state governments and the pilot like the one that I have highlighted in Lanarkshire council should be rolled out . We should remember that a children's right to 'provision' is a fundamental human right.

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It is also very important to allow children to describe their experiences and concerns in their own words. The Good Childhood Report tells us what children worry about and it is very important that we understand that the burden of toxic policies and dysfunction within the family itself is often carried on rather young shoulders.

Many children are worried about their safety within their own areas but children also worry about the ability of the family to pay their household bills. The Good Childhood Report challenges government to provide adequately funded services for children and young people. For example providing plenty of green space where children can play, supporting youth and community services, supportive lone parent employment policies would be put firmly within the responsibility of local and state government.

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If we are going to be as good as we can be as children-parents- adults- society it is important to understand the unresolved consequences of stressed childhood, parenthood, adulthood – the intergenerational transfer or the epigenetic consequences of toxic stress.

Our role as a GP is (not as an expert) but to listen and observe -for example the parent child- interaction during the 'indirect consultation'. Our job is to use our professional wisdom and experience because we often have complementary knowledge about the wider network of adults in a child's life and as a professional hub we can maximise the role of other support services. For example we work closely with health visitors in children under 5, we may liaise with 3rd sector or schools or embedded staff-Links, welfare advisors. We are trying to promote resilience and address health issues directly either in the parent or child or both.

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We are not working in an information or research vacuum- we do know what contributes to vulnerability in childhood, what impacts on parental wellbeing and what factors are protective. The challenge in this very crowded research field is to link academia, frontline services, policy makers to each other and the population of interest.

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There are significant differences in adult health indicators when comparing Govan which is a DE practice to health indicators of Whitecraigs a wealthy suburb on the southside about 20 mins away from Govan

Child poverty rates are 12 times higher in Govan and yet the immunisations rates are higher. This is an excellent example of well –coordinated public health medicine delivered by primary care - GPs

Health Visitors, Practice Nurses. The immunisation programme is a good example of how public health and a well structured primary care service can make a difference to inequity of healthcare if resource adequately. It also works because parents are involved in the delivery of health care and understand the importance of preventative health.

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An example of the impact of inequality on a public health issue is the obesity crisis. There is a gradient of inequality for both men and women with obesity levels lowest for those living in the least deprived areas. This slide maps out the impact of low socioeconomic status that determines your eating habits, your exercise habits, your proximity to cheap food outlets and the intergenerational and persistent factors that re-inforce the health behaviours that are contributing to obesity in this generation and the next. These are factors that could be applied to other health related behaviours and are also relevant to parenting behaviours- in other words an ecological approach to most health matters should be adopted.

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A big part of your life as a parent is minimising harm to children, encouraging their development in a safe and nurturing environment but we must not forget that children often like to take risks. These children leaping from heights, using sharp tools, sliding down hills- not a crash helmet or protective clothing in sight. When we talk about obesity crisis we forget as adults the boundless energy that children have and whilst risky play may strike terror into the hearts of some parents we do have to achieve a balance and encourage and support this type of physical activity which has demonstrated in some studies many benefits to the health and well being of children.

I'm going to move on and talk about unmet need and what that means in practice when working with vulnerable children and families in the DE.

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We tend to fixate on child protection processes which we use as a proxy for child well-being and safe guarding. The child protection system is well established and a vital part of maintaining the safety of children and young people who are at risk however that does not tell the whole story of the vulnerable child and family. Scotland has 0.92 million children in the age group 0-15 yrs, 0.61 million young people 16-24 yrs.

Of that population 2% are placed on the child protection register (2723). Does that mean that 98% have all their needs met?

There are 8 GP practices in the G51 postcode and the total number of children on the CPR is 15. In my practice population in Govan in 2016 we had 589 children aged 0-16 with 9 of these are recorded as ever having child protection register input (either current or historic). This is 1.53% of the total. Through our integrated care project- SHIP we identified 282 (48%) children under 18 years old that we regarded as vulnerable and merited support for a variety of factors.

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When we look at the whole of the south sector of Glasgow (the biggest health sector in Scotland) there are 111 children on the child protection register (4% of Scotland's CPR). The most common registrations are for Domestic abuse and Neglect. Child neglect is the most prevalent child maltreatment subtype in the research literature and the predicted rate which would meet

thresholds for statutory intervention at a population level, depending on the study rates of 20-30% are thought to be an accurate reflection of its occurrence.

The answer to the question of 'are all children who have unmet need contained in the CP stats?' is 'No'.

In our integrated project we are identifying a greater number of vulnerable children who do not (nor should they) meet thresholds of statutory intervention. They are considered vulnerable within their family often due to parental factors and who do benefit from a multidisciplinary approach to support them. This is what unmet need and an improved and coordinated service response looks like.

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There are several well established reasons in health and social work services that impede professionals proactively identifying and working consistently with vulnerable children. These factors emerged during a child protection workshop and are repeated findings during inquiries of significant child harm. It is relevant to consider at what point services should invoke statutory proceedings in cases of child maltreatment. But the bigger unanswered question is what would help prevent an escalation into CP thresholds or prevent sustained adversity in childhood.

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WE have an opportunity now to develop a nuanced understanding of adversity in childhood and how this impacts on the lifecourse of adult mental and physical health. Adverse Childhood Experiences (or ACES) are common, and there is a dose response relationship with increasing numbers of ACES and negative health outcome and risky behaviours. Recognition of the impact of ACES is becoming increasingly important across many policy areas in Scotland. Its main learning point for me as a GP is that ACEs offer an alternative and expansive language that is more suited to holistic family medicine and not the formality of restrictive child protection measures.

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Any talk of adversity must reflect on the protective factors that strengthen resilience in children and young people. These include environmental factors and one of the most important factors in developing resilience in childhood – having a trusted adult in your life.

The last part of my talk is very specific to general practice, what being a family doctor means, the resources that we need in DE and out of the DE practices to support parents, the emotional health of children and our role of advocacy within the wider political landscape.

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General practice is the messy end of health- we are the gatekeepers of health care but there is no gate that we can open or close. We are the hub at the centre of other services who refer into us and to whom we refer out to.

There are core features of general practice that define its functions – the 12 c's and these must reflect the consistent expectations of patient.

GPs are problem solvers, pragmatic practitioners. Our role in parenting is not an intensive therapist but as a generalist who can coordinate practical solutions that can de-stress and foster resilience in stressed families based on our trusted relationship with that family over many years.

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With respect to child health however we have a particular issue in general practice - by design and default we have diminished the importance of preventative child health.

The reduction in scheduled GP contacts through child health surveillance checks has resulted in a reinforcement of the inverse care law in relation to 'universal' child health reviews.

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The reduction in scheduled child health contact coupled with the changes to the maternity service has effectively written general practice out of a consistent and recognised role on preventative child health care. These are the unintended consequences I would suggest of well meaning service re-design with the compliance of a profession that isn't fully cognisant of its own role in supporting children and families.

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What is a vulnerable or 'troubled' family and what might that look like in general practice. This vignette that introduces DE report 29 outlines many of the family dynamics that would define this family as vulnerable across multiple generations and is a good starting point when trying to tease out the dynamics of a vulnerable family life.

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When you give well trained and experienced frontline clinicians and practitioners the resource and tools to imagine new ways of working they tend to come up with workable solutions .

These are suggested ingredients to develop new care models.

I am going to spend the last few slides talking about a test of change site, one of Scottish Government funded integrated care projects -Govan SHIP. One of the main work streams of the project is the support of vulnerable children and their parents.

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My GP colleagues in Govan (at least the ones that were old enough) had a collective memory of collaborative working in Govan Health Centre with a social worker (a generalist SW) who worked alongside with us. This relationship was lost when social work moved into their own hub and no longer had direct face to face contact with us. Why is that important? We tend to forget when strategies are operationalised the meaning of professional relationships that are built up over many years when working together on sentinel cases is grossly undervalued in the currency of system change.

When we started the project we were at our Horizon 1. This is where we wanted to move from because with shorter consultations, more physical, psychological, social and financial problems to deal with, lower expectations and less enablement (especially for patients with mental health issues) our collective GP empathy (which is key to holistic practice) was flagging. At our Horizon 1 it was not possible to work in the way that we had been trained to.

The SHIP project allows us to support vulnerable children and families because we are being given protected time to case manage and coordinate care and support through the use of our MDT

meetings and embedded workers eg LINKS. It is important that for GPs (but this will be true for other professions) time is acknowledged as an effective resource and costed in the workforce plan.

With the evolution of the SHIP project we have effectively reached our Horizon 3.

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The MDT is a key aspect of working in complex systems, complex relationships and with complex patients – one of the main patient groups that we aim to support are vulnerable children and families. We are in an ideal position to advocate for families when there are clear gaps in local service provision and we can do this because of our longstanding knowledge of the family and working relationships with those agencies that can offer support.

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In practical terms this means that we are able to proactively engage with vulnerable children and families .The DE report 29 documents many cases that have resulted in positive outcomes for children and families –either because we have been able to address child factors, parental factors or structural barriers to services or all of the above.

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Lord Laming who wrote the Climbie report (2003) used the jigsaw metaphor for joined up working- ‘widespread organisational malaise’ was a repetitive theme throughout the report. It is important that to promote positive parenting and for Scotland to be the best place for a child to grow up that we build this complex jigsaw.

It is a big picture jigsaw made up of many pieces- some are still missing and seem difficult to locate. But we have begun to build it in Scotland. Many policy areas contain a child rights based agenda - this list is a small section of current policies. But policies don't write themselves nor do they automatically translate into the mindset of individuals or organisational structures.Their progress is contingent on the prevailing ideologies that underpin local and national policy shifts.

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The GPs at the DE have written several reports that reference children and families, health inequalities and the wider social determinants of health that impact on family function. By giving GPs and the extended primary health care team the tools and resource in Govan to work in a way that reflects the true goals of general practice we can make a difference to parenting when parents require support, to child well being and safeguarding. GPs at the DE cannot make all children equal but we can make child health provision equitable, sustainable and targeted at those children and parents who require that little bit of help that makes a positive difference.