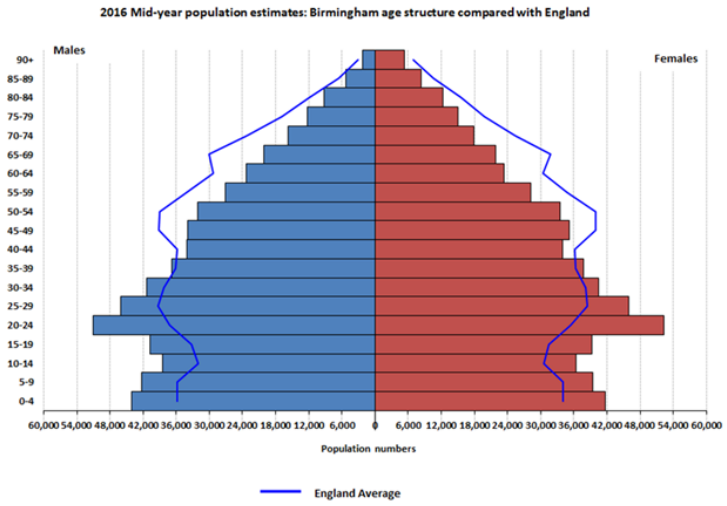
UNDERSTANDING THE NEEDS OF CHILDREN AND YOUNG PEOPLE IN BIRMINGHAM

October 2018

1. The Youngest City in Europe?

Birmingham is the largest local authority in Europe and the UK's second city, home to an estimated current population of 1,137,123[1]. The city has a younger population (Figure 1), a more diverse background and higher than average levels of deprivation compared to the rest of England.

Figure 1 - Age breakdown of Birmingham and England population



An above average birth rate and high levels of immigration in recent years has increased the number of children and young people in Birmingham putting pressure on schools and children's services. There are approximately 17,000 births in the city each year[2]. There were 20,528 overseas migrants aged less than 18 years between 2013 and2016 who were newly registered with GPs in the city[3], 30% of these were from Romania.

450,047 of our population are aged between 0-25 years and make up 40% of the total population. The city has several universities and higher educational establishments which contribute to the large numbers aged between 20-25 years in the city.

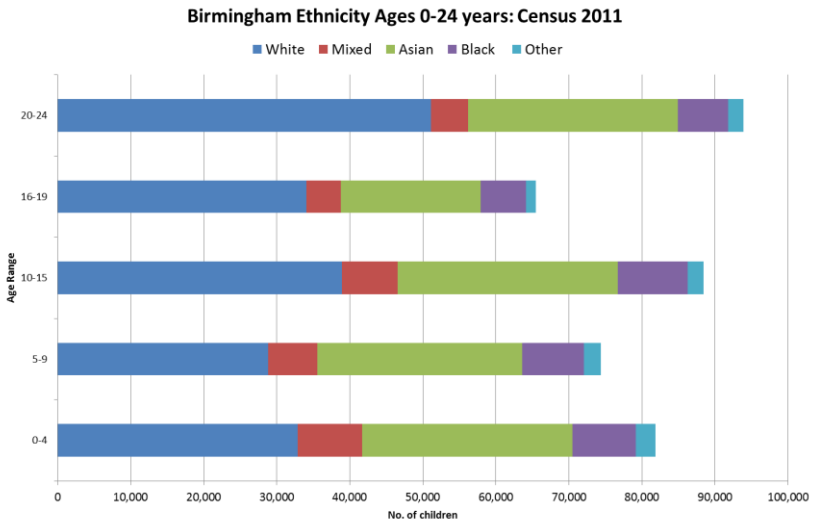
Ethnicity

According to the Census 2011 46% of the under 25 year olds in Birmingham were of White ethnicity. This compares to 79% at a national level. The next largest ethnic group was Asian with 33% of this age range with this ethnicity (10% for England). Between 2001 and 2011 the 0 to 24 age range had the most dramatic changes to its ethnic profile with an 80% increase in the Black population (+17,653). The Asian population increased by over a third (+33,996) during the 10 year period. The trend of increasing Black, Asian and Minority Ethnic (BAME) younger population in the city looks set to continue. Changes in the ethnic profile may affect demand for services.

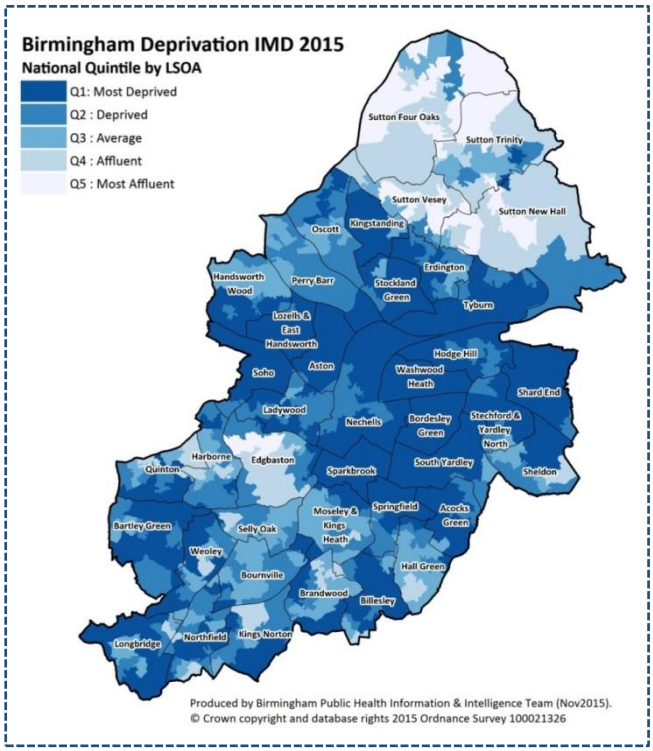
Projected population increase

The local population aged 0-24 years is predicted to increase by 2% in 2022 (an extra 10,000) and by 6% in 2027 (an extra 24,000)[4]. This will increase the demand for local schools and other services for children.

Figure 1 - Ethnicity of Birmingham population aged 0-24



Deprivation



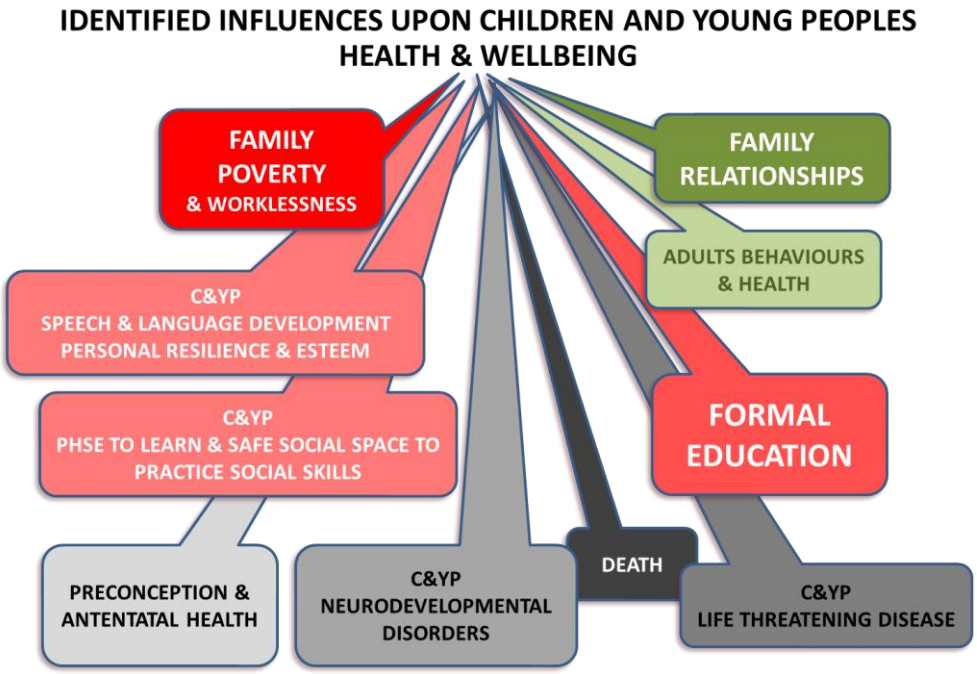
Birmingham has high levels of deprivation with 40% of the population living in the 10% most deprived areas of England. The Index of Multiple Deprivation (IMD) is a measure of the relative levels of deprivation at small area levels. Figure 2 shows the local areas by their national rank, the darkest shading being the most deprived.

Figure 2: Socio-economic Disadvantage across Birmingham

2. What Influences the Health & Wellbeing of our Children & Young People?

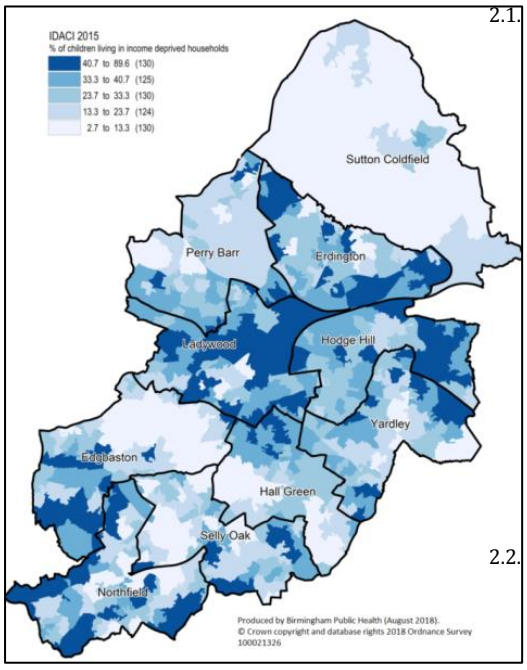
Research suggests that there are five groups of influences which can strengthen or undermine the Health & Wellbeing of our children and Young People. These are summarised in Figure 2.1 as Poverty, relationships with adults and peers, educational and skill attainment, their own or parental physical or emotional ill health, and death.

Figure 2.1:



Family Poverty

Figure 2.2: Map of Income Deprivation Affecting Children in Birmingham



2.1. Birmingham has some of the highest Child Poverty levels in the country with 37% of children living below the poverty line, significantly higher than the UK average of 25%. These levels are not uniform across the City with rates approaching 50% of children in Ladywood, Hodge Hill, and Hall Green Districts (Figure 2.2). The drivers of this poverty have changed over time with less due to unemployment and more due to low wage employment[5]. This change is recent and should not hide the serious impact that persistent family poverty has on the development and, health and wellbeing of these children.

2.2.

How we might change the pattern and impact of poverty was the focus of the Birmingham Child Poverty Commission (2016). It is clear that changing the employment prospects and the type of employment, in terms of sustainable living income and purposeful employment, will make a medium term change in the poverty levels. At the same time it is important to improve the educational and skills attainment of children living in poverty to avoid the vicious circle of future impoverishment and underachievement by these children in adulthood[6].

Relationships with Adults and Peers

The quality and sustainability of children's relationships with adults, principally primary carers/parents, has a profound impact upon the health and wellbeing of children and young people. How adults nurture and treat children can improve or undermine that child's wellbeing, health, and even chances of survival. Parents own behaviour (e.g. violence and intimidation), activities (e.g. smoking, alcohol use, drug use, dietary habits), and health (physical and mental health or illness) all contribute to this. International, national, and local research all supports the importance of these factors and action to reduce this impact makes a difference to the lives and life chances of these children[3]. This is explored further in section 4.

Young people learn their life skills and health harming behaviours through experience/experimentation. They need a robust knowledge base from which to do this. The teaching of this core knowledge in school is important although OFSTED has judged this PHSE curriculum to be variable and in need of improvement[7]. Qualitative research involving young people continues to report the dissatisfaction of young people with the quality and usefulness of this teaching. The experiential component of this learning, which is how it becomes established and developed as life skills, is less often tackled systematically in schools. It is left to extra-curricular times and places which are becoming less and less structured or supported by trusted adults or peers.

3. What is living in Birmingham like for children and young people?

The Birmingham Commission for Children (2014) met with children, young people, parents/carers, educational/social care/health professionals to understand the key issues arising from living in Birmingham. The report, *It takes a City to Raise a Child*[8], documents this evidence and found that for:

Children and young people :

- Relationships are the most important thing, especially families;
- They want to feel safer in the City and have more spaces outside school to socialise;
- They lack safe affordable spaces and activities to be with friends and families;
- They want their voice heard;
- They were positive about school and valued the educational opportunities;
- They wanted skills and knowledge get a job;
- They wanted to be a good citizen and had a real sense of place and community;
- They want to hear people tell a positive story about Birmingham and young people's achievements.

Families and Communities:

- Parenting skills and support alongside other resources because families with young children are often in 'survival mode' and lacked the time and energy for reflective parenting;
- The availability of trusted and confidence-building relationships as a way out of social isolation driven by fear of crime, of difference, of judgment;
- They all had aspirations but these were not all the same. Some wanted to work, others wanted to raise their families. One size response do not therefore fit all;
- There is a real challenge for parents to support teenage children with their education;

The seven recommendations (Table 3.1) reflect these findings. The final recommendation reflects the need for earlier intervention to avoid the development of destructive relationships and harm to children.

Table 3.1: **The Recommendations of the Birmingham Commission for Children**

i. Embed children and young people's voice into decision making through the council's 10 district structure.

ii. Bring people together at a neighbourhood level to improve children's access to, and perception of safety in, local parks and open spaces.

iii. Harness the City's assets to give enriching experiences to children through their school curriculum, and genuine skills and experience to prepare for work.

iv. Tell a positive story about Birmingham's children and young people.

v. Harness community resources to support the community's children and families.

vi. Help parents to support their children's education.

vii. Lead in the development of an early help strategy, which shows how council, NHS, and voluntary sector partners will work together to ensure vulnerable children, families, and young people get the extra support they need.

It is possible to measure the Health and Wellbeing of Birmingham's Children and Young People? The annual Birmingham Child Well Being Survey[9] gives some indications of the self-reported features of wellbeing and health harming behaviours. Figures 3.1 to 3.10 demonstrate the trends in these behaviours.

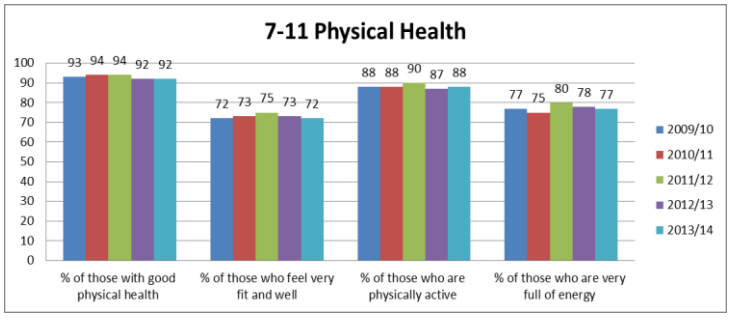


Figure 3.1

The proportion of children reporting themselves to be in good health and physically active is consistently high over time. Most feel full of energy although this reduces as they get older (Figures 3.1 and 3.2).

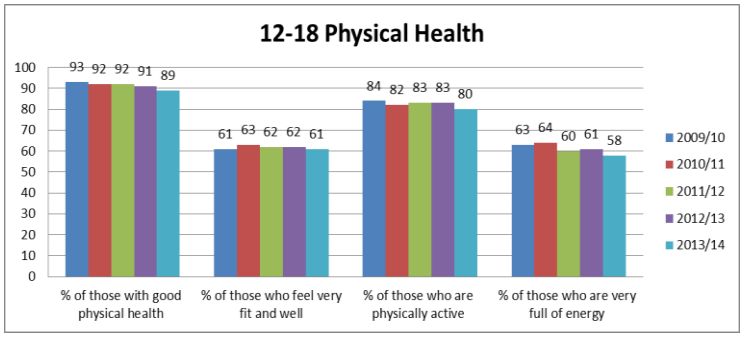


Figure 3.2

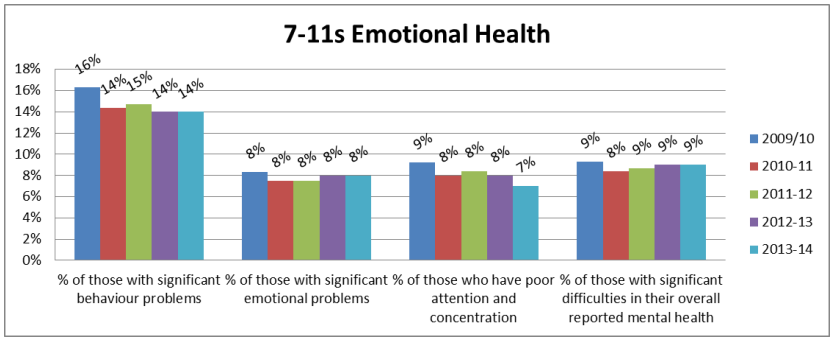


Figure 3.3

In this survey emotional health is assessed by quantifying the presence of emotional disturbance. Reliable and validated tools for assessing emotional health status have not been used. The extrapolation of good emotional health from the absence of disturbed emotional health is not very reliable. Despite this it is clear that the level of disturbance in young people is greater than younger children (Figures 3.3 and 3.4).

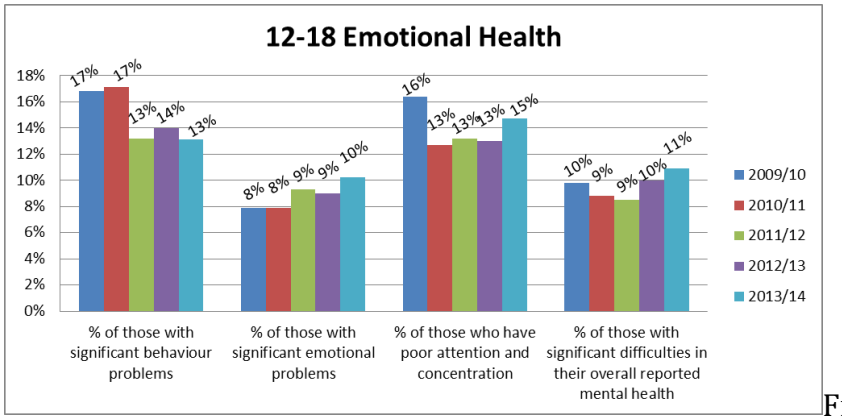


Figure 3.4

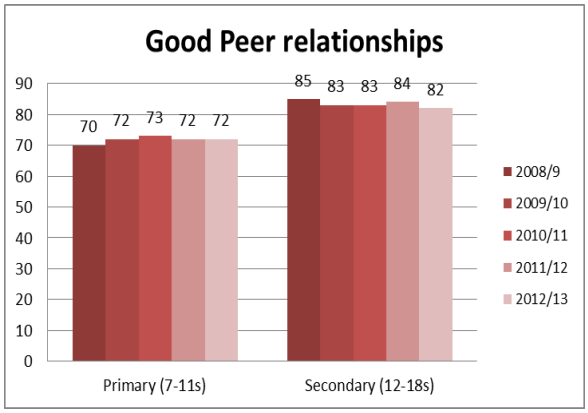


Figure 3.5

The development of peer relationships appears to be fairly strong, improving as more socialisation is developed in young people (Figure 3.5).

The majority of young people aspire to do well in life although the proportion not being prepared to value a traditional western economic model of achievement may represent other values (Figure 3.6).

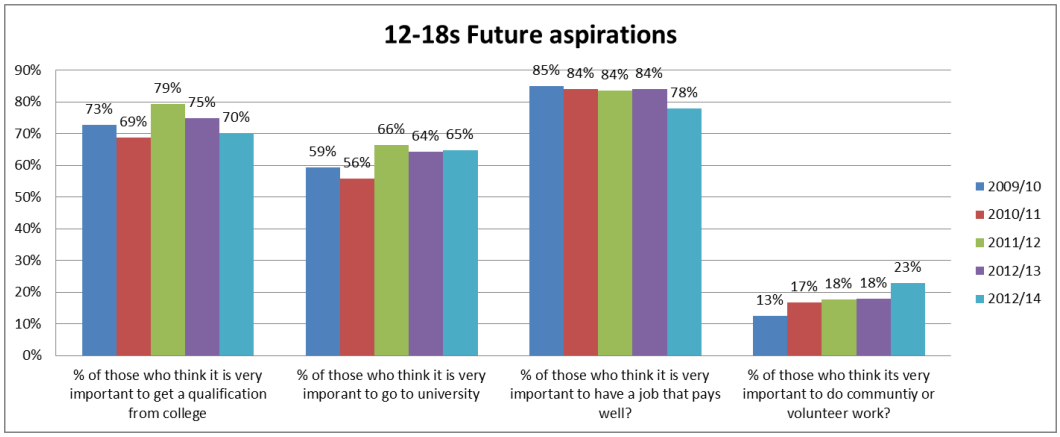


Figure 3.6

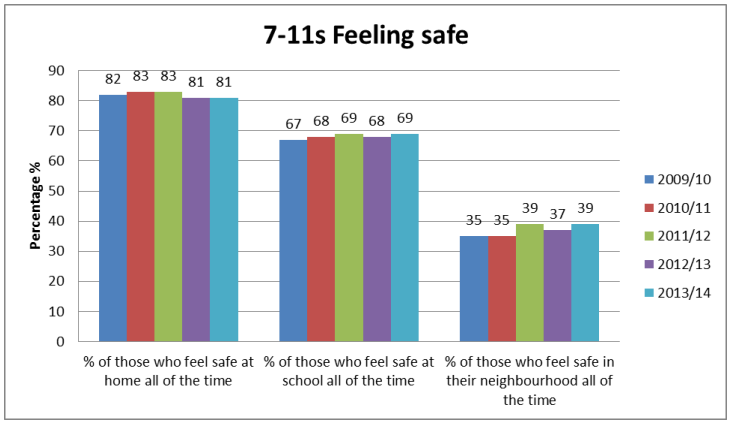


Figure 3.7

Fifteen to twenty percent of children do not feel safe at home all of the time. A third of primary school children and almost half of secondary school children feel unsafe a lot of the time at school. Being out on the streets feels even more unsafe (Figure 3.7 and 3.8) while large proportions are witnessing or hearing violence in their neighbourhoods (Figure 3.9). These ought to be worrying findings.

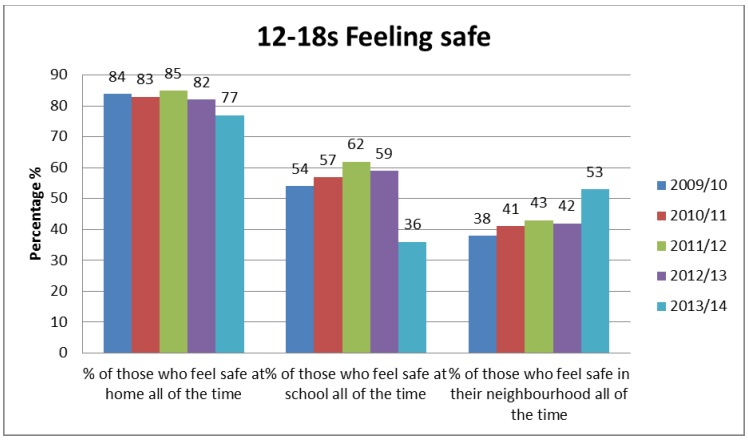
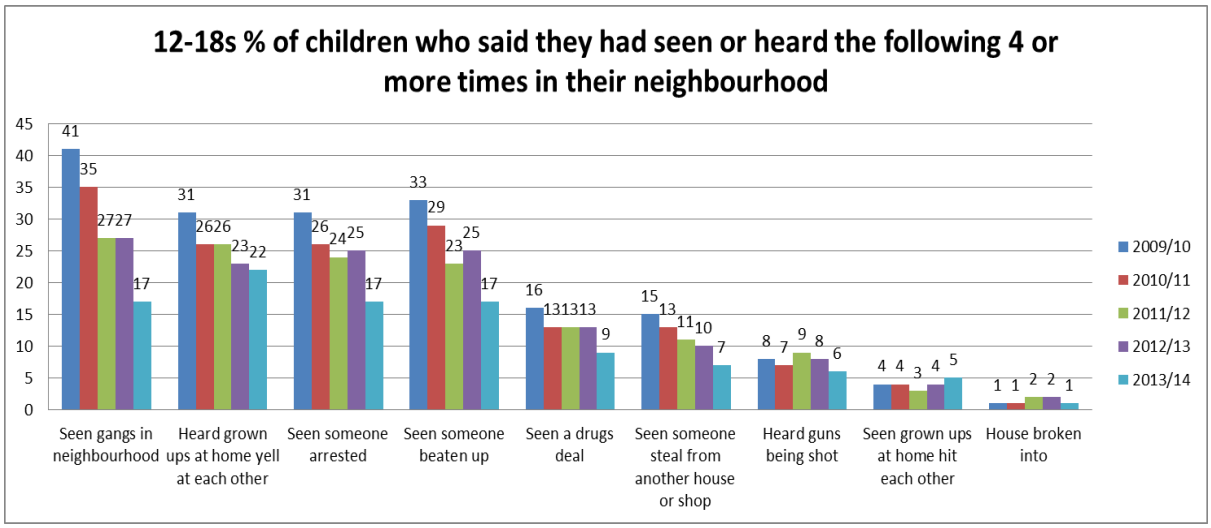


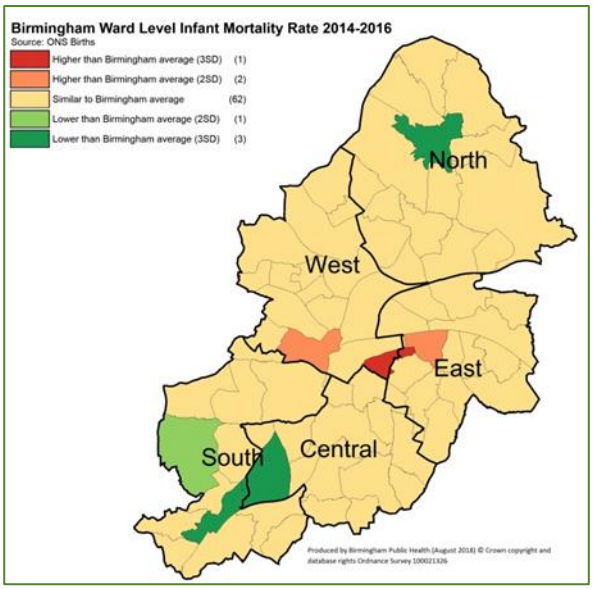
Figure 3.8

Figure 3.9



4. Drivers of Adverse Health and Wellbeing outcomes

Figure 4.1: Infant Mortality Rates in Birmingham

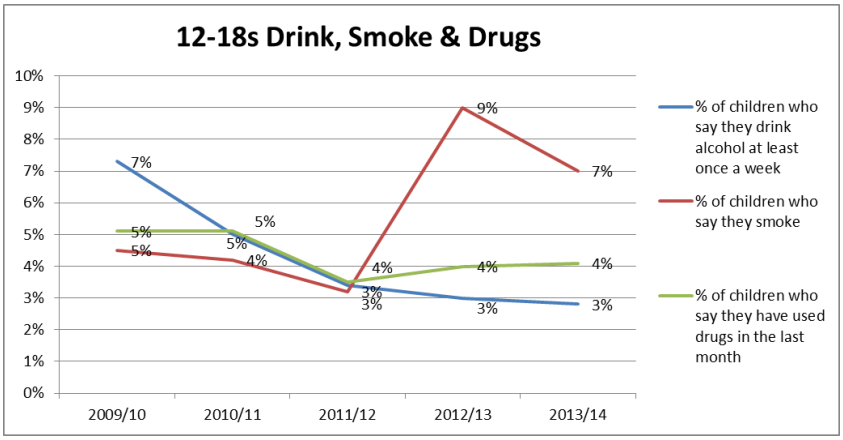


Birmingham has had an Infant Mortality Rate that is higher than the England rate since the 1960s, with a varying and recently increasing gap.[1] This persistent difference with other parts of England is also reflected in variation in the areas of the city which is statistically important (Figure 6). Almost three quarters (72% in 2015-2017) of child deaths in Birmingham occurred in the first year of life with 63% of these in the first week of life.[2] This means that 46% of all child deaths occur in the first week of life. The cause of death recorded on the Medical Cause of Death certificate suggests that immaturity (born too soon), congenital anomalies and intrapartum events are the main conditions (Figure 7).[3] This is confirmed by the analysis of categories used by the Child Death Overview Panel[3] which is also able to examine the relationship between the two principal categories (prematurity and congenital anomalies) and duration of pregnancy at birth (gestation). All of those identified as being born at less than 22 weeks of gestation of pregnancy died from the consequences of being born so soon (Figure 8).[4] If born after 22 weeks and dying in the neonatal period then equal numbers of prematurity related and congenital anomaly deaths occurred.

[1] Jeanette Davis, Birmingham Public Health Intelligence 2017
[2] Wilkes D *The Annual Report of the Birmingham Child Death Overview Panel 2018* Birmingham Safeguarding Children Board
[3] Jeanette Davis *Infant Mortality Update to the Birmingham Health & Wellbeing Board* 2017
[4] Wilkes D The Annual Report of the Birmingham Child Death Overview Panel 2013 Birmingham Safeguarding Children Board

The behaviours reported in the Birmingham Wellbeing Survey[7] (Figure 4.1) are considered in the Chief Medical Officer's Annual Report (2012)[10] to be exploratory by young people of adult behaviours. An alternative explanation is that they are symptomatic of emotional pain or disturbance of such intensity that it hurts. These behaviours are attempts to release that pain/anger. Our response to these behaviours can either remain punitive of the individual or we can use different interventions and approaches to enable recovery not just abstinence.

Figure 4.1



Support for this approach comes from the recent research into the impact of adverse experiences in childhood resulting in health harming behaviours[11]. Bellis et al found a correlation between adverse experiences in childhood (Table 4.1) and the acquisition of health harming behaviours.

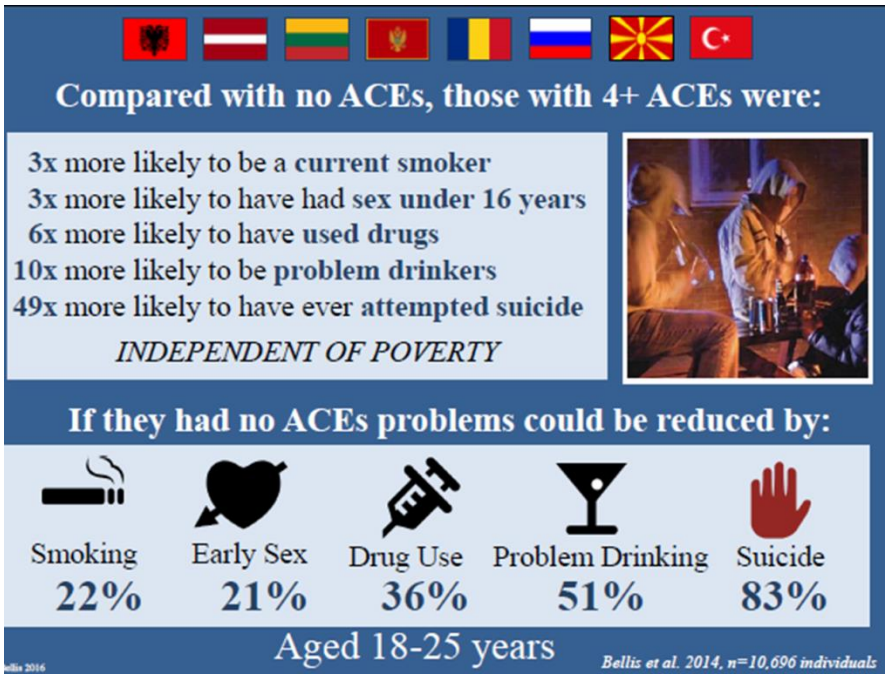
Table 4.1: **The Definition of Adverse Childhood Experiences**

Adverse Childhood Experiences	Definition
Parental separation	Were your parents ever separated or divorced?
Domestic violence	How often did your parents or adults in your home ever slap, hit, kick, punch, or beat each other up?
Physical abuse	How often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? This does not include gentle smacking for punishment
Verbal abuse	How often did a parent or adult in your home ever swear at you, insult you, or put you down?
Sexual abuse	How often did anyone at least 5 years older than you (including adults) ever touch you sexually?
	How often did anyone at least 5 years older than you (including adults) try to make you touch them sexually?
	How often did anyone at least 5 years older than you (including adults) force you to have any type of sexual intercourse (oral, anal, or vaginal)?
Mental illness	Did you live with anyone who was depressed, mentally ill, or suicidal?
Alcohol abuse	Did you live with anyone who was a problem drinker or alcoholic?
Drug abuse	Did you live with anyone who used illegal street drugs or who abused prescription medications?
Incarceration	Did you live with anyone who served time or was sentenced to serve time in a prison or young offenders' institution?

All ACE questions were preceded by the statement "While you were growing up, before the age of 18…"

The demonstrated increase in likelihood of developing health harming behaviours and poor emotional health is strong (Figure 4.2).Staff assessing children and young people should include questions concerning the adverse experiences in childhood as a means of being more alert to the likelihood of Health Harming Behaviours or other family dynamics potentially having an adverse impact upon their Health & Wellbeing.

Figure 4.2: **The Impact of Adverse Experiences in Childhood on Health Harming Behaviours and Emotional Wellbeing**



A Birmingham Health and Wellbeing Board Task and Finish group[12] has explored opportunities to prevent the impact and developed a prevention framework with occasions identified across the life course. There are discussions in many arenas considering the question of responding and reducing the impact for future generations of children. The prevention framework (Figure 4.3) has prompted action in all three prevention domains.

Tertiary preventative approach

This approach considers routinely asking about these experiences in those with established physical and emotional disease and in contact with specialist services.

Opportunities for tertiary prevention have been developed in adult substance misuse clients, complex family presentations (Think Family and Intensive Family Support) and Domestic Violence support for survivors.

The approach involves enquiring about these experiences and sharing the impact they have. This provides an opportunity for the client to recognise the impact of that previous adverse experience and offers an opportunity to be different in the future. It does not focus on the previous experience nor does it expect the client to relive the experience again and again. It is seeking to deal with the impact it is having in the here and now and for a different future. It has been demonstrated to enhance the specialist therapeutic interventions usually employed. A trauma recovery specific intervention has not been required, although this is an option in some circumstances.

Secondary preventative approach

The approach identifies children and Young People with recent adverse events, preferably as and when they occur. This is an opportunity to reduce the impact these experiences have in the present and the future. This should reduce the likelihood of multiple experiences occurring in these individuals over time.

Opportunities for Secondary Prevention have been developed into an Early Emotional Help system framework for secondary schools, in partnership with the voluntary sector and Forward Thinking Birmingham. This is intended to enhance the response to children with difficulties and concerning behaviours. The approach recognises the adverse experience impact and raises the questions with these young people. This has shown to change the responses in students with challenging behaviours supported by the City of Birmingham School and Pupil Referral Units.

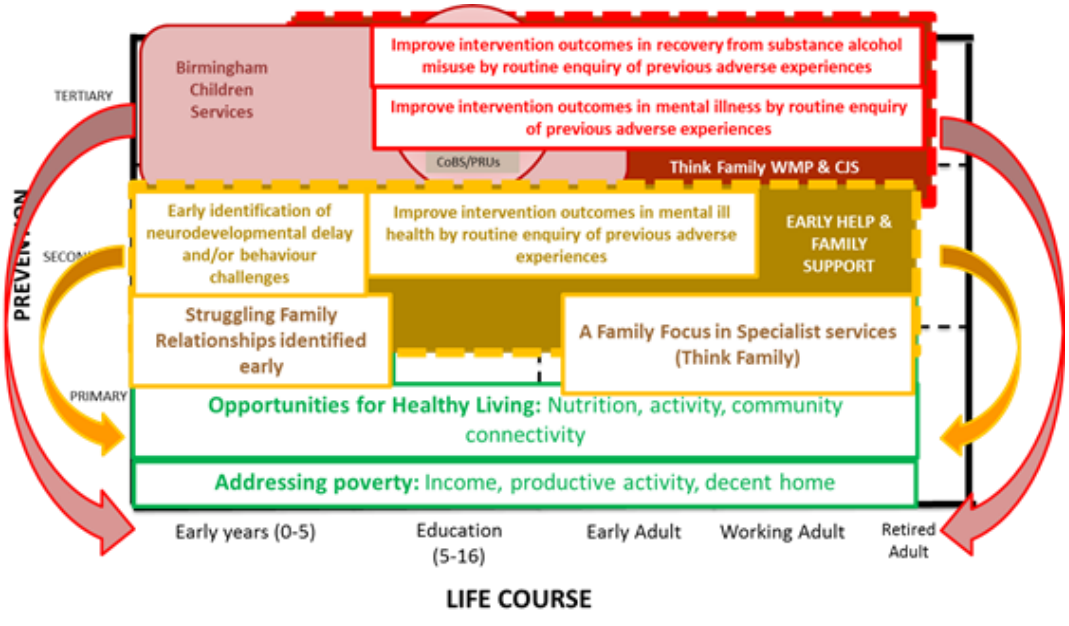
Opportunities for Secondary Prevention have been developed in the Early Years System (Birmingham Forward Steps) to support parents to relate differently to each other and their children using insights of the impact of parental adverse experiences in their childhood. This enhances the effectiveness of programmes such as Positive Parenting Programme and the Solihull Approach.

Primary preventative approach

This approach is intended to reduce the likelihood of Adverse Childhood Experiences occurring in the first place and/or reducing the likelihood of the impact if an adverse experience does occur

Opportunities for Primary Prevention have been developed in a whole school ACE/Trauma approach to adult/student and student/student relationships through the understanding of the impacts of these experiences (Newstart programme). Half of Birmingham secondary schools have now become involved in the programme and early adopters are reporting encouraging changes in the school culture, relationships and achievements.

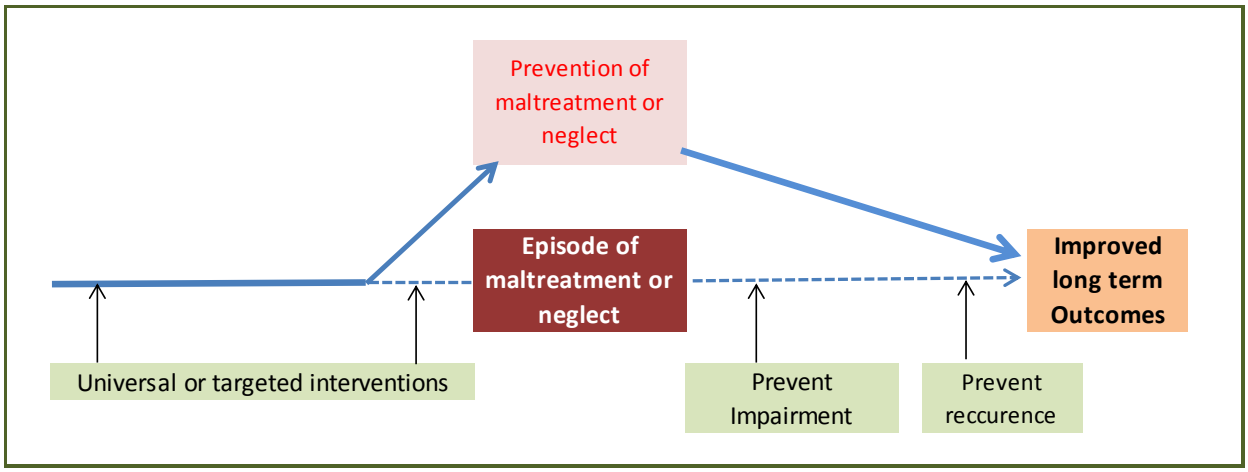
Figure 4.3: **The Potential for Impact Using the Preventative Framework**



5. EARLY INTERVENTION

Chapter 1 of Working Together (2018)[13] highlights the need to identify children and families with emerging difficulties at every opportunity and provide prompt intervention/support appropriate to need. **Reactive Early Intervention** is to respond quickly as soon as a need is identified in order to prevent further deterioration in the family circumstances and the need for more complex interventions. In a report reviewing the state of safeguarding Children, Munroe[14] described this reactive early intervention as a framework (Figure 5.1).

Figure 5.1: **Reactive Early Intervention Munroe Framework**



Reactive early Intervention can be summarised as[15]:

a) services provided to children, young people and their families to meet needs which do not require very rapid or formal statutory intervention (universal plus and/or additional needs services);

b) action to support a child, young person or their family early in the life of a problem, ideally as soon as it emerges. It can be required at any stage in a child's life from pre-birth to adulthood, and applies to any problem or need that the family cannot deal with or meet on their own;

c) provided to prevent or reduce the need for specialist interventions unless they are absolutely the correct response to meet the need and resolve the problem; and

d) provided in the most complex of circumstances as well as the simplest, responding promptly if a child is at immediate risk of harm (or has other significant or complex needs) as much as it means responding to a need which only requires advice or guidance

Identifying children and families who are at greater risk/likelihood of additional support is a key challenge for frontline staff. We presume that staff are open to recognising family circumstances with a greater likelihood of dysfunction or adverse impact upon children. So why do professionals delay intervention?

In the 1960s and 70s it was common for car drivers to service their own cars. The machines were simpler and the tools and skills easily obtainable. By the 1990s car design had changed to electronic engine management systems. These required different skills and tools which were not so easily available. Drivers have always had the choice of

not servicing and saving a small amount of money in the present but risking breakdown with more significant repair costs in the near future.

The same is true of professionals. Over the same time the issues found in families by generalist staff (GPs, Health Visitors, school nurses, youth workers, childcare staff, and school staff) have become more complex or require more expertise to address effectively. The days of a single handed GP doing it all him/herself have gone. The likelihood of a single generalist worker being able to intervene in all issues identified has also gone. The range of providers of effective interventions has increased as the evidence base of effectiveness for these interventions has developed. It should therefore be possible for the generalist worker to respond; *'I can't meet this need but I know someone locally who can help*'.

There has long been a habit of '*refer to Social Services if you can't do it yourself*'. This has been resistant to dismantling but does need to change. An approach of *'I can't help but I know a local person who can'* requires the development of networks of local people who are already in conversation with each other and for whom there will not be barriers to sharing assistance. This network should grow organically, using the skills of a nurturing co-ordinator, because trying to commission these relationships will undermine the value and power they can contribute.

The Early Help approach should facilitate intervention earlier in the development of a family's need but it is also important that when urgent action is required it will happen. The development of the Multi Agency Safeguarding Hub should start to demonstrate the reliability of action to serious concerns. The development of local Family Support & Safeguarding Hubs to connect local staff when more than two agencies/skill sets are involved should also facilitate Early Help and are to be encouraged and supported.

How can we be sure these interventions will be effective? **Early Intervention Programmes** aid the development of child and family relationships or address difficulties in those relationships. These can be delivered universally or in particular communities of higher need. The aim is to improve the child's physical; emotional; and relationships development, attainment and ultimately their employment and socio-economic independence and contribution.

In order to identify children and families who would benefit from help/intervention/support, professionals should be particularly alert (Table 5.1) for a child or family with particular features[10].

	Area
1	A child who is disabled and has specific additional needs
2	A child with Special Educational Needs
3	Young carer
4	Shows signs of engaging in anti-social or criminal behaviour
5	In a family circumstance presenting challenges for the child
	Adult carer with substance misuse
	Adult carer with mental health needs
	Domestic abuse and/or violence
	A family who is Homeless
	Family home overcrowding
	Family Poverty
6	A child showing early signs of abuse or neglect
	Physical including nutritional (under or overweight) Emotional Childhood Sexual Exploitaiton

Table 5.1

Early Intervention Programmes are formalised interventions with a body of evidence of effectiveness. These programmes should find a place in the range of responses local agencies use when offering additional or targeted specialist support to children and families in the Birmingham. Figure 5.2 demonstrates this.

Figure 5.2**: Effective Interventions by age (Allen Report[16])**

The value of defining cost-benefit, used in the Social Research Unit approach, is that it helps to support the resource allocation and the return likely to accrue from implementing the programme. This method does however favour more targeted intervention programmes for more established difficulties. In general, targeted approaches tend to be judged more cost effective than universal approaches because outputs and impact on outcome may be more easily measured and compared with a control group. Yet there is little comparative evidence to determine which approach might be **most** 'cost effective'. The evidence suggests that it is unlikely to be a question of one or the other. What is needed is a range of interventions able to provide support at different levels of need.

The Social Research Unit identified five cost –beneficial programmes, all targeted towards groups at higher risk (Family Nurse Partnership, Triple P) or those with established difficulties (SafeCare, Functional Family Therapy, MultiSystemic Therapy). Their cost-benefit scores suggest that for every £1 funding the programme will deliver more future decrease in spending (Table 5.2).

Table 5.2

PROGRAMME	PURPOSE	COST-BENEFIT
Family Nurse Partnership	Young first time mothers before 16 weeks gestation	1.87
Triple P	Positive Parenting Programme offered in disadvantaged communities	4.84
Safe Care	Home based Parent training programme to reduce risk of child mistreatment	2.07
Functional Family Therapy	Family based programme to reduce adolescent behavioural problems	12.35
MultSystemic Therapy	Family based Programme to reduce Youth Offending behaviours	1.58
PATHS	Whole school based programme to improve pupil behaviours	N/A
Incredible Years	Targeted Family programme to reduce risk of conduct disorder	N/A

The OECD suggests that expenditure on children should be regarded as if it were an *investment portfolio*, and be subjected to a continuous iterative process of evaluation, reallocation and further evaluation to ensure child well-being is actually improved.

The evidence of impact, effectiveness, and sometimes cost-effectiveness results in a number of programmes that can be prioritised for local availability (Tables 5.3, 5.4, and 5.5).

Universal Preventive Early Interventions are activities that are directed at whole populations and often targeted at populations of greater risk. In the context of children's development and achievement this is often areas with higher child poverty and social disadvantage. They are universal because they are available to all families in that population.

Table 5.3

UNIVERSAL PREVENTIVE EARLY INTERVENTIONS	
PROGRAMME	IMPACTING UPON
Sure Start Local Programmes	Improves parent child relationships, stimulating home learning environment, speech & language development
Solihull Approach	Enhances bonding and improves management of child's challenging behaviours
Incredible Years	Significantly reduced antisocial and hyperactive behaviour in children, Reduction in parenting stress and improvement in parenting competences, reduced likelihood of establishing conduct disorder.
Promoting Alternative Thinking Strategies (PATHS)	reducing sadness and depression, lowering peer aggression and disruptive behaviour

*The Impact of **Sure Start Local Programmes** on seven year olds and their families* (2013)[17] reports in the final summary:

> After taking into consideration pre-existing family, area and school characteristics four positive effects of Sure Start Local Programmes emerged from 15 outcomes at age 7, two of which applied to the whole population and two of which applied to sub-populations. For the whole population, mothers in Sure Start Local Programme areas, relative to counterparts not living in Sure Start Local Programme areas reported:
>
> a) Engaging in less harsh discipline;
>
> b) Providing a more stimulating home learning environment for their children;
>
> Additionally for sub-populations, mothers in Sure Start Local Programme areas reported:
>
> c) Providing a less chaotic home environment for boys (not significant for girls);
>
> d) Having better life satisfaction (lone parent and workless households only).

In particular, language development in the early years underpins both cognitive and social development. Hence if Sure Start children's centres were to have an observable impact upon school readiness greater emphasis needed to be given to improving children's language development.

The **Solihull Approach**[18] programme was developed in the late 1990s and uses the research from behavioural psychology and child development to enhance parental-child containment and reciprocity to enhance bonding and manage emerging child behaviours. Courses are run by trained practitioners with mothers and/or fathers, and expectant parents. It has been repeatedly evaluated[19] [20] [21] over the years and parental feedback remains high[22].

Incredible Years[23] is the other parenting intervention identified by the National Institute for Health and Clinical Excellence as cost-effective in reducing conduct disorder. The large lifetime costs associated with conduct disorder, estimated to average £75,000 in milder cases to £225,000 in extreme ones, suggest that even a low success rate would constitute good value for money. Evaluation outcomes include:

- Significantly reduced antisocial and hyperactive behaviour in children;
- Reduction in parenting stress and improvement in parenting competences; and
- Positive effects on child behaviour and parenting.

There is also a Primary School Classroom Module which is used locally by Educational Psychologists and evaluates well in terms of changed behaviours in the classroom.

Promoting Alternative Thinking Strategies (PATHS) is a relatively low-cost programme offered as a whole school programme. Evaluations of Promoting Alternative Thinking Strategies have found positive impacts in terms of:

- reducing sadness and depression;
- lowering peer aggression and disruptive behaviour; and
- improving classroom atmosphere

Selective Preventive Early Interventions are targeted towards individuals or groups of individuals that are at greater risk or showing early signs of developing difficulties (Table 5.4).

Table 5.4

SELECTIVE PREVENTIVE EARLY INTERVENTIONS	
PROGRAMME	IMPACTING UPON
Positive Parenting Programme	Reduces progression of conduct disorders.
Family Nurse Partnership	In the United States of America, children born to the parent given the support there is a reduction in reports of child abuse, reduced likelihood of becoming a teenage parent, less likelihood of involvement in juvenile crime, reduced exploratory behaviours, family required less welfare benefit support.

Positive Parenting Programme **(Triple P**[24]**)** is one of two parenting interventions identified by the National Institute for Health and Clinical Excellence (NICE) as cost-effective in reducing conduct disorder. The large lifetime costs associated with conduct disorder, estimated to average £75,000 in milder cases to £225,000 in extreme ones, suggest that even a low success rate would constitute good value for money. However a systematic review conducted in Scotland (2012)[25] found no convincing evidence that Triple P interventions work across the whole population or that any benefits are long-

term. This may have implications for a universal approach which might, in more affluent communities, draw in a smaller proportion of the population to participate. This would mask the very significant benefit at individual family level.

Family Nurse Partnership/ Nurse Family Partnership[26] has been consistent in delivering positive economic returns over 30 years of research the United States of America, Europe, and Australsia. Benefits to cost ratios of studies examined fall in the range of around 3:1 to 5:1. Some example impacts from the US evaluation include that at the age of 15:

- greater effects on reports of child abuse than at age 4 (Risk Ratio 0.29 verified reports vs 0.54 for the control group);
- fewer subsequent pregnancies (1.5 vs 2.2 for the control group);
- fewer months on welfare (average of 60 months per child vs 90 months for the control group);
- fewer arrests (average of 0.16 per child vs 0.9 for the control group)
- as well as a reduction of illicit drug use, smoking and alcohol usage.

However, the UK evaluation of the of the Family Nurse Partnership in 2015[27] [28] indicated a much weaker impact and benefits.

The Family Nurse Partnership was started in the UK in 2009 and at the time a Randomised Controlled Trial (RCT) was initiated to compare the outcomes for those teenage mothers who received the intervention against those teenage mothers who had universal services (midwifery and health visiting). Although the aims of the service are to improve pregnancy outcomes, improve child health and development and improve parents' economic self-sufficiency, this was not wholly reflected in the outcomes which were measured by the Randomised Controlled Trial.

The 4 primary outcomes which were measured in the Randomised Controlled Trial were:

1. Tobacco use in late pregnancy (34-36 weeks gestation)
2. Birth Weight
3. Emergency attendances and hospital admissions within 24 months of birth
4. Proportion of women with a second pregnancy within 24 months

The findings of the Randomised Controlled Trial showed that having Family Nurse Partnership as an intervention made no significant difference to the 4 primary outcomes compared to universal services. Some of the secondary outcomes which were considered were child development, language, breastfeeding, injuries and ingestion, social services referral, safeguarding.

i. There was some suggestion that there may be improved child development outcomes for the children in the intervention group by age 2.

ii. Mothers reported language development was better in the intervention arm.

iii. Whilst more mothers in the intervention arm intended to breastfeed, there was no difference in breastfeeding initiation.

iv. A greater proportion of children in the intervention group attended A&E, whilst a smaller proportion was admitted.

v. A greater proportion of participants in the intervention arm reported their children had been referred to Social services. This could be because needs were identified earlier in this group rather than those receiving universal services.

vi. A greater proportion of participants in the intervention arm had a safeguarding event recorded. Again this could be that safeguarding needs were identified earlier in this group rather than those receiving universal services.

The Randomised Controlled Trial findings shone a light on the very high level of vulnerability amongst first time young mothers, whether they were receiving Family Nurse Partnership or not, and which we know are associated with increased risk for their child's life time development:

i. 48% were Not in Education, Employment or Training (NEET)

ii. 35% had previously been arrested

iii. 46% had been suspended, expelled or excluded from school

iv. 56% were smoking in late pregnancy

v. 40% of the young women in the study had experienced domestic violence in the two years after the birth of their child.

The Randomised Controlled Trial concluded that there was little advantage to adding Family Nurse Partnership to existing health service provision and was not cost-effective from the perspective of maternal outcomes. The Birmingham Family Nurse Partnership ceased to take on new clients and the newly commissioned Early Years System, Birmingham Forward Steps, included a targeted approach to pregnant women with additional socio-economic and emotional needs.

Indicated Preventative Interventions are directed towards individuals or families with the earliest signs of a developing disorder, particularly the behavioural and conduct disorders but could also include specific learning difficulties. This is intervention at the earliest signs of dysfunction (Table 5.5).

Understanding the needs of vulnerable young people is a pre-requisite to strategically planning services. Researched carried out by Matt Barnes, Rosie Green and Andy Ross, (2011[29]) for the Department for Education used analysis from the Longitudinal Study of Young People in England to try and clarify needs. The research identified five forms of disadvantage among young people aged 16 / 17 years:

- Low attainment – 19%;
- Not in employment, education or training – 8% ;
- Emotional health concerns – 22% ;
- Criminal activity – 9%; and
- Substance misuse – 15%.

45% of young people experienced at least one of these disadvantages and 15% experienced two or more. This means that 40% had none of these factors.

Table 5.5:

INDICATED PREVENTATIVE INTERVENTIONS	
PROGRAMME	IMPACTING UPON
Intensive family support	The evidence endorses the role and value of family interventions. It shows a consistent reduction in all important Health & social care domains but suggests the family intervention approach had the biggest impact in relation to crime and anti-social behaviour.
Think Family approach	
Family Intervention Services	
Multi-Dimensional Treatment Foster Care	Reductions in offending, Self-harm, sexual behavioural problems, absconding from residential settings.
Functional Family Therapy	Reduction in impact of conduct disorder, adolescent alcohol &/or substance misuse, criminal activity, likelihood of entering care system
MultiSystemic Therapy	Reductions in criminal activity and mental Health problems. Family function improves.
Family Group Conferencing	Improves family relationships and interactions with reductions in disruptive or criminal behaviour.
Solution Focussed Therapy	
Cognitive Behaviour Therapy Programmes	Rebuilds relationships between young person, family and social networks.
Aggression Reduction Therapy	

The **Intensive family support** model (i.e. Family Intervention Project model) seeks to address the behaviour and other problems of young people. The primary focus is on the young person rather than the whole family. However, other family members are involved where there is a need to address the inter-connectedness between the young person and other family members' problems.

The case for early intervention in socially excluded families is made in the context of the **Think Family approach** in a report commissioned by the Cabinet Office Social Exclusion Task Force and carried out by researchers from the University of Birmingham, University of Nottingham and University of Vermont USA.

A report by researchers from the National Centre for Social Research and the Bryson Purdon Social Research for the Department for Education, *Monitoring and evaluation of* ***family intervention services and projects*** *between February 2007 and March 2011*,[30] reviewed 3,675 families who exited a Family Intervention Programme. They found that there were eight core features of the family intervention model that are viewed as critical to its success:

i. recruitment and retention of high quality staff;
ii. small caseloads;
iii. having a dedicated key worker who works intensively with each family;
iv. a 'whole-family' approach;
v. staying involved with a family for as long as necessary;

vi. having the scope to use resources creatively;

vii. using sanctions alongside support for families; and

viii. effective multi-agency relationships.

The report concludes that there is now compelling evidence endorsing the role and value of family interventions and show a consistent reduction in all important Health & social care domains but suggests the family intervention approach had the biggest impact in relation to crime and anti-social behaviour.

A 2012 Cochrane systematic review and meta-analysis (Furlong et.al. 2012)[31] found that behavioural and cognitive-behavioural group based parenting interventions appear to be effective in reducing child conduct problems and in improving parenting skills and parental mental health. There is also some evidence for the cost-effectiveness of these interventions in reducing clinical levels of conduct problems to non-clinical levels.

Annual reports of **Multi-dimensional treatment foster care** in England[32] found statistically significant differences for:

- offending
- self-harm
- sexual behaviour problems
- absconding
- fire-setting

Functional Family Therapy (FFT)[33] has been estimated[34] to have a benefit to cost ratio of around 7.5:1 and 13:1. Clinical trials have demonstrated impacts in terms of:

- treating adolescents with conduct disorder; oppositional defiant disorder or disruptive behaviour disorder;
- treating adolescents with alcohol and other drug misuse disorders, and who are delinquent and/or violent;
- reducing crime; and
- reducing likelihood or entry into the care system

The benefit-to-cost ratio of **Multisystemic therapy (MST)[35]** has been estimated at around 2.5:1. Noted outcomes from evaluations include:

- reductions of 25–70% in long-term rates of re-arrest;
- reductions of 47–64% in out-of-home placements;
- improvements in family functioning; and
- decreased mental health problems for serious juvenile offenders.

Other services that strengthen family functioning and build resilience through evidence-based interventions include **Family Group Conferencing** and **Solution Focussed Therapy.** These approaches aim to change family interaction and family relationships, and through this, individual problem behaviour

Evidence-based interventions that tackle challenging behaviour in children such as specific **Cognitive Behaviour Therapy Programmes** and the related **Aggression Reduction Therapy** combine elements of direct work with young people, parenting

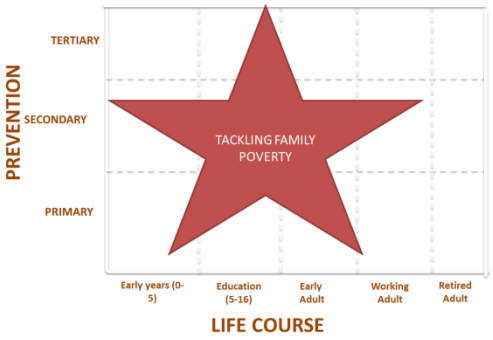
support and practical assistance with the aim of rebuilding relationships between the young person, the family and the networks around them. The approach equips the family with the tools to solve problems in the future, thereby effecting sustainable change such as reducing anti-social behaviour and enabling children to live safely at home.

6. PRIORITIES FOR ACTION

This overview addresses the wider but powerful influences on the health and wellbeing of children and young people in Birmingham (Figure 2.1).

Superimposing these drivers onto the preventative framework developed by the Health & Wellbeing Board's Task & Finish Group (Figure 4.3) begins to identify the impact areas where actions to enhance children and young people's experience can contribute benefit.

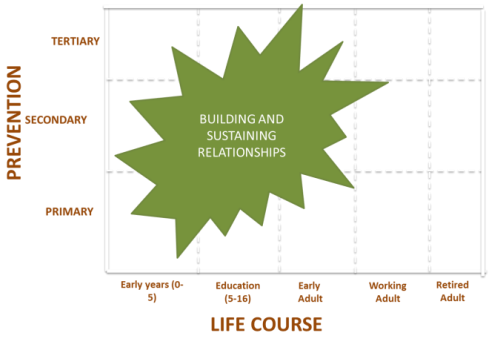
Addressing family poverty has the greatest impact in terms of actions to improve the health and wellbeing of current children, improving their prospects for adulthood and their children. This tertiary/secondary/primary preventative impact will have significant benefits. The adoption of inclusive growth[36] in economic development by Birmingham City Council will be an important step to addressing iniquitous economic disadvantage.



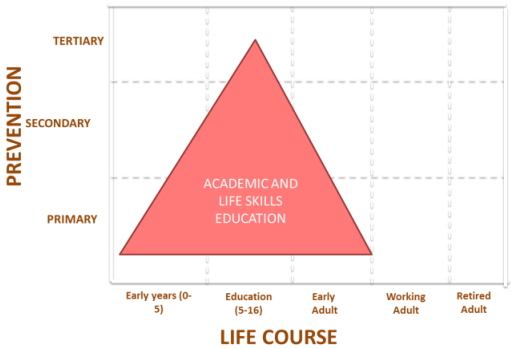
Relationships with adults and peers are the key to resilient young people and young adults.

Addressing the early attachment needs of babies and infants develops a sound platform for resilience and formation of other relationships at school and beyond.

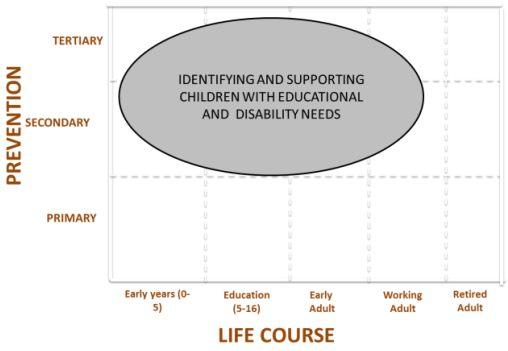
Organisational cultures, particularly schools, and service approaches that adopt and adapt to the lessons from the impact of adverse experiences in childhood will nurture and enhance this resilience.



Education must deliver an acquisition of knowledge that is then measured by educational achievement. However the greater challenge lies in the emotional and social skill education to develop a range of social skills, equipping for life as well as work.

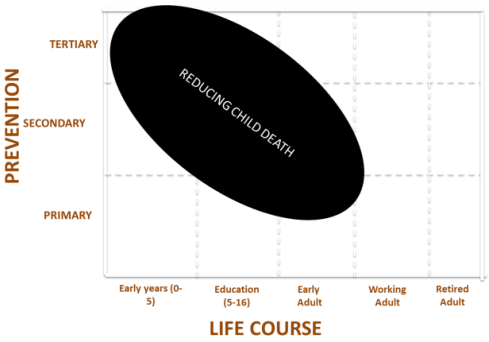


Disability of the physical body and the intellectual mind creates an additional barrier to the engagement and achievement of some infants, children, and young people. Early reliable assessment of the components of these conditions and the subsequent individual needs for support can reduce the barrier.



Death is an outcome that reduces any prospect of recordable achievement and can damage other family members' relationships and wellbeing.

The Birmingham Director of Public Health Annual Report (2018[33]) outlines the actions to reduce the likelihood of increasing death rates in infancy particularly.



This overview has addressed the wider and powerful influences on the health and wellbeing of Birmingham's children and young people. There are more focussed areas where a more detailed review of drivers and local needs would be useful. These include Children with Specials Educational Needs and Disabilities, Children In Need of care or protection, and the care of children in locality settings. Each of these will have a separate chapter to this overview as these analyses are completed and documented.

All of these analyses are intended to influence and shape strategic intentions in Birmingham.

Dr Dennis Wilkes MRCGP FFPH
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October 2018

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