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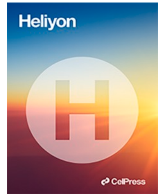

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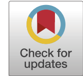

# Investigating child-facing practitioners' understanding of adversity and its impact on children's development and service provision

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ABSTRACT

Adversity during childhood is a common risk factor for poorer outcomes across physical, mental, and social health. Despite growing evidence and policy around preventing adversity and its sequalae, the incidence of adversity in childhood remains high. Child-facing practitioners (CfPs) may be well-placed to identify adversity and address its impact on children. This study investigated the understanding of adversity and current practice of CfPs working in the Education system, Healthcare and Social Care in England. An anonymous online survey was completed by 113 CfPs between April and June 2022. Data were analysed using descriptive statistics. Participating CfPs' reported using a range of assessment tools and direct observation, but there was a lack of consistency in the extent to which different types of adversity were explored in assessments. CfPs working in the Education system and Healthcare reported only liaising with Social Care services when a current worker was known to be involved with the family, or to make a referral. Indeed, a quarter of respondents from the Education system and Healthcare only considered early life experiences when capacity allowed. Over half of the CfPs in this survey 'did not know' or 'did not agree' that public services offer interventions to support families experiencing domestic abuse, parental mental health difficulties and addiction, or the impact of these adversities on children's wellbeing. The study highlights that CfPs could benefit from further training about the prevalence and impact of adversity to inform service delivery. A review of CfPs' routine assessments is needed to ensure that children's exposure to adversity is routinely identified; this will facilitate families to access appropriate support to mitigate the impact of such experiences.

## 1. Introduction

Research has identified that exposure to adverse childhood experiences (ACEs [1], which may include physical, sexual or emotional abuse, neglect, and familial factors such as parental ill health, separation or divorce, increases the risk of poorer outcomes across physical, mental and social health domains [2]. For example, adversity in childhood is associated with a higher risk of developing asthma, diabetes and obesity [3–6] as well as mental illness [7,8] and conduct disorders [9].

Unaddressed adversity in childhood is estimated to cost the UK £78·6 billion (2.8 % of GDP) [10]. The European average for

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prevalence of two or more ACEs was found to be 15.2 %, whereas in the UK the average number of people with two or more ACEs was 23.0 % [10]). Adversity is a dose-dependent risk factor for worse biopsychosocial outcomes throughout an individual's lifetime [11]. Children who experience significant adversity are reported to be less likely to be employed as adults and more likely to experience disability [12,13]. Therefore, preventing adversity during childhood has become a public and social health priority [14–16]. Screening for exposure to adverse experiences and providing appropriate interventions is likely to be an effective method to improve future population health and wellbeing [17]. However, a scoping review of screening for adversity during childhood concluded that this was dependent on staff knowledge, resources available and organisational support [18].

Child-facing practitioners (CfPs) work across many sectors, including Healthcare, the Education system, Social Care, and the Voluntary sector. CfPs could be well placed to identify adversity and address the aetiology and consequences of the adversity for children and families. A significant part of the role of CfPs is to screen, assess, respond to, and raise child safeguarding concerns. Although professionals may have concerns about the sensitive nature of screening for adversity, evidence suggests patients are receptive to enquiries about trauma [19] especially when given a rationale for these questions [20]. Furthermore a trusting relationship between professionals and patients/clients is important [19] and can facilitate more accurate reporting to screening questions about adversity [20]. Adolescents also emphasise the importance of a trusting relationship with a professional for routine ACE screening [21], although children may be reluctant to disclose abuse due to feelings of guilt, shame or fear of the implications for their family or that they will not be believed [22]. Research suggests that parents view screening for ACEs by paediatricians as an important bridge between Healthcare and access to other services to support their parenting goals [23] and that screening can facilitate onward referrals [24]. However, CfP professional development pathways may not include adequate training on adversity or the mechanisms of how adversity affects child outcomes [25–27].

Families experiencing abuse or neglect are recommended to access "early help" as outlined in NICE guidelines [28]; this includes practical and emotional support, as well as parenting programmes. The role of multi-agency working is highlighted in NICE and governmental guidance [29] yet professionals, children and families often navigate a complex system consisting of statutory bodies, the third sector, the Education system and Healthcare services in order to access the help they need. Childhood adversity and its sequalae continue to be inadequately addressed with obstacles including logistical and information-sharing barriers between services [30], a lack of staff knowledge [18], and time constraints [27]. Importantly, inadequate exchange of critical information between systems was present in 40 % of serious incident notifications in 2018/19 and has been consistently highlighted in numerous high-profile inquiries into child deaths [31]. Furthermore a recent report titled 'The multi-agency response to children and families who need help' [32] found that local resources are not consistently well understood or used by services themselves or the community. Therefore there is a current gap in our knowledge of professionals' understanding of adversity and their perceptions of how to address its impact. This information could help to identify the barriers to screening and, crucially, responding to adversity within child-facing services.

This study explored CfPs from Healthcare, Social Care, the Voluntary sector, and the Education systems' knowledge, understanding and practice around adversity.

This study aimed to investigate.

1) CfPs' understanding of adversity and its impact on child outcomes.
2) Assessments and tools to identify and address adversity.
3) Confidence in raising adversity with families and between professional bodies.
4) Perceptions of current systems and services available to support children and families experiencing adversity.

## 2. Methods

### 2.1. Participants

Participants were recruited via volunteer sampling. Organisations from Healthcare, Social Care, the Education system, and the Voluntary sector in England were contacted by email and requested to disseminate the survey to staff.

### 2.2. Procedures

The questions for an online survey were developed using the study aims and questions. In addition, questions 1–11 were informed by a national survey being conducted during the same time period by the Parent Infant Foundation which aimed to understand professionals' knowledge and views about early development, and the support available for children who have experienced trauma in their lives (https://docs.google.com/forms/d/e/1FAIpQLSdbKtgO48weJj45olj3jQ4vc-TJXFpZ6EPXljDc8a-PD_f_KA/closedform). Questions 12–15 have been previously used to evaluate professional's knowledge after completed a training event supplied by the Oxford Brain Story team (www.oxfordbrainstory.org). A draft list of survey questions was sent to 6 CfPs for suggested edits and additions, these were iteratively modified with a further 7 CfPs. The final set of 17 questions is presented in Table 1. The survey link was distributed by email from April 2022 to July 2022. Participants were presented with a participant information sheet before being asked to consent to take part in the survey. Participants then completed the 17 survey questions anonymously online. The survey was pragmatically closed when no more responses had been received for 2 weeks.

**Table 1**
Survey questions.

1) What area do you work in? (Given options: Early Years, Education system, Healthcare, SEN, Voluntary Sector, Social Care or other)
2) What is your job title?
3) Does your role include assessment/s of children and families?
4) If yes how? Please tick all that apply.
   A) Observations
   B) Specific assessment tools
   C) Direct questioning
5) Do your assessments include questions about child/caregiver relationship?
6) Do your assessments specifically ask about any of the following issues? Please tick all that apply.
   A) Developmental history (milestones)
   B) Abuse – sexual
   C) Abuse – emotional
   D) Abuse – physical
   E) Neglect – emotional
   F) Neglect – physical
   G) Whether a family member is depressed or has been diagnosed with other mental illness
   H) Whether a family member is addicted to alcohol or another substance
   I) Whether a family member is or has been in prison during child's lifetime
   J) Whether a child has witnessed domestic abuse in the household (verbal and/or physical)
   K) Significant family disruption e.g., parental acrimony/child's caregivers are separated, divorced or died
7) Do you contact children's Social Care as part of your assessment?
8) Do you think the following should be considered in assessments of children and families?
   A) Child/Caregiver relationship
   B) Early life experiences
   C) Developmental milestones
   D) Child/Family's involvement with Children's Social Care
9) I feel confident in my own understanding of the importance of parent's/caregiver's emotional/behavioural responses to their child/baby
10) I feel confident raising concerns with parents/caregivers about their emotional/behavioural responses to their child/baby
11) Do you agree with the following statements in your local area?
   A) Public services offer robust interventions to support families experiencing domestic abuse
   B) Public services support parents/caregivers on the impact of domestic abuse on their children's wellbeing now and in the future
   C) Public services offer robust interventions to support parents/caregivers experiencing mental health difficulties
   D) Public services support parents/caregivers on the impact of parental mental health difficulties on their children's wellbeing now and in the future
   E) Public services offer robust interventions to support parents/caregivers who are addicted to alcohol or other substances
   F) Public services support parents/caregivers on the impact of their addiction on their children's wellbeing now and in the future
   G) Public services work together to recognise and address the impact of parental difficulties on children's wellbeing now and in the future
12) Which of the following experiences during childhood could affect a child's wellbeing now and in the future. Please tick all that apply.
   A) Physical Abuse
   B) Sexual abuse
   C) Emotional abuse
   D) Living in a house with more than 7 siblings (distractor)
   E) Physical neglect
   F) Emotional neglect
   G) A family member who is depressed or diagnosed with other mental illness
   H) A family member who has an addiction
   I) Moving house 3 or more times (distractor)
   J) A family member who is in prison
   K) Witnessing domestic abuse in the household (verbal and/or physical)
   L) Significant family disruption -e.g., parental acrimony, child's parents/carer are separated, divorced, or died
13) At what stage of children's development do negative experiences influence the architecture of the developing brain? Please tick all that apply.
   A) In utero, when the brain is developing rapidly
   B) In infancy (0–2 years)
   C) In early childhood (3–5 years)
   D) In middle childhood (6–10 years)
   E) In early puberty (11–15 years)
   F) Late adolescence (16–24 years)
   G) I don't know
   H) No stage as it is completely dependent on child's genetics

Scored as correct: A, B, C, D, E, F
Scored as incorrect: G, H

14) Which aspect(s) of a child's development is/are most affected by negative experiences related to a child's health and well-being? Please tick all that apply.
   A) Emotional development
   B) Cognitive development
   C) Language development
   D) Auditory and visual development
   E) Gross motor skills development
   F) I don't know

Scored as correct: A, B, C, D
Scored as incorrect: E, F

15) An adult who has experienced a high number of difficult experiences during childhood is more likely to: Please tick all that apply.

(*continued on next page*)

**Table 1** (*continued*)

A) experience depression in adulthood
B) develop cardiovascular disease
C) develop an addictive disorder
D) develop Type 2 diabetes
E) struggle with planning and prioritising tasks
F) I don't know

Scored as correct: A, B, C, D, E
Scored as incorrect: F

16) Who do you think is responsible for sharing information with parents/caregivers about negative childhood experiences and their possible effect on their health and well-being? Please tick all that apply.
A) Health visitor
B) GP
C) Midwife
D) Paediatrician
E) Early Years CfPs e.g., Nursery CfPs
F) Social worker
G) Early Help Worker
H) Police
I) Teacher
J) SENCO
K) Speech and Language therapist
L) Communication and interaction Team
M) CAMHS
N) Adult Mental Health services
O) Adult Substance misuse services
P) Probation
Q) Housing
R) SEN officer
S) Family Nurse Partnership

Other – please comment

17) Understanding brain development in the Early Years is:
A) Useful in my role and I have had training
B) Is useful in my role and I have not had training
C) Not needed for my role

**Table 2**
Demographics of respondents.

| Education system | Job Title | n | Healthcare | Job Title | n | Social Care | Job Title | n |
|---|---|---|---|---|---|---|---|---|
| 25 % (n = 29) | Childminder | 8 | 46 % (n = 52) | CAMHS Clinical Psychologist | 3 | 28 % (n = 32) | Early Help Practitioner | 13 |
| | Nursery Worker | 5 | | CAMHS Children's Wellbeing Practitioner | 1 | | Family Support Worker Statutory | 6 |
| | Early years advisory teacher | 2 | | CAMHS Clinical Interface & transition Manager | 1 | | Social worker | 8 |
| | Early years manager | 4 | | CAMHS Occupational Therapist | 5 | | Employment, Education system and Training Caseworker | 2 |
| | Teaching Assistant | 1 | | Community Nurse | 6 | | Locality Worker Early Help | 3 |
| | Manager of Early years Special Education Needs (SEN) Team | 1 | | Physiotherapist | 2 | | | |
| | Assistant Head Teacher | 1 | | Health Visitor | 23 | | | |
| | Teacher | 3 | | Speech and Language therapist | 11 | | | |
| | Home School Link worker | 2 | | | | | | |
| | Emotional Literacy Support Assistant (ELSA)/Special Education systemal Needs Co-ordinator (SENCO)/Designated Safeguarding Lead | 1 | | | | | | |
| | Learner Engagement officer Elective Home Education system | 1 | | | | | | |

### 2.3. Data analysis

Data was collected via JISC online surveys and Excel was used to explore the data using descriptive statistics.

### 2.4. Ethics declarations

Participants were provided with information about the study and all provided written informed consent to participate in the study and for their data to be published. This study was reviewed and approved by University of Oxford Medical Sciences Interdivisional Research Ethics Committee (MS IDREC) with approval number: R76880/RE001, dated August 5, 2021.

## 3. Results

A total of 120 responses were received. Data are reported for 113 respondents; data from participants working in Voluntary or 'other' services were removed due to small representation from these groups (n = 7). Most respondents were from Healthcare (46 %) followed by Social Care (28 %) and the Education system (including the early years sector) (25 %) (Table 2).

### 3.1. Assessments of children and families

Ninety percent of respondents (n = 102) reported using assessments with children and families in their role. Of these respondents, the majority (87 %; n = 89) reported using a 'specific assessment tool', with 85 % (n = 87) also reporting they used 'direct questioning' and 'observation' within their assessments. The remaining 13 % (n = 13) reported using 'observation' and 'direct questioning' rather than a 'specific assessment tool' in their work.

Investigation of the areas explored in their assessments with families found that 82 % (n = 84) included questions about the child/caregiver relationship. Most respondents from the Education system, Healthcare, and Social Care reported that they only asked about emotional and physical neglect 'when appropriate' (Education system 86 %, Healthcare 59 % and Social Care 63 %) (Fig. 1); over a third (n = 50) of Healthcare respondents reported that they 'never' or 'sometimes' asked about neglect in assessments.

Most respondents (Education system 89 %, Healthcare 56 % and Social Care 66 %) reported asking about sexual/emotional/physical abuse in assessments 'when appropriate', with over 20 % of Healthcare reporting they 'never' ask about emotional abuse and 20 % stating they 'never' ask about physical abuse. Social Care professionals were more likely to 'always' ask about any type of abuse (physical abuse 14 %, emotional abuse 15 %, sexual abuse 11 %) compared to those working in Healthcare or the Education system (Fig. 2).

Respondents' answers to other issues discussed in their assessments are presented in Table 3. CfPs in the Education system most frequently reported that they asked about these issues 'when appropriate'. This was a similar finding for CfPs working in Healthcare, although a third of Healthcare CfPs 'always' ask about a family history of mental illness. Over a third of CfPs in the Education system and Healthcare reported that they 'never' ask about whether a family member is, or has been, in prison. Over 40 % of respondents working in Social Care reported that they 'always' ask about family history of mental illness (48 %), family addiction (41 %) and

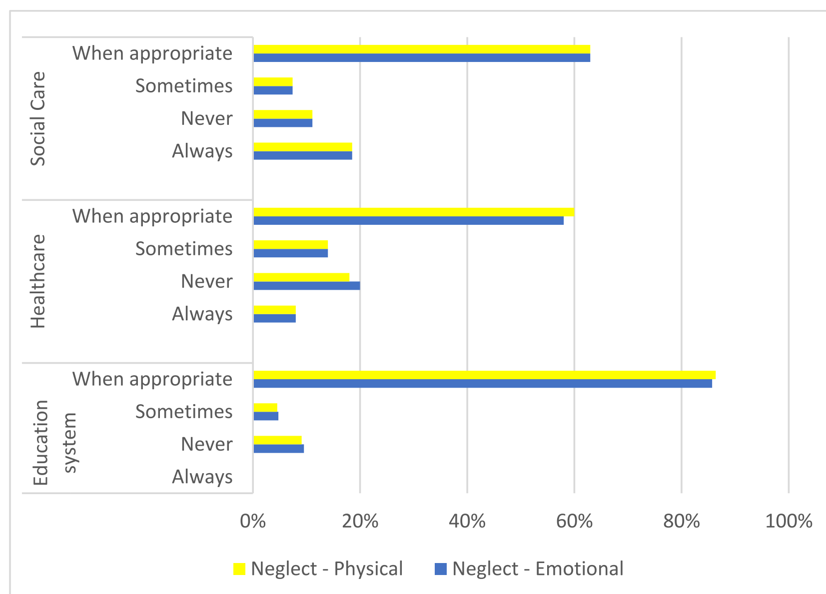


**Fig. 1.** Current practice identifying neglect (emotional and physical) within CfPs' assessments.

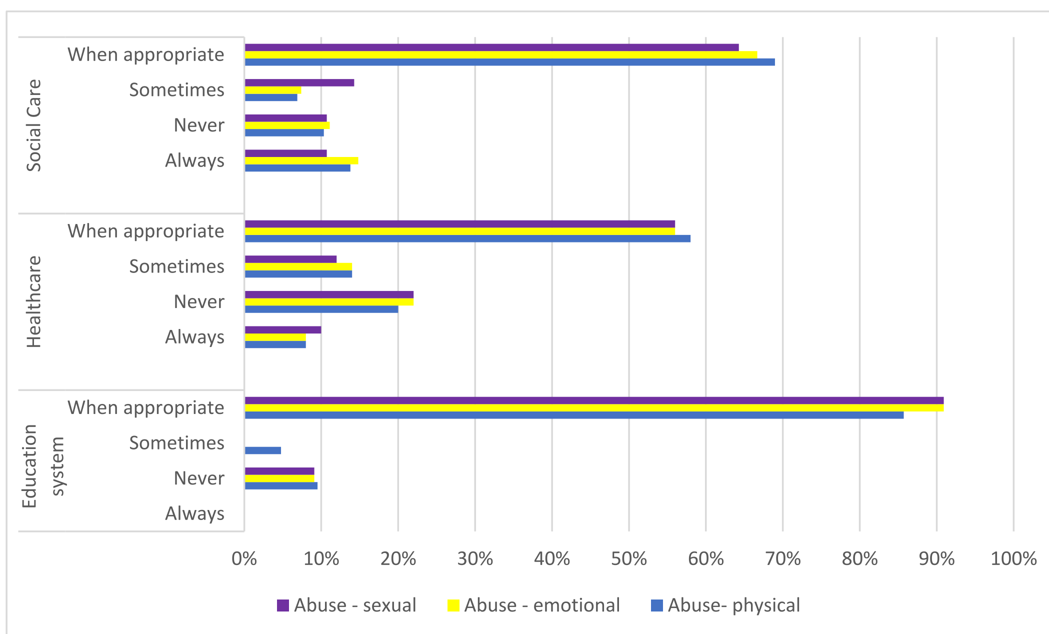


**Fig. 2.** Current practice identifying abuse (sexual, emotional, physical) within CfPs' assessments.

significant family disruption (55 %). Respondents from Social Care reported that they ask 'when appropriate' about domestic abuse in the household (69 %) and if a family member is in prison (86 %).

Respondents working in the Education system and Healthcare were asked about their routine practice regarding liaison with children's Social Care during assessments. This was not part of any respondents' routine practice, with data indicating respondents contacted Social Care to 'make a referral' (Education system 82 %, Healthcare 72 %) or to talk to a child's or family's current social worker (Education system 14 %, Healthcare 26 %) (Table 4).

Preliminary analysis for question 8 (Fig. 3) indicated a consistent pattern of responses across the sub questions. These results were therefore summarised to create a mean score for brevity. Respondents consistently reported that assessments should consider the child/caregiver relationship, early life experiences, and the child or family's involvement with children's Social Care; over 70 % of all respondents reported these should 'always' be considered (Fig. 3). Twenty-five per cent of CfPs in the Education system and 21 % in Healthcare reported that these areas would only be considered when capacity allowed (Fig. 3).

Respondents were asked for their perspectives of the public services supporting families regarding domestic abuse (Fig. 4a), parent/caregivers' mental health (Fig. 5a) and parent/caregivers' substance addiction (Fig. 6a). Respondents were asked whether they agreed these services a) offer robust interventions to support families with these challenges and b) help families understand the impact of these adversities on their children (Figs. 4b, 5b and 6b).

### *3.1.1. Domestic abuse*

Over half of respondents working in the Education system (58 %) and Healthcare (55 %) reported that they either 'didn't know' or 'disagreed' that 'public services *offer* robust interventions for families experiencing domestic abuse' (Fig. 4a). Similar response patterns were also given regarding 'services that support parents on the *impact* of domestic abuse on their children's wellbeing now and in the future' (Fig. 4b). Over half of respondents from Social Care (57 %) 'agreed' that 'public services *offer* robust interventions for families experiencing domestic abuse' (Fig. 4a), but only 44 % of Social Care respondents 'agreed' that 'services support parents on the *impact* of domestic abuse on their children's wellbeing now and in the future' (Fig. 4b).

### *3.1.2. Parental mental health difficulties*

Fig. 5a shows that over 70 % of respondents from the Education system (75 %) and Social Care (74 %) either 'don't know' or 'disagreed' that 'public services *offer* robust interventions to support parents/caregivers experiencing mental health difficulties', with a similar pattern of responses regarding 'public services support families on the *impact* of mental health on children's wellbeing now and in the future' (Education system 68 %; Social Care 78 %) (Fig. 5b). A small minority (3 %) of respondents from Social Care indicated that they 'did not know' about service provision, with 70 % 'disagreeing' that 'public services were *offer* robust interventions to support parents/caregivers experiencing mental health difficulties' (Fig. 5a). Respondents from Healthcare 'agreed' that 'public services *offer* robust interventions to support parents/caregivers experiencing mental health difficulties' (44 %), although only 34 % agreed that 'public services support families on the *impact* of mental health on children's wellbeing now and in the future' (Fig. 5b).

**Table 3**
Current practice identifying parental mental illness, substance misuse, prison, domestic abuse, and significant family disruption e.g., parental acrimony, divorce/died within CfPs' assessments.

| | Education system n = 22 | | | | Healthcare n = 50 | | | | Social Care n = 29 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Question: Do your assessments specifically ask about any of the following issues? | Always | Sometimes | When appropriate | Never | Always | Sometimes | When appropriate | Never | Always | Sometimes | When appropriate | Never |
| Whether a family member is depressed or has been diagnosed with other mental illness | 9 % | 9 % | 68 % | 14 % | 34 % | 14 % | 36 % | 16 % | 48 % | 17 % | 34 % | 3 % |
| Whether a family member is addicted to alcohol or another substance | 9 % | 9 % | 68 % | 14 % | 12 % | 24 % | 44 % | 20 % | 41 % | 10 % | 45 % | 3 % |
| Whether a family member is or has been in prison during child's lifetime | 0 % | 9 % | 55 % | 36 % | 4 % | 14 % | 48 % | 34 % | 0 % | 7 % | 86 % | 7 % |
| Whether a child has witnessed domestic abuse in the household (verbal and/or physical) | 5 % | 14 % | 64 % | 18 % | 4 % | 20 % | 52 % | 24 % | 17 % | 14 % | 69 % | 3 % |
| Significant family disruption e.g., parental acrimony/ child's caregivers are separated, divorced or died | 23 % | 14 % | 59 % | 5 % | 8 % | 34 % | 48 % | 10 % | 55 % | 0 % | 31 % | 14 % |

**Table 4**
Routine practice of CfPs in the Education system and Healthcare regarding contact with children's Social Care.

| Do you contact children's Social Care as part of your assessment? | | | | |
|---|---|---|---|---|
| Service | No - never | Yes - always | Yes - if I needed to make a referral | Yes - only if they have a current worker |
| Education system n = 22 | 5 % | 0 % | 82 % | 14 % |
| Healthcare n = 50 | 2 % | 0 % | 72 % | 26 % |

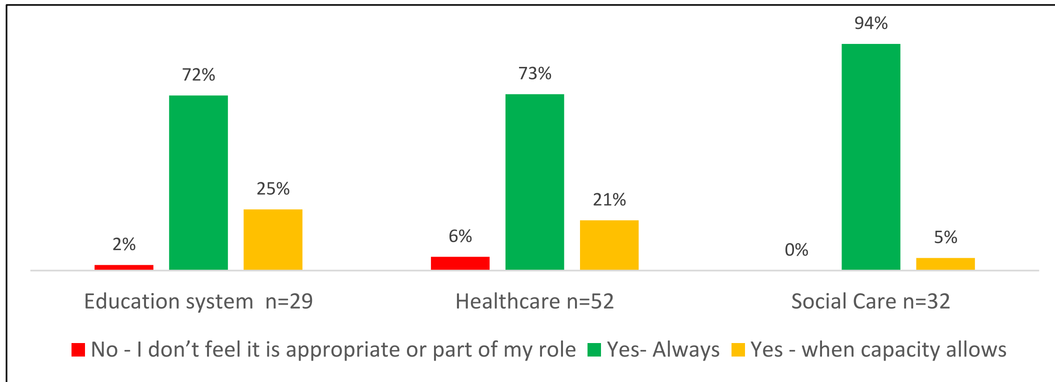


**Fig. 3.** Current practice regarding inclusion of child/caregiver relationships, early life experiences and Social Care involvement in assessment of children and families.

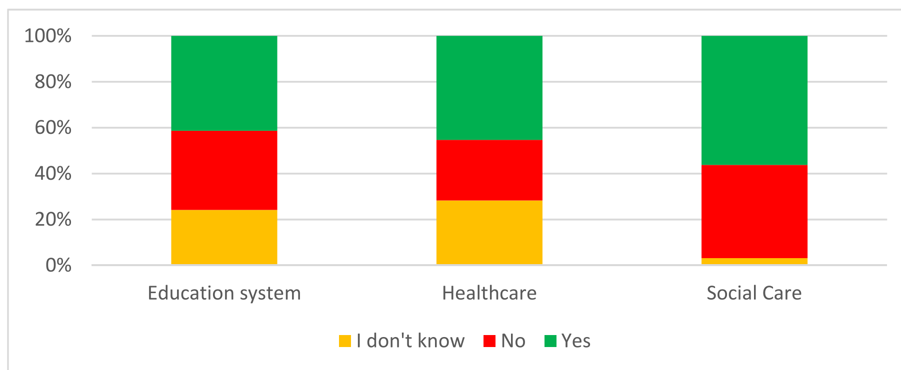


**Fig. 4a.** Beliefs about whether public services offer robust interventions for families experiencing domestic abuse (n = 113).

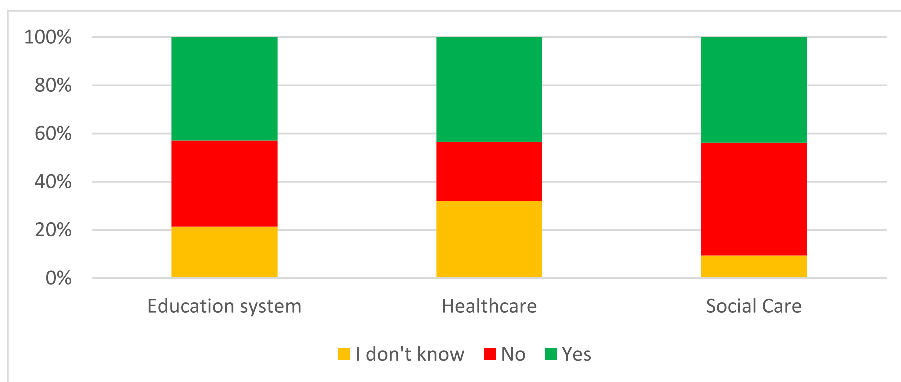


**Fig. 4b.** Beliefs about whether public services support parents/caregivers on the impact of domestic abuse on their children's wellbeing now and in the future (n = 113).

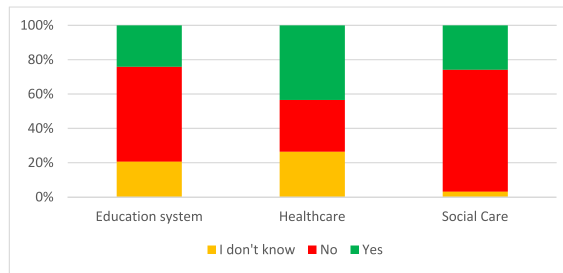


**Fig. 5a.** Beliefs about whether public services offer robust interventions to support parents/caregivers experiencing mental health difficulties (n = 113).

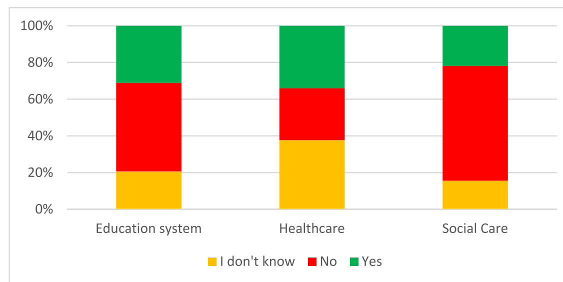


**Fig. 5b.** Beliefs about whether public services support parents/caregivers on the impact of parental mental health difficulties on their children's wellbeing now and in the future (n = 113).

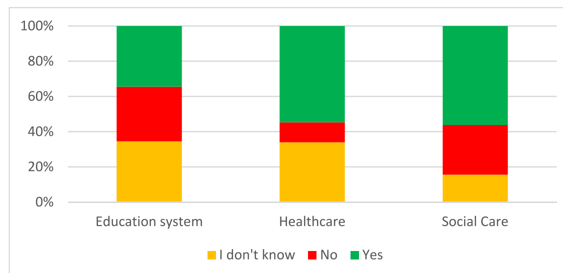


**Fig. 6a.** Beliefs about whether public services offer robust interventions to support parents/caregivers who are addicted to alcohol or other substances (n = 113).

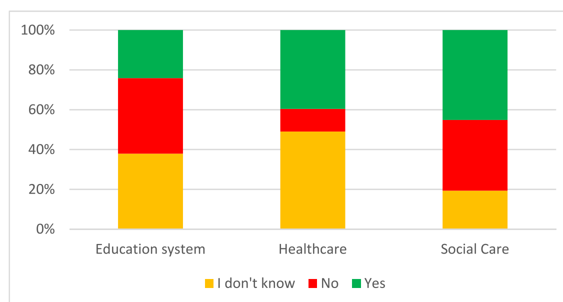


**Fig. 6b.** Belief about whether public services support parents/caregivers on the impact of their addiction on their children's wellbeing now and in the future (n = 113).

### *3.1.3. Addiction*

Over 60 % of respondents from the Education system 'did not know' or 'disagreed' that 'public services *offer* robust interventions to support parents/caregivers who are addicted to alcohol or other substances' (Fig. 6a); this was lower for participants working in

Healthcare and Social Care, although over 40 % reported they 'did not know' or 'disagreed' that 'public services *offer* robust interventions to support parents/caregivers who are addicted to alcohol or other substances' (Fig. 6a). Across all of the sectors (Education system, Healthcare and Social Care) professionals gave similar responses about interventions relating to the *impact* of parental addiction on children's wellbeing, with over half reporting that they 'did not know' or 'disagreed' that 'public services support parents/caregivers on the impact of their addiction on their children's wellbeing now and in the future' (Education system 75 %, Healthcare 62 %; Social Care 55 %, Fig. 6b).

Participants were asked if they agreed that 'public services work together to recognise and address the impact of parental difficulties on children's wellbeing now and in the future'. A higher proportion of respondents from Health (60 %) and Social Care (56 %) 'agreed' that 'services work together' compared to only 34 % of respondents from the Education system.

### 3.2. Child-facing practitioner's knowledge and confidence

Respondents were asked about their own confidence in *understanding* the importance of the caregiver's emotional or behavioural responses to their child. They were also asked about their confidence in *raising concerns* with caregivers about caregiver responses to their child (Fig. 7).

Participants in all sectors felt confident in both their *understanding* (range 66–97 %) and in *raising concerns* (72–97 %). However, 29 % of CfPs in Healthcare and 20 % in the Education system either 'disagreed', 'felt this was not part of their role' or 'did not know' if they felt confident to *raise concerns* about caregiver's emotional or behavioural responses to their child (Fig. 7).

To explore participants' understanding of adversity, respondents were asked to select the childhood experiences which they thought could affect a child's wellbeing now and in the future. Only 6 % of respondents chose all the correct experiences (response options included 10 ACEs plus distractor items). Sixty-five per cent of all respondents did **not** correctly identify 'physical neglect' and 29 % did **not** correctly identify that 'having a family member who is in prison' could affect a child's wellbeing. Overall, 75 % wrongly selected 'having 7 siblings' or 'moving house 3 or more times' which were included in the list as distractor items.

Sixty per cent of respondents correctly identified the stage of children's development when negative experiences influence the architecture of the developing brain. Respondents were also asked 'which aspect(s) of a child's development is/are most affected by negative experiences related to a child's health and well-being?' with less than 34 % of all respondents providing a correct answer (Table 5).

In response to the question 'An adult who has experienced a high number of difficult experiences during childhood is more likely to ….?' over half of Healthcare CfPs answered this correctly (51 %) compared with CfPs in the Education system and Social Care who gave fewer correct responses (14 % and 22 % respectively) (Table 6).

Over 60 % of all respondents 'agreed' that 'understanding brain development of the early years is useful for my role'. However, a proportion across all sectors agreed that it was 'useful for my role but I have not had training' (Education system 38 %, Healthcare 19 %, Social Care 25 %) (Fig. 8). Respondents (n = 113) also indicated that **all** CfPs across the Education system, Healthcare and Social Care have a responsibility for sharing information with parents/caregivers about negative childhood experiences and their possible effect on health and wellbeing. Of professions identified, health visitors were selected in 81 % of responses, with social workers (79 %), GPs (78 %), CAMHS (74 %), paediatricians (73 %) and teachers (55 %) the other most frequently-endorsed professional groups.

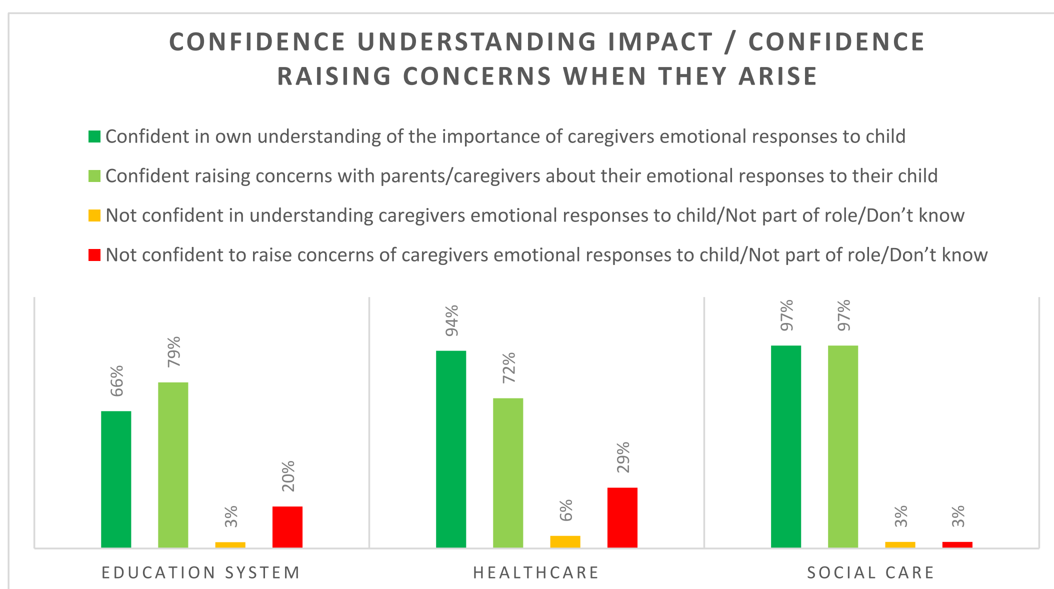


**Fig. 7.** CfPs' knowledge and confidence of understanding the impact of adversity and raising concerns about it when it arises with caregivers.

**Table 5**
CfPs' responses to which aspect(s) of a child's development is/are most affected by negative experiences related to a child's health and well-being.

| | % Answered correctly |
|---|---|
| Education system (n = 29) | 34 % |
| Healthcare (n = 52) | 32 % |
| Social Care (n = 32) | 13 % |

**Table 6**
CfPs' responses about the outcomes for adults experiencing a higher number of difficult experiences in childhood.

| | Overall % answered correctly | Experience depression in adulthood | Develop cardiovascular disease | Develop an addictive disorder | Develop type 2 diabetes | Struggle with planning and prioritising tasks |
|---|---|---|---|---|---|---|
| Education system (n = 29) | 14 % | 28 (96 %) | 9 (31 %) | 24 (82 %) | 8 (27 %) | 17 (58 %) |
| Healthcare (n = 52) | 51 % | 52 (98 %) | 34 (64 %) | 49 (92 %) | 30 (56 %) | 49 (94 %) |
| Social Care (n = 32) | 22 % | 29 (91 %) | 10 (31 %) | 24 (75 %) | 8 (25 %) | 20 (63 %) |

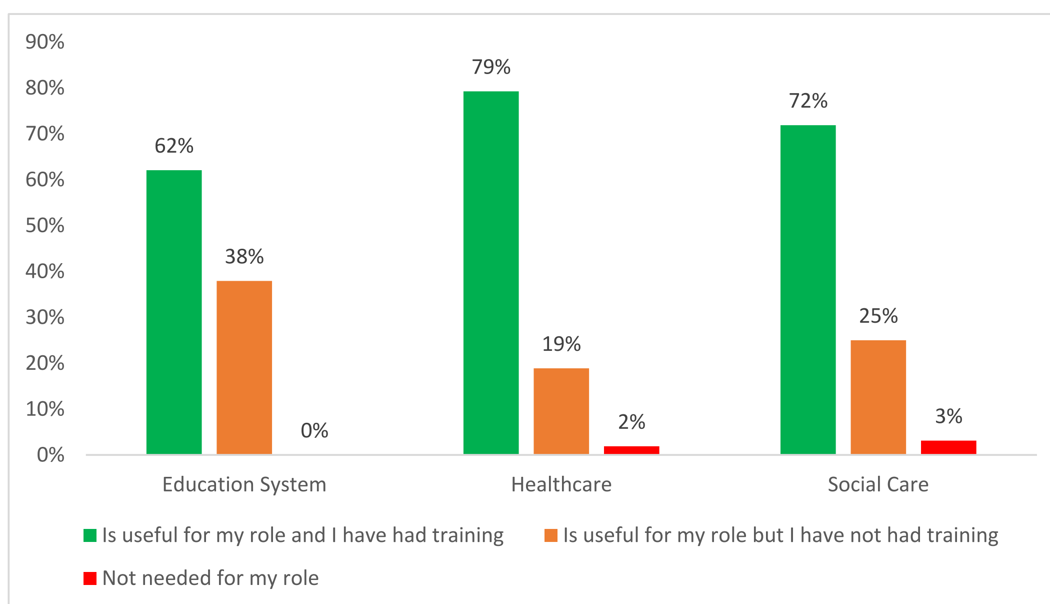


**Fig. 8.** CfPs' responses about whether understanding brain development is useful in their professional role.

## 4. Discussion

One hundred and thirteen CfPs from the Education system, Healthcare and Social Care completed an online anonymous survey. The results revealed a lack of consistency in respondents' routine inquiries about different types of adversity that children may have experienced. CfPs from the Education system and Healthcare reported that they only contacted Social Care to make a referral rather than proactively investigating if children had a documented history of exposure to adversity. Respondents did not feel there were local services to support parents/caregivers about the impact of parental mental illness, domestic abuse or parental addiction on children. Less than half (range 14–50 %) of CfPs correctly identified the impact of ACEs on long term outcomes, with 19–38 % declaring a gap in their training about brain development, despite viewing this topic as useful for their role.

### *4.1. Assessments*

Research consistently demonstrates that children exposed to adversity such as neglect, abuse, parental substance addiction and parental incarceration have poorer outcomes across their life span [2,33–38]. Adversity continues to be prevalent, for example 1 in 25

people experienced domestic abuse in the year ending March 2023 [39].

Across the UK CfPs may have multiple opportunities to identify adversity as part of their routine assessment process; these include health visitors' universal assessments, early years staff assessments via unstructured direct observation and more targeted assessments of children presenting with a need, such as in social work assessments, psychological and medical assessments [25,40–44]. However, this study found that most respondents **do not** routinely ask about adversity across multiple domains in their assessments (Figs. 1 and 2, Table 3). Overall respondents appeared more likely to ask about adversity that related to their sector, for example 34 % of respondents from Healthcare reported they routinely inquire about familial mental illness, in contrast to a much smaller number who would ask about a family member being in prison (4 %), or domestic abuse present in the home (7 %). A third of Healthcare respondents reported they 'never' or 'sometimes' ask about neglect or abuse in assessments, despite these adversities being significant indicators for poorer child health outcomes [45,46].

Our findings are consistent with previous research which demonstrated that 32 % of paediatricians report 'never' asking about ACEs [47]. Importantly, respondents from the Education system and Social Care in our study reported similar variation in their practice around assessment of adversity. Many respondents from all sectors reported inquiring about aspects of adversity 'when appropriate', suggesting that these decisions are made based on the individual judgement of practitioners; this may risk introducing conscious and unconscious bias into what questions are asked, and to whom [48–50]. This variation in practice suggests missed opportunities to discuss familial adversity in a timely way so that appropriate support can be explored to prevent the impact on children's later development and health outcomes.

The NICE guidance for Early Help Assessment stresses the importance of both observation and consideration of the child in the context of their family environment and key caregivers. The UK 2021 Green paper [51] emphasises the importance of joint working between the NHS and local authorities (responsible for the Education system and Social Care) to plan and deliver services. It states that "a good local prevention approach includes universal early identification of need for extra support." Improving the consistency of comprehensive assessment of adversity by CfPs could be achieved through utilisation of The Early Help Assessment, a tool specifically designed to identify emerging concern and share information with partner agencies [52]. However, the ADCS (Association of Directors of Children's Services) in 2018 reported "a landscape of 'early help players' who 'may or may not see themselves as being part of the early help system locally'" [53]. Furthermore, a thematic inspection of local authorities [54], noted the inadequacy of current statutory powers to make clear the roles and responsibilities of different agencies involved in the early identification of need. This is consistent with the reported perceptions of CfPs in our study, with over 40 % reporting that public services do not work together. It is therefore essential to seek clarity across services and professional groups about their perceived roles and responsibilities for early help. This is necessary in order to achieve and adhere to Working together to Safeguard Children 2023 [55] which highlights the need for multi-agency working and shared practice when working with parents and carers, as well as stronger expectations around CfPs delivering early help to address children and families' unmet need.

### 4.2. *Perception of services available*

Parental domestic abuse, parental mental health difficulties and parental addiction are recognised as potential sources of adversity for children, but services are often organised around the identified adult who is experiencing these challenges. It is striking that many respondents in our study (who were all working in a child-facing role) 'did not know' or 'disagreed' that public services were providing robust interventions for parents experiencing mental health difficulties, domestic abuse, or addiction (Figs. 4–6). Notably, most respondents from Social Care 'disagreed' that public services offer mental health interventions to support parents/caregivers. Triangulation of this finding with adult mental Healthcare providers was outside of the scope of this study, so it is unclear whether the perception of Social Care respondents reflects the overwhelming demand on services, or the need for better liaison and communication between Health and Social Care to facilitate access to adult mental Healthcare. This finding may reflect previous research and data which highlights pressures on mental Healthcare services [56,57]. Better implementation of co-ordinated early intervention support could ensure CfPs have increased communication and better working relationships with colleagues from different agencies and those working in adult-facing services.

Domestic abuse continues to be prevalent in the UK [33] with a growing body of evidence regarding the negative impact of witnessing domestic abuse on children [58]. It is therefore of note that over 40 % of CfPs across all sectors (range 43 %–58 %) either 'disagreed' that there were robust interventions for families experiencing domestic abuse, or 'did not know'. Almost 60 % also 'did not agree' or 'did not know' if services support parents/caregivers on the *impact* of domestic abuse on their children (Fig. 4a and b). Whilst these perceptions were not triangulated with care providers, the results suggest that current interventions may not be sufficiently responding to the *impact* of domestic abuse on children, or that the accessibility of domestic abuse services needs to be enhanced.

With regards to services offering support for addiction and the impact on children within affected families, there were different perceptions between respondents from Social Care and CfPs working in Healthcare and the Education system (Fig. 6a and b). Most Social Care respondents agreed that there were robust interventions for parents/caregivers experiencing substance addictions and support for parents/caregivers on the *impact* of substance addictions on children's wellbeing (in contrast to respondents from the Education system and Healthcare). These differences may reflect better professional links between substance misuse services and Social Care professionals, as adult substance misuse workers are often based within the Social Care team and contributing to a statutory Social Care plan.

### 4.3. Capacity and liaison between services

Over 70 % of all respondents 'agreed' that assessments should consider the child/caregiver relationship, early life experiences, and child or family involvement with children's Social Care (Fig. 3). However, responses from CfPs working in the Education system and Healthcare indicated that questions about substance misuse, family incarceration and domestic abuse are not consistently included in their assessments (Table 3) and over 20 % of CfPs in Healthcare and the Education system reported they would only ask if capacity allowed.

Over 70 % of these respondents reported only contacting Social Care to make referrals or if the child had a current worker (Table 2). This could risk assessments missing important information about previous safeguarding referrals, statutory child and family assessments and details of children on a Child in Need or Child Protection plan (Sec 17/Sec47) which are held on children's Social Care records. Gathering information from other agencies could facilitate comprehensive management plans and implementation of prevention strategies [24]. Sharing information appropriately across the Education system, Healthcare and Social Care may maximise the existing capacity of services by reducing the duplication of assessments [59] and promote CfPs' ability to develop a holistic picture of a child's lived-experience and understand the impact of such expereinces on their current functioning.

### 4.4. Knowledge of adversity and neurodevelopment

Tackling adversity requires professionals to have both an understanding of adversity and the confidence to raise their concerns with a child's parent(s) or caregiver(s) so that appropriate support can be initiated. Barriers for professionals in talking about adversity have been documented and include a lack of confidence, resources, and skills for follow-up support for those affected as well as insufficient time in consultations [27,60]. Evidence indicates that training on ACEs can increase health visitors', midwives' and wellbeing navigators' confidence and acceptability of ACEs screening [19,61,62].

Most CfPs felt 'confident' in their understanding of the importance of caregivers' emotional and behavioural responses to their child (Fig. 7). However 20 % of respondents from the Education system and 29 % from Healthcare did not feel confident to raise concerns with caregivers about their responses to their child. This indicates a need for specific support or training for CfPs working in these sectors in order to facilitate the sharing of concerns with families and enable access to appropriate services. These findings are consistent with previous research [63–66].

Over 60 % of professionals reported that they had 'had training' about understanding brain development (Fig. 8) however this was not reflected in the knowledge-based questions, with only a minority of respondents correctly answering questions about the impact of adversity across the life span or on child development (Tables 3 and 4). These results suggest that CfPs may benefit from additional training in neurodevelopment and the importance of a child's social environment in the early years.

Studies have shown that parental disclosure of ACEs leads to an increase in referrals to support services for families [24,67] and parental disclosure of infant's ACEs to health visitors facilitated access to enhanced or intensive support for childcare [62]. Importantly parents also reported that it was acceptable to provide health visitors with information about parental ACEs [62]. In a recent study professionals who were given training and asked to routinely ask about ACEs stated that it helped families understand their current situations in relation to past experiences and empowered individuals to increase their sense of autonomy over making change, as well as making further referrals for support [67]. If questions about social issues are deemed to be too timely or difficult it can leave family issues unaddressed, potentially leading to further cost and requiring more resources later in the child's life.

### 4.5. Strengths

This study explored CfPs' knowledge and experience of working with adversity across the Education system, Healthcare and Social Care which allowed consideration of differences in practice between sectors, as well as common barriers to screening and managing adversity.

### 4.6. Limitations

A volunteer sample was used so respondents may not be representative of the wider workforce across the Education system, Healthcare and Social Care. This study did not explore how adversity relating to racial discrimination, food scarcity or community violence was assessed by CfPs. There was also insufficient exploration of any problems related to interaction with authoritarian parents who minimise the existence of problems in their family system or the impact of fear on children's disclosure of adverse experiences.

## 5. Conclusion

Exploring CfPs' routine practice, knowledge, and perceptions of available services surrounding adversity found that there was no consistent and comprehensive approach for identifying adversity by professionals working in the Healthcare, Social Care and the Education system. Given the profound public health implications of adversity, the Healthcare sector (including universal primary care providers e.g., Health visitor/General Practitioner/Midwife) play an important role in addressing adversity [25]. Future research could examine how best to implement interdisciplinary collaboration, including ethical considerations regarding enhanced data sharing, as well as how screening for adversity can feed into long-term follow-up for specific families.

The results identified gaps in CfPs' knowledge about adversity with most CfPs unable to correctly identify all of the statements

regarding the effects of adversity on child development. This must be addressed in training curricula to enhance practitioners' confidence to raise this with families. Increasing investment in training and infrastructure around adversity is necessary to fulfil public health goals.

Respondents demonstrated uncertainty about services available to mitigate sources of adversity within the family. Closer liaison between professionals working in different sectors and across child and adult facing services could resolve this. Mapping services against evidence of family need might be required to ensure the right services are available to families to ensure adversity is supported at the earliest touch point.

## CRediT authorship contribution statement

**Emily Smout:** Writing – review & editing, Writing – original draft, Software, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Hadassah Buechner:** Writing – review & editing, Writing – original draft, Supervision, Methodology, Investigation, Formal analysis. **Rosie Lynch:** Visualization, Methodology, Investigation, Data curation. **Louise Dalton:** Writing – review & editing, Validation, Supervision, Software, Resources, Project administration, Methodology, Investigation, Data curation, Conceptualization. **Elizabeth Rapa:** Writing – review & editing, Validation, Supervision, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

## Ethics declarations

Participants were provided with information about the study and all provided written informed consent to participate in the study and for their data to be published. This study was reviewed and approved by University of Oxford Medical Sciences Interdivisional Research Ethics Committee (MS IDREC) with approval number: R76880/RE001, dated August 5, 2021.

## Data availability statement

Data is available upon reasonable request from the corresponding author.

## Declaration of competing interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests:

Emily Smout reports financial support was provided by National Institute for Health and Care Research Applied Research Collaboration Oxford and Thames Valley. Elizabeth Rapa reports financial support was provided by Palix Foundation. Louise Dalton reports financial support was provided by Palix Foundation. If there are other authors, they declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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