THE GP'S ROLE IN RESPONDING TO CHILD MALTREATMENT: TIME FOR A RETHINK?

An overview of policy, practice and research

NSPCC
Cruelty to children must stop. FULL STOP.

RCGP | Royal College of General Practitioners

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Key messages for GPs, partner agencies and policy-makers

GPs should:

- Recognise that they can contribute to a public health approach to child maltreatment through directly responding to families as well as participating in the statutory child protection system.
- Use core skills of general practice to facilitate and enact direct responses to families with maltreatment-related concerns, including:
  - developing and maintaining a strong doctor-parent and doctor-child relationship.
  - monitoring, coaching and advocating for families and providing opportune healthcare to children and parents.
- Work sensitively to support parents caring for children and to encourage engagement with primary care and at the same time take action to keep children safe.

GP practices should:

- Have structures, such as regular primary care team meetings, to oversee direct responses by the primary care team and guide GPs' participation in the statutory child protection system, including proactive and reactive information sharing.

Partner agencies* should:

- Recognise that GPs can respond directly to families who prompt concerns about child maltreatment through the doctor-parent and child relationship and through monitoring, coaching and advocating for families and providing opportune healthcare.
- Consider the relevance of GPs' responsibility for family health care when responding to maltreatment-related concerns.
- Support a public health approach to child maltreatment by facilitating GPs use of direct responses.
- Promote the flow of meaningful information to and from the GP.

*Such as children's social care, youth offending teams, and schools.

Policy makers should recognise that:

- Some GPs use their core skills to respond directly to families who prompt professional concerns about child maltreatment. Direct responses use skills such as monitoring, coaching, advocating and providing opportune healthcare.
- Facilitating direct responses to child maltreatment through policy will build on GPs' existing practice and core skills and promote their contribution to a public health (or preventive) approach to child maltreatment.
- Direct responses can be enacted through parents and other family members as well as their children and are likely to depend on maintaining a therapeutic relationship with parents and children and a strong doctor-family relationship.
- Direct responses can occur before, during or after referral to children's social care or early help services and in addition to GPs' contribution to statutory child protection procedures.
- Research is needed to determine the potential benefits and harms of wider use of direct responses in general practice in the UK.

Executive summary

1. Background

A public health approach

There are increasing calls for a public health approach to child maltreatment. A public health approach prioritises prevention and early intervention. Within healthcare services, opportunities for a public health approach are located in the contact between professionals and children or their parents or carers and are likely to be characterised by identifying and responding to parental risk factors for maltreatment and harmful parent-child interaction.

Defining the spectrum as 'maltreatment-related' concerns

This report focusses on the role of GPs for marginally maltreated children (in the grey area around the threshold for defining 'maltreatment') as well as for children whose experiences can obviously and definitively be labelled as maltreatment. We use the term 'maltreatment-related concern' to capture the full range of professional concern which is relevant to child maltreatment.

2. Structure and methods

This overview of policy, practice and research was based on a series of literature and policy reviews and answered five questions:

- Chapter 3: Why focus on GPs?
- Chapter 4: How far does policy and practice guidance support GPs' direct responses to families?
- Chapter 5: What do we know from research and practice about direct responses to maltreatment-related concerns by GPs?
- Chapter 6: What do we know about how parents, young people, adolescents and children view the doctor-patient relationship in general practice?
- Chapter 7: What is the way forward?

3. Q: Why focus on GPs?

Key findings:

- Our overview of policy and relevant research support the argument that GP practices are a first and on-going point of contact for families. GPs have a view of family health needs over the life course, opportunities for building therapeutic relationships with families and are holders of the primary healthcare records which can act as an information repository about a family.
- GPs might be particularly well-placed to identify and respond to problems relating to child neglect and emotional abuse.
- GPs' contact with families, which is often repeated over time, provides opportunity for direct responses to maltreatment-related concerns which might include on-going support and monitoring of children and wider family members.
- Direct responses could occur in tandem with GPs' participation in child protection systems and/or alongside services provided by other agencies, including children's social care.

Implication:

- Because general practice is a universal service which can take a longitudinal view of families, GPs are well-placed to enact direct responses to the children and families they see as well as participate in existing systems to safeguard and protect children.

4. Q: How far does policy and practice guidance support GPs' direct responses to families?

Key findings:

- We reviewed 109 policy documents and ten pieces of national practice guidance relevant to the four UK countries.
- Overall, government policy and practice guidance were heavily weighted towards recognition of maltreatment by GPs with GPs' responsibilities largely seen as assessment, inter-agency working and the implementation of organisational structures and/or audit.

- Policy and practice guidance indicated some expectation that GPs should monitor children with maltreatment-related concerns who are both above and below the threshold for intervention from children's social care. This expectation was more evident in practice guidance than national policy.

- Beneath explicit policy messages that all professionals must take responsibility for child safeguarding, there was a persistent sub-text which envisaged the GP's role as (primarily) 'identify and refer'. Exceptions were 'early help' policies which emphasised that GPs could take on a lead professional role for children below the threshold for services from children's social care. However, the GPs' role in 'early help' was not well-defined and there remained tension between the responsibility to 'identify and refer' and expectations that GPs should offer direct support to families.

Implication:

- Government policy and practice guidance could do more to promote GPs' contribution to a public health approach to child maltreatment through developing direct responses as part of family healthcare.

5. Q: What do we know from research and practice about direct responses to maltreatment-related concerns by GPs?

Key findings:

- We included four directly relevant research studies, three randomised controlled trials and two systematic reviews which provided indirect evidence.

- Direct responses to maltreatment-related concerns comprised a 'case-holding' approach which hinged on a trusting doctor-parent or doctor-teenager relationship and good links with health visitors (two qualitative studies, England).

- Direct responses to maltreatment-related concerns occurred before, during and after referral to children's social care (one qualitative study, England).

- Some GPs were enacting direct responses by using core skills of general practice such as monitoring, coaching, advocating and providing opportune healthcare to children (one qualitative study, England). Direct responses were often enacted through the parents (one qualitative study, England).

- Direct responses were largely enacted in response to concerns about emotional abuse and neglect in help-seeking families who often had high medical need.

- Previous research has shown it is possible to incorporate core elements of general practice, such as coaching and advocacy, into a formalised package of care which can be tested for effectiveness (three randomised controlled trials and one systematic review).

- The GPs in the included studies and the wider literature suggested that there may be potential harms as well as benefits to GPs responding directly to families who prompt maltreatment-related concerns. The potential harms are related to the GP-patient relationship and as such reflect potential problems that GPs face in managing other patients such as those with chronic conditions.

- There are no UK randomised controlled trials that have evaluated whether direct responses by GPs improve outcomes for children and families who prompt maltreatment-related concerns (three randomised controlled trials and one systematic review).

Implication:

- Some GPs use their core skills to respond directly to maltreatment-related concerns in certain families. These include maintaining a therapeutic relationship with parents and children and 'case-holding'. Because direct responses rely on GPs' core skills, this approach could be implemented more widely provided it proved safe and effective and could be adequately resourced. Research is urgently needed to determine the effectiveness of GPs' direct responses and confirm feasibility in wider general practice in the UK.

6. Q: What do we know about how parents, young people, adolescents and children view the doctor-patient relationship in general practice?

Key findings:

- We found 14 studies that reported that young parents, young people, adolescents and (though rarely included) children had highly variable experiences and views of GPs.

- Positive and negative experiences centred around whether the GP was or was not perceived as: welcoming and someone to turn to, who had time to hear about problems, was interested in them and took their problems seriously, was empathetic, and treated them respectfully and whether patients did or did not feel judged or patronised.

- A further key theme was the role of GPs for social problems: some participants felt that GPs only dealt with 'medical' problems while others perceived a broader role for GPs but felt that GPs were too keen to find 'medical' solutions.

- High variability in views and experiences of GPs might be a familiar pattern across all professional 'helping' services.

Implication:

- Given the importance of the GP-patient relationship for facilitating direct responses to maltreatment-related concerns, high variability in parent and child experiences and views of their GPs presents a challenge for wider implementation of direct responses to maltreatment-related concerns in general practice.

7. The way forward

- At a time when child protection services are under acute pressure and the role of universal services is under scrutiny, our report raises a crucial question for policy makers and professionals: is it time to rethink the role of the GP for children with maltreatment-related concerns and their families?

- We suggest that reconceptualising the GP's role to include direct responses to certain children and families would play to the existing strengths of general practice. It would also maximise GPs' contribution to a public health approach to child maltreatment.

- There is an urgent need for research that establishes whether the models of practice we have identified are safe and effective for wider implementation across general practice and identifies the system changes necessary for these models to benefit children and families.

Abbreviations

CCGs

Clinical Commissioning Groups: groups of General Practices within a geographical area that work together to plan and design local health services in England by 'commissioning' or buying health and care services to meet local need. This system of commissioning services locally was set up under the Health and Social Care Act 2012 and CCGs largely replaced the function of Primary Care Trusts (PCTs). CCG boards are made up of GPs from the local area and at least one registered nurse, secondary care specialist doctor and member of the public. In 2013/14, there were 211 CCGs in England who were responsible for £65 billion of the £95 billion NHS commissioning budget. CCGs have a 'duty to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children'.

GMC

General Medical Council: the independent regulator for doctors in the UK which protect, promote and maintain the health and safety of the public by making sure that doctors follow proper standards of medical practice.

GP

General Practitioner: a family doctor who treats acute and chronic illnesses and provides preventive care and health education for all ages and all sexes. They have particular skills in treating people with multiple health issues and comorbidities.

Health visitor

Health visitor: a specialist nurse who supports and educates families from pregnancy through to a child's fifth birthday by, for example: offering parenting support and advice on family health and minor illnesses, conducting new birth visits which include advice on feeding, weaning and dental health, physical and developmental checks, and providing families with specific support on subjects such as post natal depression.

LCSB

Local Children's Safeguarding Boards: LSCBs were established by the Children Act 2004. Each locality has a statutory responsibility to each locality to have a LCSB. The LCSB ensues that all organisations working with children have safe practices and child protection procedures in place and provide training, advice and guidance.

NICE

National Institute of Health and Care Excellence (NICE): an independent organisation that collates and accredits high-quality health guidance, research and information to help health professionals deliver the best patient care through NHS Evidence. NICE guidance is expected to be taken into full consideration by healthcare professionals and organisations when deciding on treatments for patients.

NHS

National Health Service: the publically funded healthcare system in England (primarily funded through central taxation). The services provide a comprehensive range of health services, the vast majority of which are free at the point of use for people legally resident in the country.

NSPCC

National Society for Prevention of Cruelty to Children: a UK charity aiming to prevent child maltreatment and reduce its recurrence and impact.

PCT

Primary Care Trusts: part of the National Health Service in England. PCTs were largely administrative bodies, responsible for commissioning primary, community and secondary health services from providers. Until 31 May 2011 they also provided community health services directly. Collectively PCTs were responsible for spending around 80% of the total NHS budget. Primary Care Trusts were abolished on 31 March 2013 as part of the Health and Social Care Act 2012, with their work taken over by Clinical Commissioning Groups.

RCGP	Royal College of General Practitioners: the professional body for GPs.
RCPCH	Royal College of Paediatrics and Child Health: the professional body for Paediatricians.
THIN database	The Health Improvement Network Database: a large clinical database containing primary care records for approximately 6% of primary care patients in the UK. Primary care notes are universally computerised with records made by the GP or nurse at the time a patient is seen, although other information from test results and letters is often added to the computerised record outside the consultation, sometimes by clerical staff. The primary purpose of the primary care record is for clinical management of the patient by the primary care team, including the GP.

Glossary

Child maltreatment	Includes all forms of child abuse and neglect. The terms "child maltreatment" and "child abuse and neglect" are used interchangeably in this report.
Child in Need	Children who have been judged as "in need" by children's social care services in the UK, under section 17 of the 1989 Children Act. Children in Need are defined as children who require supportive services to achieve a satisfactory level of health and development or those whose health and development will suffer without the provision of services. Under the Children Acts 1989 and 2004, statutory agencies (including health) have a responsibility to identify and respond to the needs of these children.
Child Protection (CP)	Professional actions taken to protect children who have been judged by social care services as suffering or at risk of suffering significant harm due to child maltreatment, under section 47 of the 1989 Children Act. The concept of significant harm revolves around establishing whether the child's health or development has been impaired or is likely to be impaired due to abuse or neglect, compared to what might reasonably be expected of another similar child. Under the Children Acts 1989 and 2004, statutory agencies (including health) have a responsibility to identify and respond to the needs of these children.
Child Protection Plan	Child protection services are delivered via a Child Protection Plan, which is a written report agreed upon by a multidisciplinary 'core group' of professionals and parents/carers, led by a social worker. The Child Protection Plan is based on the core assessment of the child and family and will contain details of services that are deemed necessary, realistic goals for measurable change in parental behaviour, child and parent interaction and/or child outcome and timescales for achieving those changes. The core group of professionals have a statutory responsibility to undertake a review of the Child Protection Plan, the child and the family at least every six months. Child protection services assessments and interventions are coercive. If parents or caregivers do not comply or insufficient progress is made, legal action can be initiated to remove the child and place him or her in local authority care.
Children's social care services	Statutory agency with the responsibility of safeguarding children, young people and families, including preventative family support and child protection services, child placement, fostering, adoption, working with young offenders, children and young people who have learning or physical disabilities, or homeless, as well as support for families and carers. Children's social care services are responsible for the provision of resources, training and support for those working in social care, including social workers.

General practice   The professional practice of GPs and the setting in which GPs deliver care.

GP practice or surgery   The building in which the primary healthcare team provide primary healthcare services to patients.

Primary healthcare team   The GP, practice nurse, health visitor and midwife.

Safeguarding   A term used in the 1989 Children Act and in subsequent policy to refer to professional actions to promote the welfare and wellbeing of all children, including child protection activity.

1 Background

1.1 What is child maltreatment?

Our societal norms about childhood include children's rights to nurture, understanding, and tolerance, to live free from discrimination, fear, violence and sexual exploitation or trafficking, to be protected from physical and psychological harm and neglect, to attend school, to participate in play and recreation and use opportunities and talents to contribute to society and to be supported to meet optimal health, development and growth measured by specified outcomes, even if disabled in some way.[1-3] These rights can be grouped into three broad categories: the right to protection (e.g. from harm or exploitation); the right to participation (e.g. the right to family life or of a disabled child to participate fully in society); and the right to provision (e.g. education or support from the state).[3] Child maltreatment (neglect and physical, emotional and sexual abuse) can be understood as behaviour or circumstances which seriously contravene these societal norms and can be attributed to individuals (rather than governments or institutions).[4;5]

This understanding of maltreatment as a breach of social norms is relevant not only to policy-makers and academics but also to the wider public. A recent study by the Frameworks Institute for the NSPCC found that the 20 members of the public who were interviewed had a deep belief that children were to be cared for, nurtured and protected and that participants understood child maltreatment as a violation of this fundamental notion of childhood.[6]

Increasingly, it is being recognised that child maltreatment includes a range of severity that extends far into the 'normal' population.[7-12] In this 'continuum model' of maltreatment,[10] treatment of children ranges from the optimal to the severely abusive. Conceptualising maltreatment as one end of a continuum makes it clear that there is no natural or obvious cut-off where poor treatment or poor parenting of children becomes 'maltreatment'. The 'grey area' in the middle of the spectrum can cause conceptual difficulty for members of the public and experts who are thinking about what might constitute child maltreatment[6] as well as for children and young people who are thinking about what they have experienced.[13] Children in this grey area around the threshold for defining 'maltreatment' can be thought of as "the marginally maltreated"; they might be experiencing mild maltreatment and/or not yet be seen to be suffering serious consequences from maltreatment.[11]

When defining child maltreatment and each of its sub-categories, legal documents, policy-makers and researchers draw on several key concepts including:

Likely significant harm

A recent study by the Frameworks Institute for the NSPCC reported that members of the public often used notions of *intent* to cause harm and *actual* harm to a child in order to 'draw a line' between what was and what was not child maltreatment.[6] Law-makers, policy-makers and academics rely on these concepts as well as the concept of *likely* harm to a child's health or development. UK legislation places an assessment of 'likely significant harm' at the centre of professional decisions about when and how to intervene in family life.[14-18] The threshold of likely significant harm justifies compulsory state intervention in family life according to UK law.[14-18] Establishing the threshold for actual or likely significant harm in individual cases depends to some extent on professional judgement. Statutory guidance for professionals states that thresholds should take into account the nature and severity of abuse (including likelihood of recurrence), premeditation, impact on the child's health and development, parental capacity to meet the child's needs and the child's wider social environment.[19]

The inclusion of '*likely* harm' in definitions of child abuse and neglect is important for two reasons. First, a child has a right to be nurtured and cared for and to live free from fear, violence, and exploitation whether or not they are judged to be harmed.[3] Secondly, as actual harm can be difficult to ascertain and attribute to maltreatment, predicating definitions on actual harm to the child excludes many children who are experiencing maltreatment and who might benefit from intervention.[20] This argument is supported by the studies based on children who are involved with child protection services: a Canadian study analysing a large sample of substantiated maltreatment investigations from 2008 reported emotional or mental harm resulting from maltreatment in 31% of children and physical harm in only 12%, of whom 3% were judged to require medical or therapeutic intervention.[21] Actual harm can be particularly difficult to demonstrate following early emotional abuse or neglect as disruptions to the child's

brain development may not be visible or may be particularly difficult to attribute to the maltreatment.[20;22]

Harmful actions or harmful interaction

Partly because of the difficulties of demonstrable and attributable harm, emotional abuse and neglect are generally understood in terms of the nature and quality of parent-child interaction, parental risk factors and functioning of the child.[7;19;20;23-25] Neglect includes failure to meet the child's basic needs and shares many characteristics with emotional abuse or neglect when failure involves psychological needs.[26] Many definitions of emotional abuse and neglect require evidence of persistence over time, although professionals have criticised this approach for delaying much needed responses.[27] Witnessing harm of others (e.g. domestic violence between parents) is an action that is classified as emotional abuse and maternal substance abuse during pregnancy is an action that is classified as neglect.[19]

Physical and sexual abuse tends to be defined in terms of specific and proactive acts involving children. It is widely recognised that these acts may be a one-off event or repeated over time.

The table in Appendix 1 summarises the definitions of neglect and emotion, physical and sexual abuse in statutory guidance for England and includes a typical list of actions which are considered to be physically or sexually abusive.

1.2 The size and nature of the problem

Child maltreatment is common in the population; a fact appreciated by both experts and members of the public in England.[6] A population-based survey by the NSPCC reported that 4% of children had experienced maltreatment in the previous year and three times as many children (11%) had experienced abuse or neglect over their lifetime.[24] The study used a UK representative sample of 2160 children aged over 11 years and 2275 parents of younger children. The definitions of maltreatment in the study were commensurate with those given by statutory guidance for England (summarised in Appendix 1).

Annual incidence estimates from the NSPCC study were lower than those from other population-based studies in industrialised countries using similar self- or parent-report maltreatment, which estimate that up to 10% of children under 18 years are exposed to abuse and neglect each year.[23;28] In all these population-

based surveys, rates of maltreatment were much higher in adolescents than in younger children.

Although physical and sexual abuse seem to be uppermost in the minds of members of the public,[6] population-based self-report studies consistently estimate neglect and emotional abuse (including witnessing domestic violence) to be the most common type of maltreatment.[23;24] Parent and self-report studies come much closer to accurate estimates of maltreatment in the community than those using agency data on maltreatment. However they still underestimate the true frequency of maltreatment.[23] Experts and policy-makers are increasingly focusing on neglect as the most concerning form of child maltreatment in terms of prevalence, impact and the difficulties inherent in responding.[6;29]

Although any adult can maltreat a child, large-scale surveys suggest that adults living in the family home are responsible for the vast majority of child maltreatment.[23;24] Because emotional abuse and neglect represent a failure to meet a child's basic emotional, physical or health needs (see Appendix 1 for detailed definition), these types of abuse necessarily involve an adult with a caregiving role.

Studies consistently document the inter-relatedness of different types of child abuse and neglect both with each other and with other types of adversity, such as bullying, peer/stranger violence and criminality.[4;24;28;30;31] Research into the life course of child maltreatment show long-term effects for adulthood in terms of education, employment, social isolation, criminality, mental health and other physical health outcomes.[23;32-34] Exposure to adverse childhood experiences (ACEs), a term which extends beyond maltreatment to encompass the experience of children in households with substance or alcohol misuse, attempted suicide or incarceration and/or parental separation has been shown to be associated with multiple long-term physical and mental health problems including depression, substance misuse and overall poor health.[35] This implies that 'perpetrators' of child maltreatment are themselves often struggling with their own long-term consequences of childhood adversity, manifested as mental health problems, drug or alcohol misuse, social isolation and violence. The growing body of evidence for permanent damaging physiological and neurological effects of early maltreatment on children's development and behaviour, including their ability to form relationships, empathise and control impulses, further under-scores the importance of early trajectories of childhood adversity for parents' abilities to nurture and parent their own children.[32]

As well as costs to the individual, there are costs to society more broadly: it has been estimated that the total costs of child abuse and neglect in the United States (from healthcare services, welfare services, law enforcement, legal action, education services, delinquency, crime and reduced productivity) may be as high as $94 billion dollars annually.[36] We do not have equivalent estimates for the UK but they are also likely to be extremely high.

Due to the nature, magnitude and consequences of the problem, there is an imperative to respond to child maltreatment. This imperative to respond is enshrined in law within the UK: all professionals have a statutory duty to promote child welfare and protect children from harm.[14;15;17;18]

1.3 A public health approach to responding to maltreatment

Over the last two decades, an acceptance of the continuum model of maltreatment has resulted in calls for a public health approach to the problem.[7-9;37] A public health approach places increased emphasis on prevention and early intervention and attempts to reduce maltreatment by 'shifting the curve' in order to improve outcomes for *all* children.

Attempts to shift the parenting curve rely on universal and upstream interventions to address the major risk factors for harmful parent-child interaction which are rooted in parents' own life course and capacity, neighbourhood risk factors (such as deprivation, violence and access to good schools and other services) and societal risk factors (for example, poverty and socio-economic inequalities).[38-40] Alongside up-stream and universal interventions, a public health approach can deliver targeted interventions to prevent maltreatment where need, risk of maltreatment, and/or propensity to benefit is highest and to reduce recurrence and adverse consequences where it is already occurring (see Figure 1.1).

A public health approach makes sense if the line between poor treatment and maltreatment is viewed as unclear and if small benefits for the high

Figure 1.1: Shifting the parenting curve

(Strategy 1)* Universal support for parenting – shift curve towards better parenting

(Strategy 2)* Target high risk children

4–10% of children in England each year exposed to maltreatment[1,2]

(Strategy 3)* Reduce recurrence

In England, 4.6 per 1000 children each year are the subject of a child protection plan[3]

Optimal treatment   Poor treatment   Maltreatment
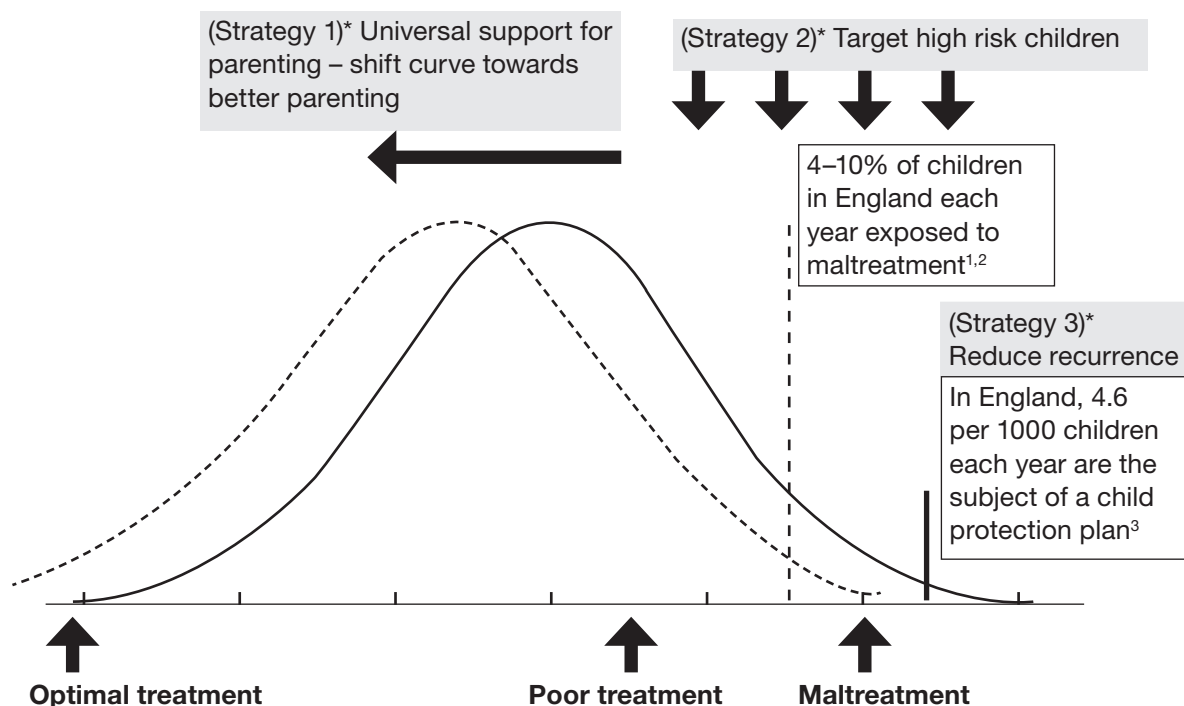
*A public health approach to child maltreatment invests in universal support for parents (strategy 1) as well as targeting high risk children (strategy 2) and attempting to reduce recurrence where maltreatment has already occurred (strategy 3)
1 Radford L, Corral S, Bradley C, Fisher H, Bassett C, Howat N et al. *Child abuse and neglect in the UK today*. 2011. London, National Society for the Prevention of Cruelty to Children (NSPCC).
2 Gilbert R, Widom CS, Browne K, Fergusson D, Webb E, Janson S. Burden and consequences of child maltreatment in high-income countries. *Lancet* 2009; 373(9657):68-81.
3 Department for Education website. Characteristics of children in need in England 2012-2013. Available https://www.gov.uk/government/publications/characteristics-of-children-in-need-in-england-2012-to-2013 2013.
Reproduced with permission from: Gilbert R, Woodman J, Logan S. Developing services for a public health approach to child maltreatment. International Journal of Children's Rights 2012; 20(3):323-42.

numbers of children in the middle of the curve can lead to great benefit for the population as a whole. A public health approach is also strengthened by its compatibility with prioritising the rights of the child as well as evidence suggesting early intervention is the most effective approach in terms of outcome and costs.[3;41]

From the perspective of healthcare services, opportunities for early intervention and prevention are located in the contact between health professionals and children or their parents or carers. As Figure 1.2 shows, addressing societal and neighbour risk factors for child maltreatment through upstream and universal interventions is usually beyond the scope of healthcare services. Instead, a public health approach to maltreatment within healthcare services is likely to be characterised by efforts to recognise and respond to parental risk factors for maltreatment and harmful parent-child interaction.

As Figure 1.2 illustrates, the concept of child 'safeguarding' is consistent with a public health approach. During the Parliamentary debates of the Children's Bill and later in the refocusing debate of the mid-1990s, it was argued that the narrow focus on child protection and establishing forensic evidence should be widened to take in the broad spectrum of child welfare, with the aim of helping families and keeping policing

and coercion to a minimum.[42;43] It was in this context that the term 'safeguarding children' was introduced as a way of referring to all professional efforts to promote the health and development of children and to maximise their life chances.

1.4 Defining the spectrum as 'maltreatment-related concerns'

In the context of a continuum model of child welfare and in keeping with a public health approach which covers prevention *and* treatment (Figure 1.1), our discussion here includes the role of GPs for children who are judged to be marginally maltreated as well as for children whose experiences can clearly be labelled as maltreatment. We use the term 'maltreatment-related concern' to capture the full range of professional concern about child maltreatment, including concern about parental risk factors for maltreatment and compromised parenting or parent-child interaction which is judged to have the *potential* to become harmful, whether or not the problem currently meets children's social care thresholds for enquiry or action. 'Maltreatment-related concerns' also include concerns that are absolutely and definitively about child maltreatment and are labelled as such.

Figure 1.2: The contribution of healthcare services within a public health approach
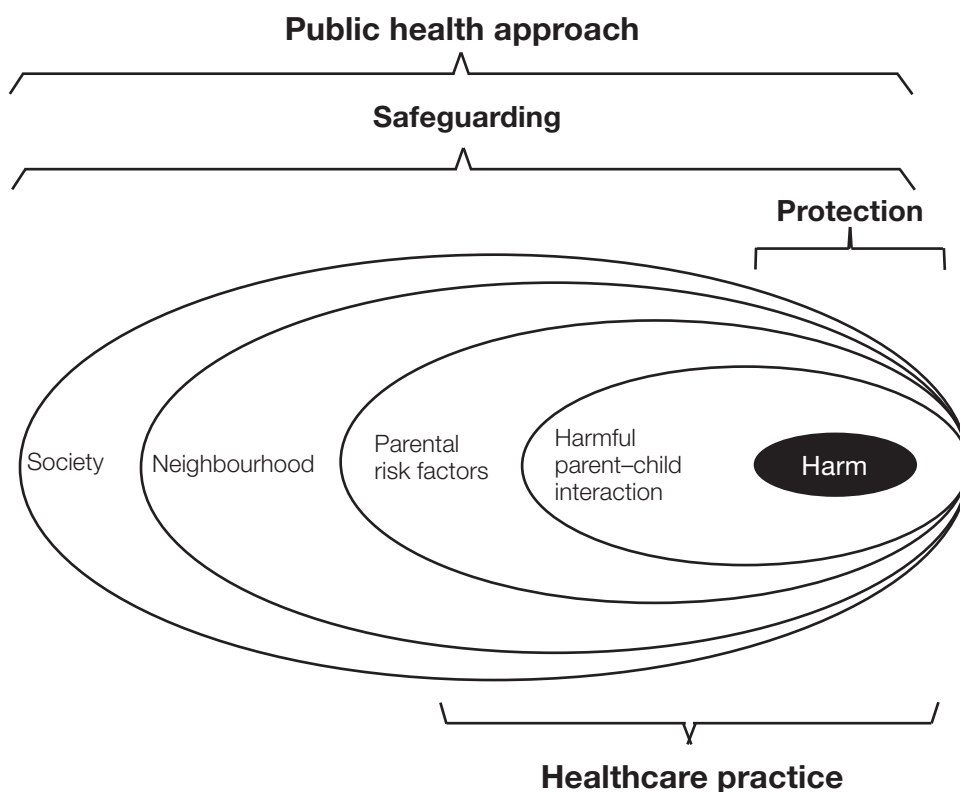
Reproduced with permission from Bentovim & Gray (2014). *Eradicating Child Maltreatment: Evidence-Based Approaches to Prevention and Intervention Across Services.* Jessica Kingsley Publishers, London and Philadelphia.

2 Structure of report and methods

This report provides an overview and commentary on policy, practice and research relevant to the role of GPs in responding to maltreatment-related concerns with the aim of defining a policy and research agenda in this area. The overview is divided into six sections:

1 Why focus on GPs?

This section provides an overview of the potential strengths of GPs in responding to maltreatment-related concerns. We outline how these strengths make GPs well placed to contribute to a public health model of responding to maltreatment, particularly for children who prompt concerns about neglect and emotional abuse. We introduce direct responses as a way of framing the strengths of general practice for adopting a public health approach to child maltreatment. This section is underpinned by a literature review (search strategy reported in Appendix 2).

2 Review of policy and practice guidelines

In section two we begin by providing an overview of policy aspirations towards a preventive approach to child maltreatment. We then review how current policy views the role and responsibilities of GPs in responding to child maltreatment, focussing particularly on how frameworks and guidance help GPs to fulfil their potential for responding directly to children and families who prompt concerns about maltreatment. We conclude this section by outlining the major policy barriers for GPs' direct responses and suggestions for how policy might better support these types of response. Methods and inclusion criteria for the review of policy are reported in Appendix 3.

3 Learning from practice and research: what do we know about direct responses to maltreatment-related concerns by GPs?

In the third section of this report, we present an overview of published examples of current practice or recommendations for good practice which have been generated by research studies. Descriptions of current or good practice can give us ideas about what types of direct responses might be feasible and acceptable in UK general practice settings. We also provide an overview of what is known about the effectiveness and safety of such responses in general practice. This section is based on a literature review (search strategy described in Appendix 2).

4 An overview of evidence about the views of parents, young people, adolescents and children on the doctor-patient relationship in general practice

As the doctor-patient relationship has been identified as an important facilitator of responses to maltreatment-related concerns from the perspective of GPs, in this section we focussed on this relationship from the perspective of parents, young people, adolescents and children. We reviewed the literature about the doctor-patient relationship, broadly interpreted to include relevant themes such as continuity of care, empathy or listening skills or the role of the doctor in responding to social problems as seen or experienced by parents, young people, adolescents and children. The full search strategy and inclusion criteria are presented in Appendix 4.

5 The way forward

Following a summary of key points and conclusions, the report ends with proposals for the way forward in terms of future policy and research agendas.

3 Why focus on GPs?

In this section we provide an overview of general practice (section 3.1) and explain why GPs have the potential to be a key player in adopting a public health approach to responding to maltreatment-related concerns (section 3.2).

3.1 Overview of general practice

General practice is the first and most commonly used point of access to the UK National Health Service (NHS). Data in this paragraph relates to England but the structure and delivery of general practice is similar across the four UK nations. In England, there are nearly 300 million general practice consultations a year[44] offered by over 8000 local GP practices.[45] Like all NHS services, it is free-at-the-point-of-use. Each GP practice has an average of approximately 6600 registered patients of all ages.[45] A full time GP sees on average 100 patients a week, 15% of which will be telephone consultations and less than 5% will be home-visits.[46] On average, face-to-face consultations last just over 10 minutes each and telephone consultations about seven minutes.[46]

There are just under 40,000 fully qualified GPs in England,[47;48] who are front-line generalists representing almost 40% of all qualified doctors in the country. On average there are five GPs employed in each GP practice,[46] though some practices will have only one GP and some larger practices will have many more than five.

General practice forms the cornerstone of primary healthcare in the NHS. The GP practice offers first-contact care delivered by a multi-professional team who offer proactive as well as reactive care to all individuals in their community. GPs have responsibility for some aspects of population health (e.g. providing screening and vaccinations), health promotion, and for treating ill-health in its social and cultural context.[48] Primary healthcare services also have a gatekeeping function for access to other NHS health services.[44] The multi-professional primary care team includes practice nurses, nurse practitioners, and sometimes community nurses, health visitors, midwives, and other allied professionals such as physiotherapists or counsellors. Not all of these professionals are employed by the practice or health service, and they are not necessarily based in the same building. Insufficient numbers of health visitors and, in England, their increasing links with Children's Centres rather than GP

practices[49] is well-recognised as a barrier to appropriate communication and GP responses to maltreatment-related concerns.[50;51]

3.2 Relevant strengths of general practice for responding to child maltreatment

The Royal College of General Practitioners (RCGP), among others, has detailed the particular strengths of general practice for identifying and referring child maltreatment. These include: the status of general practice as a universal and family-centred service, the longitudinal view of GPs, and the function of the primary care record as an information repository for the child and family.[52-54]

A universal and family-centred service

Close to 100% of the population of England, including the child population, is registered with a GP practice.[55-58] Children present frequently: a study using a representative sample of children registered with UK general practices reported that children aged under five reportedly saw a GP an average of seven times a year (in 2009).[58] This figure drops to just over two consultations per year on average for children aged between five and 18, with the exception of older teenage girls who presented twice as often.[58;59]

Poverty and family and neighbourhood social problems are recognised as contributors to major health problems in general practice,[60] as drivers of consultations,[61;62] and major risk factors for child maltreatment.[23] In addition, maltreated children have an increased risk of chronic health problems such as physical or intellectual disability.[63-66] Despite barriers to service use among these groups, the higher than average rates of poverty and chronic health problems among maltreated children are likely to bring them into contact with GPs.

As part of the family-centred universal care that they offer, GPs see multiple family members which can put them in a good position to identify parental risk factors for child abuse and neglect.[23] Some of these problems are already commonly identified and treated in general practice. For example, a study using a representative UK dataset reported that, by the time a child is 12

years old, 39% of mothers and 21% of fathers had a diagnosis of depression or had been treated for depression by their GP.[67] GPs are also managing other problems in parents that are strongly linked to child maltreatment, particularly to neglect, such as illicit substance use,[68] alcohol dependence[69] and domestic violence.[70;71]

Serious Case Reviews (reviews into child deaths or serious injury from abuse or neglect) have identified that GPs sometimes fail to identify risk to children from the parental problems of which they are aware or are even managing, including: violence, mental health problems or substance misuse.[72] Serious Case Reviews focus on rare and tragic events and highlight what can be learned from service failures, in particular setting or circumstance; they do not tell us how far practices are common or usual. Qualitative studies asking GPs in England, the Netherlands and Denmark about everyday practice report that parental risk factors and consequent concern about the parent's care for the child was the most common way in which maltreatment-related concerns were prompted.[51;73;74] Box 3.1 provides illustrative maltreatment-related concerns taken from 26 families discussed in 14 interviews which we conducted with GPs in England in 2010-11: almost half the concerns which were discussed were prompted via contact with the parents, usually without any kind of direct contact with the child (N=12/26; 46%), just under a third via child consultations, usually with the parents present (N=8/26; 30%) and just under a quarter through information received from colleagues or other agencies (N=6/26; 6%).[51]

In this same study, routine contact with multiple members of the same family for their heath needs generated concerns related to neglect and emotional abuse, which dominated the GPs' accounts of maltreatment-related concerns. These concerns largely centred on what was described by GPs as "low-level" or "compromised" parenting, either as a result of parental substance misuse or mental health issues (see Box 3.2, quote 1 and 2) or an array of problems in the family, related to health, money, young parenthood and housing (see Box 3.2, quote 3). Concern was sometimes about the potentially serious and immediate consequences of physical or medical needs of the child not being met (see Box 3.2, quotes 1 and 2) but more often concern related to longer term physical, emotional or social development of children (see Box 3.2, quotes 2, 4 and 5). In most of the 26 cases discussed in this study, the GPs could describe family life in detail including housing conditions, employment status and other health and social

problems for multiple family members as well as how these had changed over time.

The longitudinal nature of General Practice

As suggested by extremely detailed descriptions of families in our interview study,[51] repeated contacts between GPs and family members over time can allow them to build up a cumulative picture of family life which generates professional concern. In addition, a longitudinal view is also useful for responding to the chronic nature of child maltreatment which may need monitoring and intervention over long periods of time.[76-78] Although the model of seeing the same GP over many years is increasingly difficult to sustain, GP *practices* still have a longitudinal view of their patient's healthcare.[79;80] Some degree of continuity of care is maintained through the GP record which contains information from consultations, tests and prescriptions at the current GP practice and diagnoses entered at previous practices with which the patient was registered.[81] Continuity of care via the GP record is only likely to work in the context of good recording by GPs, use of the record at each consultation, accurate interagency communication and, when required, speaking with primary healthcare colleagues about the 'soft' information that may not be recorded in the notes.

Repeated contact over time aids long-term relationships and creates opportunity for building therapeutic relationships in general practice, which is considered a core GP skill. A "good" (therapeutic) GP-patient relationship has been described as including "friendship, respect, commitment, affirmation, recognition, responsiveness, positive regard, empathy, trust, receptivity, alignment between the doctor's agenda and that of the patient's lifeworld, honesty, reflexivity, and an ongoing focus on care that embraces prevention, illness management, and rehabilitation".[82] Relationships that have similar characteristics have been recognised as a common element of effective psycho-social interventions within social work.[83] Inevitably these relationships require time and energy to build and may pose a problem in the context of child protection work if parents are deliberately deceptive or manipulative.

Box 3.1: How do maltreatment-related concerns arise in general practice?

This box presents illustrative examples from a recent study[51] in which we interviewed 14 GPs in England between 2010 and 2011 and compares the examples with two other relevant studies: two studies based on focus groups with GPs in Denmark and the Netherlands, respectively and a survey of GPs in England.[50;74;75] Methods for the two English studies are reported in Table 51.

In the study maltreatment-related concerns arose following consultation with the parent (12 families), the child (8 families) or information from other professionals (6 families).

Parent consultations

Example: A GP had been seeing a woman for her chronic health condition. Initially his focus was limited to helping the young woman to use healthcare services appropriately and manage her condition, which was poorly controlled. Over a few months, the extent of the patient's chaotic lifestyle and alcohol use became apparent (and possible drug use and domestic violence). The GP knew that the patient had two young children and became increasingly concerned about her capacity to parent.

In this example, triggers include parental use of healthcare services and doctor's knowledge about the family, both also identified as important prompts for Danish and Dutch GPs[74;75] In this example, alcohol and drug use were important triggers for concern. This is consistent with other evidence about current practice among GPs in Denmark, the Netherlands and England.[50;74;75] The English study reported that GPs also perceived parental disability, mental health problems, poor standards of living and domestic violence as triggers which warranted further action.[50]

Child consultations

Example: A mother brought a 13 month old child to get antibiotics for a possible chest infection. The GP noted that the child was seriously under-dressed and that there was a lack of parent-child interaction. After asking about developmental milestones, the GP was further concerned that the child was missing out on crucial stages of her development due to 'low level parenting'. After the consultation, the GP asked other members of the team and consulted the electronic records which revealed a history of domestic violence and drug use and an older child who had already prompted concerns.

Here, triggers include symptoms of neglect, parent/child interaction and knowledge about the family, also identified as important triggers for Danish and Dutch GPs.[74;75]

Information from other agencies/professionals

Example: The practice nurse referred a two year old child to the GP after seeing bruises on the child's legs and knowing that an older sibling had previously been the subject of a child protection plan. The GPs assessed the child and history to ascertain likelihood of (non) accidental injury. In collaboration with children's social care, the GP concluded that there were issues around supervision and safety in the household (rather than violence).

In this example triggers include symptoms of possible physical abuse or neglect, also identified as important triggers in the Dutch study,[75] and knowledge about prior concerns.

*Examples were chosen to illustrate common themes and are based on GP accounts.

Box 3.2: Quotes illustrating GP concerns about neglect and emotional abuse

All quotes are taken from our interview study with 14 GPs from England, methods reported in Table 5.1 and also published elsewhere.[51]

Quote 1: "Neglect really. I think with chaotic lifestyles that the child may become… well just not be cared for adequately. […] Parents who become impoverished because of their drugs using behaviour are at just that much more risk of physical neglect of not feeding the child, not caring for the child, not changing its nappy, of not… and to an extent emotional neglect as well, just that there's not enough parenting input."
Participant 14, GP, talking about a 7 month old baby

Quote 2: "But they [the parents] are both functioning at quite a low level [because of mental health problems] so I don't think that the child is going to be beaten up, I do think that she, when she goes to nursery her speech, her speech isn't going to be good, she will be behind developmentally, that she is missing out on a crucial period of her development […] it's a sort of low level parenting issue"
Participant 0, GP, talking about a 1 year old child with older sibling

Quote 3: "He's got, ah… I think he has problems with bed wetting and soiling actually and, um, he's also got a squint which, um… which isn't bad but the mother's repeatedly failing to get him along to appointments and that kind of stuff and, ah, […] the magnitude of their problem as a family can seem overwhelming really. Um, just every one of the children has a problem which of its own in a family would be a problem, and yet, they seem to have them all in… under one roof […] medical problems… medical and behavioural problems, that kind of thing, mental health problems […] The older sister is sixteen, she's now got her own baby and they've… they'd have to have a room in the house, so I think he shares with two other siblings and the brothers are in another room […]. I mean, all of the kids have got problems of some sort or another and the parents have their own problems. The mother's had a stroke and the father's had a heart attack and… […] Unless something is done soon [about the squint] he's going to lose his eye, […] we're not talking about surgery or anything, we're just talking about patches and covering and making sure he uses the eye and that kind of stuff […]"
Participant 5, GP, talking about a four year old child from a large family

Quote 4: "And they would've been three and four at this time. And they were allowed to run around unsupervised and they were also left for extensive periods in the care of their older siblings […] the large part of the care burden fell on the 12 and 13 year old girls in the family […]. So I think that he's likely to grow up – there will be some element of cognitive delay because he's not being stimulated particularly appropriately."
Participant 4, GP, talking about a 3 year old child from a large family

Quote 5: "Clearly this girl, at 13, was out… that's probably 15 miles away, at two or three in the morning, getting drunk, you know, so that starts to feel quite neglectful. […]. I think probably she hasn't had boundaries. I think she probably is more out of control than ever comes to my attention, because your average parent of a 13 year old who isn't at home at three o'clock in the morning, you know, would have the police out looking for them and all that kind of thing. I don't think that happened, which suggests that probably that's not the first time that she's gone missing, that that is a pattern that we didn't know about […] if she falls or something or walks in front of a bus or whatever at two o'clock in the morning when she's drunk, obviously, kind of being drunk, is in itself a risk […] whether she gets into drugs and all the rest of it, if that's easily available there, whether she, like her mum, gets pregnant very early, umm […]."
Participant 7, GP, talking about a 13 year old who was admitted to A&E for alcohol intoxication

Primary care record as an information repository

The longitudinal and universal nature of general practice means that there are particular opportunities for gathering and recording information in general practice. Lord Laming concluded that information gathered in general practice might be recorded and shared to help all professionals protect children from maltreatment.[84] However, for GPs, tensions arise in sharing such detailed and highly sensitive information, often elicited as part of a therapeutic approach, with a statutory body such as children's social care.[50;85] From a public health perspective, there is concern that sharing information could undermine the therapeutic relationship which is needed to keep families engaged with general practice. Disrupting this relationship by GPs taking on a monitoring role (potentially perceived as punitive "surveillance" by patients) could discourage vulnerable families with high health needs from using primary care services or from exposing problems related to child maltreatment.[86]

The most cited benefits of recording wider information about the child and maltreatment-related concerns in general practice are making children with concerns 'findable' on the system, building up a cumulative picture of a family where a series of minor concerns might indicate a serious problem and making concerns known to colleagues, especially new or locum GPs.[54;84;85;87] The primary care record can also assist the health professional to structure their thoughts and make appropriate decisions; act as an aide memoir during subsequent consultations; make information available to others with access to the record system who are involved in the care of the same patient (including electronic transfer of records when the patient moves practice); provide information for inclusion in other documents (e.g. case-conference reports or referrals); and store information received from other parties or organisations (e.g. child protection plans).[81]

The potential of the primary healthcare record will not be realised if important information is not inputted or is buried deep in electronic files making it inaccessible to the GP who is managing the child and/or family. A recent review of Serious Case Reviews recommended that systems are needed to prompt GPs to review the records and to make sure any concerns about child welfare from GPs and other members of the primary healthcare team are inputted into the record.[88]

Although there is evidence that many maltreatment-related concerns go unrecorded in general practice,[85] a significant proportion of children in the UK already have concerns noted in their primary care record: a study of the primary care records of 1.5 million children in the UK reported that in 2010 almost 1% had a code entered into their record which indicated a maltreatment-related concern.[89] The results of this study are discussed in more detail in Section 5 of this report.

3.3 GPs and direct responses

There is now long-standing and wide-spread recognition of the gap between the occurrence of child maltreatment in the community and the small proportion of cases who receive attention from children's social care. Estimates from the NSPCC suggest that for every child who is subject to a child protection plan, there are another eight children not receiving these services[90] and an international systematic review suggested that the gap may be even higher.[23] Thresholds for intervention by children's social care are very high: social workers use the labels of 'significant harm' and 'child protection' to prioritise scarce resources in an overstretched service.[91-93] Official statistics show that a quarter of children who were referred to children's social care in 2011-12 did not receive any type of intervention.[94] Additionally, many children who do meet the high thresholds for social care intervention may only receive short-term responses from this agency as a response to crises: in 2012-13, 52% of child protection plans and 69% of child in need services lasted for six months or less.[95] Short-term service provision may be inadequate in the context of what are often chronic and entrenched family problems: a follow-up study reported that a third of 77 children with a child protection plan had their case closed within a year but continued to experience significant problems over the next eight years.[77]

Historically, policy-makers and researchers have responded to the sub-optimal coverage of welfare services for maltreated children by focusing on increasing *identification* by professionals and subsequent referral to children's social care.[7;78] However, it is becoming increasingly accepted that over-stretched children's social care services will not be able to offer assessment and intervention to the large numbers of maltreated children with whom they are currently not in contact.[90] The NSPCC estimated that providing child protection services to just a quarter of maltreated children with whom children's social care was not currently in contact would cost between £390 and £490 million in additional public spending.[90] In the absence of extra

resources, it is likely that social care thresholds for intervention would simply rise as a response to increased demand.[41;96] For these reasons, academics have begun to argue persuasively that poor coverage of services for maltreated children is driven as much by currently available responses as by sub-optimal identification of relevant problems.[7;78]

An increasing acceptance that children's social care cannot feasibly respond to all maltreatment-related problems in children has thrown a spot light on the role of universal services, particularly in terms of direct responses to children and families.[7;50;97;98] As calls for direct responses to maltreatment-related concerns by universal services are relatively recent, such responses are not well-defined. It is not clear what direct responses might look like in a general practice setting, whom they may be used for, whether they are feasible, how they might be implemented, or how far they are safe and effective in responding

to maltreatment-related concerns. Based on the strengths of general practice (as described in section 3.2) direct responses might consist of an on-going monitoring and support/intervention role.

As depicted in Figure 3.1, direct responses could occur before a referral to children's social care for lower risk cases (hopefully averting the need for a referral) or in tandem with referral to children's social care or 'early help' services and/or alongside services provided other agencies, including children's social care.

Operating effectively below the threshold for children's social care services could save time, resources and most importantly, prevent deterioration in the child's situation.

Direct responses also have the potential to challenge the well-documented preoccupation with determining whether children meet thresholds for service provision from children's

Figure 3.1: Direct responses by healthcare professionals
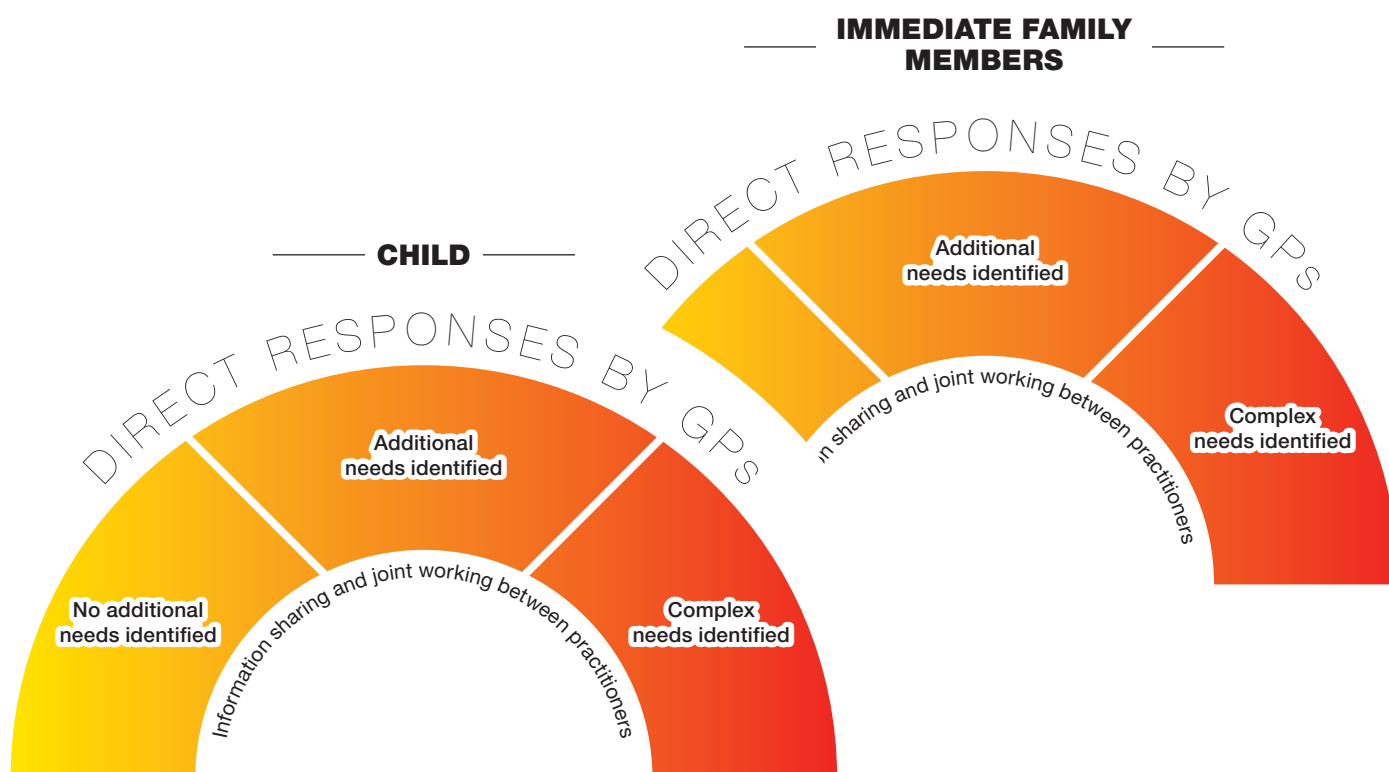
Potentially, direct responses can be enacted:

- Long-term and wherever the child is on the spectrum of need; the ways in which direct responses are used will be determined by the family's circumstances.

- For children of any age and at any stage of development.

- Through the parents, carers and other adults living in the household (immediate family) as well as the child or children; the GP might be able to respond directly to multiple family members over the same period of time.

social care and other agencies, which can divert professional attention away from efforts to help children and families. As Brigid Daniel summarises in the context of neglect:

We would suggest that it is likely to be of benefit to children if universal services are able to get on and provide support for neglected children whether they are officially labelled as such or not.[7]

3.4 Key points

- GPs have a unique and critical role in responding to maltreatment-related concerns:

  - Frequent and repeated contact with the whole family potentially allows GPs to recognise and address parental health problems that affect their capacity to care for their children, such as mental health and drug and alcohol misuse. As a result, GPs might be particularly well-placed to identify problems relating to neglect and emotional abuse. There is evidence that this is occurring in some general practice settings though we don't know how far this is common practice across the UK.

  - A GP practice can be involved with families over a long period of time which potentially enables a longitudinal view of family health needs, allows early intervention when there are maltreatment-related problems, and provides opportunity for on-going intervention and monitoring of children.

  - A trusting and/or therapeutic doctor-patient relationship, which is an underlying principle of general practice and can be built up from regular contact over time, might allow GPs to engage and work with families where there are maltreatment-related concerns.

  - The GP record can act as an information repository for the child which can be used to build up a cumulative picture of concern, to enact on-going and proactive review/monitoring and which can be shared to help all professionals safeguard children. Despite under-recording of concerns, we have estimated that almost 1% of children who are registered with a GP in the UK have a maltreatment-related code in their primary care record.

- The position of general practice as a universal service potentially gives GPs on-going routine contact with *all* children *and* their carers regardless of where they are on the child welfare continuum at any given point-in-time. This offers opportunities for GPs to enact a public health approach to maltreatment by directly responding to the very large numbers of children and their carers below the threshold for services from children's social care as well as continuing to work with those who meet child protection thresholds.

- GPs might be particularly well-positioned to identify and respond to (possible) neglect. GP focus on neglect might be explained by the high prevalence of neglect in the community, by the disproportionate difficulties in accessing child protection services for neglect (despite the fact that neglect is the most common reason for a child protection plan), by the fact that it might be easier to respond to families where parents can be constructed as 'loving' but 'incompetent' or perhaps because some aspects of neglect are medical in nature.

- Calls for universal services to respond directly to children and families are relatively recent and direct responses are not well-defined or understood in the context of general practice. Any such direct responses are likely to draw on the strengths of general practice as a universal service which can take a longitudinal view, can build relationships with families and can act as an information repository. Direct responses might consist of an on-going monitoring and support role.

In the next section we review how current policy views the role and responsibilities of GPs, focussing on how far frameworks and guidance support GPs in responding directly to children and families who prompt professional concern about maltreatment.

4 How far does policy and practice guidance support GPs' direct responses to families?

We reviewed GPs' roles and responsibilities in relation to maltreatment-related concerns as stated in current national policies in each of the four UK countries. We also review national guidance and policies from professional bodies. We discuss the extent to which national policy and guidance provide a framework for GPs to respond directly to families who prompt maltreatment-related concerns, focussing on the GP role in monitoring and providing on-going support or intervention.

As a backdrop to the review on policies about the role and responsibilities specific to GPs, we begin by describing wider child welfare legislation and policy in the UK, outlining policy aspirations for a public health approach to child maltreatment.

4.1 Overview of child welfare policy in the UK

Differential response

Similar to many other industrialised countries,[99;100] the child welfare system in the UK is one of differential response: the system includes multiple pathways to child welfare services. The multiple pathways were enshrined in primary legislation (Children Act 1989)[14] in response to arguments put forward in the late 1980s when the then Children Bill was being debated in Parliament. Later in the 1990s pathways were explicitly set out in statutory guidance following a national debate that the traditionally narrow focus on child protection, which required establishing evidence of harm and culpability, ignored the broader spectrum of child welfare need, caused delays and barriers to helping families and was directed towards coercive, and sometimes punitive interventions.[42;43] The differential response system was designed to provide help at an earlier stage as well as preventing unnecessary statutory child protection investigations which could have serious adverse effects on a child and family and be costly.

Since the enactment of the Children Act 1989 there have been multiple pathways into child welfare services in the UK. Professional decisions about which pathway is most appropriate to follow once a referral has been accepted by children's social care hinge on the concepts of 'children in need' and 'significant harm' which underpin the

Children Act 1989. For children judged to be in need of services in order to achieve or maintain a 'reasonable standard of health and development' or because they are disabled but who are not suffering or likely to suffer significant harm, there is a pathway to services, as a 'child in need' under section 17 of the Children Act 1989. Such children may include those with visual, hearing or speech impairment, mental health disorders or chronic conditions. Child in need services are voluntary: families can choose whether or not to accept state intervention. In England in 2012-13, approximately seven times as many children received child in need services (3.6% of the child population) than were the subject of child protection plan (0.46%).[95]

As described in section 1.1 reaching the threshold of 'significant harm' justifies compulsory state intervention in family life in accordance with section 31 of the Children Act 1989. There is no absolute definition of significant harm: statutory guidance for professionals states that judgements should take into account the nature and severity of abuse, premeditation, impact on the child's health and development, parental capacity to meet the child's needs and the child's wider social environment.[19] If a child is judged to be suffering or likely to suffer significant harm, statutory 'child protection' action should be initiated in accordance with *Working Together to Safeguard Children.*[19]

Early help

Professionals should undertake early help assessments to establish whether children might benefit from early help or whether they meet thresholds of child in need or children suffering or likely to suffer significant harm. Such assessments might be undertaken using tools such as the Common Assessment Framework.[19] As Munro points out in her Review of Child Protection in England, the phrase 'the Common Assessment Framework' is used to describe both the policy of encouraging integrated professional work to provide early help, and the form that has been developed by Government to help professionals to conduct a holistic needs assessment.[97] In cases which do not meet child in need thresholds, non-social work professionals (including healthcare professionals) can undertake the assessment with support from children's social care. In this

model of early identification and intervention, the multi-agency response should occur via a multi-disciplinary Team Around the Child or Team Around the Family who have the role of assessing need and deciding with the child/family a course of action to provide services. In the Team Around the Child model, a non-social work professional can act as 'lead professional' which is described as a role of advocacy, support and service coordination within a multi-agency response.[19] In England, there is no national strategy for provision and coordination of early help services. However, guidance recommends that from 2014 each Local Safeguarding Children's Board (LSCB) in England produce a threshold document to assist other professionals in responding to maltreatment and offer advice for accessing early help services.[19]

An important underlying principle of the Common Assessment Framework and the Team around the Child is that it is not just social services departments who are the assessors and providers of welfare services. The Team Around the Child model of early help was not intended to be used for children meeting thresholds of children in need (including significant harm or likely significant harm):[19] However, where a case involves complex needs, including significant harm, the burden of response is still squarely placed with children's social care.[18;42]

In its 'Getting it Right for Every Child' approach,[101] Scotland promotes a similar approach. All children in Scotland should have a 'named professional' from universal services who can be contacted in the case of any concern. For children under five years old, it is envisaged that this will be a health visitor and for school-aged children, a teacher. The 'named professional role' is in addition to the 'lead professional' role whose remit is similar to that outlined in English policy. As in England, it is envisaged that a social worker will be the lead professional for children with complex problems.

Models of differential response which include family support and early help systems are compatible with the continuum model of child welfare and a preventive approach to maltreatment. The alternative pathways to services (child protection and child in need) and early help systems are designed to allow all professionals to access appropriately therapeutic and/or compulsory services, for children across the whole child welfare continuum, such as specialist nurses, speech therapists, support works as well as core services from health and social care.

4.2 National government policy and GPs

We found 109 policy documents that related to current policy on responding to child maltreatment and mentioned GPs (between 46 and 68 policy documents in each of the four countries). Table 4.1 shows the results from the searches and data extraction for national policy documents in the four UK countries.

Overall, government policy was heavily weighted towards recognition of maltreatment by GPs with response seen largely as recognition and

Table 4.1: Results from searches of national policy documents

	England	Scotland	Wales	Northern Ireland
Potentially eligible documents	68	46	57	57
Included documents	45	19	29	16
Extracts reviewed	440	207	145	91
Mentions of GPs:				
Recognition/assessment	66	58	24	22
Inter-agency working	89	73	48	54
Organisational (e.g. training/audit)	73	74	28	8
Monitoring, on-going support or intervention	10	21	7	7

assessment, inter-agency working (information sharing, including referral to children's social care and participation in children's social care processes) and the implementation of organisational structures and/or audit. As Table 4.1 shows, there were few references to GPs having an on-going role in monitoring role or providing support for families whom had prompted maltreatment-related concerns.

There were relatively few differences between policy documents and often they appeared to be derivative of each other. Policies in Scotland and Wales emphasised the need for GPs, among health professionals, to assess parental capacity and to listen to the views of the child. Policy documents in the four UK countries consistently identified the same issues that needed to be tackled in relation to GP involvement in responding to child maltreatment, three of which related to the failure of GPs to engage in child protection processes (listed in Table 4.2). A fourth theme was the poor feedback from children's social care to GPs. Table 4.2 gives a brief comparison of policy across the four UK countries. Many of the requirements related to child protection processes, such as contributing to case conferences. GPs' roles in assessments were specified mainly in relation to physical or sexual abuse and not neglect or emotional abuse which, as described above, GPs might be best placed to recognise and respond to.

In policy, information sharing was typically conceived of as GPs passing information to children's social care either as a referral or to support assessment, planning or review led by children's social care. Less frequently inter-agency working was conceived of as information passed to GPs from other agencies: Lord Laming recommended that GPs always be informed at the point when a child about whom there had been concerns was discharged from hospital (in his 2003 review in to the death of Victoria Climbé)[84] and when A&E staff suspected that a child's injury was non-accidental (in his 2009 review into the progress of Child Protection in England)[102] while statutory guidance for England states that children's social care should provide feedback to any professional who refers a child.[19] Reference to organisational requirements such as named professionals, training and competences were relatively frequent. As has been identified elsewhere,[103] response was conceptualised as 'referral' to children's social care and, to a lesser extent, participation in this agency's processes.

In Box 4.1 we use England as an example to illustrate how the monitoring and support/intervention role for the GP was constructed in policy documents.* The five English policy documents which mentioned the role of GPs in monitoring children with maltreatment-related concerns saw the monitoring role as a step on the referral pathway to children's social care. Implicitly, monitoring children was seen as a way that GPs could identify the point at which when they needed to refer a child or share information with children's social care. Monitoring was not conceptualised as a tool to help GPs and the wider primary healthcare team decide on a primary care management plan for the child and parents.

Three documents for England mentioned GPs in the context of support or intervention, all in the context of 'early help' for children and families below the thresholds for intervention from children's social care (Box 4.1). In these documents, there was a tension between an 'identify and refer' early help role and one that envisaged therapeutic support given to children and families by GPs, possibly in the absence of other services (Box 4.1). Scottish policy presents a much clearer expectation that professionals should consider offering direct support as the first line of response.[7] Working Together to Safeguard Children states that all professionals, including those in universal services, should know about and be able to use local routes to early help services, for example by conducting an assessment using the Common Assessment Framework.[19] However, there was a lack of further detail about how GPs might enact a coordination or advocacy role, work with other services to access early help or offer direct support to children and families.

Although there was some acknowledgement of a monitoring role for children with maltreatment-related concerns and of a support/intervention role for children below children's social care thresholds, there was little recognition of GPs' unique position as providers of healthcare for children and their parents or their longitudinal contact with families. Similarly, there was a lack of detail about how the monitoring and on-going support/intervention role might be enacted in general practice. Lack of detail about GPs might be expected from national policy documents which apply to all types of professionals. In Section 4.3 we turn our attention to professional practice guidance relevant to GPs. This guidance can be expected to discuss GP roles and responsibilities in more detail.

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* England was chosen as the exemplar to be consistent with the research we identified in sections 4 and 5 which had largely been conducted in English settings.

Table 4.2: Policy documents: summary of themes in relation to GP responses to maltreatment-related concerns in the four UK countries

	England	Scotland	Wales	Northern Ireland
What should GPs do in relation to child protection?				
Be able to recognise risk factors and signs of child abuse and neglect	✓	✓	✓	✓
Make referrals to CSC and share information with CSC for children with CP concerns	✓	✓	✓	✓
Participation in child protection system process i.e. care planning or case conferences	✓	✓	✓	✓
Participation in the care planning and review for the health needs of Looked After Children	✓	✓	✓	✓
Medical assessment of minor abuse or neglect injuries	✓	✓	✓	✓
Named doctor or Practice Lead responsible for safeguarding and child protection within each practice	✓	✓	✓	✓
Key differences in the roles and responsibilities of GPs in child protection systems across the UK				
Assess parental capacity and risk factors for child maltreatment		✓	✓	
Listen to and take account of the views of child or young person		✓	✓	
Be aware of children and young people who are more likely to experience discrimination, disadvantage or maltreatment		✓		
GPs could be the lead professional to coordinate support to prevent need for statutory assessment	✓	✓	✓	
Issues that need to be tackled in relation to GP responses				
Poor attendance of GPs at child protection conferences and case reviews	✓	✓	✓	✓
Weak engagement and integration with local child protection systems and processes	✓	✓	✓	✓
Low willingness to share information with key agencies in child protection system	✓	✓	✓	✓
Poor communication and follow-up by social workers following child protection referrals	✓	✓	✓	✓

Box 4.1: Summary of the GP role in monitoring and providing on-going support and intervention, as presented in English policy documents

England: Five documents mentioned the GP's monitoring role and three the GP's role in offering on-going support or intervention. This summary draws only on text which specifically mentioned GPs and does not include general guidance which is applicable to all professionals.

MONITORING

Health

Two documents[104;105] referred to the role of the GP in monitoring the health of children and families with maltreatment-related concerns. One stated that the lead health record for Looked After Children should be the GP record (to enable monitoring of health needs)[104] and the other highlighted how GPs have opportunity for recognition of fabricated and induced illness in children through routine monitoring of pregnancy and child health promotion.[105]

Maltreatment-related concerns

Two documents[84;106] mentioned the GP's role in monitoring maltreatment-related concerns. As a government inquiry and response to that enquiry, the two documents were highly related. The enquiry by Lord Laming suggested that had 'social' information been collected about Victoria Climbié at the time of GP registration, the GP would have known that this was a child who needed careful monitoring. Lord Laming recommended that GP registration be extended to routinely involve collecting wider information about a child's life. He also recommended that every child in hospital about whom there were concerns should not be discharged without an identified GP (with the implication that the GP was key to monitoring the concerns).[84] The Government accepted the first recommendation but not the latter, stating that it was not a hospital consultant's role to force a family to register their child with a GP.[106]

Impact of interventions

One document about care leavers recommended that a child's GP be consulted prior to review meetings in order to get their views about progress.[107]

SUPPORT OR INTERVENTION

Two government reports ('Supporting Families in the Foundation Years' and 'The Munro review of Child Protection in England')[97;108] and 'Working Together To Safeguard Children' (2013)[19] highlight the role that the GP has in early identification and intervention for families below the thresholds for intervention from children's social care. In all three documents, routine contact between GPs and families was portrayed as an opportunity for identifying problems and offering early help.

The GP's early help role was envisaged in two ways:

- First, it was portrayed as one of identification and referral: 'GPs and health visitors are well-placed to identify problems early and arrange access to therapeutic and support services'[97] and 'They [GPs] can have a key role in helping family members access local early help services.'[108]

- Secondly, the role was seen to include therapeutic support provided directly to children and families by GPs: 'The early help assessment should be undertaken by a lead professional who should provide support to the child and family, act as an advocate on their behalf and coordinate the delivery of support services. The lead professional role could be undertaken by a General Practitioner (GP)'[19] and 'They [GPs] are ideally placed to identify, act on and *provide support* for problems as soon as they arise, drawing in, *where necessary*, support from other services' (our emphasis).[108]

No further details were given about how the support or advocacy role might be enacted.

4.3 Review of professional practice guidelines relevant to GPs

We reviewed national guidance from professional bodies governing the role and responsibilities of GPs. We determined whether guidance addressed recognition of maltreatment-related problems, interagency working, monitoring or an on-going support/intervention role.

We found nine guidance documents in our searches that related to current practice by GPs as well as one that was published as we were writing the report. The focus of all ten documents is summarised in Table 4.3.

As guidance from the General Medical Council (GMC), the RCGP, and the Royal College of Paediatrics and Child Health (RCPCH) applies to all four countries, seven documents applied across all four UK countries. The remaining three guidelines were published by the National Institute for Health and Care Excellence (NICE). NICE clinical guidelines apply only to England, Wales and Northern Ireland and NICE public health guidelines apply only to England.[118] However, the value of NICE guidelines is recognised in all four countries and can be considered relevant across the whole of the UK.[118] In the ten documents, the overwhelming emphasis was on recognition of maltreatment, referral to children's social care, supporting children's social care in assessment, planning and review and information sharing with children's social care.

Three documents highlighted the importance of 'seeing the child behind the adult' for healthcare professionals who treated adult patients, which includes GPs.[54;87;117] The documents outline a responsibility to enquire about children and consider the impact of the problems they are treating (e.g. mental health problems) on their patient's capacity to parent and on the child. This message was embodied in the 'Think Family' policy agenda of the 1997 government[40] and has since been written into multiple pieces of guidance for specialist healthcare professionals[119;120] and guidance about promoting child well-being within healthcare services.[121-123] Some UK hospitals have implemented a policy of asking all adult patients with known substance misuse, mental health problems or domestic violence about dependent children at home[124;125] and in the Netherlands this is a country-wide policy in Emergency Departments.[126]

Although there was considerably less emphasis on an on-going monitoring role, several documents had clear expectations that healthcare professionals (including GPs) had an on-going and proactive monitoring role for children with maltreatment-related concerns, both above and below the threshold for child protection services. Box 4.2 illustrates some of these expectations.

Three documents, the GMC guidance, the NICE guidance on domestic violence and the 2014 RCGP toolkit, mentioned any responsibility of healthcare providers for providing on-going support or intervention to children with maltreatment-related concerns.[87;114;117]

The GMC guidance briefly states that support and intervention should be offered but does not give further details. The NICE guidance on domestic violence states that a coordinated package of long-term care should be offered to the child and non-abusing carer which might consist of advocacy and therapy, should aim to strengthen the relationship between child and non-abusing carer, should address the child's own intimate relationships and should be offered to the non-abusing parent and child together or in parallel. Both the GMC and NICE attribute this role of on-going support only to certain services, defined by NICE as 'child and adolescent mental health, health visiting, sexual health, social care and specialist paediatric services for child safeguarding and looked after children and youth services'.[117] The role of other healthcare services, including general practice, was conceived of as 'identify and refer', either to children's social care or local early help services.

In contrast the 2014 RCGP toolkit envisages an on-going supportive role for GPs when responding to children and parents who prompt maltreatment-related concerns. The 2014 toolkit was the only piece of guidance to recognise that GPs might be able to offer support simultaneously to parent and child and that GPs might to respond to child maltreatment *through the parent* whom they were treating.[114] Specifically, the toolkit suggests that GPs can intervene to improve management and treatment of parental mental health conditions, addictions or chronic ill health with the consequence of improving circumstances for a neglected child. The guidance also suggests that GPs consider measures to enhance parental competence and social support for parents.[114]

The 2009 NICE guidance 'When to suspect child maltreatment' explicitly acknowledged that there will be cases in which health care professionals have on-going concerns which do not reach thresholds for referral to children's social care (where maltreatment is 'considered'). This guidance makes very clear that 'doing nothing' is not an option for health professionals in these and recommends gathering more information,

Table 4.3: Guidance published by professional bodies (by publication date)

Policy document Title (Department, date of publication) *Target Profession*	Document emphasis			
	Recognition & Assessment	Inter-agency	Monitoring/ support	Other**
Child Protection Reader (RCPCH, 2007)[109] * *Paediatricians but relevant to all healthcare professionals.*	★★	★		
NICE Clinical guidance No.89: When to suspect child maltreatment (NICE, 2009)[110] *All healthcare professionals*	★★★	★	★	
Public health guidance, PH28: Promoting the quality of life of looked-after children and young people (NICE, 2010)[111] *All healthcare professionals*	★★	★★	★	
Safeguarding Children and Young people: roles and competences for health care staff (RCPCH, 2010)[112] *All healthcare professionals*	★	★	★	★★★
Child Protection Clinical Networks: Protecting Children, Supporting Clinicians (RCPCH, 2010) [113] * *All healthcare professionals*		★★★		
Safeguarding Children & Young People: A Toolkit for General Practice (RCGP, 2011)[54] During the writing of this report, there was a revision of the toolkit which has not yet been published. We based our analyses on the 2011 version with reference to an unpublished draft of the 2014 version where it differs from the 2011 version.[114] *General Practitioners*	★	★★	★	★★★
Protecting children and young people: The responsibilities of all doctors (GMC, 2012)[87] *All doctors*	★★	★★	★	
Looked after children: Knowledge, skills and competence of health care staff (RCPCH, 2012)[115] *Specialist medical staff for looked after children (could include GPs)*	★	★	★	★★★
Child Protection Companion (RCPCH, 2013)[116] * *Paediatricians but relevant to all healthcare professionals*	★★	★★	★	★
Public health guidance, PH50: Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively (NICE, 2014)[117] *All healthcare professionals (focus on parents with some recommendations about working with affected children)*	★★	★	★★	

Key: ★★★: Strong emphasis; ★★: Consistent emphasis; ★: Slight emphasis

*Documents may not apply directly to GPs but have high likelihood of relevance to the profession. Shaded areas are explicitly beyond the remit of the document. **Other: refers to interventions for affected children or families or organisational interventions such as audit or training.

GMC: General Medical Council; **NICE:** National Institute for Health and Clinical Excellence; **RCGP:** Royal College of General Practitioners; **RCPCH:** Royal College of Paediatricians and Child Health; **LAC:** Looked after children; **GPs:** General Practitioner

Box 4.2: Expectations of a proactive monitoring role for GPs in practice guidance: illustrative examples

Appoint a lead member of staff for each vulnerable family or for a group of vulnerable families (known to be living in 'challenging circumstance') who will be responsible for following-up missed appointments and any childcare or child protection concerns.[54] This might be a doctor with responsibility for a specific family or another member of staff such as a receptionist who might already be following-up other patients such as those with diabetes. This good practice recommendation from the NSPCC was reiterated in a recent review of implications for Primary Health in Serious Case Reviews by the NSPCC which stated that practices should 'have in place a process and procedure for tracking and collating information on vulnerable children and families for those who do not attend appointments and who are not available for planned home visits'.[88]

Follow-up missed appointments with GPs or other agencies such as therapists, community healthcare providers or secondary care.[114]

Follow-up high numbers of unscheduled appointments with GPs, out-of-hours services, A&E and walk-in clinics.[114]

Follow-up concerns about domestic violence by putting in place procedures to review these families.[54]

Review progress of families where there are known parental problems, such as substance misuse.[54]

Follow-up referrals to children's social care (check if no response from social care[54] and escalate concern if you feel that the agency or professional has not responded appropriately).[87] Monitor the child's welfare during and beyond referral and any assessment undertaken by children's social care.[114]

Make provision to review the child if there are on-going concerns which do not meet threshold for referral to children's social care[110] or following referral to children's social care (depending on level of concern).[54]

Regularly review children subject to a child protection plan at primary care team meetings.[54]

discussing with colleagues and making provision to review the child.[110]

Recording of information on maltreatment-related problems in GP records was a focus of several guidance documents.[54;87;110] Following GMC guidance published in 2012, there is a professional and legal imperative for all health professionals to record all concerns about child maltreatment in the child and parent's record as part of their clinical management of the child. Failure to meet these professional responsibilities may result in investigation and, potentially, removal of a doctor's right to practise medicine. The GMC guidance recommends recording relevant concerns, including 'minor concerns', along with relevant clinical findings, decisions, actions, any information sharing with other professionals and conversations with the child or family.[87] The GMC clarifies confusion about recording third party information in a patients' record by recommending that concerns about maltreatment should be recorded in both the child and parent's record, if the health professional has access to both (section 52, p 31).[87] Recommendations by the GMC build on those of NICE in 2009 which recommended that health professionals record all concerns about maltreatment whether or not the concern met the threshold for referral to children's social care.[110]

Recommendations for recording 'minor' concerns recognise the opportunity for building up a cumulative picture of a child's social welfare via the primary health care record. Specific advice for GPs includes seeking wider social welfare information at routine contacts and using structured Read codes to record child welfare concerns.[54]

4.4 GPs as commissioners

The focus of this policy review is on GP practice. However, GPs now also have a commissioning role in protecting children and promoting their welfare.[19] The newly established Clinical Commissioning Groups (CCGs), which have strong GP involvement, have a 'duty to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children' (Chapter 2, Working Together to Safeguard Children).[19] Working Together to Safeguard Children sees CCGs as the major commissioners of local health services and responsible for the quality of activity to protect children and promote their welfare.

As general practitioners are independently contracted and have different arrangement with each of the relevant health bodies in the four nations. It is important that commissioning bodies are aware of the minimum statutory requirements that they must meet when looking to provide general practice services. Some responsibilities in respect of the commissioning role are set out in Appendix 5.

4.5 How far does policy support GPs' direct responses to families?

Perceived dependency on referral to children's social care

As described in section 4.1, the concept of 'child safeguarding', 'child in need' services and systems to support 'early identification and intervention' were introduced into policy to help professionals respond to a broader spectrum of child welfare than was possible within the child protection system. However, there still persists a perception among professionals, including GPs, that responses to maltreatment-related concern must be enacted via a referral to children's social care and that services are only available through the child protection system, accessed via referrals to children's social care. This perceived (or perhaps actual) dependency on children's social

care appears to be driven largely by two factors: first, the discrepancy between service need and availability; and secondly, an unacknowledged mismatch between the problem that practitioners face (maltreatment) and policy focus on service thresholds as determinants of action which does not explicitly grant permission for GPs to respond directly to child maltreatment.

The discrepancy between service need and availability

It is widely acknowledged that it has been difficult to implement the political vision for a broad focus on child welfare.[42;127] The system is pulled in two directions and, in the context of scarce resources, responses for those at the sharp end of the continuum have been prioritised. As Jane Tunstill summarises:

> Over decades, perennial changes have consistently skewed the balance between proactive support services for families and reactive crisis driven child protection responses in favour of the latter.[127]

Public and media outcry over failure of services to prevent child deaths has been identified as a key driver of the prioritisation of child protection responses.[42]

Although in 2012-13 there were more than seven times as many children who received child in need services than child protection services,[95] qualitative studies consistently report that front-line professionals and families experienced difficulties in accessing services before child protection thresholds were met.[41;86;128;129] Similarly, in an evaluation of 'early help' services for neglected children in nine Local Authorities in England, professionals and families experienced a lack of services for 'low level' neglect cases, stating that that most help was available to families with 'complex needs'.[130] This experience was summed up by Dr Quirk (a GP) when providing oral evidence to the House of Commons Education Committee in 2011:

> There does not seem to be anything underneath the children's social care child protection system that then can provide support for that family locally.[131]

The perceived gaps in support services (such as parenting courses, help with family budgeting or access to early mental health support) have been attributed to lack of resources, high case-loads, welfare cuts, administrative burden and practitioners prioritising families with higher levels of need.[130] Inadequate provision of early help and preventive services has been exacerbated by the 28% cuts in Local Authority funding, which disproportionately affected services designed to support children, young people and families below thresholds for child protection services.[132]

The perception that welfare services are only available to children at the sharp end of the spectrum and only via children's social care child may be part cause and/or consequence of GPs apparent lack of engagement with local systems for early identification and prevention.[130] Dr Quirk commented that 'the majority of GPs in England would not know what the CAF [Common Assessment Framework] stood for and do not use it'.[131]

A lack of permission for GPs to work with child maltreatment

As envisaged by policy, the type of response that GPs should enact hinges on judgements about whether the child meets the thresholds of 'significant harm' or 'child in need'. If children are below the child in need threshold, they can be offered services via early help routes but if they meet these thresholds, a referral should be made to children's social care:

If at any time it is considered that the child may be a child in need as defined in the Children Act 1989, or that the child has suffered significant harm or is likely to do so, a referral should be made immediately to local authority children's social care.[19]

The terms 'significant harm' and 'child in need' describe service provision thresholds within children's social care. They do not describe the problems that children experience and therefor do not easily map onto the GP's experience of seeing children and families.

Children who prompt concerns about maltreatment will almost all be 'in need' of services and many will be at risk of suffering *long-term* significant harm. If professionals acknowledge that their concerns are about 'maltreatment', they are implicitly stating that this a child in need and possibly a child at risk of significant harm, both of which necessitate a referral to children's social care. Uncertainty among GPs about the net benefit of referral to children's social care, especially for children who are not at the most extreme end of the spectrum,[50;51;78] discourages labelling of concerns as 'maltreatment'. Professor Brandon (social work academic) summarised the systemic disincentives to label 'maltreatment' in her oral evidence to the House of Commons Education Committee:

[This leaves] all of these below-the-threshold agencies—teachers, GPs, health visitors—[…] working with child abuse, but they are not allowed to call it child abuse.[131]

Currently, national policy does not explicitly acknowledge that healthcare professionals need to respond to concerns about 'maltreatment' which do not meet thresholds for referral to children's social care.

Persistent sub-text of 'identify and refer'

The perceived dependency on children's social care for enacting responses to concerns about child maltreatment is part of a persistent narrative which sees the role of the GP as primarily 'identify and refer' for any type of welfare concern in children. There are reports that practitioners of all kinds still see referrals as a way of handing over responsibility[41] and that even the Common Assessment Framework is being used as a referral mechanism.[133] The 'identify and refer' role is problematic in the context of insufficient services to which to refer and ambivalence about the net benefits of high-level child protection services which are available.

The 'identify and refer' narrative is a sub-text beneath the explicit policy message that all professionals must take responsibility for protecting children and promoting their welfare and must contribute to multi-agency assessment and service provision for children above and below children's social care thresholds.

What could policy do to better support direct responses by GPs?

Policy should explicitly acknowledge that universal services will be working with child maltreatment in situations where there may not be available support services to which to refer the child or family. With this in mind, it seems sensible for policy to further challenge the 'identify and refer' role of the GP and promote responses to maltreatment-related concerns which can be delivered continuously as part of care in general practice and before, alongside or after referral to other agencies, including children's social care.

4.6 Key points

- We reviewed 109 policy documents and ten pieces of national guidance relevant to the four UK countries.

- Policy and practice guidance was found to be heavily focussed on recognition with GPs' responsibilities largely seen as assessment, inter-agency working and the implementation of organisational structures and/or audit.

- There was some expectation that GPs should monitor concerns both above and below the threshold for intervention from children's social care, although little advice about how this might be achieved. Monitoring was seen as a step on the referral pathway to children's social care (i.e. to aid decisions about when to refer). The expectation of a monitoring role was more evident in practice guidance than national policy.

- Beneath explicit policy messages that all professionals must take responsibility for child safeguarding, there was a persistent sub-text which portrayed the GP's role as primarily 'identify and refer'. Exceptions were early help policies which envisaged that GPs could take on a lead professional role and advocate and coordinate services for children below the threshold of significant harm. However, the GPs' role in early identification and help was not well-defined and there remained a tension between expectations that a GP should primarily 'identify and refer' and expectations that they could also offer therapeutic support to families, perhaps in the absence of other services. Practice guidance focussed very heavily on the GP's 'identify and refer' role.

- On the whole, government policy and practice guidance does not play to the strengths of general practice. The 2014 RCGP toolkit was the only piece of guidance to explicitly acknowledge the on-going role of support and intervention that GPs can play for children with maltreatment-related concerns, including via responses aimed at parents.

- Policy could better support GPs by acknowledging that they will be responding to children with child maltreatment where they may be a lack of other services to refer to.

5 Learning from practice and research: what do we know about direct responses by GPs

5.1 What might constitute a direct response by GPs?

The third section of this report presents an overview of published examples of current practice or recommendations for good practice which have been generated by research studies. Descriptions of current or good practice can give us ideas about what types of direct responses might be possible in UK general practice settings. Learning about what is possible is the first step towards understanding what might be effective in helping children and families with maltreatment-related concerns in general practice.[134-136]

In our literature review, we found four research studies which provided descriptions of current responses to child maltreatment and maltreatment-related problems by GPs in the UK and/or which had developed recommendations for good professional practice in this area. Three of these four studies were carried out by some of the authors of this report. An analysis of a large primary care dataset (THIN: The Health Improvement Network) by Woodman et al. (2012a)[89] and one mixed methods quality improvement study also by Woodman et al. (2012b)[85] focused on recording of maltreatment-related concerns. A further qualitative study by Woodman et al. (2013)[47] and one mixed methods study by Tompsett et al. (2010)[48] investigated *all* GP responses, including wider responses that can be under taken before or in additional to referring to children's social carTable 51: Studies reporting current and/or good practice among GPs in the UK: methods and resultse.[50;51] Table 51 provides a summary of the aim, methods, results and conclusions of the four studies.

Table 5.1: Studies reporting current and/or good practice among GPs in the UK: methods and results

Study	Study aim and methods	RESULTS		
		Current GP practice	Practice recommendations	Study conclusions
Tompsett et al. 2010[50]	*Aim:* to describe the nature and consequences of tensions and conflicts of interests for GPs when protecting children and promoting their welfare, to explore how these tensions and conflicts are seen by professionals and the public and to suggest ways of managing them. *Methods:* mixed methods study including a literature review; a survey of 96 English GPs (although only 93 completed the ranking of indicators), in-depth interviews with a sub-set of 14 GPs; interviews with 19 key stakeholders (including strategic level staff from two Primary Care Trusts and Local Safeguarding Boards (LSCBs); three focus groups with young people, young mothers and a minority ethnic group; and a Delphi consensus about the guiding principles of GPs in responding to maltreatment (with 25 experts). Data was collected between 2006 and 2007.	Many GPs sought local solutions with the family, managing child welfare concerns within the primary health care arena, especially via the health visitor. GPs saw their role as strongest for concerns about *neglect.* Four GP roles were identified, see Table 5.3 for more details: **The case holder:** GP has on-going relationship with family before, during and after referral to children's social care. **The sentinel:** GP identifies and refers the concern to other agency. **The gatekeeper:** GP provides information to other agencies for decision-making about access to services. **Multi-agency team player:** GP has continued engagement with other professionals outside the practice (e.g. GP contributes actively to social care child protection processes).	• involve parents in decisions and take time to make those decisions. • be clear with parents about limits of confidentiality (the dilemmas of this are discussed in detail in the study). • encourage consultative and reflective practice. • sharing information with other professionals. • arrange for follow-up of a child when there are on-going concerns. • ensure that parent and child have a separate GP where there are conflicts of interest. • record concerns, decisions and actions. • take a long-term view, especially about the doctor-parent relationship which may eventually recover from damage or difficulty.	We need greater clarification of the GP role at each stage in the process of early assessment, intervention and multi-professional support for families, especially for children with (possible) neglect. Health visitor responsibilities could be increased. Policy makers could explore ways of raising the profile of child protection and child welfare work amongst GPs through initiatives that would help GPs prioritize this work. Further research is needed to evaluate outcomes for children following GP responses, including outcomes for children who were involved by GPs in decisions about them.

Table continued overleaf

Table 5.1 *continued*: **Studies reporting current and/or good practice among GPs in the UK: methods and results**

		RESULTS		
Study	Study aim and methods	Current GP practice	Practice recommendations	Study conclusions
Woodman et al. 2012a[85]	*Aim:* to develop a simple intervention to improve the quality of recording of maltreatment-related concerns by GPs. *Methods:* A collaborative multi-component mixed methods study including descriptive analyses and incidence estimates of recorded maltreatment-related concerns in child records in 11 study practices and a UK representative sample of 442 practices in The Health Improvement Network (THIN), brief telephone interviews, a workshop, and a consensus development meeting with GPs from 11 study practices. A systematic analysis of current practice and an iterative consensus approach was used to develop a quality improvement intervention.	GP used maltreatment-related Read codes* and/or free-text and/or alerts to record concerns. There were 350 Read codes* which could be used by GPs to indicate a maltreatment-related concern but only 82 codes were used more than once in the small dataset (11 practices) or more than 10 times in the large dataset (42 practices). There was little overlap in the types of maltreatment-related codes used in the two datasets. Many recognised maltreatment-related problems were uncoded. Some recognised problems were not recorded in any form.	As a minimum, GPs should use the code 'Child is cause for concern' whenever child maltreatment is 'considered' the code is 13If for systems using Version 2 (5-byte) codes and XaMzr for systems using Clinical Terms Version 3 (CTV3) codes.* Further details of the case should be coded as appropriate and additional free text should be encouraged. Important concepts to hold in mind include: • Why is the child cause for concern? • Is the family cause for concern? • Are child protection or social care services involved? • What other professionals are involved? A code should indicate when a period of concern has ended. Further details available at http://www.clininf.eu/maltreatment	Recommendations for coding cannot be comprehensive. The best type of recommendations should offer a framework for coding that is feasible to implement, easy for GPs to remember, and does not risk 'putting off' GPs who are less experienced. Using a template (data entry form) may help increase coding and improve standardisation.
* All GP practices in the UK use the Read code system, a hierarchical coding system for recording clinical consultations and information relevant to patient management. There are different versions of Read codes: the majority of GP practices use Version 2 (5 byte) with a minority using other sub-types, including Read Clinical Terms CVT3 and the systematised nomenclature of medicine clinical terms (SNOMED CT).				

Table continued overleaf

Table 5.1 *continued*: **Studies reporting current and/or good practice among GPs in the UK: methods and results**

Study	Study aim and methods	RESULTS		
		Current GP practice	Practice recommendations	Study conclusions
Woodman et al. 2012b[89]	*Aim:* to determine variation over time and between practices in coded maltreatment-related concerns in children's primary healthcare records. *Methods*: Epidemiological analysis of a UK representative sample of 448 practices contributing data to the THIN database between 1995 and 2010. The THIN database contains records for approximately 6% of the UK population. Annual incidence of maltreatment-related codes was calculated for each calendar year and % change per year was estimated from 1995-2010. Rate ratios in 2010 were used to investigate variation by child age, sex and deprivation. The number of standard errors between the mean prevalence for each practice between 2008 and 2010 and the grand mean (mean of all practices) was calculated to investigate variation between practices. Over-dispersion was taken into account. Outlying values were pre-defined as those more than three standard errors above or below the grand mean. All analyses were	From 1995-2010, annual incidence rates of any coded maltreatment-related concerns rose by 10.8% each year (95% confidence interval 10.5, 11.2; adjusted for sex, age and deprivation). In 2010 the rate of maltreatment-related codes was 9.5 per 1000 child years (95%CI: 9.3, 9.8), equivalent to a prevalence of 0.8% of all registered children in 2010. Rates were highest in the youngest and/or most deprived children. 20.8% of the 33,191 children with a maltreatment-related code in 1995-2010 had a code in more than one calendar year. There was no evidence of variation between practices in the rate of maltreatment-related codes once case-mix and random error was taken into account	N/A	Maltreatment-related codes are common and annual rates were not driven by a few 'expert' practices: the average GP is recognising and recording maltreatment-related problems. Recording is a necessary but not sufficient part of responding. There is considerable scope for improving recognition and/or recording. The steady increase in coding is probably a result of changes in recording behaviour in relation to child maltreatment and/or increased recognition. Interventions to improve coding need to be evaluated for impact on subsequent action and outcomes for the child and family.

Table continued overleaf

Table 5.1 *continued:* **Studies reporting current and/or good practice among GPs in the UK: methods and results**

Study	Study aim and methods	RESULTS		
		Current GP practice	Practice recommendations	Study conclusions
Woodman et al. 2013[51]	*Aim:* To provide a rich description of current responses to concerns related to child maltreatment among a small sample of English GPs. *Methods*: Qualitative in-depth, face-to-face interviews with 14 GPs, 2 practice nurses and 2 health visitors from four English practices with at least one 'expert' GP (expertise in child protection and/or welfare). Participants selected and discussed families who had prompted 'maltreatment-related concerns' Data collected between 2010 and 2011. Thematic analysis of data.	Concerns about neglect and emotional abuse dominated the interviews. There were seven GP actions: • Monitoring • Advocating • Coaching • Opportune healthcare • Referral to other agencies • Joint working Facilitators of actions were: 'trust' between parents and GPs good GP-health visitor relationships/links and framing the problem/ response as 'medical'. Narratives indicated GPs spent energy building relationships with parents with the aim of improving child well-being. GPs saw limitations as working in a reactive system, potentially prioritizing parental needs over those of the child or 'missing things.'	N/A	This study describes responses that are feasible where there is some expertise and interest within general practice. GPs used core skills of general practice skills for on-going management of families who prompted concerns about neglect and emotional abuse, especially in families with high health need and who were perceived to be help-seeking. Policy and research focus should be broadened to include strategies for direct intervention and on-going involvement by GPs, such as using their core skills.

The analysis of 448 GP practices in the UK (see Table 5.1, Woodman et al. 2012b) reported that maltreatment-related concerns were entered in almost 1% of the 76, 9940 children's primary care records in 2010.[89]

This study did not find any evidence that a few 'keen' or 'expert' practices were driving the incidence of maltreated-related codes which suggested that GPs across the board were recording maltreatment-related concerns (see Table 51, Woodman et al. 2012b). Given the large and representative nature of the dataset, which covered 6% of the UK population in 2010, it is reasonable to generalise these results to all UK general practice settings. Based on children aged less than 18 years or under who were registered with general practice in England in April 2011 (just under 11 million),[57] we can estimate that nearly 90,000 children would have had a maltreatment-related code in England in 2010. For an average English practice with 1600 registered children,[47] this is equivalent to a new record for 130 children each year and more for practices with higher rates of deprivation and/or very young children (see Table 51, Woodman et al. 2012b).

As the measure of maltreatment concerns was specific but not sensitive,* the study results provide a minimum estimate of all recorded concerns. As many identified problems go unrecorded (see Table 5.1, Woodman et al. 2012a) and because maltreatment-related codes appeared to be used as a one-off flag in a single calendar year to indicate concerns which may often be chronic (see Table 5.1, Woodman et al. 2012b), the study tells us that *at least* 1% of children in the sample had a maltreatment-related problem known to general practice in 2010. The true proportion of children with known problems in general practice is likely to be much higher.

A collaborative study between researchers and the RCGP brought together 11 GPs and analysed data from their practices to generate a consensus recommendation that a single 'cause for concern' code should be used as a minimum flag for maltreatment-related concerns in the primary care record (See Table 5.1, Woodman et al. 2012a).[85] In the second phase of the same study, the coding recommendation was implemented in the 11 practices and rates of recording measured before and after implementation. Following implementation, there was a significant increase in the rates of maltreatment-related codes in the 11 practices. These data are expected to be published later in 2014.

In summary, the two studies which focus on recording maltreatment-related concerns in general practice[85;89] found substantial numbers of children with maltreatment-related concerns known to GPs. Some of these children had concerns coded in their primary care record. Recording concerns is a necessary but not sufficient response to child maltreatment and these two studies cannot tell us how else GPs might be responding to the significant burden of maltreatment-related problems known to general practice.

The remaining two studies reported GP accounts of their own practice which had been ascertained through interviews and questionnaires. There is considerable overlap between the results from these two studies which together suggest that at least some GPs in England are directly responding to children and families who prompt maltreatment-related concerns.[50;51] In the study by Tompsett et al. (2010; Table 5.1), GPs who completed a closed question postal survey indicated that they preferred to address issues directly with the parent or ask a health visitor to monitor the family rather than refer to children's social care.[48] This was particularly true when concerns were prompted by parental risk factors such as alcohol and drug use or mental health issues but was also the case for a hypothetical instance of a 'neglected' child.[†] Similarly, referral to children's social care and interagency working were only two of a range of responses described by the GPs in the other interview study (see Table 5.1, Woodman et al. (2013)). The other five responses identified by Woodman et al. 2013 included monitoring and advocating for whole families, coaching the parents and providing opportune healthcare to the children. Table 5.2 provides a detailed description of the seven responses and shows how they related to different family types, as depicted in the GPs' accounts.

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* As this measure was specific, it was unlikely to erroneously include children without maltreatment-related concerns, such as children who had high need due to disability. The measure was not sensitive for *recorded* concerns as it did not include free-text entries and was not sensitive for *known* concerns as many concerns in general practice remain unrecorded.

† 'Neglected' children were not further defined in the postal survey sent to GPs. Three of the 96 GPs who responded said that they could not answer the multiple choice questions about their responses without further information about context and severity. It is not clear how many GPs said they would make a simultaneous referral to a health visitor AND children's social care.

Table 5.2: Detailed description of seven responses identified in the qualitative study with GPs by Woodman et al. (2013)

*There were four distinct types of families that emerged from the GP accounts:

'stable at this point in time but it's a never ending story': narratives describing families with previous very serious maltreatment-related concerns who had since achieved a fragile stability that required extra vigilance from participants. The main concern was usually about possible neglect and emotional abuse.

'on the edge': narratives describing families who were barely coping and liable to tip over the edge at any moment. The main concern was about possible neglect.

'was it, wasn't it': narratives describing situations where participants had a high degree of uncertainty as to whether physical or sexual abuse had occurred and much time was spent trying to establish whether it had or not. Ultimately, physical and sexual abuse were ruled out but often concerns about lack of supervision (neglect) persisted.

'fairly straightforward': uniformly brief narratives in which there was high certainty about physical abuse and decisive onwards referrals.

What	For whom*	How	Why	Context
1. Monitoring: keeping a 'watchful eye' on families and being 'a bit more vigilant' *Response enacted through children, parents and wider family members and other professionals.*	Frequently 'stable at this point' and occasionally 'on the edge' families'.	Using well-child checks and consultations for parental health problems to assess well-being of children and coping/risk factors in parents. Receiving information about family life and parenting from relatives esp. grandmothers. Assessing the family and risk during (routine) GP post-natal home-visits. Checking the electronic health records for subsequent presentations to colleagues. Interpreting missed appointments as a possible sign of escalating problems in the family. Usually this relied on the individual practitioner but one GP was developing a practice-wide system to capture all missed primary and secondary care appointments by <16s. Using vulnerable family meetings to gather information and anticipate stressful points in a family's life. Health visitors were essential for the meetings to fulfil a monitoring function.	To ascertain whether or not there was relevant information that needed to be passed onto children's social care (in the form of a referral) or to inform decisions about how they managed the child or parent within primary care. Missed appointments could result in a phone call from the GP and, if necessary, a letter and/or discussion in the vulnerable families meeting.	When they felt a family would seek help and disclose information, GPs felt comfortable with monitoring and risk assessment of 'stable at this point' families. Honest disclosure and help-seeking in families relied on GPs being seen as a 'trusted ally' GP monitoring might be limited by a 'health' focus and lack of wider information. For younger children, GPs relied on health visitors for information they needed to fulfil their monitoring role.

Table continued overleaf

Table 5.2 *continued*: Detailed description of seven responses identified in the qualitative study with GPs by Woodman et al. (2013)

What	For whom*	How	Why	Context
2. Advocating: 'you've got to stand up and shout for people' (making a case to other agencies on the participant's behalf). *Response enacted through parents and other services.*	Frequently 'on the edge', 'was it, wasn't it?' and occasionally 'stable at this point' families.	Supporting requests for improved housing or benefits. For 'on the edge' families, interceding with children's social care to make this agency recognise the seriousness of the family's problems and offer what they considered to be a more appropriate level of service (usually child protection services) For 'was it, wasn't it?' families, interceding with social care to reduce an unnecessarily heavy-handed or insensitive approach and encouraging these families to demonstrate cooperation with children's social care.	Improving quality of life (housing, poverty) was seen to impact on parenting and therefore on child welfare. GPs saw many 'on the edge' children as in need of protection (& sometimes removal) in order. For 'was it, wasn't it' families GPs encouraged compliance in order to avoid a more coercive approach from children's social care which might lead to thing "getting worse" for children. Instead GPs wished to help children's social care provide supportive services.	The need to intercede with children's social care was seen as greatest in the 'on the edge' families whose children has suffered 'terrible neglect' over years but where maltreatment did not pose an immediate threat to child's physical safety and/ or was not as 'barn door' or 'obvious' as some of the other types of abuse.
3. Coaching: activating of parents by attempting to shift mind-set, take responsibility for their problems and, eventually, change behaviours. *Response enacted through parents.*	Frequently 'on the edge' families.	Talking to parents, usually the mother, to encourage them to 'look at different ways of thinking about things', such as realising 'that there was actually a problem with the children' or that 'stopping drinking was a good thing'. Talking to parents, usually the mother, to encourage them to 'change their life' or 'change her behaviours'.	A parent's willingness or ability to recognise that there was a problem (in the GPs eyes) seemed to make the difference between situation perceived as hopeful and one perceived as hopeless for the family. Parental (maternal) recognition of the problem was seen as the first step in intervening to improve the situation for the children.	This was described as a difficult task that was often attempted but infrequently achieved. In order to have a hope of changing parental mind-set (and eventually behaviour), GPs saw that the parents needed to be engaged with primary care and to see the GP as a 'trusted ally'.

Table continued overleaf

Table 5.2 *continued*: Detailed description of seven responses identified in the qualitative study with GPs by Woodman et al. (2013)

What	For whom*	How	Why	Context
4. Opportune healthcare: providing (missed) routine and preventive healthcare for children during consultations for other reasons. *Response enacted through children and parents.*	Frequently 'on the edge' families.	Meeting preventive healthcare needs of the children during parent/child consultations for other reasons (e.g. overdue immunisations or developmental checks). This had to be done immediately as the parents could not be relied on to come back at a later date.		Facilitated by being able to offer something that the family wanted such as letters for benefits or housing (leverage) and easy access to a health visitor who could help them access other initiatives.
5. Referral to other services Although there were mentions of referral to the police or to specialist child protection assessment clinics, these were rare. In contrast referral to children's social care and/or paediatric services were more common. Referral to the health visiting team was considered as part of the primary health care team *Response enacted through other services.*	Frequently 'fairly straightforward', 'was it, wasn't it?' and occasionally 'stable at this point' families.	**Children's social care** • Immediately, decisively and directly following consultation with a child or parent. • After using health visitor opinion or follow-up to confirm or counter GP concerns, sometimes via an additional filter of the 'safeguarding lead' in the practice.		Direct referrals to social care involved certainty about physical abuse. For emotional abuse, neglect or highly uncertain physical abuse GPs used follow-up by health visitors to scale concerns up and meet thresholds for referral to children's social care or provide reassurance and avoid referral.
	'was it, wasn't it?' families.	**Paediatric services** • Referral to hospital paediatricians for an assessment of injuries or symptoms which might be related to physical or sexual abuse. • Children referred to paediatric services were also simultaneously referred to children's social care by the GP.	GPs sought a full assessment and documentation of child injuries or symptoms, including probable cause.	GPs recounted stories of how paediatrician behaviour did not support or encourage future referrals.

Table continued overleaf

Table 5.2 *continued*: Detailed description of seven responses identified in the qualitative study with GPs by Woodman et al. (2013)

What	For whom*	How	Why	Context
6. Working with other services GPs described working with children's social care and in only one case paediatric services (see above). *Response enacted through other services.*	Frequently 'was it, wasn't it?' and 'on the edge' families.	**Children's social care** • In only two cases did GPs describe joint-working with children's social care. This was done largely through one-way communication of information (e.g. GPs informing children's social care about parental learning difficulties or missed child health appointments). • In most cases, GPs relied on the health visitor to act as intermediary between GPs and social care, mainly at the vulnerable families meetings. Health visitors were depended on to 'keep us abreast' of children who were receiving 'child in need' services and of the full content of reports and plans. • Attending joint child protection meetings (infrequently) or (more frequently) writing reports or using the health visitor as the health representative at these meetings. One GP practice allowed children's social care to hold meetings in the practice seminar room without cost in order to increase GP attendance.	None stated by the GPs in the study. We might assume this is because it was obvious to them that they were following statutory guidance to refer and/or referral threshold guidance from Local Children Safeguarding Boards.	Motivation to attend joint meetings or participate in on-going joint-work occurred in the context of GPs feeling they knew the family, had a unique (often 'medical') contribution to offer, had to advocate for the child to receive appropriate services or felt responsible for the family as they had made the referral.
		Paediatric services • There was only one case where a GP described working *constructively* with a paediatrician. In other cases, referral to paediatricians was seen as a necessary but disruptive part of the GP response to the family.	The GP sought a second opinion about the likelihood of sexual abuse.	The GP turned to a paediatrician whom she knew and felt could be trusted.

Table continued overleaf

Table 5.2 *continued:* **Detailed description of seven responses identified in our qualitative study with GPs (Woodman et al. 2013)**

What	For whom*	How	Why	Context
7. Recording of concerns *Response enacted through electronic health record.*	All families	Variable completeness of recording (but GPs were worried and embarrassed when they had not recorded, saying there was 'no excuse'). Variable use of relevant Read codes, preference of recording something 'vague' in favour of something specific and favouring of free-text entries over Read codes. Higher acceptability of recording facts compared to opinions or 'feelings'. Two participants felt that recording practice was changing - moving away from 'vague' or euphemistic recording to more specific, structured and complete recording with increased use of Read codes. One participant reported that it was most difficult to record concerns about long-term neglect and emotional abuse which were vulnerable to remaining 'all in my head'.	GPs highlighted the importance of recording for case-finding, continuity of care with other doctors in the practice and information sharing with children's social care.	There were perceived threats to the doctor-patient relationship from recording (from patients seeing the records) and conflicting views about the ethics and acceptability of recording third party information in the child's records.

*'For whom': In this study, the narrative analysis of cases generated typology of families which contained four narratives describing four types of families which were named using *in vivo* codes (i.e. quotes from participants): 1) **"Stable at this point in time but it's a never-ending story"**: narratives describing families with previous very serious maltreatment-related concerns who had since achieved a fragile stability that required extra vigilance from participants. The main concern was usually about possible neglect and emotional abuse; 2) **"On the edge"**: narratives describing families who were barely coping and liable to tip over the edge at any moment. The main concern was usually about possible neglect and, in some cases, emotional abuse; 3) **"Was it, wasn't it?"**: narratives describing situations where participants had a high degree of uncertainty as to whether physical or sexual abuse had taken place and where much time was spent trying to establish whether the suspected abuse was likely to have occurred; 4) **"Fairly straightforward"**: uniformly brief narratives in which there was high certainty about physical abuse and decisive onwards referrals.

As Table 5.2 describes, robust therapeutic relationships with parents and pathways for information sharing with health visitors, such as regular primary care team meetings to discuss vulnerable families, were seen as necessary facilitators of direct GP responses in the most recent qualitative study with GPs (Woodman et al. (2013)),[51] a view shared by the professionals in the study by Tompsett et al. (2010).[50;51] However, both studies found evidence that relationships and links between GPs and health visitors may be insufficient to support the monitoring function ascribed to them and focus groups with parents in the study by Tompsett et al. (2010) suggested that not all GPs are successful in establishing trust with families.[50] Both studies suggested that GPs might be most involved in responding to maltreatment-related problems when they can see a 'medical' role for themselves, when they perceive that the child will not meet social care thresholds for action and/or where the GP perceive that children's social care responses are not in the child's best interests.[50;51] In the qualitative study by Woodman et al. (2013), GPs described most involvement with families who had high health need, were seen to be help-seeking and were constructed by GPs as 'loving' but 'incompetent' parents with a legacy of their own difficult childhood and challenging personal circumstances.[51] In the study by Woodman et al. (2013) and the study by Tompsett et al. (2010)[50], the characteristics that drove GP involvement were most compatible with families who prompted concerns about neglect. It was not clear how GPs arrived at judgements about which families they thought suitable for direct responses and how or whether they assessed capacity for parental change and/or risk to the child.

In the study by Tompsett et al. (2010), the 'case-holder' was the only role that involved responding directly to families (Table 5.1).[50] It was a role that was recognised by the majority of GPs but not by other professionals in the study.

Table 5.3 demonstrates how most of the responses to maltreatment-related concerns described in the qualitative study by Woodman et al (2013) can be conceived of as components of Tompsett's 'case-holder' role. Together, the two qualitative studies suggest that 'case-holding' might be a key component of GP responses to maltreatment-related concerns. However, as described in Section 4.5, policy concentrates on the GP's role as 'sentinel' (refer to children's social care), 'gate-keeper' (share information with other agencies) and 'multi-agency player' (support children's social care processes; see Table 5.3 for more detailed description of these roles, as defined by Tompsett et al. (2010).[50] There appears to be a mismatch between GP practice which often comprises of responding directly to families, and policy and guidance where direct responses were rarely mentioned.

Table 5.3: Overlap between the 'case-holder' role defined by Tompsett et al. (2010) and findings from Woodman et al. (2013)

Four roles outlined by Tompsett et al	Relevant findings from Woodman et al 2013[51]	
	Similarities	What Woodman et al. adds
1. The case holder: GP has on-going relationship with family before, during and after referral to children's social care. This role builds on voluntary disclosure and establishing trust over time with the parents. This role was clearly identified by GPs but not recognised so much by the stakeholders.	Comparable to the role that GPs in the sample described in relation to "stable at this point", "on the edge" and "was it, wasn't it?" families, both in the on-going nature of the relationship with families and in the reliance on voluntary disclosure and trust by parents. This was the most commonly described role by the GPs in this sample.	This role might be performed most commonly where: • Families had multiple health problems (including those caused by child neglect) which: – Provided a reason for repeated contact. – Legitimised GP intervention in maltreatment-related concerns. – Offered opportunity for establishing trust and reciprocity and encourage help-seeking behaviours by meeting high need. • GPs perceived that children's social care was not/not likely to offer appropriate services. • GPs could construct concerns as due to "incompetent" (rather than "malicious" parenting) which allowed sympathy with the parents and facilitated on-going GP involvement. These factors were typical of families who prompted concerns about chronic *neglect*. In this study, the equivalent role also included monitoring, coaching, advocating and providing opportune preventive healthcare.
2. The sentinel: GP identifies child maltreatment and refers the concern to children's social care or other health services.	Comparable to the role for families with "fairly straightforward" concerns (infrequently described) for whom concerns were referred onwards with no further involvement.	This role might be performed most commonly where: • GPs perceived that other agencies responded (or would respond) appropriately. This was typically in cases of concerns about *physical abuse* or, less frequently, an episode of acute neglect.
3. The gatekeeper: GP provides information to other agencies so that those agencies can make decisions about access to services.	This role was not directly comparable to any described by the GPs in my sample in terms of responding to child maltreatment, although it is well known that GPs fulfil a "gatekeeper" role in terms of enabling access to secondary services such as paediatrics and mental health services.	The GPs did offer information to children's social care, especially for "stable at this point" families. However, this information was unprompted and resulted from on-going monitoring and risk assessment for families with a history of very serious child-maltreatment concerns who had achieved a fragile stability.
4. Multi-agency team player: GP has continued engagement with other professionals outside the practice. This role is fulfilled when GP contributes actively to social care child protection processes.	Comparable to the few instances in which GPs described working with children's social care and actively participating in their child protection processes.	This role might be performed most commonly where: • GPs knew the families well and did not trust children's social care to offer appropriate services. For example, one GP perceived the child protection plan to be making unhelpful and stressful demands on a family by stating that a grandparent move in with the child and parents. • GPs perceive that there were medical issues giving them a unique medical perspective.

5.2 Are direct responses by GPs feasible and acceptable in UK general practice?

The in-depth qualitative work in the qualitative studies by Woodman et al. (2013) and Tompsett et al. (2010) used small samples of GPs who were likely to have a more than average amount of expertise and interest relevant to child protection and child welfare (Table 51).[50;51] We cannot generalise from these two studies to the wider GP population. However, there are a several reasons to hypothesise that the direct responses of monitoring, advocating, coaching and providing opportune healthcare might be feasible and acceptable more widely in UK general practice as responses to maltreatment-related concerns.

First, as Table 5.3 shows, there was remarkable consistency between the results of the two qualitative studies (Woodman et al. (2013) and Tompsett et al. (2013)) which were conducted in two different samples of English GPs.[50;51] Secondly, the families described by the GPs in the Woodman et al. (2013) study[51] are likely to be familiar within general practice (see Table 52 for description of families); they are compatible with descriptions of families and adults with broader social welfare problems in general practice[137] and with 'heart-sink' patients (whose chronic and multiple problems cannot be cured or solved and who evoke exasperation, defeat and helplessness in the GP).[138;139]

Thirdly, the skills and actions inherent in the direct responses (as described in Table 5.2) reflect core GP skills:

1. Monitoring, which can also been termed review or 'watchful waiting' is a substantial part of GP practice and has been used as part of proactive management for other groups who present with a mixture of social and welfare problems, such as the frail elderly.[140]

2. Acting as an advocate to help patients access and navigate services within and beyond the NHS constitutes part of managing chronic health conditions in general practice and is expected by patients.[141-144]

3. Coaching incorporates elements common to promoting 'self-management' of chronic disease and 'motivational interviewing', in which professionals attempt to activate the response from patients by encouraging them to take responsibility for their own health.[145]

4. Providing opportune healthcare as a routine part of consultations has been long considered a fundamental part of the GP consultation.[146] Tompsett et al. (2010) also concluded that the GP role in responding to maltreatment-related concerns was an extension of 'normal' GP work.[50]

Fourth, other studies have depicted some of the strategies used in direct responses as current, acceptable or even promising GP practice in responding to child maltreatment. Building rapport, providing education and assertive follow-up have been described as acceptable strategies for dealing with families at risk of child neglect in general practice.[50] Lastly, we know that GP responses to social welfare concerns in children, including concerns about child abuse or neglect, are often aimed at building a relationship with the parents.[50;73;74;147]

On the other hand, there are changes within general practice which are likely to present challenges to the feasibility of direct responses by GPs to families who prompt maltreatment-related concerns.[79;80] Responding directly to maltreatment-related concerns may be beyond the scope of a 10 minute consultation and difficult given the increasing GP workload: GPs are under pressure to take on increasing care of chronic conditions and to keep patients out of hospital, to open practices for more hours in the week, and to have more active involvement in local commissioning. Most recently, the Chief Medical Officer called for named GPs to coordinate care for children with long-term conditions.[148] These demands are exacerbated by dwindling access to support from health visitors, who are no longer practice-based.

In summary direct responses to concerns about child maltreatment draw on core skills of general practice and as such are likely to be feasible in wider general practice in the UK. However, it is not without its challenges and there may be costs (financial and opportunity) of GPs adopting such a role. As described in Section 4, direct responses by GPs are not addressed in policy or practice guidance and, as described in Section 5.1, the study by Tompsett et al. (2010) suggests that such a GP role might not be recognised by other professionals. Based on studies about recording of maltreatment-related concerns, direct responses will not be visible in routine data. For these reasons, any such role is occurring below the policy radar and remains uncosted and unmonitored. Direct responses are likely to be

highly variable across the UK in terms of coverage and quality.

5.3 Are direct responses by GPs effective and safe?

Evidence is lacking about the efficacy and safety of any responses to maltreatment-related concern in general practice, including the types of direct responses described in section 5.1. In our literature searches, we found only two interventions relevant to GP responses to maltreatment-related concerns which had been evaluated using three randomised controlled trials (the SEEK, IRIS and WEAVE trials) and two systematic reviews of interventions delivered in primary care to prevent child maltreatment (which included only one trial: the SEEK trial) and for woman exposed to domestic violence.[149-156] Although some of the trials have promising results, it is not at all clear if strategies such as on-site social workers/access to specialist staff or motivational interviewing/counselling of parents with risk factors for maltreatment, as used in the SEEK study, are likely to improve outcomes for children and families when delivered in English general practice. Appendix 6 contains a detailed summary of methods and results for the two interventions and a summary of the systematic review on interventions delivered in primary care to prevent maltreatment.

The SEEK, IRIS and WEAVE trials can also provide some insight into the types of direct responses by GPs which were described in section 5.1 above. The 'coaching' and 'advocacy' actions described in Table 5.2 share characteristics with the motivational interviewing and advocacy component of the SEEK, IRIS and WEAVE trials, as described in Appendix 5. It is not clear from these trials whether motivational interviewing improves outcomes for children and families but the results from the SEEK trial suggest that it is a promising avenue for further exploration (see Appendix 5). A systematic review of the effectiveness of interventions for domestic violence in general practice concluded that 'advocacy' (which shared characteristics with both 'advocacy' and 'coaching' in table 5.2) could reduce abuse and improve women-centred outcomes such as social support and quality of life.[156] Like the GPs in the qualitative study by Woodman et al. (2013),[51] the authors of this systematic review concluded that positive impact was likely to be greatest for a subset of patients who actively sought help.

The GPs in the two qualitative studies described above saw the potential for both benefit and harm when GPs enacted direct responses to maltreatment-related concerns.[50;51] Many of the potential benefits and harms cited in these two studies centered around the doctor-patient relationship and echo benefits and harms which have been attributed to the GP-patient relationship in qualitative studies about the management of chronic conditions. A trusting and constant doctor-patient relationship has been seen by both doctors and patients as facilitating honest disclosure of hardships (such as domestic violence and past abuse), to help patients cope with these issues,[157] and to offer GPs a mechanism for changing patient attitudes and behavior.[145;157] However, GPs also agree that if the relationship is not sufficiently strong, attempting to 'coach' patients might scare them away from using services[145] and a dysfunctional doctor-patient relationship might promote tolerance of 'bad' behaviour by doctors or may make GPs more likely to miss new and serious symptoms.[157;158] Analyses of maltreatment-related child deaths suggest that therapeutic relationships can be very dangerous for the child if professionals do not recognise disguised compliance (apparent co-operation by parents used to diffuse professional intervention) or if empathy with parents is accompanied by 'silo' working (failure to look at a child's needs outside of their own specific brief).[159] Even recording of concerns, which is widely recommended in policy (see section 4), may have net harm if it does not lead to effective intervention[85] or sharing of concerns with other colleagues or professionals.

There is an urgent need to improve the evidence-base about the efficacy and safety of GP responses to maltreatment-related concerns, including direct responses and especially for the large numbers of concerns which are below child protection or child in need thresholds for action. The three randomised controlled trials which we reviewed have shown it is possible to incorporate core elements of general practice, such as advocacy and coaching, into a formalised package of care which can be tested for effectiveness.

Any future research into effectiveness of direct responses must investigate GPs engagement with and role in local child in need and early help processes as well as how the wider primary care team might support the GP in responding to maltreatment-related concerns.

5.4 Key points

- We found four relevant studies focusing on recording of maltreatment-related concerns (N=2) and all GP responses to child maltreatment (N=2). Three of the studies were conducted by authors of this report. Additionally, we found three randomised controlled trials and two systematic reviews which provided indirect evidence.

- In two qualitative studies, direct responses to maltreatment-related concerns comprised a 'case-holding' approach which hinged on a trusting doctor-parent or doctor-teenager relationship and good links with health visitors.

- One qualitative study reported that direct responses approach occurred before, during and after referral to children's social care.

- In one qualitative study GPs were enacting direct responses by using core skills of general practice such as monitoring, coaching, advocating and offering opportune healthcare to children. Responses were often enacted through parents which, in combination with a reliance on a trusting doctor-parent relationship, is likely to present a problem for safe risk assessment of the child's situation when parents are deliberately manipulative or falsely compliant.

- GPs in the studies were most preoccupied by responding to issues relating to neglect and emotional abuse; GPs most commonly described using direct responses for help-seeking families with high medical need and in cases where they perceived children's social care to be over or under responding.

- Previous randomised controlled trials have shown that it is possible to incorporate core elements of general practice, such as coaching and advocacy, into a formalised package of care which can be tested for effectiveness.

- Because direct responses use core skills of general practice, this approach could be implemented more widely.

- There is an urgent need for research to determine whether direct responses to maltreatment-related concerns by GPs improve outcomes for children and families and if so, for whom and in which contexts. It is also imperative that potential harms of direct responses are measured, both to children and families and services (opportunity cost).

6 Parent, young person, adolescent and child view of the doctor-patient relationship in general practice

The results from section 5 suggest that a strong and trusting doctor-patient relationship might be a necessary facilitator of GP responses to maltreatment-related concerns. However, the views of parents and children were absent from the studies reporting GP responses to maltreatment-related concerns which we reviewed in section 5.

This raises a question: do parents and children experience the doctor-patient relationship in a way that might give GPs a credible chance of enacting the kinds of direct responses to maltreatment-related concerns which were described in section 5.1? To address this question, we conducted a literature review with a broader focus: how are GP services in the UK seen and experienced by parents, young people, adolescents and children?

6.1 Methods

We included any study which collected data published in 2004 or later in any of the four UK countries. We interpreted 'the doctor-patient' relationship broadly to include relevant themes such as continuity of care, empathy or listening skills or the role of the doctor in responding to social problems. In order that we understood views and experiences of the GP-patient relationship in the context of views about other professional groups, we briefly extracted data about all professionals from the included studies. See Appendix 6 for detailed inclusion criteria and search methods.

6.2 Results

We found 14 relevant studies which reported views or experiences about the doctor-patient relationship in general practice from the perspective of children, adolescents, young people or parents in the UK. As Table 6.1 and 6.2 show, six of the studies used interviews or focus groups and one used a questionnaire to capture the views and experiences of vulnerable young parents and young people (including those with multiple disadvantage,[160;161] those who had been in care,[50;160] unaccompanied asylum-seeking children,[162] inner-city families whose children had behavioural and emotional problems,[163] those identified as 'vulnerable' by practitioners[13] and young mothers).[164] The remaining seven studies

sampled their participants from populations not known to be especially vulnerable or disadvantaged (i.e. the 'general population'). Three of the studies based on the general population used interviews or focus groups to collect views and experiences, including one unpublished study (Woodman et al., Table 6.1)[165;166] and four used questionnaires, including the unpublished Well Centre study (see Tables 6.1 and 6.2).[167;168;168;169]

With the exception of two surveys which included participants from Northern Ireland, [169] and the whole of the UK,[167] studies reported views and experiences of GP-patient relationships in English settings.

Four of the studies included views from children aged less than 13 years old[13;162;167;168] but none included views from children aged less than 11 years. A previous review of health surveys in England noted similar under-representation of patients aged less than 16 years.[170] Seven studies included 'young people' (aged over 18 years), including the unpublished study of the Well Centre.[13;50;160;162;164;165] The age distribution of participants in these studies was sometimes not reported. See Table 6.1 for detailed methods and results for each study and Table 6.2 for an overview of study methods and results.

Table 6.1: Characteristics and results of included studies reporting parental, young person, adolescent or child views about the GP-patient relationship

Author, publication date, country and study aim	Study population and methods	Results relating to GPs		Results relating to other professionals
		Positive	Negative	
Qualitative studies: vulnerable populations				
Boddy, 2012 England[161] Aim: evaluation of health-related work by family intervention services (FIS).	Interviews in 2007-9 with 40 parents and young people from 20 families in 4 areas of England. Families had multiple problems, including drug and alcohol use, domestic violence, extreme poverty, criminality or anti-social behaviour. Interviews conducted soon after families finished the intervention and again seven months later. FIS tried to address unmet health needs, difficulty in engaging with/accessing health services, and capacity to manage chronic health difficulties.	GPs facilitated quick access to secondary care services.	Primary care was very difficult to access, GPs were perceived to be dismissive and not to listen. No accounts of a supportive relationship between families and GPs.	Mixed accounts of social workers: criticism about high turnover, lack of sensitivity and/or resources but also accounts of positive relationships and reliable and helpful social workers.
Cameron, 2007 England[160] Aim: To compare experiences of care leavers with young people who have had difficulties (but no care).	Interviews in 2003-6 with 80 care leavers aged 17-24y from 13 'leaving care teams' in England and 59 young people aged 16-29y 'in difficulty' (e.g. homeless, addiction problems, a criminal record) from housing and advice support services in 4 areas in England. Participants had multiple and above average health needs. 53 participants were aged 18y or under.	GP was (by far) the most frequently mentioned health care contact for both groups and most care leavers (90%) and those in difficulty (68%) were registered. 9% of care leavers nominated their GP as the most helpful services which was high compared to many other services (2% of those 'in difficulty' rated GP the most helpful).	Experiences of GP services were highly variable. 4% of care leavers nominated their GP as the least helpful service (14% of those 'in difficulty'). Participants described GPs as medically incompetent, lacking social skills, having their own agenda (not listening), rushing them out the room and too focussed on prescribing.	All-round holistic services (e.g, 'one-stop shops' or leaving care services) were valued more highly than services designed to meet one type of need e.g.. health services, benefit services or housing services. Aside from one-stop shops, care-leavers, nominated GP services the most helpful service (but not seen as so helpful by those 'in difficulty').

Table continued overleaf

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Table 6.1 *continued*: **Characteristics and results of included studies**

Author, publication date, country and study aim	Study methods	Results relating to GPs		Results relating to other professionals
		Positive	Negative	
Chase, 2008 England[162] Aim: To explore wellbeing and mental health in unaccompanied asylum-seeking children and young people.	Interviews in 2006 with 54 children and young people aged 11-23y seeking asylum on their own in the UK. All lived in London.	GPs helpful in accessing secondary care or counselling.	Large variation in quality of general practice. Widespread lack of expertise/and knowledge of the specific needs of asylum seeking young people. Participants reported an unhelpful emphasis on prescribing.	Mixed accounts of interactions with social workers including trusting relationships but also a lack of sensitivity or consistency and fairness of resource allocation. Negative account of hospital doctors as rude and insensitive.
Cossar, 2013 England[13] Aim: To examine young people's perceptions of maltreatment, and to explore their experiences of telling and getting help from both informal and formal sources.	Content analysis of an online peer support site where young people post and respond to problems involving abuse and neglect (261 threads). Interviews in 2010-11 with 30 young people aged 11-20y, identified as vulnerable by practitioners. Six focus groups in 2010-11 with children, young people (general population), .parents and practitioners	When asked hypothetically about helping a neighbour's child, most parents were reluctant to go to children's social care and said they would turn to schools, the police or their GP.	Unlike other professionals, doctors were largely absent from online posts. The doctor's role was viewed as 'medical' e.g. attending to non-accidental injuries.	Police were also seen to have a one-dimensional role (to stop the maltreatment) while teachers, social workers and youth workers were viewed in a more holistic way.
Sayal, 2010 England.[163] Aim: To explore factors influencing help-seeking behaviour.	8 focus groups with 34 parents of children aged 2-17y who lived in South London and who were concerned about their child's emotional health or behaviour (but child not currently receiving services from specialist mental health services (CAMHS)). 52% of parents were from black or minority ethnic groups and 59% were single, separated or divorced. Date of focus groups not given.	Parents reported that their GP had been concerned, helpful and sympathetic when they raised their worries about their child. Parents described GPs who were passionate, especially about child health. Parents trusted their GP and felt they had made good decisions in the past. These parents had often experienced continuity of care through significant life events.	GP's role seen as 'medical' by parents. Parents felt their GP had not taken their concerns seriously, had not listened and were not interested. Time too short for GP to see whole picture/listen. Parents feared stigmatising labels and possible removal of the child as a consequence of seeking help from GP.	Mixed experiences of health visitors: some parents felt they had not taken their concerns seriously whilst others saw them as helpful and sympathetic.

Table continued overleaf

Table 6.1 *continued*: Characteristics and results of included studies

Author, publication date, country and study aim	Study methods	Results relating to GPs		Results relating to other professionals
		Positive	**Negative**	
Tompsett, 2010 England.[50] Aim: To explore tensions and conflicts of interest for GPs in 'child safeguarding'.	Focus group with 12 young people aged 17-20y who had been looked after, 4 of whom were also parents and most of whom were registered at one practice. Focus group with 7 mothers under 30y, most of whom were registered at the one practice.	Two mothers reported positive experiences with their GPs, saying that they felt reassured, listened to and were not rushed. At one practice, one GP was viewed by several mothers as very good with children.	For 11/12 young people, visiting the GP was not a positive experience. None of the young people and most mothers felt that the GP did not know themselves or their children well. Both groups felt GPs did not have time for them and did not listen. Some mothers felt GPs were too interested in prescribing. Two 'looked after' children, thought GPs had been intrusively questioning.	Mothers felt that midwives and practice nurses knew them and their children best.
Vulnerable populations: quantitative studies				
Healthwatch Warwickshire, 2013 England.[164] Aim: to capture young people's experiences of GP services in Warwickshire	Survey in 2013 with 185 young people aged 13-25y, completed face-to-face with researchers, on paper or online. Recruited from social media, youth clubs, community groups and groups for vulnerable populations e.g. those in care. As the relevant results relate specifically to young mothers, this study was classified as sampling a 'vulnerable' population.		Young mothers felt patronised by GPs and that this was due to their young age rather than parenting ability.	

Table continued overleaf

Table 6.1 *continued*: Characteristics and results of included studies

Author, publication date, country and study aim	Study methods	Results relating to GPs		Results relating to other professionals
		Positive	Negative	
General population: qualitative studies				
Children North East & Streetwise, 2011 England.[165] Aim: to explore knowledge and attitudes about involvement in decisions about health and health services.	9 focus groups (number of participants not specified) of young people 13-25y old in the Newcastle area. Research conducted by young researchers.		GPs didn't always listen properly or seek to offer solutions which were acceptable to the young people (too keen to prescribe or refer to counselling). Some participants, especially young parents, felt judged.	
French, 2012 England.[166] Aim: To assess young people's experience of visiting their GP and what they would like from this service.	Questionnaires (N=60), focus groups and interviews in 2011 with 172 young people (age not reported) in Brighton and Hove, using peer facilitators.	In the three 'case studies' young people also reported having seen GPs who did not make them feel rushed, empathised, understood them and made appropriate referrals.	A common theme was that the young people did not feel respected; they felt that GPs viewed them as a stereotypical youth group. Some felt the GPs were only interested in 'medical problems'. Many felt their GPs had been patronizing, judgmental, difficult to understand, and keen to give them a prescription for medication and get them out the door (high variability according to individual GP).	Practice nurses were frequently seen as more caring and having a more comfortable way of interacting with young people.

Table continued overleaf

Table 6.1 *continued*: Characteristics and results of included studies

Author, publication date, country and study aim	Study methods	Results relating to GPs		Results relating to other professionals
		Positive	**Negative**	
Woodman, unpublished England. Aim: To explore young people's perspectives on the role of the GP for children and young people with social problems.	Consultation in 2012 using two small discussion groups with 8 young people aged 15-18y who were taking part in the NCB PEAR project, which supported young people's involvement in public health research. Young people were asked about their experiences of GPs and asked what they thought the GP should do in some case studies of young people with social/family problems.	There were a few young people who felt they could turn to their GP.	Many comments about feeling uncomfortable at the GP and anticipating judgement. GPs were described as not youth friendly, blunt, not listening, and not believing what young people say. There were concerns about GPs being intrusive.	
General population: quantitative studies				
Action for Children, 2013 England and N. Ireland.[169] Aim: To explore the actions of parents and carers when their child is unwell.	An online survey with a representative weighted sample of 2,000 parents and guardians from England and Northern Ireland.	82% rated GP the most trusted professional for child's health. 85% rated GP service as "very/quite helpful". 60% said they "knew a lot" about GP services.		GPs/family doctors were the most frequently used, most understood and most trusted source of advice, help or treatment for sick children, compared to other professionals and family/friends.
Balding and Regis, 2012 UK.[167] Aim: To understand school pupils' health and related behaviour and attitudes.	Survey of over 31,000 pupils aged 10-15y from UK schools.	Most children reported feeling comfortable during their last visit to the GP (see right).	20% & 22% of girls aged 12-13y and 15-16y, respectively reported feeling 'quite' or 'very' 'uneasy' during their last visit to the GP. The same figure was lower for boys (15% and 16%, respectively).	
French, 2012 England.[166] Aim: see above	See above	52% young people reported they were comfortable talking to their GP about mental and emotional issues.	36% reported feeling uncomfortable talking to their GP and 12% answered 'unsure'.	

Table continued overleaf

Table 6.1 *continued*: Characteristics and results of included studies

Author, publication date, country and study aim	Study methods	Results relating to GPs		Results relating to other professionals
		Positive	**Negative**	
NCB, 2012 England[168] Aim: To gain teenagers' views on health and health services.	Online survey of 263 young people aged 11-19y who were members of NCB and/ or b-live (online service aiming to support young people).	48% would talk to their GP if they were worried about their health.	While most said they were very/quite comfortable visiting their GP, over a quarter (N=77) said they were not; they felt embarrassed (60%), found it hard to explain their problem (53%), felt like they were being judged (42%), and did not understand what the doctor was saying to them (36%).	
Well-Centre 2013, unpublished	Evaluation of Well-Centre in 2013 using 139 aged 13-30y who attended the centre. The Well-Centre is a youth health centre staffed in London by GP (adolescent health experienced), 2 youth workers and CAMHS nurse. Young people can drop in or have booked appointment. Service continues to be developed in collaboration with young people.	98% felt welcomed. 96% would recommend it. 96% would return. 93% got what they wanted from the visit.		

Table 6.2: Summary of positive and negative views and experiences of the GP-patient relationship, by study

			Parents (P), young people 13y+ (YP) or children <13y (C)	Positive: Can turn to/feel welcomed/I trust the GP's advice	Positive: Positive experience (no further details)	Positive: Feel reassured	Positive: Feel listened to/GP empathetic	Positive: Don't feel rushed	Positive: GP facilitates access to secondary care/other services	Negative: Too much emphasis on prescribing	Negative: GP dismissive/feel not listened to/feel not believed	Negative: Unhelpful/negative experience (no further details)	Negative: GP is patronising/feel judged	Negative: Feel rushed/as if GP wants to get rid of me	Negative: GP's remit is narrowly 'medical' (or 'physical')	Negative: Quality/experience of general practice depends on GP**
Qualitative	Vulnerable population	Boddy 2012	P & YP						×		×					
		Cameron 2007	YP	×						×	×	×		×		×
		Chase 2008	C & YP		×		×		×	×						×
		Cossar 2013	C & YP	×											×	
		Sayal 2010	P	×			×	×			×			×	×	×
		Tompsett 2010	P & YP			×	×	×		×	×	×		×		×
Survey*		Healthwatch 2013	YP										×			
Qualitative	General population	Children North East 2011	YP							×	×	×				
		French 2012 (incl. a survey)	YP	×		×	×	×	×	×			×	×	×	×
		Woodman unpublished	YP	×							×	×	×			
Surveys**		Action for Children 2013	P	×												
		Balding and Regis 2012	C & YP	×									×			
		NCB 2012	C & YP	×										×		
		Well-centre unpublished	YP	×												
Count of Studies				9	1	2	4	3	3	5	6	4	5	4	3	5

*Questionnaire using closed questions
**Based on conclusions of/inferences from study as well as comments by individual study participants.

We found seven relevant literature reviews which are described in Table 6.3 and which were used to contextualise our findings.

Together, the 14 studies provide a picture of highly variable views and experiences of the doctor-patient relationship in general practice in the UK. As Table 6.2: Summary of positive and negative views and experiences of the GP-patient relationship, by study summarises, nine studies reported views and experiences of GPs as a professional to whom participants could turn, who welcomed them and whose advice could be trusted, including the two unpublished studies.[13;160;163;166-169] Three studies also reported views and experiences of GPs as empathetic, good listeners and not rushing patients.[50;163;166] However, 12 studies reported negative views and experiences, many of which were diametrically opposed to the positive accounts: participants felt that GPs didn't listen to them, were dismissive, didn't believe or take them seriously, patronised or judged them, had a narrowly 'medical' remit and were too focussed on prescribing, including the unpublished study by Woodman et al. (see Table 6.2).[13;50;160-168] Illustrative quotes for the most common positive and negative views and experiences reported in the 14 studies are provided in Boxes 6.1 and 6.2, respectively.

Table 6.3: Overview of existing literature reviews of parental, young person, adolescent or child views about the GP-patient relationship

Review	Aim and methods*	Relevant conclusions	Overlap with our review**
Hagell, 2013[171]	Aim: to get a full picture of the UK's adolescents. Methods: Collected sources which had a significant sample size (generalizable), used reliable and valid survey instruments and met ethical standards. Search methods not clear. Not systematic.	It is important for GP services to be youth friendly.	Balding and Regis, 2012
Clements, 2012[172]	Aim: to examine the available evidence on how well general practice is delivering for children and young people, including experiences of the services and challenges in access. Methods: Not clear. Not systematic	It is essential that young people feel they will be treated with respect and taken seriously when they go to the GP. GP surgeries should be more youth friendly in terms of booking, waiting areas and hours.	Cameron, 2007 Chase, 2008 NCB, 2012
Hargreaves, 2012[170]	Aim: to investigate what data are available on the NHS experience of children and young people (0–24y), and how their experience compares with that of older patients. Methods: Review of 38 national surveys undertaken or planned between 2001 and 2011, identified by the Department of Health. Systematic.	The voice of under 16s is not included in most national surveys. Despite high levels of overall satisfaction, young adults report a poorer experience of care than older adults. Findings support view that the 'NHS is designed by older people for older people.'	None

Table continued overleaf

Table 6.3 *continued*: **Overview of existing literature reviews**

Review	Aim and methods*	Relevant conclusions	Overlap with our review**
La Valle, 2012[173]	Aim: to synthesis evidence on children and young people's views and experiences of health provision in England. Methods: Included data from England from 2007-2012. Searched databases and gathered examples of local and national consultations with children and young people (<25y) Focussed on vulnerable groups. 112 studies were included. Rapid evidence review. Not systematic.	High levels of satisfaction with some aspects of health services but young people rated their experience less positively than older NHS users. Primary, secondary and mental health staff were sometimes reported to be unfriendly and not respectful but also nice, helpful, kind, comforting and caring. Children and young people value trust and mutual respect and it is especially important for those with chronic conditions or mental health problems.	Cameron, 2007 Chase, 2008
Lavis, 2010[174]	Aim: to draw together research on children and young people's views and experiences of mental health services. Methods: Not clear. Not systematic.	Young people feel they are treated differently because of their age. They feel GPs are lacking in understanding, awareness, empathy, and interest and are reluctant to offer support. Young people feel hospital staff can treat them as 'time-wasters'.	None
Robinson, 2010[175]	Aim: to collate children and young people's views about what they want from health professionals in England. Methods: Included data from England published 2000-9 on children and young people <25y. Searched databases, websites, and journals. 31 studies included, inductively analysed and grouped into themes. Systematic.	Children and young people want their health professionals to be familiar, accessible and available; to be informed and competent; to provide accessible information; to be good communicators; to participate in care; to ensure privacy and confidentiality; and to demonstrate acceptance and empathy. Health professionals often seem to fall short of these standards though the picture is not universally poor.	None
Freak, 2007[176]	Aim: To gain young people's views on 'helping' health professionals. Methods: Included international data before 2004 on children aged 12-19y. 54 qualitative studies included.	Young people want their healthcare providers to maintain confidentiality, explain carefully, listen, be sympathetic and understanding, have mutual trust, be competent and experienced, not to patronize or judge them and to treat them as an individual and not as 'just another patient'. They also want to see the same person and, for girls, to see a female doctor for some problems.	None

*Systematic = search strategy reported, attempts to be comprehensive and appraises quality of included studies.

**Studies included in the existing literature review and in APPENDIX 1: Definition of child maltreatment from English statutory guidanceTable 61 andTable 62: Summary of positive and negative views and experiences of the GP-patient relationship, by study Table 62.

Box 6.1: Positive accounts of visiting a GP: quotes to illustrate most common themes from studies in Table 6.2

Feel as if can turn to GP/feel welcomed/trust the GP's advice

Quote 1: 'I have a fantastic GP. And she knows all of us . . . we've been with her for 11 years. And I think that's the best person who would have an overview . . . if there were any medical problems or mental health problems.' (parent of 14y old girl with hyperactivity and conduct disorder problems)[163]

Quote 2: 'He [the GP] makes you feel […] you're not wasting his time, come back whenever you feel like it… he kept saying 'Come back, phone me, you're not over-reacting' and he made you feel so you know, that you weren't panicking about your kids." (mother, age of child not reported)[50]

Feel listened to/GP is empathetic

Quote 3: 'In fact I find it easier to talk to him [the GP] about my depression than any other health worker I see. That's because he acknowledges my feelings and he empathises with me. He's always treated me like an adult from the way I see it, he's never, like, patronised me.' (young man, aged not reported)[166]

Quote 4: 'Whereas this guy [GP] actually sat down, talked, see what the problem was for example, and he pointed me to go and see somebody… and then the day after he said 'I want to see you first thing in the morning, nine o'clock.' And then you feel like oh, he actually cares a little bit."(young person, age not reported)[50]

Don't feel rushed

Quote 5: '… it's absolutely brilliant, they don't rush you out. I was in there with my doctor for over forty minutes the other week. Just crying and talking, he weren't even trying to rush me out the door, which I thought was really good.' (mother, age of child not reported)[50]

Quote 6: 'They really have a passion for caring for people and helping [you to] get better. Those are the ones I've found have got more time for their patients to make sure overall, apart from this ailment, are you OK?' (parent of 4y old boy with hyperactivity and conduct disorder)[163]

GP facilitates access to other services

No quotes provided in studies.

* Common themes = featured in three or more studies

Box 6.2: Negative accounts of visiting a GP: quotes to illustrate most common themes from studies in Table 6.2

Too much emphasis on prescribing

Quote 7: 'They just want you to come in and sign your prescription.' (young man, 18y old)[160]

Quote 8: 'If you had a mental or an emotional issue they would just put you on anti-depressants' (young person, age not reported)[166]

GP dismissive/feel not listened to/feel not believed

Quote 9: 'GPs don't listen to young people, and they don't believe what the young people say.' (young man, 17y old; Woodman unpublished)

Quote 10: 'I've spoken to him [GP] on about five occasions. It's always been brushed under the carpet.' (parent of 2y old)[163]

GP is patronising/feel judged

Quote 11: 'GPs judge and patronize you, they don't take you seriously.' (young person, age not reported)[166]

Quote 12: 'We're not gonna ask about it if we get nothing but negative, like judgements and that back, then we'll just end up keeping quiet, where if you just listen to us we might actually just say, right we need help with this.' (young person, age not reported)[165]

Feel rushed/as if GP wants to get rid of me

Quote 13: 'When I've been before it's just been, "Well, if you feel any worse, come back." That's all. They'll say that and shoo you out the room kind of thing. […] Nothing, no. "We haven't got time for anybody like that." Unless you're dying they haven't got time for you.' (young woman, 20y old)[160]

Quote 14: 'I'm trying to talk to her and she kept looking at her watch like this… and she was going "I do have the next patient in a minute or two…" (mother, age of child not reported)[50]

GP have a 'medical' (or 'physical') remit

Quote 15: 'I think a lot of young people wouldn't go to the doctor for mental or emotional stuff because they'll just be told that it's not that and they're just overreacting.' (young person, age not reported)[166]

Quote 16: 'With my doctor, it was like he just didn't have time for me; he didn't really care because it wasn't a physical problem and acted like I was just making it up.' (young person, age not reported)[166]

Quality/experience of general practice depends on individual GPs

Quote 17: 'I know that GPs only have a certain time to see people but in the past I have always felt like he wants to get rid of me. It just felt like he wants to get onto the next patient and that he didn't have time for me. He was just like "yep, you're done, see ya later, bye" […] My GP now is cool – she's awesome. I just sit there and she's like "so what do you want?"… […] she has pushed a lot of my mental health stuff through [..]. She was like "ok, what's actually going on?" during the worst stages of my breakdown.' (Young person, age not reported)[166]

* Common themes = featured in three or more studies

In several of the studies, young people (including young parents) expressed the view that they were treated differently by GPs because of their age:[164-166]

'Young people don't get taken seriously and we don't get listened to properly. Often my GP is quite patronising.' (young person, age not reported)[166]

'Some (doctors) think just cos you're young, you're proper daft.' (young person, age not reported)[165]

There was no obvious difference between the views and experiences reported by studies based on vulnerable populations and those based on the general population (Table 6.2). Due to difficulties in accessing adult-orientated services and talking confidently with professionals,[176] children and young people may share some characteristics with vulnerable populations. As all but one[169] of the studies sampled from the general population were based primarily on young people, this may explain why similar views and experiences were reported by 'general' and 'vulnerable' populations. In support of this hypothesis, the two studies reporting solely positive views and experiences of GPs were based on parents from the general population and young people who had received specialist youth-orientated GP services (Well-Centre; Table 6.2). However, both these studies used highly structured questionnaires which, as Table 6.2 shows, generated a far narrower range of views and experiences than studies allowing participants to speak discursively about their views and experiences (in interviews and focus groups).

Contrasting views were reported by different participants in the same studies (Table 6.2) and also by the same participants about different GPs (for example see Box 6.2, quote 17). One study which included participants registered at the same two practices reported that accounts of specific GPs were consistently positive or consistently negative across participants.[50] This suggests that the polarised views and experiences are driven by variation between GPs and their professional practice as well as vagaries of interactions between differing GP and patient expectations.

Although there was high variability in views and experiences of GPs as reported by parents, young people and children in the studies, this might be a familiar pattern across all professional 'helping'

services. A literature review of adolescent views of 'helping' professionals concluded that teenagers found it difficult to talk to *all* professionals.[176] APPENDIX 1: Definition of child maltreatment from English statutory guidance1 shows that the same criticisms and compliments were made about health visitors[163] and social workers[162] as of GPs in the included studies. From other relevant literature reviews (Table 6.3), we can see that there were mixed accounts of *all* health professionals by children and young people. Many were criticised as judgemental, not listening, unavailable, uninterested and not treating them as an individual, though the picture was not universally poor (Table 6.3).

In the context of views and experiences of other health professionals, GPs do not seem to be any worse at engaging and forming relationships with children, young people and parents than other helping health professionals and, perhaps, than some professionals from other agencies. Indeed, in one study, GPs were nominated as the second most helpful service by care-leavers (after one-stop shops and housing projects).[160]

Together, the studies suggested that some parents, young people and children saw the GP as having a 'one dimensional' or narrowly 'medical' remit. This took two forms: either participants believed that GPs were only there to attend to 'physical' problems rather than emotional distress[163] or participants felt that GPs *should* help them with emotional problems but that GPs did not share this holistic view and had their own 'medical' agenda.[50;162;165;166] The perceived role of the GP as narrowly 'medical' appeared to explain why GPs were very infrequently mentioned (compared to other professionals such as teachers) in 261 online forum threads about abuse and neglect.[13] In four studies that did not meet our inclusion criteria and were not included in the review, vulnerable young people did not appear to value, recognise or have experienced GPs as a source of help for emotional distress or mental disorders.[177-180] In three of these studies, vulnerable young people did not mention GPs (or doctors) when they were talking about which professionals had helped them (which therefore meant the studies were excluded from our review).[178-180] In the fourth study, young people spoke about GPs but data was collected in 2001 (before our 2004 cut-off for inclusion).[177]

There are several weaknesses to the data included in our review. Due to the age range of included studies, our results relate to secondary school aged children, and young people. There were little data from parents and younger children. It is likely that responding to younger children will

present different issues in general practice and we should be cautious in generalising our findings to younger age groups or to wider groups of parents. With the exception of the study by Balding and Regis (2012) which sampled a large and captive population of school students, none of the study samples can be considered representative either of the vulnerable population of interest or of the general population. There were few efforts to achieve representativeness and by dint of participation, participants were a self-selecting group who were perhaps more likely to attempt to engage with services and view them differently to their peers. In addition, variability in patient experiences of general practice are likely to be driven by practice characteristics, such as size, availability or resources and specialist interests of the GPs working there as well as characteristics of the registered patients in each practice such as deprivation and age. Information about practice and list characteristics were not reported in the studies and we do not know whether there were consistent differences in the experiences and views of children, young people and parents in (for example) rural compared to urban practices or practices with a large proportion of children and families and those with a higher proportion of elderly patients.

Studies based on questionnaires provide very limited insight into views and experiences and it is very difficult to attribute views to the GP-patient relationship: young people may feel uncomfortable due to their experience of the reception/waiting area of the surgery, for example.[166] We have focussed on the GP-patient relationship but a large proportion of patient contact will be with other members of the primary healthcare team (practice nurses, health visitors or nursery nurses). As only one questionnaire study used a validated survey tool,[167] we do not know how accurately their measured patient's views. The qualitative samples, which provided the richest accounts of views and experiences, were necessarily small. These types of studies can provide hypotheses about the types of experiences that parents, young people and children may have but they cannot quantify how common they are across the population.

6.3 Key points

- 14 studies reported that young parents, young people, adolescents and (though rarely included) children had highly variable experiences and views of GPs.

- Negative and positive accounts centred round whether or not the GP was or was not perceived as welcoming, someone to turn to and who had time to hear about problems, was interested in the patient and took their problems seriously, was empathetic, was respectful and whether patient did or did not feel judged or patronised.

- A further key theme was the role of GPs for social problems: some participant felt that GPs only dealt with 'medical' problems while others perceived a broader role for GPs but felt that GPs were too keen to find 'medical' solutions.

- Variation in experience is likely to be driven by differences between individual GPs and their professional practice as well as the vagaries of inter-personal relationships between two actors.

- High variability in views and experiences of GPs might be a familiar pattern across all professional 'helping' services.

- Young people believed that they were treated differently (worse) specifically because of their age.

- Given the nature of the data, we were not able to quantify how common specific experiences were across the population in the UK.

6.4 Implications

Given the probable importance of the GP-patient relationship for facilitating direct responses to maltreatment-related concerns, high variability in secondary school age children, young person and parent experiences of their GP challenges the feasibility and safety of implementing direct responses in general practice.

As GPs seem to focus on their relationship with the parent (as described in section 5), research is needed into the views and experiences of parents, particularly of children who have prompted maltreatment-related concerns. We cannot assume that GPs across the country attempt to build relationships either with parents or children nor, when time and effort is invested in the relationship, that the patients experience the relationship in the same way as the GP intended. It may be especially important to build relationships with younger patients when parents are "the problem" for the young person or child.

It is possible that some patients, especially adolescents or vulnerable parents, might see practice nurses or health visitors as more approachable and as having a less 'medical' agenda. Future research into direct responses to maltreatment-related concerns should investigate how they can occur within the context of the wider primary healthcare team.

7 Key points, conclusions and the way forward

7.1 Key points

- The strengths of general practice as a universal and longitudinal service mean that GPs are well-placed to enact direct responses to children and families as well as participate in existing systems to safeguard and protect children. However, direct' responses are not well-defined or understood.

- By excluding direct responses from its vision of the GPs' role, government policy and practice guidance does not play to the strengths of general practice.

- Direct responses to maltreatment-related concerns might comprise a 'case-holding' approach which employs core skills of general practice. Evidence is lacking about the efficacy or safety of direct responses in the context of maltreatment-related concerns. Common sense suggests that the safest way of GPs enacting direct responses is within the context of multi-agency working.

- Given the probable importance of the GP-patient relationship for facilitating direct responses to maltreatment-related concerns, high variability in parent and child experiences of their GP challenges the acceptability and feasibility of widespread implementation of direct responses to children and families who prompt concern about maltreatment in general practice.

7.2 Conclusions

- This report throws out a question to policy makers and professionals: is it time to rethink the role of the GP for children with maltreatment-related concerns and their families?

  - Reconceptualising the GP's role to include direct responses to maltreatment-related concerns would play to the existing strengths of general practice. It would also maximise GPs' contribution to a public health approach to child maltreatment.

- There is an urgent need for randomised controlled trials that evaluate what works and for whom in the way that GPs in the UK respond to maltreatment-related concerns. Models of GP practice in this area need to be rigorously evaluated for effectiveness, safety and cost to services.

7.3 Policy agenda

Policy-makers should reassess policy in light of evidence about current practice. Policy should:

- Recognise that GPs can respond directly by providing therapeutic support to families who prompt concerns about maltreatment.

  - This can occur before, during or after referral to children's social care or early help services and is in addition to their role in the current safeguarding and child protection systems.

  - Responses might be enacted through parents and other family members as well as their children and are likely to depend on a strong doctor-family and doctor-health visitor relationship.

  - Including direct GP responses in policy will play to GPs' strengths and better support their potential in enacting a public health approach to child maltreatment,

- Determine how direct responses by GPs can be developed for children and their parents above and below the threshold for children's social care intervention and how they can work within multiagency systems for early help. There will inevitably be decisions about when direct responses within general practice are not enough. For this, GPs will need likely reflection time, supervision, advice and training as well as a willingness to be involved in very skilled, potentially stressful and time-consuming work. Developing policy in this area will help define the 'lead professional' role for GPs, as outlined in Working Together to Safeguard Children.[19]

- Acknowledge the potential importance of the doctor-family relationship for responding to maltreatment-related concerns in general practice and developing ways of integrating support for families from other professionals to support GPs in their responses.

- Support research to developing the evidence-base about the effectiveness of direct responses by GPs for families with maltreatment-related concerns.

7.4 Research agenda

There is no robust evidence-base about what works and for whom in the way GPs respond to maltreatment-related concerns. Models of GP practice in this area need to be rigorously evaluated for efficacy, safety and cost. Programmes of research are needed that:

- Harness the core skills and strengths of general practice for responding to child maltreatment by building on evidence about current practice.

- Test how to effectively and safely shift GP responses to maltreatment and early interventions for vulnerable families into mainstream general practice.

- Evaluate how agencies and practitioners who are working directly with the family (such as children's social care, health visitors, drug and alcohol workers) and GPs can work more collaboratively. This could include evaluating interventions to improve information flow from and to the GP from children's social care, which is reportedly poor. Such evaluation will support policy recommendations about how the 'case-holder' GP role (direct responses) can work *in unison with* the GP's role as sentinel, gatekeeper and multi-agency team player.

- Investigate how to promote help-seeking behaviour in parents, children and young people with maltreatment-related problems and ensure that vulnerable parents and adolescents feel able to engage with GPs, are listened to and not judged.

- Investigate how to maximise GP-health visitor links and relationships and/or investigate other ways in which GPs can monitor children, parents and families.

- Determine whether GPs seeing adolescents or adults should ask about children living at home and devise and test strategies for responding to maltreatment-related concerns prompted by contact with an adult family member or sibling.

- Evaluate the impact of GP responses, in terms of benefit and harm to children and families as well as service impact.

Appendices

APPENDIX 1: Definition of child maltreatment from English statutory guidance

Type	Definition
The text in this table is taken from Working Together, 2013 (pp85-86).[181]	
Physical abuse	A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.
Sexual abuse	Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.
Emotional abuse	The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.
Neglect	The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to: • provide adequate food, clothing and shelter (including exclusion from home or abandonment); • protect a child from physical and emotional harm or danger; • ensure adequate supervision (including the use of inadequate care-givers); or ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, the child's basic emotional needs.

APPENDIX 2: Search strategy for literature review on GP role

All searches last conducted in October 2013

N and source	Search concepts	Search terms/methods
• #1 MEDLINE, PsycINFO, • Social Policy and Practice, • Embase. • (via Ovid)	• primary care AND (maltreatment OR social welfare) AND child AND since-2000 AND in English.	1. (primary adj care).ab,ti. 2. (family adj physician).ab,ti. 3. GP.ab,ti. 4. (general adj pract*).ab,ti. 5. 1 or 2 or 3 or 4 6. nurse.sh. or nurse.ti. or nurse.ab. 7. 5 or 6 8. (health adj visitor).ab,ti. 9. 7 or 8 10. child abuse.sh. 11. (child adj maltreat*).ab,ti. 12. (child adj abus*).ab,ti. 13. (physical adj abuse).ab,ti. 14. (deliberate adj injury).ab,ti. 15. (non-accidental adj injury).ab,ti. 16. (nonaccidental adj injury).ab,ti. 17. (shaken adj baby).ab,ti. 18. (intentional adj injury).ab,ti. 19. (child adj protection).ab,ti. 20. (neglect or victimisation or victimization or "child in need" or "well-being" or "well being").ab,ti. 21. (social conditions or social support or social welfare or social work).sh. 22. (safeguard* or welfare or psychosocial or "social work*" or "social care" or "social services").ab,ti. 23. 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 24. 9 and 23 25. limit 24 to (english language and yr="2000 -Current") 26. (child* or adolsecent* or infant*).ab,ti. 27. child.sh. 28. adolescent.sh. 29. infant.sh. 30. 26 or 27 or 28 or 29 31. 25 and 30

Table continued overleaf

N and source	Search concepts	Search terms/methods
#2 Google	Safeguarding AND GPs (policy).	(safeguarding OR "child protection") AND GP "child protection" AND "social care" "child protection AND "social policy"
#3 NSPCC website http://www.nspcc.org.uk.	Safeguarding policy relevant to GPs and social work	Browsed the "research, statistics and information" section, searched for "GPs" in the online library and used weekly email alert for new publications and reports.
#4 Snowballing	NA	Using recommendations from experts, bibliographies of relevant publications, "related publications" link on Pubmed and searching for works by key authors or related to key policy documents.
#5 The Health and Social Care Information Centre website http://www.hscic.gov.uk/.	Seeking statistics about primary care services.	Browsed "primary care" section.

N and source	Search concepts	Search terms/methods
#2 Google	Safeguarding AND GPs (policy).	(safeguarding OR "child protection") AND GP "child protection" AND "social care" "child protection AND "social policy"

APPENDIX 3: Methods for policy review

The process of devolved government, started in the UK in 1997, created the opportunity for different government policies and structures in relation to child safeguarding in England, Scotland, Wales and Northern Ireland. These have been reviewed in detail elsewhere.[42;182;183]

We assessed any document published by national government in each of the four UK countries that is current and nationally applicable. We included documents that mentioned the activities of GPs in relation to any form of child maltreatment or to safeguarding, child protection or statutory care processes for affected children. We also included government documents or statements that referenced primary care but did not directly refer to GPs, provided we could infer that statements were intended to refer to GPs.

We searched the websites of government departments and professional bodies (Table A3.1) using terms for child or young people, safeguarding, and GPs. We also searched the NSPCC Inform website (http://www.nspcc.org.uk/Inform/policyandpublicaffairs/ppa_wda48585.html), and websites listed in the RCGP Child Safeguarding toolkit.[54] We used the bibliography of each relevant document in order to locate additional policy instruments.

Table A3.1: Websites searched for policy documents or professional guidance relating to health in the four UK countries

England	Northern Ireland	Scotland	Wales	UK-wide Professional bodies
UK Government	Northern Ireland Assembly	Scottish Government	Welsh Assembly Government	General Medical Council
NHS England	Northern Ireland Executive	NHS Scotland	NHS Wales	Royal College of General Practitioners
Department of Education	Health & Social Care in Northern Ireland	Health and Social Care Directorate	Health and Social Care	Royal College of Paediatrics and Child Health
Department of Health	Department of Health, Social Services and Public Safety	Healthcare Improvement Scotland	Children in Wales	National Institute for Health and Clinical Excellence
Children's Commissioner for England	Northern Ireland's Commissioner for Children and Young People	Scotland's Commissioner for Children and Young People	Children's Commissioner for Wales	
Care Quality Commission	Regulation and Quality Improvement Authority	Scottish Intercollegiate Guidelines Network (SIGN)	Healthcare Inspectorate Wales	
NHS Commissioning Board	Northern Ireland Office (UK Gov)	Scotland Office (UK Gov)	Wales Office (UK Gov)	

One reviewer screened documents for relevancy and excluded documents were checked by a second reviewer to make sure no relevant policy or guidance was excluded.

Potentially eligible documents were assessed to determine whether they were relevant to current policy, child safeguarding, child protection, or looked after children, and GPs. We extracted any statement that referred to GPs, either explicitly or in terms of health professionals dealing with children.

We analysed these extracts of text to understand how policy from government departments and professional bodies conceptualised the GP's role. We focussed on elements of the GP role that might contribute to a public health approach to child maltreatment:

- Recognition of early signs and risk factors, including via parents.
  - On-going support and monitoring of the child and family, especially for those below the threshold for action by children's social care.

These categories were decided a priori, based on the strengths of the GP in adopting a public health approach in responding to maltreatment (as outlined in Section 3 of this report) and including interagency working with children's social care. We also considered the consistency of the roles, responsibilities and duties of GPs in responding to child maltreatment between the UK nations.

APPENDIX 4: Methods for literature review on GP-patient relationship from parental and young person perspectives

4.1 Inclusion criteria

We were seeking any kind of study, report or document (including webpages) that reported parent, young person, adolescent or child views and/or experiences of the doctor-patient relationship in general practice or GPs in any of the four UK countries.

4.1.1 Data must have been collected in 2004 or later (i.e. following implementation of new 2004 GP contract - also coincides with the introduction of a 'qualitative' MeSH term in MEDLINE in 2003).

4.1.2 Must be a research study, audit, service evaluation or local intervention which included an evaluative element.

4.1.3 Must report the views of parents and/ or young people and/or children about the doctor-patient relationship in UK general practice. Adult patients must be asked in their capacity of parents (i.e. not just participants who might also have children). The doctor-patient relationship will be interpreted broadly to include relevant themes such as continuity of care, perceived empathy or listening skills or perceived role of the doctor in responding to social problems.

4.1.4 Can include general population or be restricted to vulnerable or socially disadvantaged groups (but we will not include studies focussed on specific conditions such as asthma or cancer).

4.1.5 Views can be about:

4.1.5.1 standard care in general practice;

4.1.5.2 interventions or service modifications which were designed to improve delivery of services to parents, and/or young people and/or children;

4.1.5.3 specific GPs or specific consultations or a specific practice or group of practices.

4.1.6 Views can be measured via surveys (quantitative data) or through in-depth interviews/focus groups (qualitative data).

4.2 Searches

Due to poor indexing and the writing conventions of qualitative research, much relevant research reporting patient views and experiences will be missed if researchers limit their search sources to large health databases.[184;185] For this reason and because we want to include grey (unpublished) literature, we used a range of search strategies (see Table A4.1).

Table A4.1: Search sources and methods

Search # and source	Dates searched	Methods/terms
#1 MEDLINE (via Ovid)	04.02.14	(Qualitative research or survey) and (general practice or GP) and UK and (parents or young people or adolescent or children) See Table A4.2 below for full details
#2 Google and Google Scholar	05.02.14	Used the following terms and looked through the first hundred hits on both search engines: GP AND relationship AND (children OR adolescent AND parent AND young people) AND UK AND published in/after 2004
#3 Key informant	Jan-Feb 2014	Emailed contacts (N=7) at the RCGP and other experts e.g. deep end GPs http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/
#4 Websites	Feb 2014	Association for young people's health http://www.youngpeopleshealth.org.uk/5/our-work/71/gp-champions-project/ General Practitioners at the deep end http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/ National Children's Bureau http://www.ncb.org.uk/ Royal College of GPs http://www.rcgp.org.uk/
#5 Biblio-graphies	Feb 2014	Searched the bibliographies of included studies and 7 included literature reviews (see Table 63: Overview of existing literature reviews of parental, young person, adolescent or child views about the GP-patient relationshipTable 63). For journal publications, we used the 'related citation' search in PubMed. We contacted authors where appropriate. Hagell, 2013[171] Clements, 2013[172] Hargreaves, 2012[170] La Valle, 2012[173] Lavis, 2010[174] Robinson, 2010[175] Freake, 2007[176]

Table A4.2: Full MEDLINE search strategy

RUN ON 04.02.14			
Concept		**Terms***	**Hits**
Setting	#1 General practice	(primary adj care).ab,ti. OR GP*.ab,ti. OR (general adj practi*).ab,ti. OR (general practice).sh. OR (general practitioners).sh.	242701
	#2 UK	(United Kingdom).ab,ti. OR UK.ab,ti. OR England.ab,ti.OR England.sh. OR Wales.ab,ti. OR Wales.sh. OR (Northern Ireland).ab,ti. OR (Northern Ireland).sh. OR Scotland.ab,ti. OR Scotland.sh.	210950
Population	#3 Parents, YP, adolescents or children	parent*.ti,ab. OR parent.sh. OR family*.ti,ab. OR families.ti,ab. OR family.sh OR mother*.ti,ab OR mothers.sh. OR father*.ti,ab. OR father.sh. OR (young adj person).ti,ab. OR adolescent.ti,ab. OR adolescent.sh. OR adolescent health services.sh.OR teenage*.ti,ab. OR child*.ti,ab. OR child.sh. OR child health services.sh.	3443359
Study type	#4 Qualitative research**	interview.mp. OR experience.mp. OR qualitative.tw.	660460
	#5 Patient surveys/ questionnaire	questionnaire*.ti,ab. OR questionnaires.sh. OR survey.ti,ab.	708530
	#6 Audit	Audit.ti,ab.	22953
	#7 Evaluation	evaluation studies.sh. OR evaulat*.ti,ab.	207131
Topic	#8 doctor-patient relationship	(physician patient relations or physician's role or "patient acceptance of health care").sh. OR (engagement OR relationship OR trust OR continuity).ti,ab.	815237
Date	#9 2004 onwards		
	#1 AND #2 AND #3 AND (#4 OR #5 OR #6 OR #7) AND #8 AND #9		294

*ab=abstract; ti=title; sh=subject heading (i.e. indexed term); mp= multi-purpose (title, original title, abstract, subject heading, name of substance, and registry word fields)

** Filter developed by team at McMasters for optimal sensitivity and specificity for qualitative research about human health in MEDLINE database (via Ovid) http://hiru.mcmaster.ca/hiru/HIRU_Hedges_MEDLINE_Strategies.aspx#Qualitative

APPENDIX 5: Role and responsibilities of clinical commissioning groups relating to child maltreatment

England

In England, Section 11 of the Children Act 2004 as set out in Chapter 2, Working Together to Safeguard Children places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.[19] This duty covers NHS organisations, including the NHS Commissioning Board and clinical commissioning groups, NHS Trusts and NHS Foundation Trusts; and GPs as a contracted services are also subject to the same duty. This means that GPs have a statutory duty to:

- protect children from maltreatment;

- prevent impairment of children's health or disability;

- ensure that children are growing up in circumstances consistent with the provision of safe and effective care;

- undertake that role so as to enable those children to have optimum life chances and to enter adulthood successfully.

GP practices should have in place arrangements that reflect the importance of protecting children and promoting their welfare, including:

- a clear line of accountability;

- a senior board level lead to take leadership responsibility;

- a culture of listening to children;

- arrangements which set out clearly the processes for sharing information;

- a named GP in each LSCB area and a lead and deputy at each practice;

- safe recruitment practices;

- appropriate supervision and support for staff, including undertaking relevant training.

GPs must ensure all staff at practices are competent to carry out their responsibilities for protecting children and promoting their welfare and creating an environment where staff feel able to raise concerns and feel supported in their role of protecting children and promoting their welfare:

- staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities;

- all professionals should have regular reviews of their own practice to ensure they improve over time;

- clear policies in line with those from the LSCB for dealing with allegations against people who work with children.

APPENDIX 6: Methods and results of relevant randomised controlled trials

We found two interventions which are indirectly relevant to the questions of efficacy, safety and cost of GP responses to child maltreatment in the UK and have been evaluated using randomised controlled trials.

Evaluations of the 'Safe Environment for Every Kid (SEEK)' intervention in American paediatric primary care settings reported a reduction in child maltreatment in a high risk sample (measured as involvement in child protection services, medical problems relating to possible neglect and self-reported child assault by parents) and lowered psychological aggression and minor physical assaults towards children in relatively low-risk mothers.[154;155;186] The SEEK intervention consisted of training doctors to recognise parental risk factors for maltreatment, use motivational interviewing techniques with families, direct families to local services and provided doctors with access to an on-site social worker. Following training, doctors felt more comfortable and confident in identifying and responding to parental risk factors for maltreatment and doctors who received the training were viewed favourably by patients.[187] There were methodological limitations to this trial including high loss to follow-up (20%) and lack of an intention-to-treat analysis. Even if we agree that the results of the trial are promising, this intervention was implemented with paediatricians in a primary health and welfare system that is significantly different to the UK model. We do not know whether or how far the results can be generalised to the UK general practice setting.

Evaluations of interventions to improve outcomes for women experiencing domestic violence provide the second set of indirect evidence about GP responses to concerns about child maltreatment in England. The 'Identification and referral to improve safety (IRIS)' trial evaluated a training plus support intervention for women experiencing domestic violence in general practice in two PCTs in England. The intervention programme included practice-based training sessions, a prompt within the medical record to ask about domestic abuse, and a referral pathway to a named domestic violence advocate, who also delivered the training and further consultancy. The IRIS trial used referrals as its main outcome measure and reported a much increased referral rate in the intervention practices to the specialist advocacy service (Incidence rate ratio: 22.1 (95%CI 11.5, 42.5)) and two other specialist domestic violence agencies (Incidence rate ratio: 6.4 (95%CI 4.2, 10.0)).[152] However, in absolute terms, the increase in referrals was so small that it was unlikely to be of any clinical significance (increased from 0.03% to 0.04% of all women) and other researchers have questioned the assumption that an increase in referrals indicates an improvement in services and/or outcomes for women.[188] The cost effectiveness analysis of the trial was very uncertain: the confidence intervals indicate that there could be a societal cost of as much as £136 per woman or a societal saving of up to £178 per woman over one year).[151] There is no mention of children or child safeguarding in any of the publications relating to the IRIS study. A similar trial in Australia (WEAVE) evaluated training of GPs to identify domestic violence and offer/deliver several 30 minute counselling sessions on emotions and relationships to women with identified domestic violence. This trial did not find any difference between the intervention and control groups in quality of life, safety planning and behaviour, or mental health 12 months after the intervention. GP inquiry about the safety of children was higher in the intervention group at six months post-intervention (odds ratio 5.1 (95%CI 1.9, 14.0)) but we do not know whether this had any impact on women or their children.[150]

A recently published systematic review, which included one trial (the SEEK study described above) concluded that there was insufficient evidence to assess the balance of benefits and harms of interventions delivered in primary care.

In summary, from the available evidence it is not at all clear if strategies such as on-site social workers/access to specialist staff or motivational interviewing/counselling of parents with risk factors for maltreatment are likely to improve outcomes for children and families when delivered in general practice settings.

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