Written evidence from the Institute of Health Visiting (GRC0024)

The impact of COVID-19 on education and children's services

Submission to Parliamentary Petitions Committee by: Institute of Health Visiting
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About the Institute of Health Visiting

The Institute of Health Visiting (iHV) was established with the support of the Cabinet Office and Department of Health in 2012. We are a charity self-funding through our membership scheme, professional development/training programmes and successful partnership work. Our aim is to strengthen the quality and consistency of health visiting services for the benefit of all children, families and communities and to reduce health inequalities.

Our evidence

Our evidence comes from the underlying scientific basis for the foundations of healthy infancy and childhood for longer term health and social outcomes, health inequalities, life-chances; and effective programmes / services. Specifically, we address and make recommendations reflecting:

- **The importance of the transition to parenthood for maternal and infant health, especially mental health**
- **Our immediately available evidence from health visitors and services user organizations on:**
  - **The impact of COVID-19 measures on: Parents and infants**
  - **The impact of COVID-19 measures on: Sources of support – formal and informal (including, but not limited to, health visiting).**

1. The importance of the transition to parenthood for maternal and infant health, especially mental health

We welcome the opportunity to present evidence on the importance of early childhood for childhood health, development and learning throughout the life course. There is rightly concern COVID-19 'lockdown' measures deny school age children many of the crucial benefits of school. However, there is substantial evidence that the greatest influence on children's prospects comes from their first 2-3 years of life from conception most of which is spent in the home environment and community.

The petition under consideration by the Committee focusses on maternity leave, a key component of support for the transition to parenthood. Key to navigating the transition to parenthood is to have practical, social and emotional support both in the home and the community. Without these supports, even 'normal' challenges of parenting a new baby can be very hard to navigate, resulting in normal challenges assuming greater significance for parents, their close relationships and especially their developing infant. The requirements of social distancing or 'lockdown' impose a level of isolation from sources of support and therefore exacerbate the 'normal' challenges of parenting. Maternity leave entitlement serves many purposes, amongst which many mothers value the opportunity to build their social networks and establish how they will balance motherhood with other ties and their relationship with

their baby. The duration of maternity leave has a measure of personal choice according to circumstances. Present circumstances of lockdown are designed to protect the adult population from the COVID19 virus that imposes costs on everyone, but the first year of life is highly formative for both babies and their parents. For mothers, there is

- the cost of lack of access to the expected supports;
- exposure to increased isolation within the home including relationship difficulties

2. The impact of COVID-19 measures on: Parents and infants

Babies are highly dependent on their primary care-givers to be alert to, responsive and able to meet their needs for nurturing care. Therefore, the wellbeing of mothers and their babies are interdependent.

Learning from other countries and previous pandemics there are likely to be more adverse effects for vulnerable parents and children, with domestic violence and abuse, safeguarding and mental health needs of vulnerable populations likely to increase as the crisis continues. Calls to helplines bear out this this is the case in this pandemic. Health visitors are telling us that there has been a significant impact of lockdown on the mental health of families and that can impact the parents' abilities to nurture their infants.

The understandable focus of the response to COVID-19 on saving lives could result in the needs of children and families being overlooked unless the focus of the national response is broadened to include the secondary impact of COVID-19, alongside the immediate treatment of COVID-19 infected patients. Similar warnings have been raised by leading academics throughout the world who are following the course of this pandemic in other countries. Early evidence from China[1], France and Italy suggests that the lockdown conditions created by the pandemic, particularly the isolation of families, could lead to the doubling of the number of victims of domestic abuse at a time when there is a significant scaling back of the services available to support victims. A similar pattern is emerging in the UK, with the National Domestic Abuse helpline reporting that it has already seen a 25% increase in calls and online requests for help since the lockdown.

There is evidence of the impact of COVID-19 lockdown on families from increased calls to help-lines for child abuse, domestic violence and mental health concerns. These three factors combine to form a 'toxic trio'[2] of risk to the physical and mental health of children including babies.

The World Health Organisation (WHO)[3] has reported that the coronavirus pandemic is also inducing a considerable degree of fear, worry and concern in the population:

> *"In public mental health terms, the main psychological impact to date is elevated rates of stress or anxiety… levels of loneliness, depression, harmful alcohol and drug use, and self-harm or suicidal behaviour are also expected to rise."*

The impact of the COVID-19 pandemic on maternal or perinatal mental health is to increase risk factors and reduce access to sources of support, whether informal or formal.

What is Perinatal Mental Health? [4]

[1] https://www.sixthtone.com/news/1005253/domestic-violence-cases-surge-during-covid-19-epidemic
[2] https://www.childrenscommissioner.gov.uk/publication/are-they-shouting-because-of-me/
[3] World Health Organisation (Europe) (2020) Mental Health and COVID-19 http://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/novel-coronavirus-2019-ncov-technical-guidance/coronavirus-disease-covid-19-outbreak-technical-guidance-europe/mental-health-and-covid-19
[4] https://maternalmentalhealthalliance.org/download/mental-health-champions-briefing/?wpdmdl=5374

Perinatal mental health refers to a woman's mental health during pregnancy and the first year after giving birth. Perinatal mental health problems include those that existed before pregnancy, as well as illnesses that develop for the first time, or are greatly exacerbated in the perinatal period. Examples of perinatal mental illness include antenatal and postnatal depression, anxiety, obsessive compulsive disorder, postpartum psychosis, post-traumatic stress disorder (PTSD) and experiences of trauma. These illnesses can be mild, moderate or severe, requiring different kinds of care or treatment.

If untreated, these perinatal mental illnesses can have a devastating impact on the women affected and their families. In the UK, they all too often go unrecognised, undiagnosed and untreated.

- More than 1 in 10 women develop a mental illness during pregnancy or within the first year after having a baby (NSPCC, 2013)
- 7 in 10 women will hide or underplay the severity of their perinatal mental illness (Boots Family Trust Alliance, 2013)
- Suicide is a leading cause of death for women during pregnancy and one year after birth (MBRRACE-UK, 2016)
- If untreated, perinatal mental illnesses can have a devastating impact on the women affected and their families (Centre for Mental Health and London School of Economics, 2014)

The impact of COVID-19 will be felt across the population as a whole but is likely to have the most detrimental effect on those who are already disadvantaged and, in particular, our most vulnerable infants and children whose needs are at risk of being hidden from sight. A recent paper from Jack Shonkoff[5] warns that:

> *"We cannot lose sight of the massive consequences of these threats to the health and development of our most vulnerable children and their families - now and for years to come… As we pull out all the stops to prevent broader infection, we must also remain vigilant in caring proactively for those who are especially vulnerable to the threat and consequences of social isolation."*

Health visitors who, it should be remembered, reach *all* families, report

Heightened anxiety:

- Lack of support
- Financial difficulties
- More families on universal credit
- Challenge in being shut into a relatively small living space, perhaps in a city or in a block of flats where it's harder to get out at all.
- Accessing food, nappies, formula milk if using it
- Fear of catching COVID
- **Hard to admit to struggling to a near stranger so may wait longer to seek help.**

Although these needs are increased by COVID-19 measures, they are likely to be less visible and under-reported. The Children's Commissioner[6] summarises the situation as follows:

[5] Shonkoff J (2020) Stress, Resilience and the Role of Science: Responding to the Pandemic. https://developingchild.harvard.edu/guide/a-guide-to-covid-19-and-early-childhood-development/

[6] https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/04/cco-were-all-in-this-together.pdf

Many children are potentially vulnerable due to difficulties their families were facing before lockdown. For these families the loss of support networks, alongside the anxiety and financial pressures caused by COVID-19, could be what tips them from being able to cope, to reaching crisis point. There are many hundreds of thousands of children in England living in households where there is domestic violence, adult mental ill health and substance abuse. Many of them are not known to social services. For those who are known to services, during the current crisis, there is a real risk that many more will become 'invisible' – those who were getting early help from non-statutory services, or those assessed as 'lower risk' by social workers. While some children will still be getting home visits from social workers, those assessed as lower risk will be more likely to get support through virtual contact.

Concerns around the needs of 'hidden' children have been exacerbated by the pandemic. Last year the Children's Commissioner[7] drew attention to the large numbers of '*hidden*' vulnerable children, estimating that in total 2.3 million children are living with risk because of a vulnerable family background. Within this group more than a third are "invisible" (i.e. *not known* to services) and therefore not getting any support. At the most extreme end of the spectrum, as in previous years, currently the highest rate of homicide for any age group is in babies under the age of 1[8] . Now, under COVID-19 restrictions, far more children are 'hidden'.

Under these circumstances, mother and / or fathers with small babies are under twin pressures:

1) *Within the home*, they are less likely to have any form of direct face to face social contact or support, formal or informal, AND
2) They are less able to avail themselves of any form of face to face social contact or support, formal or informal, *outside the home*.

The easing of some COVID-19 restrictions in early June will be welcome but continue to diminish was mothers would have expected in maternity leave and cannot restore lost opportunities that are foundational for parenting, family life and early infant development.

3. The impact of COVID-19 measures on: Sources of support – formal and informal

3.1 Informal Support

Attending groups with a baby does not impact on a baby's development – It's the nurturing time which they spend with their carers which will impact their development. However, the petition to provide the option of extended maternity leave expands on the COVID-restricted time to access support, laying foundations for healthy and confident parent and infant relationships and wellbeing. Examples of restricted support include

- Grandparents, friends, nursery for older child
- Maternity leave plans turned on their head
- Being a new mum/dad is one of the most pleasurable but can also be one of the most challenging life changes that anyone embraces
- Community services including health visiting and Children's Centres much reduced in access and availability

[7] Children's Commissioner (2019) Childhood vulnerability in England 2019. https://www.childrenscommissioner.gov.uk/publication/childhood-vulnerability-in-england-2019/

[8] Office for National Statistics (2018) Homicide in England and Wales: year ending March 2018. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2018

- Informal venues and social spaces unavailable sue to social distancing.
- Formal and informal parent and baby groups and activities

Health visitors tell us:

- More families are now vulnerable. There is often a 'honeymoon' for the first few weeks post-natally as the partner may be at home with time to offer more support, but after that, the reality of the situation may start to bite and with it increased anxiety and postnatal depression.
- They are concerned about more alerts from the police for domestic violence incidents
- More mothers suffering with anxiety or depression, but hidden from view
- NSPCC are reporting more calls to their helpline and more mental illness reported by callers

3.2 Health visiting support

Health visitors are Specialist Community Public Health Nurses registered with the Nursing and Midwifery Council (NMC). Health visitors are nurses or midwives who have undertaken additional public health training at graduate or masters level. Their training equips HVs to use their understanding of public health, the wider determinants of health and impact of health inequalities in their skilful work, recognising and responding to individual needs with the aim of improving health outcomes for every child and family.

> *"Health visitors are an essential part of the country's support structure for young children and their parents – especially those who are struggling to cope. But they can only do this if they have the time and capacity to develop good, trusting relationships with families. I am very concerned that the huge pressure on health visitor services is making it harder for them to do this, meaning some vulnerable children are in danger of falling through the gaps."*
>
> **Anne Longfield, Children's Commissioner for England**

Health visiting is the only service that proactively reaches out to all children and families with babies and children under the age of five to systematically assess health and developmental needs and provide support proportionate to that need.

The NHS guidance on prioritisation of Community Services[9] drastically reduces the health visitor-led Healthy Child Programme to two of the five minimum mandated contacts in the antenatal period and the New Birth review and more limited targeted support for some families. To comply with the government's social distancing rules, most health visiting contacts are also largely taking place remotely, unless there is a compelling need for a face-to-face contact. It can already be hard for parents to share personal worries or problems like domestic violence and abuse, mental health or substance misuse with a stranger, and eliciting needs like these will be even harder over the phone, creating an additional challenge if either parent wants to speak privately about the things that are really worrying them and may be placing them and their children at risk. Breastfeeding support and physical assessments for growth or minor illnesses over a telephone or video call are also far from straightforward.

From June 3rd, 2020 revised NHS Guidance on prioritisation of Community Services[10] was issued. Of relevance to support for the transition to parenthood the iHV especially welcomed:

- The removal of the wording around redeployment of health visitors
- The reinstatement of the health visitor 6-8 week postnatal review

[9] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0145-COVID-19-prioritisation-within-community-health-services-1-April-2020.pdf

[10] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0552-Restoration-of-Community-Health-Services-Guidance-CYP-version-3-June-2020-1.pdf

- The inclusion of additional safeguards to protect vulnerable children – "Face-to-face contacts should be prioritised for families who are not known to services to mitigate known limitations of virtual contacts and support effective assessment of needs/ risks"
- Prioritisation of home visits where there is a child safeguarding concern.

For babies there is no substitute for proactively seeking out those who missed checks or haven't been seen; nor for identifying parents who are struggling with mental health or other issues that impact on their parenting capacity without support. The needs of these babies and very young children may therefore remain hidden for a considerable time or remain unknown and therefore unmet.

What parents most value about health visiting is:

- the opportunity for a trusted and knowledgeable practitioner who is readily accessible to them[11].

This particularly applies to the most disadvantaged families who are less likely to access formal or centre-based services. To be effective, services need to be built around the needs of infants, children and their families, with relationships at the core of all health visiting provision. *Continuity of relationships with a known health visitor* and collaboration with other services are essential to the early identification of need and the provision of effective support for families with young children and should be a priority for the rebasing of the service as the strictest requirements of social distancing are eased.

3.3 The health visiting service capacity prior to and during COVID-19 pandemic

In November 2019 we surveyed frontline health visitors working with families and communities. Our survey[12], the latest of six conducted annually from 2014, indicates the impact on the quality of the service available to families, and workforce capacity and morale from sustained reductions in funding. It found:

- There is considerable unwarranted variation between local authorities in the quality of the health visiting service that health visitors are able to provide which may not be based on best practice or the family's level of need.

- The health visiting service has become increasingly driven to demonstrate compliance to key performance indicators, reducing their capacity to respond to identified needs and utilise their skills to address key public health priorities and reduce inequalities.

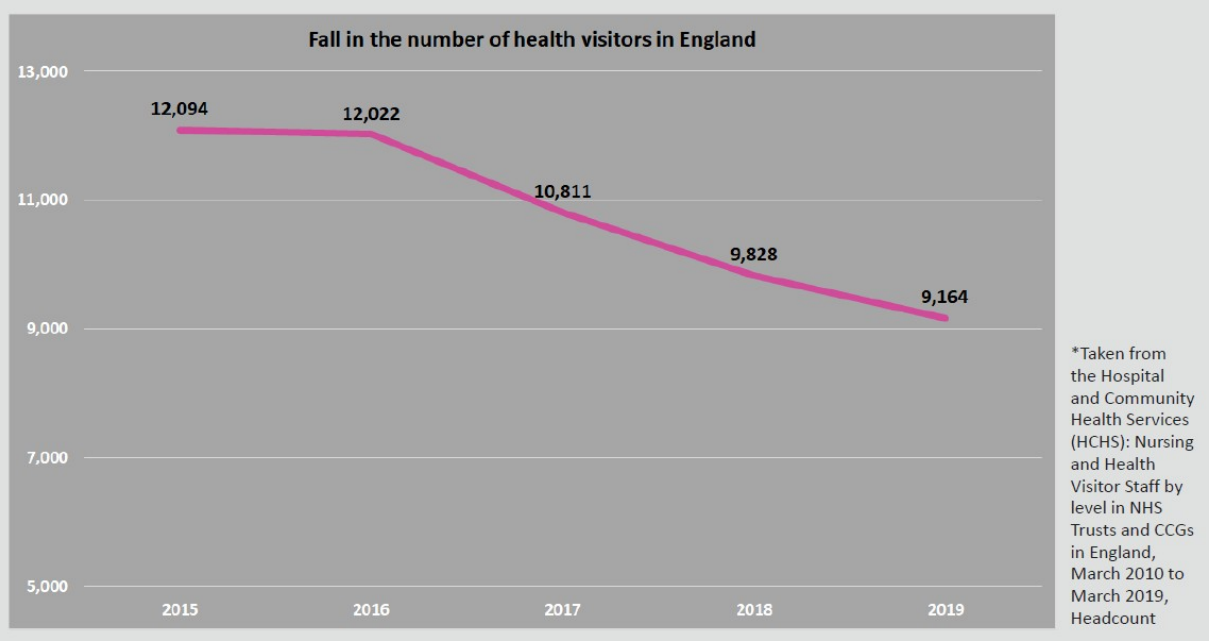
- 'Continuity of health visitor' is increasingly difficult to deliver in practice despite being highly valued by parents and strongly associated with improved outcomes.

- Health visitors report high levels of work-related stress and distress from concerns about the risks to which "hidden" vulnerable children and families are exposed and how many are now left unsupported.

Key to delivering an effective, quality service is a well-trained professional workforce in sufficient numbers that is well motivated and supported to provide a personalised public health approach to families with young children. In our 'State of Health Visiting' survey in 2019 we describe the increase in health visitors' caseload size due to service cuts. This is due to the fall in the numbers of health visitors in England since 2015, see Figure 2 below.

11 https://ihv.org.uk/wp-content/uploads/2020/01/HV-Vision-Channel-Mum-Study-FINAL-VERSION-24.1.20.pdf
12 https://ihv.org.uk/wp-content/uploads/2020/02/State-of-Health-Visiting-survey-FINAL-VERSION-18.2.20.pdf

Figure 2. Fall in the numbers of health visitors in England since 2015 and before COVID-19*



The fall in health visitor numbers has continued since March 2019. Moreover, **redeployment of health visitors for COVID-19 has drastically reduced the service further in many locations to support the capacity for the NHS to meet the COVID-19 demand**. We are concerned that an already very serious gap in provision and overstretched workforce **is being reduced to 50% or less**. Prior to the pandemic in 2019, 29% of health visitors we surveyed were already responsible for 500-1000+ children (iHV, 2020). The recommended maximum number of children per health visitor is 250.

A Specialist Perinatal Mental Health HV tells us:

> *I am reaching out to as many of my old clients as possible, (even those who are not strictly perinatal anymore) and getting a lot of response from mothers. One mother, previously presented as well and coping, has been in touch today saying she is crying non-stop because baby is refusing the breast, with this and looking after a toddler who would normally be at nursery, she says she is in a "state" and " cannot cope". From this I just want to make the point that the term vulnerable has very broad application [beyond those identified as 'at risk'].*

The COVID-19 measures have exposed and increased unrecognised needs and widened inequalities. They have drastically reduced mothers' capacity to access and develop their own sources of support for navigating the transition to parenthood. At the same time formal sources of support including health visitors – rated by parents as the most common source of support and guidance in a 2015 survey by the Early Intervention Foundation[13] – have been reduced over the last five years and pared back drastically through COVID deployment.

[13] https://www.eif.org.uk/files/pdf/best-start-at-home-overview.pdf

4. Recommendations

1. The Committee should consider how maternity leave entitlement can be made available to support mothers make choices that meet their needs to navigate the transition to parenthood and meet their babies' needs for strong foundations to health and development.

2. The Committee should consider other supports available alongside maternity leave.

3. The Committee should argue to government that the restoration of health visiting services needs to exceed the *status quo* in order to provide an effective service within the wider system to narrow inequalities and lay foundations for health, social mobility and recovery from current hardships. Specific recommendations are set out in the Institute of Health Visiting's 'Health Visiting in England: A Vision for the Future'.