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What Works in Promoting Good Outcomes for Children in Need in the Community?

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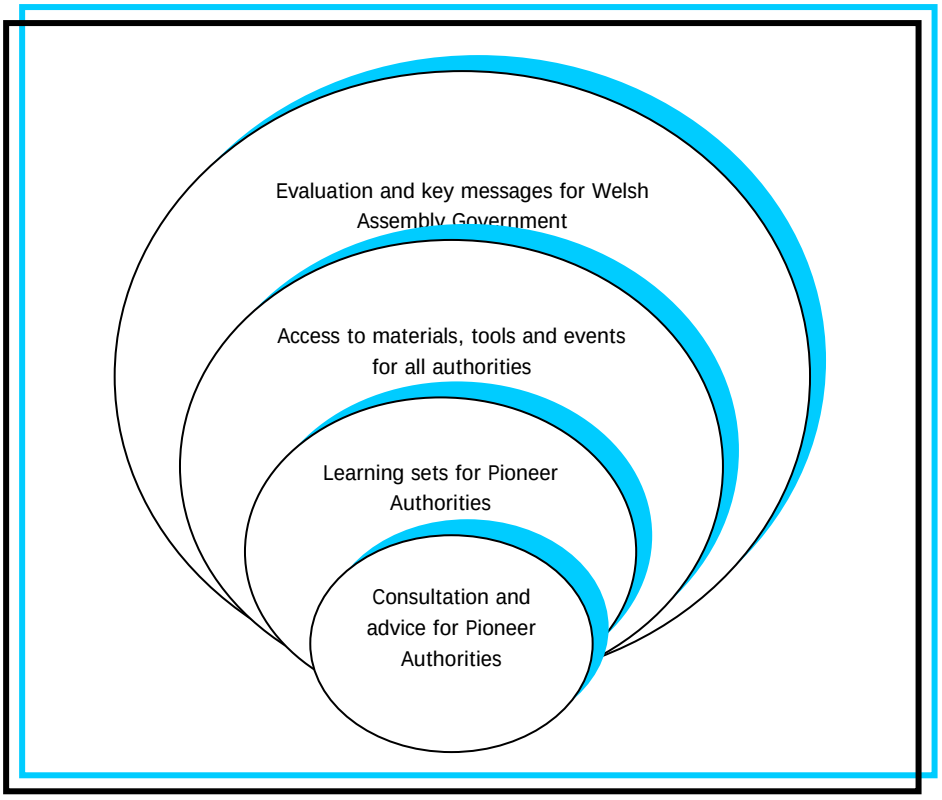
Introduction

This paper has been prepared to support the commissioning of children in need services in Wales as part of the Better Outcomes for Children in Need Programme sponsored by the Social Services Improvement Agency (SSIA). The over-arching aim of the Programme is to achieve more cost effective and improved matching of services for children in need through effective strategic commissioning, focussing on areas such as:

- The overall distribution of resources and services across family support and substitute care.
- The targeting of services towards effective points and methods of intervention that meet the needs of children and young people at risk of entering the care system.
- Improved quality of placement and other services for looked after children and young people, leading to improved outcomes.

The Programme will be undertaken between January 2007 and March 2008, and comprises a series of four complementary activities co-ordinated by the Institute of Public Care (IPC) at Oxford Brookes University. These activities are outlined in the diagram below:



This is one of a series of four background papers produced by IPC in January 2007 to inform the national programme. The full set of background papers is as follows:

- The Role of Commissioning in Improving Services to Children in Need.
- National Trends in Children in Need Services.
- What Works in Promoting Good Outcomes for Children in Need in the Community?
- What Works in Promoting Good Outcomes for Looked After Children and Young People?

These papers will be further developed during 2007-08, with the addition of guides and tools, including on topics such as managing the market, commissioning information sets, and developing and monitoring contracts. It will also be complemented by a series of case studies outlining the progress of approaches that are being applied and tested during the course of 2007 by five Pioneer Authorities in Wales.

The process, or cycle, of commissioning in relation to public care services is explored in detail in the first paper in this series: 'The role of commissioning in reconfiguring and improving services to children in need'. This document is concerned with helping commissioners to gain an understanding of what works in promoting good outcomes for children in need living at home. This area of service provision can be identified by a variety of titles or headings, including: family support, high level preventive services, or remedial services to children in need. It specifically includes provision for:

- Children and young people who are at risk of abuse or neglect.
- Children and young people who, without the intervention of the local authority are unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of services.
- Children and young people who are likely to have their health or development significantly impaired, or further impaired, without the provision of services.
- Children and young people who come within the statutory definition of 'disabled'[1].

Developing an understanding of key research findings and 'what works' in relation to these kinds of services is vital for steering commissioning processes (for example, it can inform the kinds of questions required to be answered in the development of a commissioning strategy), and also for ensuring that any subsequent re-shaping of services is based on available evidence about what works, and why. The knowledge base in this field is ever-growing, and therefore, this paper merely provides a summary of what is known about best practice relating to the provision of services for children and young people in need at the date of publication.

Managers of children's social services are, quite rightly, interested in 'what works' in improving outcomes for children in need and also crucially in preventing the need for looked after services. However in practice, there is a heavy overlap between the kinds of services that may be appropriately delivered to children and young people in need and their families, and others who are vulnerable but not yet within the statutory definition 'in need'. An example of this overlap can be found in parenting education services, where group and individual interventions may be similar for a range of families, not all of whom will be officially 'in need'. Similarly, domestic violence services are often designed and provided to support parents and children irrespective of whether they meet statutory thresholds. Sometimes, the lack of specificity of services to children in need presents no barrier to effective intervention: indeed much of the research has emphasised that interventions often work better where families do not feel stigmatised. However, in other cases, an added dimension may be required, for example to ensure that family support is not only effective from the parent's perspective, but also safeguards the child or young person. The recently published 'Costs and Outcomes in Children's Social Care' study undertaken for the Department for Education and Skills suggests that there is still insufficient evidence about the impact of lower level preventative services on children and families to be clear that they have a positive impact in the medium to long term, in particular on referral levels to statutory children's services. The study urges managers and commissioners to be very cautious about assuming that early intervention services such as Home Start or general family support services targeted at levels of need below statutory thresholds will generate savings for the care system in the short term, or about justifying it on that basis. The authors suggest that it may be better to justify the development of these kinds of services on the basis of benefits to the recipients, for which there is some evidence, rather than short to medium outcomes defined by professionals, and to strike a balance between investment in these kinds of services and those for children and young people who are on the verge of the care system. The study also highlights the risk of a positive opinion from service users being confused with effectiveness in terms of improved child wellbeing, parent functioning or other positive outcomes as defined by professionals or researchers.

The study describes what continues to be a 'fierce system of rationing, responses to a narrow definition of need, and patchy co-operation with other agencies' for children in need, but also finds evidence of positive outcomes for children, young people and families who have had access to more specialist provision targeted at children in need or other children and families experiencing serious difficulties. Particular examples of positively evaluated specialist services in this study included specialist adolescent support services, one intensive parenting education programme (SPOKES), and targeted health visiting.

This paper explores the following:

- Risk factors for children and young people becoming children in need.
- Factors promoting resilience in children and young people.
- Messages from research and best practice about the overall configuration of services for children in need.
- Interventions specific to younger children in need.
- Interventions specific to older children and young people in need.
- Interventions targeting specific parental risk factors.
- Interventions for children and young people with disabilities and their families.

Some of the interventions described in the sections above relate specifically to children in need or children and young people with considerable difficulties; other interventions relate to children, young people and families with need levels just below these thresholds. In each case, we attempt to extract what is known about service effectiveness and the sources of information about effectiveness, and to distinguish between the extent to which they have the potential to impact on demand for care services, risk and resilience factors, or simply the general wellbeing of children and parenting capacity where there is no risk of removal into care.

Key risk and resilience factors for children and young people

Research has identified a number of child and family risk factors or characteristics that may make children and young people vulnerable and at greater risk of abuse or neglect. Many of these risk factors are inter-dependent, and some are poor outcomes in themselves. Example child-related risk factors include: low birth weight, having a disability, having problems at school, and having mental health problems. Example parent-related risk factors include: substance misuse, mental health problems, being a young parent, poor parenting skills, or having experienced abuse and neglect as a child. Example family-related risk factors include: domestic violence, family of 4 or more siblings, frequent home moves, lone or step parent family, and low income. Professionals working with children in need and their families are likely to be able to identify a number of these risk factors within the vast majority of their caseloads.

Research also shows that the ability of children and young people to resist the effects of risk factors, including those described above, will be influenced by a number of other child and family 'resilience' or 'protective' factors. The most commonly cited resilience factors are as follows[2]:

- Having a resilient temperament (biological resilience).
- Enjoying good health and development.
- Having good problem-solving skills / coping strategies.
- Having supportive and involved grandparents.
- Being brought up in a birth family (presence of at least one supportive parent).
- Parental or carer interest in activities, including school in particular.
- Access to high quality early years education.
- Having a pro-social peer group.
- Attending a school with good 'ethos', and a lack of bullying.
- Having access to challenging activities in and out of school, including physical activities.
- Living in a supportive community.

Some of the key messages about the promotion of resilience are[3]:

- Risk factors are cumulative – the presence of one increases the likelihood that more will emerge.
- Transition points in children's lives can be both threats and opportunities.
- Where the cumulative chain of adversities can be broken, most children are able to recover from even severe exposure to adversities in early life.
- Managed exposure to risk is necessary if children are to learn coping mechanisms.
- Acute episodes of stress are less likely than an accumulation of adversity to have long-term adverse effects on children's development.
- The goal in promoting resilience should be effective adult adjustment rather than eliminating the legacy of all childhood difficulties.
- Children and young people who have experienced difficulties report more often being helped by non-professional supporters (friends, family, and community), rather than by professionals. Social-care and other professionals should avoid weakening informal sources of support.

These risk and resilience factors are explored in more depth in the subsequent sections of the paper. Key service areas identified within the best practice literature tend to link closely with either messages from research about risk (for example: services for families of substance misusing parents or for families where there is domestic violence), or resilience (for example: out of school activities and opportunities for young people in need), or both (for example: parenting education). The next section in particular is a good example of how the research community has responded to the risk / resilience debate by attempting to isolate some of the over-arching messages about optimum service configuration to minimise one and maximise the other.

Messages from research about the overall configuration of services for children in need

The research literature and national guidance has identified some of the key characteristics of effectively configured services to vulnerable children, young people and families including children in need as follows[4]:

- Services are accessible to children, young people and families in their localities, and within a range of settings.
- Services are acceptable, for example, parenting advice linked with other advisory services (such as employment and child care); one stop shops that are both welcoming and helpful for older children and young people.
- Services are as non-stigmatising as they can be. Generally, targeted services should be embedded in more open-access services, so that a more graduated response can be provided.
- Services include a particular focus on key transition points in a child's life, such as the change from primary

to secondary education, transition from child to adult services for young people with disabilities.

- There is a whole-child/young person and whole-family approach that is as enabling and empowering as possible.
- There are good links with relevant adult's services (in particular mental health or drug and alcohol services) so that these services take account of the developmental needs of the child or young person.
- Services are evidence-based, grounded in robust evaluation of what works.
- Where possible, new services are built on existing local networks and services that are already working well.
- Services are sustainable, with support continuing for a long as is needed.

The importance of effective assessment, planning, and case coordination

In order to make good decisions about the best way to work with children in need and their families, an effective assessment is essential. Good assessment ensures that key workers, providers, children, young people and families have a clear focus for the work they are undertaking. Urgent, child-centred planning, with an emphasis on clarifying the desired outcomes for intervention with the child and family, is also essential to maintain the focus, and to avoid case drift.

The Framework for Assessment of Children in Need[5] provides a systematic way of analysing, understanding and recording what is happening to children and young people within their families and the wider context of the community in which they live. The assessment is designed to be used for identifying need and planning care for children and young people in all settings, and can be used as a basis for referral to more specialised settings. The Framework details a series of principles underpinning the assessment process, including that it should:

- be child-centred;
- be rooted in child development;
- ensure equality of opportunity;
- involve working with children and families;
- build on strengths as well as identify difficulties;
- be inter-agency in its approach (both to assessment and to the provision of services);
- be a continuing process, and not a single event;
- be carried out in parallel with other action and provision of services; and
- be grounded in evidence-based knowledge.

However, assessment is a complex activity: more than simply the gathering of information. Applying the Framework is unlikely in itself to bring about good assessment and care planning without training, support and professional development to enable practitioners to practice and develop their skills, particularly those related to analysis. Social

work professionals frequently report that they need access to specialist support and information, for example about working with parental substance misuse or mental ill health, to enable them to confidently assess risks; work jointly on cases and / or access timely specialist support for the child and/or their family[6]. Some local authorities have responded by developing multi-disciplinary field work teams including, for example, social workers and substance misuse workers who can collaborate within assessment and planning but also in ongoing interventions with children and families.

However, both internal and external audit activity within field work teams continues to identify that some plans for children in need lack focus, often describing the package of care to be delivered but failing to identify the desired outcomes of intervention with the family, or failing to link care packages with evidence[7]. The recent 'Costs and Outcomes' study (2007) suggests that even core assessments are relatively cheap to undertake compared with the resource implications of incorrect decisions they influence, and that more needs to be done to ensure that decision making is undertaken at a consistently high level, including through the continuous monitoring of assessment and family support planning activity[8].

The Integrated Children's System (ICS) has been developed in response to these and other issues relating to the assessment, planning and review of children in need identified by recent research, inspections and inquiries. Each local authority will be required to produce its own solution for ICS that delivers the business requirements set out in the national guidance, and makes use of guidance documents that address practice, core information requirements, ICT functionality, information outputs and the learning from pilot sites. The system will be required to be implemented across England and Wales from 2007 onwards[9].

In order to plan effective interventions for children and young people where a number of agencies are or might be involved, many local areas have developed 'team around the child' or multi-disciplinary resource meetings to assist in determining and securing the right response. These panels may involve children and young people in need and / or those who are vulnerable but do not quite meet the statutory threshold. Where interventions are ongoing and multi-disciplinary in nature, the research and national guidance has also identified the need for a lead or key professional role to ensure good case co-ordination, for example for children and young people with disabilities who have complex needs, children and young people on the child protection register, and children or young people with special educational needs. Where the child is in need, this lead professional is likely to be the designated social work practitioner.

Specific interventions for children in need and their families

Within the context of overarching messages about service configuration and the importance of careful assessment and planning outlined above, a wide range of interventions for children in need have been positively evaluated. These include some interventions with a proven impact on demand for care services, and a number of others impacting on risk and resilience factors, or simply the general wellbeing of children and parenting capacity. In the sections below, we explore in particular:

- interventions specific to younger children and their families;
- interventions specific to older children and young people and their families;

- interventions targeting specific parental risk factors, such as substance misuse or domestic violence; and
- interventions for children and young people with disabilities and their families;

Including the extent to which research and individual service evaluations indicate good practice, or areas for improvement and change.

Interventions specific to younger children in need and their families

Both the research and national guidance across the United Kingdom accept that all children should be supported within their families unless it is against their best interests for them to remain at home. If younger children at increased risk of abuse or neglect are to be supported in the family home, child and family risk factors need to be identified as early as possible and a swift response provided, building on child and family resilience factors. Given the often multi-faceted nature of risk factors, a multi-disciplinary package of support may be required. However, many of the successful interventions specific to younger children in need focus on improving the quality of parenting and parent-child interaction. Parenting has been identified as the single largest variable in health outcomes for children, including: teenage pregnancy, substance misuse, truancy, school exclusion, child abuse, criminal activity and mental illness[10]. By the time a child is 2 years of age, poor parenting practices and interactions can often be firmly established. Where parenting is inhibited by specific parental characteristics such as substance misuse, a more specialist approach may be required[11].

A. Targeted Health / Home visiting

Home visitors can include professional health visitors or trained volunteer 'community mothers'. A 1996 review of health and home visiting studies has concluded that family support provided by these visitors reduces the incidence of childhood injury, improves maternal well-being, and has positive effects on the parent-child relationship[12]. Longer term studies of health and home visiting programmes have also shown a reduction in criminal behaviour among children and young people previously involved in some of the programmes[57]. There is evidence of the effectiveness of some programmes on the subsequent life course of the mother, including on the number of subsequent pregnancies, the use of welfare and the uptake of employment.

The main recommendation of national reports and guidance over the past decade has been for more effective targeting of health / home visiting for more vulnerable families, for example young parents, substance misusing parents, or parents of low birth-weight children[13]. Low birth weight has a negative impact on infant and longer-term health of children, and has been linked with prospective mothers of low socio-economic group having poor diets, being pregnant whilst a teenager, and smoking or drinking alcohol during pregnancy. Other causes of low birth weight include being born prematurely, or as a result of fertility treatment (multiple births). Low birth weight is associated with an increased risk of infant mortality, and abuse or neglect in children and young people[14].

Targeted support and home visiting has been developed in many areas with very good results. Evaluations have generally identified improvements in parenting leading to more positive outcomes for children. However, the success of targeted programmes is highly dependent on the way in which the service is actually delivered on the ground. The

following 'tips' for successful programmes have been identified in the research literature[15]:

- To achieve lasting impact with high risk parents and children, multi-disciplinary strategies and multiple methods should be used, combining home visiting with other services such as: a 24 hour contact telephone number; free transport to any non-home based care; practical help for family problems; and development of support networks.
- Mothers are generally more willing to receive support and guidance before or around the time of their first birth.
- Interventions including both parent and child appear to be the most effective.
- Interventions matched to the needs of parent and child are more likely to be successful than merely applying standardised programmes. No single approach will have the answers.
- Screening tools and approaches can be used to target at risk parents, for example: young parents, lone parents and mothers with mental health problems including post-natal depression.
- Offering a small number of high intensity services to a family is likely to be more effective than a large number of low intensity components. Frequent visits over a period of time (greater than 6 months) are best.
- The development of targeted health visiting programmes may result, initially at least, in a greater number of children being removed to the care system.

The Oxfordshire Home Visiting Study[16] published in 2006 is a three-year evaluation of an intensive home-based health visiting service for mothers at risk of poor parenting and abuse. This service was delivered by health visitors attached to forty GP surgeries across two counties. Health visitors identified families with significant risk factors during pregnancy using a checklist including: acute mental health problems; drug / chaotic alcohol user; threats to harm baby; abuse / neglect of previous children. Partnership training improved the capacity of health visitors to engage high-risk families in potentially therapeutic relationships and to identify abusive family relationships in the first year of life. The study identified that weekly home visiting during pregnancy and throughout the first year of the infant's life could improve maternal sensitivity / infant cooperativeness, prevent the loss of social support, and enable the early identification of abuse in high-risk families.

A slightly older study of targeted health visiting also identified positive results. The Child Development Programme in Bristol[17] offered monthly support visits from specially trained health visitors to first time parents as well as those with two or more children facing particular problems in coping. Home visits were more intensive than conventional ones, and the health visitors provided strategies for tackling child care issues by both parents. Parents were encouraged to set themselves developmental, dietary, health and other tasks to carry out with their children in the month following the visit. Families participating in the programme generally had better children's diets and general health, children aged three and under showed greater concentration and better social behaviour, and children's story books were more likely to be available in the home. In the long term, immunisation rates were higher and children suffered lower rates of physical abuse and registration on Child Protection Registers than a control group of non-programme families.

'Home-Start' is one of the largest providers of support and befriending for parents of young children in the UK, established over 30 years ago. In 2003, there were over 330 Home-Start schemes in Wales, England, Scotland and Northern Ireland. The service provides home visiting by trained volunteers to families under stress where there is at least one child aged under 5 years of age, encouraging families to widen their network of friends in the community and make effective use of available services. An evaluation of the service in 2000[18] found that two out of three mothers, including a high proportion with physical and mental health problems, reported improvements in their well-being. One in three said their involvement with Home-Start had helped them make positive and consistent changes. Frost et al argue that Home-Start is a service capable of bridging the gap between the universal services provided by health visitors, and services provided directly by social services, via a voluntary, non-stigmatising, flexible service[19]. However, a recently published evaluation of 13 Home Start Schemes in Northern Ireland and England found more mixed results. The study identified that some parents considered they had benefited from Home Start support, but many simply grew more confident as parents, started to find routines and solutions, acquired more help or child care, and generally began to take control of their lives. In particular, it was very difficult to attribute any improvements for parents and children with the input from Home Start, as there was the same degree of improvement on all scores for both the sample receiving a service and a control sample[20].

B. Family Centres / Multi-Function Family Support

Family centre-based support has characterised local authority services to younger children in need and their families over the last 20 years. Sure Start programmes and Integrated Children's Centres are the modern manifestation of the family centre style approach to core delivery of these services. A study undertaken by Barnardo's in 1996[21] argued that an open door family centre model run on neighbourhood and community development lines is more attractive to local people and better able to reach more families in need than those accessible only through referrals. However, a later study[22] by Pithouse et al (1999) tracked the progress of families who attended a referral-only family centre for up to two years after the initial referral. Numbers on the Child Protection Register decreased markedly during and after attendance at the family centre. The Audit Commission, in discussing the role of family centres, has suggested that a mix of open access with a quota of referred families is generally preferable to a completely closed system[23].

Very recent research has produced more mixed findings. An exploratory study funded by the DfES and published in 2007 evaluated the costs and effectiveness of multi-function family support services provided to high risk families including children in need aged 12 and under[24]. A sample of centre-based and outreach family support services provided by social services departments and voluntary agencies in the North of England were studied. Despite most carers appreciating the range of informal services, there was little evidence for the overall effectiveness of the services investigated for the study. Furthermore, there was very little evidence that outcomes were associated with whether the service was centre based or outreach. In most services evaluated, the study found that interventions were unstructured, outcome goals were inadequately specified, and staff did not have the necessary training to undertake the complex work required. The key findings from this study and from the recent evaluation of Sure Start programmes in England are that[25]:

- In many areas, more needs to be done to 'reach out' to the most disadvantaged families and children.
- Services need to be clear about the goals to be achieved with each child and family, and the theoretical rationale behind specific interventions.

- Families should be offered services as their problems are identified, rather than waiting until their difficulties have exceeded a notional high threshold for services.
- Interventions that in particular aim to build and support the carer's own support networks may be the most effective.
- Staff employed to deliver family centre or outreach services must be suitably qualified and well trained to deliver a service to meet the needs of harder to reach families in particular.

C. Targeted Parenting Education Programmes for Parents of Younger Children

Parenting style has been shown to have a pervasive influence on health and well-being in childhood and adult life, and adequate or good parenting has been shown to have a protective influence against some of the factors linked to poverty[26]. There is growing research knowledge about the different styles of parenting and the impact that these have on outcomes for children, including the identification of 'positive' and 'negative' qualities[27].

Positive and negative qualities in parenting	
Positive	Negative
Authoritative	Authoritarian
Warm and affectionate	Cold and hostile (high criticism, low warmth)
Clear limit setting	Inconsistent rules
Quick to recognise needs	Unresponsive to needs/inflexible
Accepting of faults	Rejecting
Predictable and consistent	Unpredictable
Respecting the individual	Disrespectful
Open and effective communication	Inadequate supervision
Recognising good qualities/behaviour	Punishing bad qualities/behaviour
Empathic	Inappropriate expectations

Overall, 'low warmth, high criticism' parenting styles have a strong association with emotional and behavioural difficulties in children and young people, while positive, nurturing relationships between children and parents/carers are a crucial foundation for well-adjusted development in children. Parental communication style and conflict resolution style in particular, have been described as key variables in the development of child conduct and peer relationships.

'Parenting education' covers a wide variety of activities, methods and client groups; it can be offered on an individual or group basis, in clinics or community settings such as schools and family centres. Some programmes aim to help families learn more about how to bring up their children at different stages of their childhood; others are targeted at families whose children are exhibiting behavioural problems, or provide support and education to referred families where there is a risk of family breakdown.

Parents of younger children in need frequently require help with their parenting, although they may, at least initially, receive support unwillingly. Many targeted parenting programmes have been developed from the well-evaluated materials devised by Carolyn Webster-Stratton and colleagues at the University of Washington for children aged 3-8 years. The Webster-Stratton Programme includes:

- Videotapes of actual parent-child interaction, in which appropriate and inappropriate behaviours are modelled, and used to prompt group discussions.
- Support for parents to set clear expectations for their children's behaviours and to reinforce positive behaviour, while using effective, non-violent strategies to discourage negative behaviour.
- 'Buddy calls', whereby parents call each other to share experiences regarding the assignments they have been set.
- Direct work with children, such as Webster-Stratton's Dinosaur Curriculum, and working with children's teachers as well as their parents.

Other parenting programme models that have proved effective in trials include the Positive Parenting and the Strengthening Families / Strengthening Communities programmes. Studies in both the US and Britain have identified that Webster-Stratton and other similar programmes can lead to significant improvements in children's behaviour, better parenting skills, and improved levels of stress and anxiety for parents, with effects that last over time [28] .

Although targeted parenting education such as Webster-Stratton can be very effective, it does not work for all families. Up to a third of parents continue to experience difficulties after involvement in parenting programmes and although the reasons for this are not well understood, recent research seems to show that parental depression in particular reduces the effectiveness of programmes[29]. A further criticism has been the failure of these programmes to address wider problems with life circumstances[30], including the repeated finding that parents from lower socio-economic backgrounds are less likely to engage and / or more likely to drop out of the parenting programmes[31].

The literature has identified the following characteristics of successful programmes:

- Behaviourally orientated programmes (where parents are trained to use praise and reinforcement effectively) seem to have more impact in changing children's behaviour than those which emphasise relationships and communication. Programmes combining behavioural parenting approaches with other techniques such as problem solving appear to be the most effective. However, relationship-based programmes do also have some positive outcomes for parents, and can lead in particular to decreased family conflict.
- Group based programmes may be more successful in improving the behaviour of children aged 3-10 years, than working with parents on an individual basis, and are likely to be more cost effective as well as more acceptable to parents as non-stigmatised support.
- The most effective facilitation approach seems to be an interactive model of learning that values parents' own

ideas and experience, thereby increasing parents' confidence and providing peer support.

- Working with parents alone is not enough to achieve long-term change in children with severe or complex problems. Parenting programmes that include direct work with the child are likely to be more effective.
- Professionals need to work collaboratively to have most impact. Schools are important influences on children's lives and teachers need to be involved to ensure improvements at home are reproduced in the school.
- Radical changes in children's behaviour and parent/child relationships are unlikely if services do not address the context in which children are brought up. Parenting education alone cannot solve factors that adversely affect parenting such as poverty, lack of community and social support networks, and domestic violence.
- Parent education needs to be offered in accessible locations, through the provision of transportation, day care and flexible scheduling.

'Mellow Parenting' is a programme designed to support families whose relationship with their children is under severe stress. Referrals for the programme usually come from GPs, health visitors, or social workers. A recent study of the programme identified that mothers showed significant improvement in their mental state, and improvements in the child's behaviour and mother-child interaction were noted. The key factor appeared to be the mother's willingness to invest emotional energy in the group and the child. However, improvements often weren't maintained where the mother's partner was hostile to their involvement in the group, suggesting the importance of involving fathers as well as mothers in parenting programmes[32].

Fathers have a key role in caring for children and a larger than expected proportion (approximately 30%) of all childcare in the UK is provided by fathers, yet to date, the availability of parenting support to fathers has been patchy in the UK. Some of the barriers existing projects have found in delivering services to fathers are:

- Parenting groups are often run by women and can be seen as 'female orientated'. Men respond more positively to groups led by men and there are few male counsellors and leaders.
- Groups and activities are often held during working hours.
- Research, and services, are mostly concentrated on mothers needs and fathers coping strategies will not necessarily be the same as those of their partners.
- Family centres are often seen as 'feminised environments' and they do not have a positive approach to working with fathers.

National guidance is now promoting a cultural shift in all family support provision to include fathers, and various projects across the UK are now taking up the challenge.

In Rhondda Cynon Taff, a Dads' Support Worker has been recruited to support fathers of pre-school children in actively contributing to their child's development, including by direct one-to-one support to fathers at risk of abusing their children and other 'high risk' groups, and the provision of training and support to other professionals. Increasingly, the work will involve the establishment of links with other organisations to ensure that fathers in high-

risk categories, such as teenage fathers, are identified; and a network of support groups are developed with the support of volunteers.

D. Services for Young Parents and their Children

Britain has the highest rate of teenage pregnancy in Europe: twice as high as in Germany and six times as high as in the Netherlands. Wales has a consistently higher rate even than in England[33]. Early parenthood tends to restrict the life chances and choices of young people, limiting their opportunities for education, training and employment and making them more likely to be dependant on benefits. In addition, the children of teenage parents are more likely to suffer ill health, have childhood accidents and be admitted to hospital as well as having a much higher chance of becoming teenage mothers themselves. The mortality rate for the babies of teenage mothers is 60% higher than for the babies of older mothers.

Young women aged 15-17 who have been in care are three times more likely to become teenage mothers than others of their age[34]. Other risk factors for teenage pregnancy and parenthood include:

- Living in a deprived area.
- Being the daughter of a teenage mother.
- Disengagement from school, including poor school attendance and attainment, and being excluded from school.
- Not being in education, training or work aged 16-17.
- Having been sexually abused.
- Having mental health problems.
- Being involved in crime.

Where young women experience multiple risk factors, their likelihood of teenage parenthood increases exponentially. The 1999 Social Exclusion Unit report on teenage pregnancy found evidence that young women who experience multiple risk factors (including having a mother who was a teenage parent, having emotional problems at age 7 and age 16, and low educational attainment at 16) have a 56% chance of becoming a teenage mother compared with a 3% chance for young women experiencing none of these factors[35].

The Social Exclusion Unit has identified key services that should be available to all teenage parents, including[36]:

- Help back into education or training. Specialist Pupil Referral Units for teenage mothers (including special services within a general pupil referral unit) can sometimes offer both child care and the personal attention that motivates and encourages young women to return to education
- Specialist housing, which offers more than ‘a flat of your own’, to include adult and peer support, child care, and help with education, training and work. These are often described as ‘semi-independence units’.
- Services to provide non-stigmatising health care, and help with post-natal depression.

- Parenting programmes (teenage mothers are less likely than average to engage their children in activities such as visits to the library or nursery rhymes, to be aware of accidents, and to have children admitted to hospital).
- Networks for men or fathering, including young fathers' groups.

Some of the best examples of services for this group of young people provide a combination of two or more of these services, frequently commencing before the child is born. Recent best practice services are outlined in the recent DfES 'deep dive' review, which also identifies key characteristics of high performing authorities with regard to teenage pregnancy. Examples include:

The Liverpool Brook / Abacus + So to Speak Outreach Service is an example of provision designed to be as young people-focused and acceptable as possible. Two discrete, but highly visible sexual health and contraceptive advice services are located in the city centre and provide drop in appointments every weekday from 10am to 6pm and on Saturdays from 10am to 2pm. There is a Male Information Worker at the centre 5 days a week to provide sexual health and contraceptive advice to male clients. The services are supported by strong outreach work provided by 'So to Speak', which trains professionals to improve their ability to engage with young people on sexual health issues and provides young people with information to make informed choices about their sexual health. The team employs a number of different methods of delivery, including face-to-face work with small groups of young people and parents; and promotional campaigns[37].

Manchester Vulnerable Babies Project[38] is a multi-agency initiative designed to work with young parents to improve the life chances of at-risk babies born in the city. The programme targets parents of unborn babies and children under 12 months who demonstrate certain risk factors. The intervention is centred on meetings between professionals representing several agencies and the parents, during which support plans are drawn up, and include actions to eliminate or reduce the risk factors the baby faces.

Newpin Teenage Mum's Project, in Peckham[39] works with young mothers to change the effects of destructive family behaviour and to provide opportunities for positive parenting; to raise levels of self-esteem and increase the educational and employment opportunities for young mothers. Funding is from the Department of Health, local authority, health authority and health trust. Additional money has been provided by businesses and private trusts. The service provides: weekly parent support groups; a personal development programme (including child care and tutoring); a telephone support line available 24 hours a day; and practical help with budgeting and benefits.

E. Interventions to Address Child Emotional and Behavioural problems

Coping with children who have emotional or behavioural difficulties is a common reason for families requiring support. It is not possible to identify the causes of emotional and behavioural problems in children with certainty, but several risk and protective factors have been identified including abusive or neglectful parenting[40]. Some studies have suggested that a third or more of children and young people who have experienced abuse and neglect have a mental health problem. Behavioural manifestations of abuse and neglect among children have been explored above. Mental health problems particularly associated with abuse or neglect include:

- Depression.
- Low self esteem.
- Mood or anxiety disorders.
- Conduct disorders.
- Self harm.

Whilst the NSF[41] identifies a need for effective mental health promotion programmes in school years and for older children, it also identifies a need for programmes at higher need levels to improve parent / carer and child attachment and protection from abuse and neglect. The 'Costs and Outcomes' study for the DfES suggests that the ability of social workers to access child and adolescent mental health services for children at risk of abuse or neglect is 'surprisingly low', despite evidence of very high levels of mental ill health among these children (93% of the 234 children in this study appeared to have a recognisable psychiatric disorder)[42]. The study also identified that around 50% of the at risk children with mental health problems also had mothers with mental health problems, indicating a case for collaboration with both CAMHS and adult social services.

A study by Hutchings[43] investigated long-term outcomes for pre-school children in Wales referred to a primary Child and Adolescent Mental Health (CAMH) service, by comparing sixteen families who accepted treatment with ten families who declined the service. Improvements, which were still evident two years later, were found in child behaviour and maternal mental health in the treated group. The early intervention treatments focussed on enabling parents to improve their management of their child's behaviour.

A later study by the same research team[44] illustrated the effectiveness of early, intensive, intervention for young children who display early severe conduct disorder. Two treatments for severe conduct disorder in children, aged between two and ten, referred to a CAMH team were compared. Children received either a standard treatment or a structured intervention that included a three day intensive unit based phase and home based follow up. The outcomes for children's behaviour; parental mental health and social isolation were better in the intensive group. The programme has now been extended to train health visitors in the use of behaviour management strategies with the parents of 'at risk' pre-school children. Work has also started on delivering the Webster-Stratton 'Dinosaur School' programme within the CAMH service, and to train teachers to deliver a classroom version.

Recent guidance from The National Institute for Clinical Excellence (NICE) recommends group-based parent training / education programmes in the management of children aged 12 years or younger with conduct disorders. Individual-based programmes are only recommended where the family's needs are too complex for a group-based programme. For all programmes used, it is recommended that there should be good independent evidence that they work well, and those providing the programmes should make sure that support is available to help parents take part if they would find it difficult to do so otherwise[45].

The Parent Adviser Service is an example of child and adolescent mental health promotion delivered largely through home visiting. It aims to promote better mental health by making appropriate, less stigmatising support available to young children and their families when under stress. Parent Advisers can be health visitors, but also paediatric community medical officers and other professionals trained and supported by CAMH specialists in the skills of

parent counselling, parenting and child management behaviour. Compared to a control group, families using the service experienced a significant reduction in the severity of their problems, increased parental self-esteem, decreased levels of parental stress and emotional difficulties, improved environments for the children and improvements in children's behaviour[46].

Interventions specific to older children and young people in need

Teenagers represent a substantial proportion of admissions into local authority care. Whilst admission can offer short term advantages and may in some circumstances be the only safe option, it is generally accepted that many young people who have entered care at a 'later' stage in their childhood do not gain significant advantage and often return to live at home with parents upon leaving care. However, preventive services are sometimes insufficiently responsive or offered too late to divert the young person from care[47].

Recent research undertaken on behalf of the DfES[48] has explored the reasons why older children and teenagers come to the brink of placement, the circumstances in which some of them are placed, and patterns of placement for these young people[49]. Families participating in the research complained of a general difficulty in gaining access to services before they were on the brink of family breakdown. The study found that health, including in particular mental health problems and /or disabilities were apparent in 76% of the young people and 72% of the parents also had mental health difficulties (including depression and anxiety disorders in particular). One half of the families involved reported marital conflict and 43% reported past or existing domestic violence.

The following interventions specific to older children and young people in need, and specifically those designed to prevent late entry into care, have been identified in the literature:

A. Specialist Support Teams for Adolescents / Crisis Intervention

In 1994, The Audit Commission argued that, given the specific needs of adolescents, the outcomes of work with them are likely to be improved by specialisation[50]. Since then, adolescent support teams have been developed rapidly, with generally high degrees of success. Support teams usually offer an intensive, short-term service which aims to prevent adolescents inappropriately entering public care. A team typically comprises staff with previous experience as residential social workers, youth workers or family centre workers. Recent UK and American studies have revealed that[51]:

- Short-term, structured interventions of this nature may work best with families who are motivated to change and who do not have chronic or severe problems. The model appears to be less successful in work with families whose problems are both long-standing and severe, for example where parents have serious mental health or substance abuse problems, or where children's behaviour problems are associated with long histories of neglect.
- For young people and families with severe problems, better outcomes are apparent where support from more than one service can be obtained and co-ordinated by a 'case manager' or 'key worker'.
- Working with both the young person and parent(s) is generally much more successful than working with only one party.

A recent research study compared outcomes and costs for young people (aged 11-16) referred to adolescent support teams with those for others receiving a more mainstream social work service[52]. The study which took place in eight English authorities, of which six had specialist support teams and two did not, found that both types of intervention could be effective in helping families to resolve crises and in providing them with strategies for addressing their difficulties in the future. However, young people receiving more mainstream support were twice as likely to become looked after as those receiving a service from one of the specialist teams. They were also nearly five times more likely to become looked after for long periods than those referred to specialist teams. There was no statistically significant difference in the total cost of all services used per young person per week between the specialist and mainstream provision. The research concluded that specialist support teams should form part of a continuum of support services for children and families, ranging from lower-level social work services offering advice and support to young people and parents before problems become severe, to intensive services once problems reach crisis point.

Merthyr Tydfil Rapid Response Team[53] was created in 2001 in order to address the high number of children being accommodated. The team provides support to families, aimed at reducing the need to place young people in care; support to foster placements aimed at preventing breakdown and reducing the frequency of change for the children concerned; and support to children and young people returning home following a period in care. The team operates on a 24 hour basis, 7 days a week. The service has received positive feedback from service users and has resulted in a substantial reduction in the number of out-of-hours admissions to care for this local authority.

NCH[54] currently have twelve crisis intervention projects across the UK. These provide a range of timely, intensive, focused interventions, developed in partnership with local authorities to achieve change by building on strengths within families, as an alternative to children being looked after in local authority accommodation. The work is primarily targeted at children where there is a high risk of family breakdown, although the model can also be adapted to support children in family placement or as part of a planned return home from residential care. NCH's crisis intervention services provide a strategic approach to preventing accommodation, and are delivered through contract agreements. An evaluation of the first year of operation of the NCH Crisis Intervention Service in Tower Hamlets identified that 76% of young people referred to the service did not subsequently enter the care system.

The Adolescent Support Services and Skills Training Team (ASSIST)[55] in Dorset was singled out in their 2001 Joint Review as an example of good practice, providing a good range of focused support services for adolescents and their families to prevent family breakdown, and minimise the number of children accommodated by the local authority. The Team comprised of four sections: Adolescent Support; Post Care; Substance Misuse Team; and Community Resources. The Unit also worked with young people who are being looked after by the Council to assist them to return home where this was appropriate.

B. Family Group Conferences

Family group conferences (FGCs) originated in New Zealand, where it is mandatory for all children and young people subject to child protection procedures. This intervention brings together the family, friends and other significant people in the life of the young person, in a meeting to decide on future action to support a young person where there are child protection or youth justice issues which require resolution, or where they are at risk of becoming accommodated. The combined strength of the whole family is utilised, with the aim of helping them to identify the support and resources they need to keep their children at home. This approach can also offer an

effective way of finding alternatives to care within the family circle, not only for young people, but also for children and their families. Children, young people and their families frequently report that they find FGCs empowering and less obtrusive than other forms of intervention.

South Tyneside Council has expanded its Community Family Support Service using resources from the Children's Fund, allowing weekend and evening access to the team and quick responses to referrals. Family Group Conferencing is one of the approaches taken by the service to help children remain with their family. South Tyneside estimated that 92% of young people using the service during its first year of operation would have entered care had the service not been in place[56].

The London Borough of Merton has a range of services in place including short-term targeted family support services, parenting classes, family group conferences, and written agreements with families. Services are designed specifically so that interventions can be put in place at short notice where a need is identified. These services help avoid the need to bring children into care, coupled with a system in which there is senior level oversight of any decision to accommodate a child or begin care proceedings. Merton report some significant indicators of success with this approach, including a reduction in the numbers of children looked after from 220 in 2001 to 117 by January 2006[57].

The All Wales Family Group Meeting Network[58] is the network for agencies involved in the delivery of family group conferences in Wales, and for organisations and individuals with a commitment to promoting good practice. The Family Rights Group[59] has produced a toolkit for Family Group Conferences which will be launched in Wales in 2007. The toolkit is aimed at both new and existing projects and offers a comprehensive guide to setting up a FGC project and FGC best practice.

C. Interventions to Address Adolescent Emotional and Behavioural Problems

Struggling to cope with older children and young people who have emotional or behavioural difficulties is a common reason for families themselves requesting support, including from local authority social services departments. These problems may or may not be a result of abuse or neglect within the family. A recent study[60] sought to identify how the mental health needs of children on the child protection register were being met across three contrasting local authorities in England. One of the key drivers for this study was the perceived lack of interagency working between CAMH services and social services, of particular concern given the high rates of mental health problems amongst looked after children and those supported in their own homes. Another was the paucity of evidence on how best to support young people with mental health problems on the edge of or within the child protection system. The study found that:

- 93% of the 157 cases examined made reference to the young person having one or more symptoms of childhood mental health problems; half of the cases mentioned conduct disorder and 45% mentioned unipolar depression. Oppositional defiant disorder, attention deficit hyperactivity disorder, and anxiety disorder were each referred to in about a quarter of the cases.
- Parental ill-health, parental substance misuse, maternal and sibling mental health problems, parental learning disabilities, and family contact with the criminal justice system were identified in approximately two thirds of cases.

- Despite high rates of severe mental ill-health and emotional and behavioural difficulties among children in the child protection system, only 33% of children and young people in the sample were referred to CAMHS during the year in which the study took place.
- Although both health and social care professionals expressed a wish for joint working and more effective communication strategies, cultural differences in perceptions between the social and medical approach often acted as a barrier.

Example service provision for high level mental health needs, including for young people in need are: 'The Storm Project' and 'Functional Family Therapy'. The Storm project[61] is a Swansea-based service working with young people who have mental health problems, although not necessarily a diagnosed condition. The project uses a range of approaches including cognitive behavioural therapy, art and creative activities as well as outdoor pursuits to encourage young people to build their own resources of self-confidence and self-esteem. The project, which is funded through Cymorth, works closely with schools and employers or training providers to help stabilise young people's position. Many of the young people have experienced some form of abuse, about a third have experienced domestic violence, and a similar proportion have parents with mental health problems themselves. Being part of a wider CAMH service means that, if workers have serious concerns with any young person, they can quickly access other resources, bypassing any waiting list. Project staff have a range of professional backgrounds including occupational therapy, mental health, nursing, teaching, youth work, and psychology.

Functional Family Therapy is a short-term intensive intervention programme, very similar to the adolescent support team model, but which uses trained family therapists to deliver support to young people and their families. It is used with young people aged 11 to 18 who are displaying anti-social or criminal behaviour, and also with families where young people are at risk of entering care or for those returning home. Up to 30 hours of direct services are provided over a three month period, ranging from clinical sessions to telephone discussions, working with each family member both separately and together to bring about a change in behaviour. Functional Family Therapy has been successfully implemented internationally and cross-culturally, in urban and rural settings, and from a range of treatment settings, including clinics and home-based programmes. The DfES is proposing to explore the effectiveness of this model before promoting it pro-actively in England[62]. However, previous evaluations carried out in the USA[63] have already demonstrated the effectiveness of Functional Family Therapy in reducing recidivism (including serious and adult criminality) and the use of care interventions.

For children and young people who may not yet be at the brink of care, a primary care CAMHS model for the delivery of preventive services has evolved in some parts of England and Wales, showing considerable potential for the improved co-ordination and delivery of effective early interventions. In practice, the detail of this model varies, including examples which offer consultation to primary care workers, and others where trained workers offer consultation to teachers, youth workers and others and also undertake some direct work with children and young people. From case studies of existing projects, the kinds of professionals involved include nurses, education psychologists, social workers, clinical psychologists, and sometimes health visitors or community psychiatric nurses. They are usually expected to have particular expertise in community mental health support for children, or have experience in generic primary care and a desire to develop mental health expertise. Close links with tier 3-4 CAMH services need to be maintained, through case liaison and advice sessions, or in the secondment of staff from the tier 3-4 service. Although each model has had a different focus at its inception, all are currently looking to combine the best aspects of the others to create an optimum activity mix, based on the available evaluation evidence. This evidence has tended to describe the impact of programmes on waiting list numbers and length (for tier 3 services),

although there is some research underway which attempts to understand the effect of these models on service user/primary care worker satisfaction and, ultimately, on outcomes for children and families.

Over and above these relatively specialist schemes, children and young people in need may also benefit from access to other more mainstream mental health promotion programmes. The National Service Framework identifies the following characteristics of effective mental health promotion programmes for older children and young people[64]:

- In school years, programmes which develop whole-school approaches to improving mental and social well-being that include both staff as well as pupils.
- Out of school approaches that focus on developing life skills and building social support. Research into outdoor pursuit programmes, such as Outward Bound, has demonstrated their effectiveness in improving self-esteem of young people.
- Effective joint working arrangements to actively promote mental health and psychological well-being in children and young people.

D. Services to Address Drug and Alcohol Misuse in Young People

Although misuse of drugs or alcohol cuts across the social spectrum, it is known that problematic patterns of use are concentrated among those who are socially and economically disadvantaged. Children and young people who are vulnerable because of deprivation, inadequate parenting, and behavioural problems in primary years in particular are more likely to misuse drugs or alcohol, and to begin to do so at an earlier age. The period 11-13 years following transition to secondary school is a particularly vulnerable age for the onset of drug or alcohol (and other) problems[65].

Equally, there is a link between substance misuse and other problems that make young people vulnerable to poor outcomes. For example, the risk factors for substance misuse and mental health problems are similar, and some sources estimate high rates of co-existence of both types of problem. The ONS survey (2000)[66] suggests that 24% of 11-15 year olds who drink alcohol more than once a week have a mental disorder, which is three times higher than those who had never drunk any alcohol. It was also suggested that approximately 50% of young people frequently using Cannabis have a mental disorder, compared with one fifth of those using Cannabis less than once a month, and 10% of those who never use Cannabis. There is a strong link between drug and alcohol misuse by young people and offending behaviour.

Although the majority of young people can be 'reached' by mainstream services, for example, through schools or primary health care services, a significant minority including children and young people in need do not engage with these services. The literature seems to suggest that preventive initiatives should also be targeted at selected neighbourhoods and vulnerable 11-13 year olds, particularly those already experiencing problems at school, or those who are excluded from school, and that young people should be able to access a range of support from the same source, for example: substance misuse and sexual health services. Services working with young people at risk of substance misuse need also to be aware of the likely co-existence of mental health problems, and be able to refer young people as appropriate[67].

Research also indicates that, even where problematic drug use is evident, this is often unaddressed by universal services with which these young people are in contact, because of their increasing detachment from the mainstream; there is little evidence of self-motivated help-seeking; and in some cases poor assessment processes and skills amongst the workforce involved with the young person. The suggestion is that there needs to be more effective and innovative models for drug services to 'reach out' into the community, and in particular to connect with young drug-using peer groups, and the families of young drug users[68]. Research with young people has identified that they want services that are confidential, welcoming, and help to make them feel safe[69]. Multi-component prevention programmes, where a broad range of social problems and parenting issues are addressed are well-established in North America, and are beginning to be piloted in the United Kingdom.

The Parallel Health and Well-Being and Outreach Centre[70] in Bolton is a 'one stop shop' designed by and for young people, to meet their emotional, social, sexual and physical health needs. The Parallel Centre includes services focusing on specific issues, such as drugs and alcohol and teenage pregnancy, and staff based at the centre provide outreach services to pupil referral units and 'looked after' young people in particular. This programme was established in 2003 and was initially funded from Neighbourhood Renewal Fund. From 2006, it has become fully funded by the Primary Care Trust. Parallel was highlighted by the recently published 'Youth Matters' Green Paper as an example of good practice in terms of its holistic approach to young people's health. Small scale research projects have been already been undertaken, but comprehensive evaluation outcomes are still to be received.

The Young People's Development Programme (YPDP) is a three-year initiative funded by the Department for Health in partnership with the Department for Education and Skills to address problem behaviour for young people aged 13-15, in particular teenage pregnancy and substance misuse. The 27 pilots are supported by a Primary Care Trust and / or Local Authority, and build on existing young people's development programmes in deprived areas. The projects work with up to 30 'at risk' young people at a time, and for at least a year. An evaluation process is underway to determine the impact and identify critical success factors. Subject to a positive evaluation, the Department of Health would wish to encourage Children's Trusts to apply the approach more widely[71]. The second interim report has highlighted the following achievements for the first cohort at 9 months after joining:

- The programme is continuing to engage with and retain large numbers of 'at-risk' young people.
- Over 90% of participants stated that attending the project had 'helped them' in some way, higher than those attending comparison group projects.
- Further work is required by the projects and partner organisations to ensure that a greater number of at risk young people remain engaged with mainstream schooling in order to strengthen the health and achievement link.

E. Out of school activities

Out of school activities can include both learning (study support) and leisure activities. Study support includes homework and study clubs, sports and outdoor activities, museum trips, the creative arts, community volunteering, mentoring and other opportunities to pursue a range of interests. These activities are generally offered in a more informal and less structured setting, which can be attractive to young people, including those from disadvantaged

areas and children and young people in need. Participation usually helps to improve motivation, self-confidence, build self-esteem, and can also have a significant impact on levels of criminal and other problem behaviour[72].

CEP – Merthyr Tydfil is an outreach curriculum enhancement project that encourages young people to get involved in activities they would not be able to pursue in school. Activities offered at 'drop in' centres include: football and other sports tournaments, courses, public speaking, outdoor pursuits, IT and Duke of Edinburgh Awards. A bus is provided to take young people to and from activities. An evaluation of the programme provides evidence of positive impact from the young people themselves[73].

The Home Office sponsored 'On Track' programme aims to reduce the number of children up to age 12 involved in crime in areas of high deprivation and has promoted the development of preventative interventions, including safe environments for children and young people to meet with friends and play based on the needs and wishes of the communities concerned[74]. A 2006 national evaluation[75] found that On Track projects appear to have been successful in targeting children deemed to be 'at risk', and their parents. Since the inception of the On Track project in Rhondda Cynon Taff, there has been a dramatic reduction in the number of referrals to social services, specialist education services, and CAMHS as well as a reduction in Youth Offending Team caseloads in the area.

The NCH Family Centre Winchestown in Blaenau Gwent is a family centre offering 'whole family' packages, ranging from washing and telephone facilities for young parents to leisure activities for teenagers. Whilst generally open-access, staff aim to build relationships with vulnerable young people across the age range. Cymorth funding has contributed towards staff costs at the centre. NCH works in close collaboration with the statutory services to target young people in need. A 'beneficial by-product' of the activities for teenagers is reported to have been a 50% drop in crime in the area[76].

F. Parenting Education

The majority of parenting programmes, both mainstream and specialist, are targeted at parents of younger children, although many parents of older children and young people also require help with behaviour problems that emerge in particular in adolescence. Parents of young people in need frequently require intensive parenting support including support to be provided as part of a wider package of services[77]. Research has identified the following critical factors for successful parenting programmes for older children and young people[78]:

- Targeted interventions which tackle more complex types of parenting difficulties.
- Interventions that work in parallel (though not necessarily at the same time) with parents, families and children, even in the most severe cases.
- A focus on enhancing family relations, as a protective factor for adolescents, particularly those at risk of problem behaviours, such as substance misuse or offending.
- Transmission of straightforward factual information using a range of media.
- Delivery by 'authoritative' professionals.
- A range of formats, from low-level and short-term to longer and more intensive programmes; with follow-up / booster sessions, for problems of greater severity or higher risk groups of parents.

- A focus on concrete issues (eg health care; home safety; child development; substance misuse; monitoring and supervision).

Teenagers in Trouble: Skills for Parents[79] is a video-based information package developed by the Trust for Adolescence (2003). The 45 minute video includes groups of parents talking about the problems they are experiencing with their teenagers, with dramatised interactions of some of the issues raised during the group discussion, for example: boundaries, negotiation, neighbourhood and peer influences, where to seek help and support. The video is accompanied by separate booklets for parents and a facilitators' guide.

YMCA's 'Parenting Teenagers' Initiative established a number of projects across the UK to provide YMCA centre-based help and support to the parents of teenagers. The main factors which led the YMCA to set up the initiative were the relative lack of support for parents of teenagers compared with that available for parents of younger children, and the increasing numbers of young people accessing accommodation at the YMCA, as a result of family breakdown. The initiative was evaluated by the Trust for the Study of Adolescence. Funding was agreed for 29 projects, which included group-based courses, 'Dad's and Lads' projects, mediation schemes, and transition evenings. A variety of outcomes were identified, including[80]:

- Benefits to parents – gaining information about their teenagers, about young people and their behaviour, sharing ideas and experiences, feeling supported in their parenting, and acquiring strategies to promote better communication and relationships.
- Factors that worked well – using a 'hook' to attract parents and teenagers, offering taster sessions, advertising courses widely, being responsive to the needs of parents and willing to adapt programmes in particular to allow parents to have a greater input.
- Factors that did not work well – attracting sufficient parents, engaging parents in the specific part of the project that addressed parenting and relationships, using the words 'parenting course' or 'parenting education', organising events that lasted too long for participants, and the use of poor quality or unattractive venues.

Interventions targeting specific parental risk factors

A. Interventions for Families where there is Parental Substance Misuse

Drug or alcohol taking which harms health or social functioning is described as 'substance misuse'. This may involve dependency (physical or psychological), or be part of a wider spectrum of problematic or harmful behaviour. It is difficult to estimate the number of children whose parents have drug or alcohol problems. Using population and prevalence figures, Alcohol Concern suggests that there are likely to be some 800,000 children in England and Wales living in a family where a parent has an alcohol problem, and the 'Hidden Harm' report in 2003[81] estimated that there are between 250,000 and 350,000 children of drug users. At any one time, at least 5% of the adult population experiences alcohol dependence and 2% drug dependence[82].

Substance abuse disorders in parents are strongly associated with the onset of both physical abuse and neglect of the children, almost tripling the risk of maltreatment[83]. One study in the United States[84] found that alcohol abuse was the most frequently noted type of substance abuse in families rated as 'high risk' child protection cases, with 24% of mothers and 18% of fathers in such families abusing alcohol. In the United Kingdom, approximately one third of the parents in a study of the families whose children were at risk of suffering emotional maltreatment or neglect had problems with the misuse of drugs or alcohol[19]. There is also a strong association between alcohol abuse and both domestic violence and parental mental health problems. However, whilst illegal drug disorders are associated with neglect, there is no direct association with the physical or sexual abuse of children. Women who use cocaine in particular during pregnancy have been found to be at increased risk of serious parenting failure, resulting in the neglect or abandonment of their young children[85].

All members of the family, including the parent(s) misusing drugs or alcohol, are likely to have needs that should be addressed. Apart from attention to the 'problem' addiction, the needs of the parent misusing drugs or alcohol may include: help with parenting; with health and emotional problems; past and current relationship difficulties; domestic violence; employment or money problems; and in attending appointments or getting day, or hospital treatment; or a creative alternative to hospitalisation such as a safe house for parents and children together. Where there is a non-dependent parent, they are also likely to be under stress. They may want their partner to stop drinking or taking drugs, and they may be able to play a crucial role in influencing the outcome of treatment. Their supportive presence can be an important protective factor for the children. All this makes it important that they too get help. Children of substance misusing parents, whether or not they are acknowledged as being 'in need' may require:

- The identification of relatives, or a resource family, backed by financial support, to provide continuity in care, such as occasional or planned respite periods.
- Home-based help – to establish routines and boundaries, and provide practical help or advice.
- Individual and/or family counselling to help parents and older children understand their difficulties, and work for positive change.
- A volunteer befriender for school age children, and a recreational activity so that they can enjoy and benefit from normal activities.
- The opportunity to attend a group for children whose parents have a health problem (not necessarily mental health).

Messages from research show that a co-ordinated response is required. The Social Care Institute for Excellence 2003 research review promotes the use of collaborative protocols to further good practice in delivering multi-agency responses[86].

An example 'best practice' model for the provision of services for parents with problem drinking and their children is illustrated in Tunnard's 'research in practice' guide[87]. This model is described as an intensive service to reduce the number of children looked after because of parental dependency on alcohol. It aims to provide a consistent response regardless of whether the referral comes from social services, health, education, the voluntary sector, or direct from families. In particular, it seeks to establish a range of creative ways of engaging with family members, to overcome the barriers for both parents and children in this need group in making use of services. 'This requires an acknowledgement of parental anxiety that their children may be removed, an emphasis on support for parents as well as concern for children, and the mobilisation of wider networks to provide support in working for change'. Agencies introduce parents to the project co-ordinator, and they can also choose a professional of their choice to act as their mentor, and be their link person to the co-ordinator. A package of services is agreed for families within two weeks of referral, to address their health, child-related and social needs including those listed above. The thresholds for this intervention are children whose emotional or social impairment is significant, or likely to become so without provision of a service.

'Option 2'[88] which has been operational for 6 years in Cardiff and the Vale of Glamorgan is an intensive intervention programme, aimed at supporting parents with a substance misuse problem to care safely for their child(ren) and to avoid the need for their being taken into care. Option 2 workers intervene when child protection teams are considering removing children, or placing them on the 'at-risk' register, and where a parent is struggling with substance misuse. The programme is run by Cardiff's Community Care Service, in close partnership with the community addiction unit, other drug misuse specialists, and with Children's Services. Option 2 aims to focus its interventions on enabling people to learn and practice essential new skills and patterns of behaviour during these 'crisis' periods, in order to halt the cycle of substance abuse, low self-esteem and parental neglect. The team works intensively with families for up to 9 hours per day for a maximum of six weeks, and continues to assess risk to the child during this period. The outcomes for families using the service appear to be extremely positive, including achievement of goals, reduction in harmful drug/alcohol use by parent(s), and keeping families together by preventing children being removed from home. The annual running costs of the project is only slightly more than the cost of keeping one child in residential care for a year, and the team work with approximately 12 families a year. The team has also produced training and a manual 'Preventing Breakdown' for work with high risk families elsewhere in the UK.

B. Interventions with Families where there is Parental Ill Health

A significant proportion of parents and other carers who abuse or neglect their children have mental health problems. Maternal depression in particular has been identified within the research as present in abusive or neglectful families, including where the mother is not the perpetrator of the abuse. In a Social Services Inspectorate inspection of family support services in England, social workers identified that parents had mental health problems in approximately a quarter of children in need cases[89]. In a recent study examining the mental health needs of children on the Child Protection Register, approximately 50% of parents had mental health problems themselves, indicating the importance of engaging clinicians and other adult mental health workers in identifying and meeting the needs of the children of their patients[90].

The physical ill-health of parents is also a consistent theme in the research literature relating to children at risk of becoming vulnerable, not least as a result of their becoming young carers. Research by Loughborough University found that young carers are likely to experience[91]:

- Problems with education – a lack of time for homework/exams.
- Isolation from other children and from family.
- Lack of time for recreation.
- Guilt and resentment from reconciling conflicting needs of themselves and their parent.
- Feelings of no-one to turn to – professionals working only with the adult patient.
- Problems in the transition to adulthood (finding work, accommodation, relationships).

A knowledge review carried out in 2006 for the Social Care Institute of Excellence on supporting parents with physical and/or sensory impairments, learning disabilities, mental health problems, long term illnesses and drug or alcohol problems, identified very little research on the experiences of disabled parents generally, as most of the research evidence concerns parents who are in touch with children's social services and/or specialist adults' services[92]. The review found that the focus appeared to be either on the children in the family or on the impact of the adult's disability on their personal needs, and seldom focused on the whole family and how to support and help the parents in their parenting role. There was very patchy recognition of the need for children's and adults' services to work together. Demarcations between children and adult's services, particularly evident within social services departments, often serve as a barrier to a holistic approach, in which the needs of all family members are considered. Responsive inter-agency working is crucial and recent changes in national policy and practice have sought to improve levels of integration, with initiatives such as Sure Start, which as part of their remit seek to promote good mental health amongst parents as well as younger children's development.

CAPE Project, London Borough of Greenwich[93] is a three year project, funded by the Gatsby Charitable Foundation to work with families in which a parent or carer has mental health problems. Many of these families have already had some contact with the statutory services. An inter-disciplinary team is in the process of being established and will initially consist of three or four practitioners. Children and family services and/or adult mental health services will manage cases, but the CAPE project will be commissioned by them to work with families (parents and children) on a short-term focused intervention basis to achieve specific goals. Referral forms require the referring workers to be specific about the intended aims and outcomes of the interventions and the follow-up care plans. The project has a budget for evaluation to ensure that good practice will be evidence based and sustainable in the long term.

Young Carers' Projects have been established across Wales to provide support that young carers perceive to be voluntary and non-intrusive.[94] Most of these projects are provided by voluntary sector organisations such as: Princess Royal Trust for Carers, National Children's Home, Barnardos and Crossroads. 'Children in Wales' facilitate a young carers' workers network and have a full list of projects on their website[95].

The Disabled Parents Network (DPN)[96] is a national organisation of and for disabled people who are parents or who hope to become parents, and their families, friends and supporters. DPN operates a helpline run by disabled

parents, produces a quarterly newsletter, and compiles information briefings to assist disabled parents with a range of issues. DPN also provides disabled parents as speakers, workshop leaders and training, as well as a separate research forum to promote and publicise research about disabled parents.

C. Interventions for Parents with Learning Disabilities

A 2005 briefing of research into supporting parents with learning disabilities[97] found that one in fifteen adults with learning disabilities have children, and nearly half (48%) of those who do become parents end up not looking after their children. The research literature on parenting by people with learning disabilities focuses principally on mothers, with parent couples and fathers in particular not well represented in literature. The literature also tends to focus on very young children, up to school age, so the changing role of the parent as children grow up is not well reflected. Research published by the University of Bristol in 2006 shows that early, proactive, multi-disciplinary parenting support for these parents, can reduce problems and protect children, as it enables any potential issues to be resolved as they arise, and before they become a crisis and/or child protection issue[98].

Training programmes for parents with learning disabilities tend to focus on child care, child safety, and mother-child interaction, although the results of research into the effectiveness of these programmes are inconclusive[99]. However, home-based programmes do demonstrate some success and are generally preferred to 'centre-based' programmes as a form of parenting education, with information and training found to be most effective when it is tailored to the abilities of individual parents[100] [101]. A barrier to effective support and service provision for parents with learning disabilities is the division and blurring of responsibilities between adults' and children's services, with the needs of parents with learning disabilities often falling between the two, and their needs as parents only being identified when a crisis is reached and there is a potential child protection issue[102]. According to Barnardos, information needs for professionals working within this field include: tools for assessing parental competence; knowing how to access resources and services to support parents; and how best to teach practical parenting skills to parents with learning disabilities[103].

The Special Parenting Service, Cornwall[104] is one of the best known and longest running specialist service in the UK, offering support to families where one or both parents have a learning difficulty. It provides home-based services, assessment, teaching programmes, parenting groups and advocacy for parents. The service is funded by the Cornwall Partnership Trust to provide a comprehensive parenting assessment utilising a Parent Assessment Manual, which assesses parents' knowledge, skills and practice across 34 parenting domains. The assessment focuses on both the needs of the child as well as the parent and provides a risk assessment and priority ratings in terms of a family's need for support. Multi-disciplinary specialist training for professionals is provided across the UK. The service had had a significant impact on reducing the number of parents with learning difficulties whose children need to become looked after.

The Parenting Support Service, North Tyneside[105] is provided by a small team, made up of community nurses and support workers, which is part of the local Community Learning Disabilities Team. The team support around 25 families and the children's ages range from babies to age 15, with most aged 5-13. The team tends to be involved with families on a long term basis and the support provided to the parent reflects the needs of the child. The team work with other services as appropriate, including schools, and health visitors. Parents can attend a support group which provides peer support, and helps parents develop skills through discussions, speakers and using adapted parenting courses.

D. Interventions for Families Experiencing Domestic Violence

Recent research (2006) has found that in initial child protection conferences there is evidence of domestic abuse in approximately 50% of cases[106]. An overview of research studies on child protection in 1995 also identified domestic violence as an issue that was present in many (30-50%) of families who were likely to maltreat their children[107]. It has also been identified as a significant source of stress for families in other studies, and there is a clear link between abuse of drugs or alcohol and domestic violence[3, 4]. The majority of children whose mother is being abused are aware of it, often more so than their parents realise, and, as well as the emotional abuse, many children sustain a wide range of physical injuries as a result of family violence[108]. The violence does not automatically cease when the relationship does: approximately one third of police calls to incidents of 'domestic violence' come from separated women who are being harassed by ex-partners.

Children suffer the effects of domestic violence in a number of different ways[109], including: the impact on their behaviour and emotional well-being; effects on their cognitive abilities and development; disruption of their community, family and friendship networks; moving schools; and financial problems if they have to leave their community. Generally, children witnessing domestic violence have significantly more internalised (depression, anxiety) and externalised (aggression, antisocial) behavioural and emotional problems than children who are not in these abusive environments. One study[110] found that children who had recently left violent situations and were currently residing in refuges showed significantly lower levels of competence on a number of parameters, including school performance, than children from a comparison group, with younger children being the most effected.

In the UK, work with and support for families where there is domestic violence has developed in a number of directions including:

- Work with (primarily women) survivors of domestic violence.
- Work with children living in circumstances of domestic violence.
- Work with mothers and children.
- Work with (usually male) perpetrators of domestic violence.

Over the past 20 years, the main specialist providers of services in the UK for women and children living with domestic violence have been Women's Aid and other women's refuges and outreach services. Increasingly, the provision of support to non-abusive carers now tends to be regarded as the most effective child protection strategy, not least because positive outcomes for children are highly dependent upon the level of support they receive from this parent[111]. This support should include practical support and information on welfare and legal rights; and the creation of networks of support (including links for women from ethnic minorities with sympathetic women's organisations). There may be a need for joint assessment (which might involve a person from an adult's team specialising in mental health or alcohol abuse alongside a worker from a children and families team). Around 50% of SSDs in England and Wales have a designated person responsible for domestic violence policy or practice development work, although often this work is carried on top of normal duties. Young people who are victims of domestic violence may require a variety of services including:

- One-to-one direct work. Where evaluated, this work has emerged very positively. Few formal psychological or counselling services in the UK are offered by professionals with knowledge of domestic violence, in spite of those having received it finding it useful. Instead, this work is often undertaken by children's workers in refuges. A 1996 survey found that children's workers existed in 80% of Women's Aid affiliated refuges and 55% of non-affiliated refuges. Despite what was described as 'chronic under-resourcing', this emerged from the research as a major resource for children[112].
- Play work and provision of play facilities; working with and through mothers to help children; workshops and children's meetings; liaison and advocacy with other agencies (also usually provided by a children's worker).
- Group work. Evaluation of groupwork programmes have demonstrated effective outcomes. The groups can help children feel less responsible for the violence, to learn about how to keep safe and how to seek help safely, as well as about non-violent conflict resolution generally. They can be accessed by children in refuges, as well as those still living at home.
- Assistance with school work, or behaviour in the classroom.

Work with men who are violent to their female partners is relatively recent in the UK. The impact of programmes run mainly by the Probation Service and voluntary sector has been inconclusive to date, not least because it is difficult to identify suitable 'measures of success' and because programme effectiveness is highly dependent on the extent to which community responses (police, courts, and services for women) reinforce the message that men can and must end their violence. The suggestion is that changing behaviour is a long-term process, especially for someone who has used violence and abuse for a long time: programmes of at least 75 hours of group work are usually recommended over a period of at least 30 weeks. Within the literature, there appears to be an increasing consensus that, in addition to being supported by comprehensive community responses, the most effective programmes share a number of features[113]:

- An understanding that the man's violence is the problem in question, and a recognition that he resorts to violence because of expectations of authority and rights in a personal relationship.
- An understanding that violence involves physical, sexual and psychologically abusive behaviour.
- Structured, accountable programmes with clear inter-agency protocols.
- Programmes that have parallel women's services.
- Sessions co-facilitated by mean and women who can model respectful ways of working.
- Content that includes an analysis of violent or abusive incidents, the recognition and tracking of moods and emotions, the examination of male socialisation and attitudes to women, developing empathy with others, and the development of a range of cognitive skills and techniques for increasing control over well-being and behaviour.

Given that no programme can guarantee that the perpetrator has changed sufficiently or will be safe, the primary focus of such programmes is often not on men changing, but on women and children being safer, by the perpetrator programme working closely with the women's support services and other agencies.

The Domestic Violence Outreach Scheme[114] in Northern Ireland provides direct work with children, divided into 'safety work' (offered while the danger from the perpetrator is still real), and 'recovery work' (undertaken when the children have moved into a safer phase of their lives). Recovery work takes the form of group-work, based on a model developed in the USA. Mothers attend their own group in parallel with the one for the children. A crucial part of the project's overall approach is that successful work with children cannot be achieved unless there are also services for women, to help them rebuild a safe and fulfilling life for themselves and their children. The project delivers individual counselling and also runs a 16 week programme aimed at educating and empowering women to deal more effectively with domestic violence in their lives.

The All-Wales National Helpline for Victims of Domestic Abuse provides confidential support to men, women and children who are victims of domestic abuse. The helpline which operates 24 hours a day, 365 days a year offers practical help and advice including emergency refuge accommodation and safety planning and advice.

The Schools Team – Wrexham Counselling and Support[115] offers support to children and their families in primary schools to enhance the parent / child relationship. The 'Butterflies' Domestic Abuse programme provides therapeutic support to children and mothers across North Wales.

Respect[116] is the UK association for domestic violence perpetrator programmes and associated support service.

Interventions for Children and Young People with disabilities and their Families

Approximately 770,000 (7%) of children in the UK are disabled. A child's additional needs, such as a physical disability, special educational needs, or behavioural problems may affect only a minor part of the child's life, or may be a major and challenging factor. However, families including children with disabilities tend to be greatly financially disadvantaged, with 29% of disabled children living in poverty. Meeting a child's needs for care and support often hinders parents' capacity to earn, and at the same time creates additional financial demand. Single parents, the parents of more than one disabled child, and parents of more severely disabled children seem to be the worst affected. Research also shows that parents, particularly mothers, of significantly disabled children are likely to experience higher levels of stress, their mental health is found to be poorer and they are more likely to become single parents than similar parents in the general population[117]. The recent review of services for disabled children and their families undertaken by The Audit Commission revealed that, in spite of some pockets of good practice, there is still a lottery of provision across England and Wales, with too little services provided too late, and a jigsaw puzzle of services to be navigated by families[118]. Overall, the Audit Commission concluded that services for disabled children are still the 'Cinderella' service.

Research has also identified that children with disabilities are at significantly increased risk of abuse and neglect, although a national under-reporting of abuse of these children is also well-documented[119]. Beresford and colleagues reviewed services to support children with disabilities and their families, and identified the following particular needs[120]:

- Good quality information about services.
- Early identification and detection.
- Financial assistance.
- Breaks from care.
- Home help and practical support, e.g. to deal with behaviour and sleep problems.
- Parenting skills and strategies, such as managing sleep and behaviour problems.
- Social and emotional support to children and young people, parents and other siblings. Parents greatly value self help groups, befriending schemes and counselling support schemes such as the Parent Adviser Scheme.
- A key worker for all children with complex needs and their families, to work in partnership with them, coordinating service provision and providing a clear point of reference for the family.

Beresford concluded that services which seem to work have the ability to encompass an individual approach to assessing and meeting need, underpinned by respect for the views of family members, openness and honesty in information sharing, and flexibility of provision. The national Children First Programme and National Service Framework have more recently emphasised all of the above, and have added to Beresford's list the need for increased access for disabled children and young people to inclusive play and leisure opportunities, and improved services at transition from children's to adults' services across Health, Education and Social Care. The emphasis on

inclusion should, however, be tempered by recent research that seems to indicate some disabled children and young people are initially more comfortable attending leisure services exclusively for themselves, and are likely to require support from parents or others to attend more inclusive leisure services[121]. More choice appears to be the key.

Family-based respite care schemes have been evaluated and shown positive effects on the well being of parents of disabled children. Parents reported higher levels of social support and morale and lower levels of stress. Many believed short term care played a significant role in ensuring that they are able to continue to care for their child at home. Traditionally, short term care has been seen as a means of supporting parents, but now the emphasis is that it should be a positive experience for the child as well. Family-based short term care is most often used but home sitting and school holiday schemes can also offer good alternatives. A recent report by Barnardos and NCH for the Welsh Assembly Government identified that disabled children and young people have mixed views about spending time away from home with short break services[122]. Parent workshops organised for the Council for Disabled Children identified features of a good short-term care programme which included:

- The service being local.
- The programme being a positive experience for the child.
- Greater responsiveness to demand.
- Careful preparation for first placement.
- Short term care being available in a choice of settings.

Family Link Schemes match selected families (or sometimes a couple or a single person) to families who have a disabled child; the child gradually spends time getting to know them, in order to give the parents a break[123].

Brynhwfa Respite Unit[124] was established in May 2001 to respond to the needs of children and young people with varying learning and physical disabilities on Anglesey who could not be placed with foster parents, due to their high care needs and/or specific behaviours. The success of the 2 bed-roomed short term respite unit is largely due to the continuity of staff care, extending from the community into the respite unit, as care is provided by support care staff from social services who are specially trained to work with individual children/young people in the unit, as well as in the community and in other activities, such as a Saturday and/or holiday clubs.

East Riding of Yorkshire[125] was one of the 23 pathfinder children's trusts established in 2003. The trust has established a direct payment scheme for disabled children and those with life limiting illness. A recent evaluation of the scheme demonstrated the 'overwhelmingly positive' impact that it had had upon family life, including in particular its ability to enable children to make new friends and develop their confidence.

Conclusion

This paper provides a starting point for commissioners seeking to gain an understanding of 'what works' for children in need and their families. As there are many reasons for children and young people being in need, the subject matter is necessarily diverse. As commissioners gain an understanding of local needs and services and the impact of existing family support provision on the demand for higher levels of intervention (particularly for placement services), it is likely that one or more of the areas outlined above will stand out for further investigation before seeking to re-configure existing provision. This exploration can take a number of forms, not least more in-depth reviews of the research and best practice literature, but also other more 'direct' approaches to understanding the key features of successful interventions in practice, such as semi-structured telephone interviews with best practice sites and reviews of their local evaluations, many of which are not written up formally in research publications. For example, in some areas where parental substance misuse and / or domestic violence is a particular feature of families in need, more intelligence could be gathered to understand how services have worked successfully with families of children in need in order to re-shape existing local provision. Often, this involves a careful examination of service impact and application of service 'success factors' to local requirements, rather than a wholesale reproduction of the best practice service locally.

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