



Growing Support

A Review of Services for Vulnerable Families with Very Young Children

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"It's everyone's job to make sure I'm alright."



What supports do families need?

Characteristics of fieldwork sites

The sample

1. Young children have a range of needs that must be met if they are to reach their potential. These include:
 - nourishment;
 - physical care;
 - secure attachment to a consistent carer or carers;
 - stimulation and human interaction;
 - stable and consistent routines;
 - opportunities to explore the world around them and have increasing independence; and
 - protection from danger.

2. The Children (Scotland) Act 1995 identifies children in need, within a wider definition including children who are disabled or affected by disability, as including children in need of care and attention because:
 - they are unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development unless a local authority provides services for the child; or
 - their health or development is likely to be significantly impaired, or further impaired if such services are not provided.
3. The Act places a duty on local authorities to safeguard and promote the welfare of children in need in their area and, where possible, to promote their upbringing by their families. To achieve this local authorities must provide a range and level of services that meet children's needs.¹ Other agencies, including health services, are required to collaborate with them.²
4. This report describes the findings and conclusions of an inter-disciplinary review of social work and health services in Scotland to support vulnerable families with young children aged 0-3 years. It also takes account of other important services such as early education and childcare, housing, health services for adults and Children's Hearings.
5. The inspection team visited five areas – Glasgow, Moray, South Ayrshire, Edinburgh and West Lothian. The areas were chosen because they represented different population sizes and social demography and provided services in different ways. We reviewed social work case records and talked with families who used services. We interviewed professionals in local authority and health services and the voluntary sector and met with Children's Reporters in each of the five areas. Appendix A provides an account of the inspection process as experienced by the two lay members in the inspection team. Appendix B provides a summary of the people who were interviewed.
6. This review set out to answer the following questions:
 - What support do local authorities and health services provide for families with very young children?
 - How well do these services meet the needs of these families and how far do they improve outcomes for children in need?
 - How well do services work together?
7. We looked at social work and health services for families with young children and some services provided by local authority education departments. Some of these services provided advice, guidance or assistance to all families with young children, including those who may be vulnerable. Others were designed to promote children's welfare in adverse circumstances and included services for children whose health or development

¹ Children (Scotland) Act 1995, section 22

² Children (Scotland) Act 1995, section 21

would otherwise be compromised. We did not look at specialist services for children with disabilities or children affected by disability, although some information about the experience of families with disabled children emerged from our review of case records and in our discussions with parents. This review was informed by an overview of relevant research and practice literature that is included in Appendix C. Appendix D lists the members of the steering group for the review.

Characteristics of fieldwork sites

8. The local authority areas we visited were diverse. Glasgow presents particular and chronic economic and social problems in concentrations unmatched in the other four authorities. There are pockets of significant disadvantage and deprivation in each of the authorities although in Moray this is more widely dispersed.
9. There were fewer social work practitioners per head of child population in Glasgow than in the other areas visited with the exception of Moray. Of the five, Edinburgh has the highest ratio of practitioners per child population. South Ayrshire's expenditure on children's services as a proportion of all Social Work Department spending is approximately half that of the other local authorities. The authority has a significantly lower rate of registration on the Child Protection Register than any other Scottish local authority.
10. The local authorities all reported a number of factors that placed services under pressure and all stated that demand now outstripped existing capacity. Each local authority had plans for expanding support to families with children under 3 but there was little evidence at this early stage that this had yet made significant impact at a local level because:
 - vulnerable families are transient and highly mobile – current systems of health screening and health care, allocation of support and duty services are geared towards stability of tenure in housing;
 - access to all services in some rural areas, suburban villages and peripheral urban areas can be very poor;
 - of increasing need linked to high levels of drug misuse, particularly on peripheral public housing estates in urban and suburban areas; and
 - increasing numbers of young single parents from ethnic minority communities present distinctively different needs in urban areas.
11. Additionally, Glasgow reported that the local authority has disproportionately fewer resources to meet high concentrations of need since local government reorganisation.
12. The demand on social work services from the Children's Hearing system has been rising rapidly in recent years. Referrals of children to Reporters on grounds of lack of parental care rose by 71 per cent from 1998/99 to 1999/2000.³

³ Scottish Children's Reporters Administration's 2001 statistical bulletin no. 24; referrals of children to Reporters and Children's Hearings

The sample

13. The review examined the case records of 147 families with children aged 3 years or under in touch with social work services. The majority of these families were experiencing profound and acute stresses. More than four out of five of these families had a social worker allocated to help them. Of the remainder, most were supported by staff in family centres or similar services. A small number had been in touch with the local authority's duty service.
14. Over a third of the families, 58 (39 per cent) had been the subject of child protection enquiries and 55 (37 per cent) of the index children were, or had been named, on the Child Protection Register. A fifth, 31 (21 per cent) had been referred by the Reporter. Fourteen (9 per cent) had been looked after in local authority accommodation. Twenty-three (16 per cent) cases involved young mothers who had been accommodated by the local authority just before or during a pregnancy and were now parents of young children. At the time of the review the index child was looked after by the local authority in over a third of the sample cases. Three-quarters of these looked after children lived at home.
15. More than half the families in the sample (54 per cent) were headed by a lone parent. The proportion of lone parents in the sample was high in each of the five local authorities. The percentage of families in Scotland headed by a lone parent at the time of the 1991 Census was 15 per cent. Almost one in five of the families were affected by mental illness, usually that of a parent or partner. A similar proportion included a history of drug dependency or alcohol misuse. In over a quarter of the families there was a history of domestic abuse. The incidence of family difficulties we found in this sample are similar to the characteristics and experience of families in which social services have conducted child protection enquiries.⁴
16. In 31 cases drug misuse was a significant factor in the families' need for support. These families presented a wide range of other problems usually linked to parental drug misuse. Some families were homeless or highly mobile, with a succession of tenancies. Several parents, usually although not exclusively fathers, had been imprisoned for offending. Relatives were a strong source of support in many families with children looked after regularly and sometimes permanently by grandparents or parents' siblings. Four babies had been born withdrawing from drugs.

⁴ Gibbons, Conroy and Bell (1995) *Operating the English Child Protection System: a study of child protection practices in English local authorities*, HMSO

17. Almost all (94 per cent) of the families whose cases we reviewed appeared to be of White British ethnic origin. But in almost a third of these cases (30 per cent) the ethnic origin of the family was not recorded. Eight families were recorded as being of non-white British origin, the majority of these families were of Asian origin. One family included a child of mixed race who lived with her White British mother. This child's father was described as Asian. There was no other information about him in the child's case record. In most cases (138) it seemed likely that the family's first language was English. In three of the seven cases involving Black families the family's first language was not recorded.
18. The family's religious persuasion was recorded in only six cases (4 per cent). Two of these were White British families, one Catholic and one non-practising Protestant. The remainder were Muslim Pakistani families. It appeared that ethnicity, culture and religion were perceived as relevant only if a family was Black.
19. In one case involving deaf parents it seemed that the parents' first language was likely to be a sign language as staff needed interpreters to assist communication. This was not recorded.

'It's everyone's job to make sure I'm alright.'



What supports do families get?

Agency and professional perceptions of vulnerability

How do local authorities assess vulnerable families with children in need?

What support is being provided to meet needs and reduce risk?

Health visitors

Special health services for adults and children

Support from social work services

Voluntary sector support

Children with disabilities – a poor service

A continuum of support?

1. We found that there was a high degree of consensus between agencies and professionals about what makes children and families vulnerable. There was far less consistency about when and how professionals and agencies should intervene with individual families.
2. Most practitioners and managers in health and social work services agreed that vulnerable families needed particular help to access and engage with universal services such as health and education and also needed specific services which tackled their particular problems. Most saw the responsibility for enabling these families to have better access to universal services as lying elsewhere. Social work services argued that health and education agencies needed to work harder to ensure that their services were more attractive and accessible to families in difficulty. Health and education agencies suggested that input from social work services could encourage and better enable vulnerable families to engage with mainstream services.

How do local authorities assess vulnerable families with children in need?

3. Each agency in contact with families will carry out some assessment of their situation in order to decide what services to offer. We looked for information about:
 - the index child's and family's perceived needs and on what this assessment was based;
 - the nature and extent of any perceived risk and how conclusions had been reached; and
 - information about the family's social circumstances including family and social relationships and social supports, housing and financial circumstances and their wider environment.
4. One in five cases included evidence of assessment in each of these three areas of need, risk and social circumstances. These were amongst the most well-managed in the sample. Half of these cases displayed major strengths, with many examples of excellent practice. In these cases assessments were based on regular and consistent contact and observation of children and their families (including in some instances contact with extended family members), information from other agencies and a good understanding of the family's social history and each member's personal history. There were examples of cases that included this kind of comprehensive assessment in each of the local authority areas.
5. Only four cases in which assessment had addressed all these areas dropped below satisfactory standards. All four came from one local authority and reflected that authority's difficulty in sustaining support for vulnerable families because effort was focused on child protection and crisis management.
6. There was evidence of **assessment of need** in two-fifths, 60 (40%) of the case sample. Almost all of these cases concerned families with complex and multiple problems including drugs, alcohol, domestic abuse, parental youth and previous cause for concern. More than two-thirds of these children (21) were named on the Child Protection Register and a similar proportion (19) were looked after. In just over a third of these cases the records indicated that outcomes were already very positive for the child who was well supported either within his or her birth family or protected in alternative family care, usually with grandparents.
7. Assessments of need most often identified mothers' needs for practical and emotional support to combat social isolation, alleviate mental health or relationship problems and low self-esteem, and described children's needs for consistent care. Social workers frequently perceived a need to support parents to parent, for example in setting appropriate boundaries on children's behaviour. Some assessments focused too much

on parents' needs and material circumstances rather than assessment of individual children's needs. They overlooked the impact of enduring parental problems on very young children's longer-term welfare. In too many cases the focus of assessment was on immediate stresses within families and tackling practical problems rather than the long-term outcomes for the child. Where families were affected by parental drug or alcohol misuse, there was little information about the extent of misuse, whether adults were thought to be drug or alcohol dependent and whether they were receiving help from specialist treatment or rehabilitation services. We found little attention to the role and contribution of fathers and cohabitants in families.

8. A higher proportion of cases included evidence of **assessment of risk** to the index child or others in the family. Risk was considered in just under half of the cases reviewed (49%). 51 of these cases concerned children who were or had been named on Child Protection Registers during their first three years, indicating that of the 55 children registered, the local authority had carried out an assessment of risk to the child in 92% of cases. The quality of these assessments varied. In many instances risk assessment was explicit and well evidenced, clearly identified the nature and source of risk, and informed prompt action to safeguard children's welfare. In some cases clear and skilled initial assessment and intervention was evident but this was not sustained after initial crises subsided.
9. Some of the case records did not make sufficiently explicit the nature of the perceived risk, what the consequences of exposure to continued risk might be or the factors that might exacerbate or reduce risk, even in reports and minutes of child protection case conferences. Risks were usually presented in general terms with proposals for action reflecting these, for example 'continued support to mother' rather than specifying what aspects of the family's function needed to be addressed, why and how. In a minority of case records it was not possible to identify either the category of child protection registration or the nature of the perceived risk from the current case file.
10. Parents told us that they knew social workers and other professionals were worried about their child's safety. We found that they were often uncertain about what their social workers thought might happen to their child if the risks were realised. Social workers and their managers told us that they had communicated their concerns about risk clearly to families. Both parents and professionals find discussion of risk to children stressful.
11. Planning and outcomes were significantly better in those cases in which the social worker gave attention to risk **and** needs. There were indications that the child's safety and welfare had stabilised or improved since intervention in two-thirds of these cases (24/37) and informed monitoring indicated the need for further action in most of the remainder.

12. In two of the local authorities we found evidence of consistent, thorough and careful assessment of risk in response to concerns about a child's welfare. But, despite this good practice in risk assessment, many of these cases displayed significant weaknesses and poorer outcomes because there was insufficient attention to the needs of the child, other children in the family or parents' needs. This resulted in a lack of clear direction in case planning for achieving change and too great a focus on 'monitoring' which families experienced as punitive and unhelpful. In a minority of cases, a focus on child protection enquiries with the emphasis on risk assessment, without timely consideration of the families' own needs or wider circumstances had caused significant distress for parents who were then less willing to make effective use of supports offered.

Case example

Child protection enquiries were initiated when a paediatrician queried the cause of small marks on a young child's back. Police and social workers carried out enquiries jointly. A further medical examination established that the marks were the result of a dermatological condition, not injury as suspected at first. The case record contained no information about the child other than the Health Visitor's report that he was 'screaming and difficult to settle'. Although the department offered a further social work visit when enquiries ended it did not acknowledge or apologise for the distress and fear the parents had suffered, or explain to the family the potential benefits of future involvement. The family did not want further contact effectively depriving the child of future support.

13. In another local authority the emphasis on supporting families wherever possible on a voluntary basis was not combined with sufficient attention to risk. In two local authorities there was more consistent assessment of both needs and risk and most cases in these authorities reached satisfactory standards.
14. Across both health and social work services in all areas, the assessments almost always related to the mother's ability to parent or protect her children and her needs. Men were largely invisible in the records or in discussion in terms of their contribution to family life and wellbeing, their needs, or in an assessment of the levels of risk they might pose.
15. Most cases included evidence of **assessment of the family's social circumstances**. This was more often limited to consideration of the family's housing or financial circumstances than available social supports. In almost a quarter of the sample cases assessment was limited to gathering information about the family's social circumstances. In almost all cases in which there was a disabled child there was insufficient assessment of the suitability of the family's housing and financial circumstances and the impact of the child's disability on family life.

16. Social workers made good use of other professionals and agencies to inform their assessments drawing on the skills of, and information from, family centre staff, specialist services, foster carers, and specialist health professionals. There was evidence of good liaison and collaboration with other professionals including health visitors and residential and throughcare staff particularly in assessing the needs of very young mothers, female pregnant drug users, care leavers and their babies.
17. Although the assessments drew on the knowledge and expertise of others, they were frequently too narrowly focused. In those cases which included attention to two out of the three areas of assessment (risk, needs and circumstances), there was most commonly attention to 'risk and circumstances', followed by 'needs and circumstances'. Attention to both 'risk' and 'need' was less likely. This reflected the route of, and reasons for, a referral. When referred for child protection investigations, needs not immediately related to the perceived risk were rarely identified and, where risk could not be established, services ceased contact.
18. Focusing on the parent and/or the child as separate entities, both health and social work professionals often overlooked the quality of parental interaction with very young children leading to under recognition of behaviours which may lead to emotional abuse or neglect, and failure to thrive.
19. The assessments were also often too narrowly focused in other respects. For example, consistent and sustained support for young mothers who had previously been looked after was evident across all the fieldwork sites. The assessment and support provided by aftercare workers generally focused on these young women's needs with insufficient attention being given to the needs of their very young children. Little attention was also given to young women's needs as young and vulnerable parents. In contrast, children's social workers in touch with these young parents too often focused on the safety and welfare of their young children without fully assessing and meeting the needs of the young mothers and were perceived as threatening or unsympathetic by the young people.
20. In the small number of cases concerning families from minority ethnic communities there was insufficient analysis of the impact of ethnicity or racism on family problems and implications for how these might be resolved. Social workers tried hard to have regard to considerations of ethnicity, culture and religion, but in all areas they needed more information and advice to support their efforts, although some local authorities were making good efforts.

21. In a small number of cases (17) there was no assessment of the child or individual family members. In four cases in one local authority this was because the sole support provided to the family was group work for the mother. Although there was evidence that parents valued this input, and maintained regular attendance and commitment, recording of individual intervention was limited and there was little or no information about the child. Links between the voluntary agency providing support to parents and the statutory services in touch with the family were poor.
22. In another case although there was no information about the child or family on the case file, the local authority had provided funding for a service in response to the assessment and request of another agency, promptly, and to evident benefit to the children and family. Reliance on the assessment of other professionals in allocating a service was rare and we found evidence of considerable duplication in assessment. In the remainder of these cases there was no information and little evidence of progress or improvement in the child's circumstances. In some cases problems or concerns remained unchanged over time, or there was insufficient information recorded in the case record to assess the impact of contact with the department.

Case example

The parents of two young children under 3 were involved in an angry and violent relationship in which both drank heavily. The children were neglected, exposed to emotional trauma and very confused. The social worker made a clear assessment of the family's needs, circumstances, and potential risk and acted quickly and decisively, placing the couple's very young children with their grandparents whilst further family work was undertaken. The local authority supported this arrangement despite conflict between the different families and carefully explored options for the children's eventual return to one of their birth parents, who had subsequently separated. The social worker assessed both mother and father's parenting and problems separately, with a clear focus on their capacity to meet the children's needs, the children's attachment and their need for continuing contact with the non-caring parent, in this case, mother. The social worker gave explicit and even-handed messages to both parents about what they needed to change before the children's return could be considered and provided support to each in their attempts to achieve this. The children were subsequently successfully placed with their father, under local authority supervision and with intensive support from the local Children's Centre and Health Visitor, and regular contact with the social worker.

23. We found examples of skilled, comprehensive and well recorded assessments by local authority social workers. Too many cases fell short of this standard, focusing on immediate risks to children's safety or family problems. There was little evidence of a consistent approach to assessment in any of the local authorities we visited, other than a focus on risk at the expense of needs. One local authority was beginning to pilot a local framework in some areas, and although this looked promising, most of the examples we found were incomplete.

What support is being provided to meet needs and reduce risk?

24. Midwives provide the bulk of ante-natal care and support for families in the immediate post-natal period, generally for the 10 days after birth. Support is offered through attendance at clinics, home visits and parenting classes.
25. We spoke to midwives individually and in groups about their role in supporting the most vulnerable families. Most perceived themselves as offering the same service to all new parents and some suggested that all mothers of new-born babies are vulnerable to some degree. As with other professionals there was broad agreement about the range of factors which make particular groups of mothers and their children at increased risk of early problems with care and bonding. Often these are associated with poorer take up of midwives' advice and support.
26. There was far less consensus about whether the midwife has a role in identifying particularly vulnerable families and offering extra help to them. Midwives did not necessarily provide more input to these families and said that their core training did not specifically address the needs of vulnerable families. For example, although many victims of domestic abuse report assault during pregnancy, midwives said they did not receive advice about the impact of domestic abuse on families and children. Some practitioners had had occasional study days but there is no consistent programme of post-qualifying training tackling related risk factors in families which affect child welfare. One midwife said that if she was concerned about the social circumstances of a mother or baby she would convene a case conference. One of her colleagues said that she would feel uncomfortable doing this and yet another clinic-based midwife advised that she would find it impossible to ask all pregnant mothers whether they had suffered domestic abuse.

I'm really there as a midwife. It's the role of other agencies to provide support, ours to refer on. For example, families will often need financial help, or help with housing problems – I would pass this on to the Health Visitor.

27. Practitioners working in specialist settings or areas of multiple disadvantage were more confident than their colleagues in more affluent areas about combining support for parents during pregnancy with assessment of potential risk to their unborn or new-born baby. These routinely participated in inter-agency work to promote and protect the welfare of the babies in families where risk was evident. Many midwives were anxious about involving social workers, fearing that removal of children would be the most likely option. Although separation may occur in a minority of cases the vast majority of children in need are supported by local authorities at home. But many were inclined to the view of one practitioner on inter-agency collaboration:

I hate it – I feel it's such a responsibility, like a jury. Is my contribution helping to separate this mother and baby?

28. In Edinburgh one LHCC had recently established a 'midwifery forum' to promote a more strategic approach to ante-natal care and foster good relationships with local Health Visitors. As targeted programmes have had poor attendance and been unsuccessful the LHCC's objective is to enhance take up and delivery of universal maternity services by vulnerable families.

Health visitors

29. The key contact with health services for the families in our review sample was with their health visitor. Most of these families had a designated health visitor although levels of contact varied widely from weekly in some instances to very limited contact in others. Health visitors undertook careful surveillance of young children's growth and development and provided emotional support for mothers. They were ideally placed to identify family stresses and early health or parenting problems. Health visitors were in close contact with local child care resources and provided early referral to day care services when they perceived parents under stress.
30. Whilst every child potentially has access to a named health visitor, in many cases contact with a family may be very limited or not necessary. For some the input is more important. Like midwives, health visitors did not have a clear sense of the extent of their responsibilities towards vulnerable families and practice varied widely according to the demography of the area in which the practitioner worked, their experience and confidence and perceived support from colleagues and management. In one area pre-school education services expressed concern that the stress on meeting minimum requirements for all meant that health visitors' regular contact with a vulnerable family in the first year of life tails away. There may be no contact with a child at all, if parents do not present for periodic developmental checks, until the child is ready to begin pre-school education, by which time behavioural difficulties are often more entrenched.

31. We found a range of initiatives designed to help vulnerable children including:
- the development of specialist expertise in working with vulnerable families;
 - special clinics, programmes and group work activities;
 - structured, monitored, targeted and evaluated health visiting through the ‘Barker Integrated Urban Model’; and
 - multi-disciplinary teams and co-location of health visitors in children’s centres.
32. Although we found examples of excellent support for children and families within the range of health services we visited, the majority of health care was reactive. Preventative work by health services was focused on universal health surveillance and general health promotion advice. It took little account of the difficulties that vulnerable families may have in following the comprehensive and sensible advice offered. We concluded that health visitors’ contact with parents and children needs more careful focus to avoid duplication, superfluous surveillance and achieve maximum impact. A greater focus on health promotion and direct work with parents rather than routine health surveillance would better meet the needs of vulnerable families.

Specialist health services for adults and children, for example, drugs and mental health services

33. Other than that of midwives and health visitors, most contact with other health services centred around diagnosis and treatment of the individual patient. Specialist services rarely considered the family’s wider circumstances unless there was evident immediate risk to a child, for example of physical injury.
34. Links with specialist services for children were less than effective across all authorities, particularly in those cases where families’ social circumstances were perceived to underpin the child(ren)’s problems. Social workers, managers and education staff perceived psychological or child mental health services as not readily accessible, with lengthy waiting lists, inflexible appointment-based systems, and families discharged quickly if they failed to attend appointments. We found examples of specialists refusing referrals when children’s home circumstances were unstable or uncertain, or when parents were deemed unwilling to engage or unlikely to work co-operatively. In some cases where the local authority had referred a child for support the response had been that as the family circumstances made the child’s prognosis poor, there was no point intervening.

Support from social work services

35. Most of the families in our sample had an allocated social worker working with them. Social workers carried out assessments of families' situations and made referrals to other services such as family or child care centres. In the most well-managed cases social workers provided considerable practical and emotional support for parents through counselling, advocacy and providing access to goods and money. There was little emphasis in each local authority on social workers' direct work with families or counselling for parents, although there were excellent examples of this being offered or arranged in more complex cases, particularly those involving children's removal. Most allocated social workers attempted to provide some counselling around conflict in family relationships but more commonly monitored children's development alongside health visitors and nursery staff and relied on other staff or agencies to offer remedial or therapeutic input. In a minority of cases in each local authority there was evidence of skilled engagement with families and systematic family counselling. Where there was more than one child in a family the needs of the youngest, particularly pre-lingual, children were likely to be overlooked in the need to deal with pressing crises presented by older children.
36. Local authorities provided families with a great deal of material and financial help. Social workers arranged help with holiday costs for families under stress, purchase or loans of some childcare equipment, basic furniture, bedding and clothing, and administered small grants and crisis payments to some families without immediate resources. They applied to charities on families' behalf and arranged subsidised child care or respite services.
37. Many social workers made good use of specialist services with appropriate referral to local child and adolescent mental health services, adult psychiatric or specialist substance misuse services in relevant cases. They kept in close touch with other services, particularly housing and benefits agencies, and were powerful advocates for their clients. However, there were lengthy delays in access to specialist services for families. Local authorities funded residential placements for adults with addiction problems, sometimes with their children.
38. Family support workers, family aides or home carers offered practical advice and support to parents with parenting and household management and sometimes offered respite by looking after children at home and taking them to school or on outings. These staff also played a part in monitoring children's development. One local authority had developed a local programme to promote good parenting skills through delivering a series of sessions on knowledge of child development and how to respond to children's behaviour positively. Some children's centre staff and social workers had been trained to provide the programme with the involvement of the local voluntary sector family centre.

39. Out of Hours or emergency services played a key part in dealing with crisis referrals. They were quick to respond despite the constraints and difficulties in working when other services and resources were unavailable. In these circumstances they had no alternative but to spend time talking directly with families to understand their immediate circumstances and problems. In one local authority social work staff and users told us that new contractual arrangements for out of hours services with a consortium servicing a number of neighbouring authorities had eroded the service which had become less responsive, relying on telephone contact rather than visiting families in crisis. Another planned to move from joint arrangements with another authority to a more local arrangement to tackle this kind of problem. Rural authorities have particular challenges in providing out of hours services across large areas but the quality of the response appeared generally good.
40. Out of Hours staff in all the local authorities were skilled and experienced. They gathered a great deal of information and offered good professional insights into the supports needed. This contact was often extremely important in setting the context for the families' further contact with daytime services. Some families made regular use of the Out of Hours services for advice and support. This model of intervention in which a prompt and reasonably robust assessment is formulated on the basis of urgent family contact should be more common in daytime responses to initial referrals.
41. Many of the children using day care or nursery placements had siblings in nurseries, or had home care. Most of these cases did not demonstrate expected benefits as social work contact reduced proportionally and there was reliance on these staff to monitor and support the family with little direction or measurement of outcomes.
42. Family centres or their equivalent brought together a range of practical, material and emotional supports for parents usually underpinned by some form of child care. We found examples of family centres providing group work with children and adults (often with crèche facilities), drama workshops for young people, a venue and sometimes supervision for parents' contact with children in care and a great deal of individual counselling for parents in centres and through home visiting. Some families had received consistent support from their local family centre over some years and these seemed able to engage even isolated and unwilling parents well. In some areas of Glasgow a discrete, community-based support service, run by the social work department but at arm's length from the local area team, provided emotional and practical support for families in difficulty, from a local base and using other community meeting facilities. Families found contact with this service very helpful and described this kind of support as less stigmatising.

43. When older children presented behavioural problems and proved difficult for parents to manage, local authorities provided respite services. Child care centres provide excellent advice and direct support for parents on setting appropriate boundaries, consistent routines, physical development and nutrition. Parents reported that they learned a great deal from following the examples set by child care staff. We found less evidence of sustained work with parents and their children on emotional development, play or developing independence and identity.
44. Support workers in the Throughcare team supported young people towards independent living by assessing their knowledge and skills in managing a tenancy, assisting them with housing, benefit and grant applications and liaising with other agencies on their behalf. There was little evidence of information sharing with field social workers or other relevant professionals.

Voluntary sector support

45. In each local authority area voluntary sector services played an important part in assessment and support for families. They offered home visiting services, parents' support groups, child care and play sessions with parents, advice, advocacy and emotional support for young homeless people or people leaving local authority care, and specialist assessment of families with complex needs for the local authority. In some areas they provided a venue and supervised contact sessions for parents with children in foster care or in extended family placements.
46. In one local authority the voluntary sector provided most non-statutory support services, with social work services working with children under supervision or on the Child Protection Register or with complex needs. Support for families with younger children was delivered by a national voluntary organisation from a centrally-located family centre, with outreach and project staff working in outlying rural areas. Families were very positive about the quality of both the premises and support. The voluntary sector service was working with a less (but still) disadvantaged group of families and focusing on secondary prevention. The local authority and the voluntary organisation had worked hard to establish a robust strategic partnership which was bearing fruit in new developments and more creative approaches to local problems of scale and rural isolation.

Children with disabilities – a poor service

47. Within the sample of families there was a small number of children who had physical or learning disabilities or sensory impairment. The majority of cases involving disabled children were managed poorly. There were lengthy delays in responding to referrals, making decisions and between contacts. The impact of the disability on the family as a whole was not taken into account in planning and carers' needs were not consistently assessed. Singleton specialist social workers attached to local authority children and families teams were assigned all assessment of children with disabilities. They reported that their tasks centred around co-ordination of community care packages or future needs assessments with little scope for ongoing direct work with children or families. Health and education services reported that social work services were difficult and slow to obtain in the absence of an allocated social worker. Disabled children appeared to have little priority.

A continuum of support?

48. Health services argued that they needed better direct access to some of the resources and supports currently controlled by social work departments. They wanted to access support staff such as family aides to undertake intensive teaching of parenting skills and household management without reliance on social work referral and assessment. They perceived the threshold for access to this kind of support as currently too high.
49. We found that unless there was an inter-agency child protection plan or supervision plan in place support for families was poorly co-ordinated. There were examples of social work services providing a 'link social worker', a social worker designated to attend regular meetings with other agencies or services to foster better communication. These link social workers were not empowered to take decisions on allocation of resources and took information back to their own service for case allocation and resource decisions. All agencies agreed that there was a need for better communication and co-ordination between services but saw this as a need for change in systems of communication rather than changing their own practice.

'It's everyone's job to make sure I'm alright.'



How well does support meet vulnerable families' needs?

Outcomes for children
Quality of social work practice
Social workers contact with families
Families' expectations
Families' experiences of health services
Social work services
Family centres
Working in partnership with families
Working with families in stressful situations
Working with extended families
Working with men
Keeping purposeful and effective records

Outcomes for children

1. In more than half of the cases we reviewed where there were concerns about children's safety, development or welfare, local authority social work involvement brought about some immediate improvement. In one in five of the families children had been looked after away from home during the local authority's involvement but most of these children quickly returned to their families of origin. In half of these cases (20) grandparents or relatives had taken over the child's care from parents, with local authority approval and support. In only six of the 147 cases were plans being considered or progressed for children's permanent placement in substitute care. The fears expressed both by families and professionals that social work departments were likely to permanently remove children from their parent's care are not reflected in reality. Social workers worked hard to effect children's speedy return to their families or extended family carers.

2. They also went to great lengths to support parents in looking after their children at home. In almost three-quarters of cases children remained within their families during local authority involvement and in over half of these cases outcomes seemed broadly positive, with a reduction of perceived risk. In one local authority we found creative use of foster care placements for younger pregnant women. For example a young woman in her twenties had had two previous children removed from her care. The foster carer's intensive and consistent support during the pregnancy enabled this young mother to accept her help and advice when the baby was born. This was a creative and effective use of an experienced foster carer to support a young parent through pregnancy.
3. There were 21 cases in which there were continuing concerns for children's welfare in their families but no decisions about whether children's welfare was best promoted within their families had yet been made. In some of these cases intensive support was provided, but there was little evidence that children's circumstances were improving.
4. In a further 20 cases it was not clear whether the eventual outcome had improved the child's welfare or circumstances and in just under a quarter of cases there was no information about the outcome of intervention for the child.
5. We found that agencies relied too much on local policy or guidelines to direct professionals' decision making. These were applied regardless of evidence that indicated alternative options were more likely to safeguard and promote a child's welfare.
6. We found a number of cases in which it was far from clear that the child's welfare was the paramount guiding principle. These were cases in which children had experienced consistently poor standards of parenting despite extensive teaching and support from professionals and other agencies. The severity of parental problems was such that there seemed little likelihood of the child's core needs being consistently and reliably met in the foreseeable future. Parents in these families were often not perceived to be deliberately abusive or neglectful. All professionals found it hard to judge what should be the threshold for removing children in these families from their parents' care. We found examples of health and social work services allowing children's care to drift below adequate standards for unacceptably long periods before taking protective action. Family support plans, inter-agency child protection plans and supervision plans did not describe clear goals with parents and timescales within which improvement in the child's circumstances should be achieved. This compromised the child's right to a secure future in an alternative family.

7. When very young children were looked after away from home the local authority's efforts to reunite the family also meant that insufficient attention was given to planning for the child in the event that parents were unable to fulfil their parental responsibilities until the child was much older. We found examples of children returning to the care of parents whose situation and parenting appeared to the review team to be very unpromising. We were particularly worried by those cases in which children were now securely attached to alternative carers who had provided them with a much higher standard of care than they would now experience. Local authorities advised us that it was important that these children returned 'home'. We query whether the concept of 'home' adequately reflected the child's experience and perception. Care by birth parents, by extended family carers, foster care and adoption are neither exclusive, nor sequential pathways.

Quality of social work practice

8. We looked at the way in which local authority support services met the needs of the children and families in our case sample. The quality of social work practice and intervention was satisfactory or better in almost two-thirds, 94 (64 %⁵) of the cases we examined. In each of the fieldwork sites we visited we found examples of casework reaching excellent standards. Good practice was characterised by:
- prompt responses to concerns about children's welfare and development;
 - social workers' clear and focused assessment with attention to both risk and needs, alongside families' social circumstances;
 - clear plans which recorded realistic objectives and timescales;
 - patient and persistent direct work with parents and extended families based on regular and reliable contact by social workers and other support staff;
 - good communication and collaboration with other professionals and agencies; and
 - effective oversight and review by skilled and supportive line managers.
9. In these cases social workers worked closely with support staff and directly with families, some of whom were very anxious and hostile, to bring about change and improvement in parenting and families' circumstances. Staff maintained a clear focus on the child's welfare but also considered parents' circumstances and needs. Social workers displayed evidence of a strong commitment to working in partnership with parents but also took decisive action when standards of care seemed likely to cause immediate harm to a child. In most of these cases the basis for the local authority's intervention was clearly set out and children were at least protected from danger, and at best their welfare was actively promoted.

⁵ 20 cases (14%) scored level 1 and 72 cases (49%) scored at level 2

10. The remaining 53 cases (36 per cent) were less satisfactory and a minority 11 (7 per cent) displayed major weaknesses. These cases were characterised by poor information most commonly focusing on the presenting problem(s) and the families' current circumstances. A lack of information about individuals in the family, particularly young children and fathers, hampered assessment and planning. Social work contact lacked purpose and goals, was ill-directed, and sometimes very infrequent. Many of these social work records lacked clarity about the purpose of social work visits and nature and content of assessment.
11. Where allegations of abuse were made there was a focus on establishing grounds for intervention usually around a particular incident rather than consideration of wider factors in the family. In some instances social workers' focus on progressing child protection enquiries seemed disproportionately punitive towards parents suspected to have harmed their children. This was unhelpful in establishing a relationship within which work to protect children could take place. There was little attention to review of effectiveness of services. Inter-agency collaboration was patchy.
12. Four of the 11 cases displaying major weaknesses concerned children with disabilities or developmental delay, two concerned cases of families from minority ethnic communities and five were unallocated and managed through duty services (a system whereby a 'duty' social worker deals with all referrals or enquiries on a daily basis). Of the 26 cases scored which were managed by duty services, less than a third reached satisfactory standards. Duty systems tended to offer minimal responses and operated as an agency filtering mechanism rather than a helping service in its own right for families in crisis. Most cases were characterised by inconsistency of service and response and, in some cases lengthy delays before decisions were made. The weakest were crisis driven and showed little evidence of improvement in families' circumstances or functioning. Families were not given any idea of when they might be allocated a social worker, if at all.
13. There were examples of services and support offered by the local authority which families found particularly helpful. Child care provided by childminders, nurseries and family centres, and home visiting by home support workers effectively provided respite and support for the most vulnerable families under stress. Their contribution to promoting the index child's welfare was often not adequately evaluated or reflected in the local authorities' records.

Social workers' contact with families

14. Allocated social workers' contact with families for whom they were responsible varied widely (see table 1). In all authorities social workers tended to maintain regular and frequent contact in the early stages of involvement and during periods of crisis, tailing off as immediate risks to children's safety reduced or crises receded. In over a quarter of cases (28 per cent) social workers visited families at least weekly. Families would often have even higher levels of contact with their social worker during periods of heightened family stress or crisis or at times of review. However, in just under a quarter of cases families had much lower levels of contact with their social workers seeing them less than monthly and less than half saw their social workers more than once a month.
15. Higher levels of contact were associated with more comprehensive assessment and usually, but not always, better outcomes for children. In the best managed cases there was evidence of social workers' skilled engagement with families and family counselling. First line management provided supportive contact for families in their social workers' absence. In some instances social workers' higher level of contact reflected that families in these cases had multiple difficulties and problems and children were exposed to higher levels of risk with a poorer prognosis. In these cases outcomes were not always as good for children. There is a need for activity and contact to be focused. Even where families were visited regularly there were cases in which there was little evidence of assessment of need or risks.
16. Where the level of contact was less frequent than monthly there was less evidence of progress in alleviating risk or promoting the child's health and development. In many cases when a worker was on long-term sick leave cases were not reallocated. Unallocated cases were associated with poorer outcomes. The duty social work service responded to referrals by focusing on investigation of risk to children's safety or welfare rather than exploration of families' needs for support.
17. Low or irregular levels of contact with social workers were associated with weaker case management and poorer outcomes. However, in many of these cases families were receiving consistent and regular support from home care workers or family aides, or were in close touch with family centre staff at the child care centres their children attended. Families valued this support highly and made good use of it. In some cases social workers relied too much on these staff to assess and monitor children's welfare, and to provide information on which to base their own assessment rather than visiting and developing a relationship with the child and family directly.

Table 1: **Frequency of contact**

	Weekly or more	Fortnightly	Monthly	Less than monthly	Not recorded	Total per local authority
Authority 1	11	4	3	4	7	29
Authority 2	7	3	8	7	4	29
Authority 3	5	3	6	13+1		28
Authority 4	14	6	4	5+1		30
Authority 5	4	12	6	3	6	31
Total	41 (28%)	28 (19%)	27 (18%)	34 (23%)	17 (12%)	147

18. In those cases in which families were caring for disabled children there was generally very low levels of contact by social workers. Contact was usually to complete an assessment of the needs of the child and their carers rather than to provide support or services.
19. More than one in 10 files did not record the frequency of contact with children and families sufficiently enough to allow analysis. We took this to indicate that contact was infrequent in these cases.
20. We concluded that:
 - social work support is of good quality in many cases and can be very effective in bringing about good outcomes for vulnerable children at most risk;
 - practice within local authorities is too variable and more needs to be done to bring the standard up to that of the best;
 - duty systems do not provide a responsive, helpful or safe service. They build in lengthy delays to decision making;
 - child protection enquiries need to be integrated within a framework for assessment of children in need so that responses to referred families focus on risk and needs as required by national guidance; and
 - some children's future wellbeing is being significantly compromised by remaining with or returning to their family homes.

Families' expectations

21. We asked a wide range of people who are in touch with social work and health services about the stresses families with young children face and the kinds of support they thought would be helpful. We talked with parents individually and also in small groups in each local authority area. Some had allocated social workers; others were in touch with local family centres or other support services. Some had had extensive involvement with social work services and had complex and stressful personal histories which aroused a lot of professional concern about the safety and welfare of their children. Others used local child care services or had children with disabilities and were using family centres for respite or to assist their child's learning and development. All were families with children in need.
22. Overall the groups were often more critical of statutory services. They gave accounts of conflict with medical staff and were dismissive of available supports from health visitors and social workers. In contrast almost all were very positive about support from staff in family centres or equivalent community-based support services or voluntary agencies whom they felt respected and listened to them. Their comments echoed those of many of the helping professionals.
23. There was a perception in the more rural areas that provision was concentrated in the urban centres and there were strong feelings of isolation, particularly for lone parents. Most people relied heavily on support from extended family for child care and help with transport.
24. A significant proportion of parents described stresses associated with the breakdown of parental relationships and the fear of violence or harassment from ex-partners, usually men. One parent described her fear of her ex-partner taking her child from nursery. Pervasive anxiety about threats from partners, family or neighbouring residents in areas of multiple disadvantage was common.
25. Parents said that what they wanted was:
 - time to themselves – a break away from children;
 - someone to talk to who could give advice; and
 - contact with other parents who were going through the same problems.
26. Few parents referred to difficulties in parenting their children directly as an area with which they needed support. Parenting problems were more likely to emerge in discussion of the supports provided.

27. Parents found support which came to them particularly helpful, and were grateful for visits from professionals such as health visitors and family aides. Increasingly in some areas more sustained home-based support was provided on an outreach basis by family centres, after referral by health visitors and social workers. In some areas parents said that this kind of support was not as readily available as previously or that the extent of help received depended on which area of the local authority they lived in. One local authority was reducing the number of child care places available in family centres in order to provide increased levels of outreach work by staff, and was re-contracting with a specialist family assessment service provided by a voluntary agency to increase home-based work with vulnerable families.

Families' experiences of health services

28. Some parents were critical about their contact with health professionals, particularly GPs and health visitors, with whom they had most contact. Parents were most positive about those professionals who took time to discuss their problems and were honest about the help they could provide even if that was limited. Examples of input from professions allied to medicine were described much more positively. Parents seemed to have clearer information and expectations of specialists and could describe these.

The speech and language therapist was brilliant – she sees my child twice a week; she brings booklets, does activities and explains things. She treated you as an equal and was interested in the child.

29. Although parents appreciated that GPs and medical staff were hard-pressed, many described stressful and difficult contacts with hospital and community-based doctors, and some had painful accounts of professionals' failure to listen to them or to take their concerns seriously.

They just dismissed me as an over-anxious mother.

30. Few parents had a consistent relationship with a named GP and described contacts as hurried. Some medical professionals, particularly in hospital, were seen as remote and patronising. Parents said that they were often not given information that they needed to make confident choices about health care for their children. Some felt that health professionals 'wrote them off' if they came from a disadvantaged area, thinking that they would not be able to understand complex conditions or that they did not provide good care for their children. They felt that too often GPs were too ready to prescribe tablets and unwilling to take time to listen to their problems and worries. The emerging consensus from user focus groups was that doctors provided little technical information and that parents needed more advocacy and support to be empowered to ask questions, find out what they needed to know and to make informed choices for themselves and their families. One parent described having used a patient advocate

from a health project with very successful results. Carers (such as relatives or foster carers) of children who were moving around frequently because of family problems reported difficulty in obtaining GP services.

31. Some parents had positive relationships with health professionals.

The biggest help was the health visitor and the GP – they were honest, the GP listens to you – doesn't always have an answer but takes the time and interest.

32. Health visitors were more often seen as a potential source of support. They compensated for deficiencies in information provided by doctors, offered clear and simple explanations of health problems and treatments, ensured that parents understood, and gave practical help on health problems. But here too families described experiences of practitioners who were 'difficult to get a hold of' and occasionally they perceived professionals as critical and judgemental.
33. Some families had had very little contact with their health visitor. Others had had much more and found this a reliable and helpful support. There seemed to be little consistency or understanding of why the differences in frequency of contact came about.
34. Some families felt that health visitors did not take on families with more complex problems where children had special needs or other difficulties and referred on. Others felt the health visitor did not really pay attention to their family's individual needs and were not sure what the purpose of the contact was.

Someone to talk to – mine put me in touch with a mother and toddler group.

She gave me advice on sleeping but it wasn't helpful – they're not listening to what the problem really is.

The health visitor comes in and looks all round about – it feels like an inspection – stressful.

35. Some families described availability of services in smaller suburban or rural areas as poor in comparison with the cities. Large city children's hospitals appeared to offer better facilities for parents when children were admitted. Accommodation allowing them to stay overnight with their child was highly valued.

Social work services

The social work is bad news.

I thought social workers came in and took your child away.

People think you must be battering your kids if you've got a social worker.

I wouldn't own up to having a social worker.

36. We were concerned at the very negative perceptions of many local authority social work services held by parents in the groups. Again and again parents described their fear that if they confided in social workers their children might be taken away. This related mainly to area team social workers who were seen as powerful and threatening by two groups of parents:
- those who had little or no experience of area team social workers; and
 - those whose children had been the subject of professionals' concern to the extent that there had been child protection enquiries, their children had been named on the Child Protection Register, or in a small number of cases, the local authority had removed their children from their care.
37. Parents seemed less fearful of other groups of local authority staff who were seen to be providing other services first and foremost and were less associated with the social work department.
38. These parents' views were informed and shaped by a number of sources, including views from relatives or neighbouring families, and the media. Many suggested that involvement with the social work department brings great stigma stemming from an image of social work presented in the media as working only with problem families and failing parents. Some were concerned about what others would think of them if they had a social worker; others reported that extended family were not happy about their contact with the social work department. But few people without an allocated social worker had clear information and ideas about what social workers were for or what they did, other than removing children at risk, or what services and support they might provide.
39. Amongst those who had had extensive contact with area team social workers views were more positive. Many described extensive support and excellent relationships with their social workers. Even those who were less positive acknowledged that field social workers tried hard to help them. Amongst those who had had children removed from their care there was often acceptance that such action had been necessary, despite their anger and fear.

40. Area social work teams were perceived as 'over-worked' and very busy. In some areas parents felt there were far too few social workers. Families described difficulties and frustration in trying to get an allocated social worker and to obtain the services they thought they needed. Some felt that social workers did not have the range of skills and knowledge to help them tackle their personal problems effectively, others that social workers were over qualified to give them the kind of help they wanted. While some parents felt anxious that support would be withdrawn prematurely, others argued that once you had a social worker they were very reluctant to cease contact. One young mother admitted into care at 16 said 'years later they were still in touch'.

They're not a great help – we've been trying to get help for our children and can't get it.

We needed a court order to force the social work department to take our child into care – we have five children, two with disabilities and the older children have problems. We want respite – a break away from the child.

41. There was a strong perception that social workers responsible for monitoring children's welfare exacted very high standards from parents already under stress.

One parent described her situation:

I have three children – two older ones. I was suffering domestic violence, I was isolated and I had a low birth-weight baby. I asked for a psychiatrist or a social worker to help. The social worker lifted [my child] and placed her with my sister. I got her back on Tuesday after one year. I had no back-up. I'd brought up my other older kids without problems. I wanted somebody to be there for me, to back me up. The impact of contact with a violent father on the children wasn't considered. I went to counselling, I had a CPN, I done everything I could do. I couldn't please them. I feared they wanted me to fail.

42. Parents described how difficult it was, in view of their fears, to ask for help from social work services; when they did so this was a momentous decision. The response they receive often colours their relationship with social workers and other staff for a considerable period.

Making the phone call was a big, big decision ... it meant that he would be charged.

I was left high and dry.

43. Reports from many parents echoed our findings about the wide variation in frequency of contact with allocated social workers. Higher levels of consistent contact were associated with better relationships. Parents wanted more choice about the social workers they worked with, and, for example, to be able to ask for a female social worker. Parents said they found it hard to change their social worker if they felt they did not get on, and were anxious about complaining in case services were withdrawn. Complaining to senior social workers was felt to be ineffective as their concerns would not be taken seriously. Too often the social work department did not return their calls.
44. We found that:
- families' strongly negative perception of contact with field social workers hindered them from seeking early help from social work services;
 - this perception is not well grounded in fact or families' experience;
 - families with experience of support from field social workers were more objective and realistic about the support available and valued contact with social workers; and
 - local authorities' referral and allocation procedures do not promote an ethos of partnership with families.

Family centres

45. Almost all of the parents in groups were very positive about the support they received from family centres. This seemed related to the three things they said they valued most highly: respite, good emotional support and advice and social support from peers. Family centres invariably offered some combination of these three things. Parents argued that there was a need for more places, more staff and more support for themselves in child care provision of whatever kind. They wanted staff who could deal with specific special needs and were trained in specific issues such as learning how to play with children, dealing with disability, racism and resultant inequalities, and managing children's difficult and challenging behaviour.
46. Many parents had attended group work programmes in their local family centre or equivalent. The nature of these groups varied: some were parents' support groups with the agenda and activities set by parents themselves with help and practical support provided by a group worker; others were a set series of sessions bringing people with similar problems or stresses together to discuss how to solve these, or for educational programmes. People generally said that they found groupwork very helpful, especially when this included crèche facilities. They offered 'a bit of space' and the chance to meet people in the same situation.

47. Parents described the most helpful characteristics of group work as:
- the knowledge that you are not alone in your predicament;
 - hearing others' experience and advice about what works;
 - having other adults to talk to;
 - knowing that the group will keep your business confidential;
 - having interesting and different things to do, and 'getting out of the house'; and
 - leaving your responsibilities behind.
48. Some of these characteristics were evident in each of the groups running in the local authority sites we visited. Parents also identified common gaps in group work. They felt that their children could also benefit from groups but that there seemed little available for younger children. Most demanded that parents were also present (such as mother and toddler groups and playgroups). There is little provision for fathers, especially single fathers – most groups are oriented towards women.
49. Some participants commented that the support of the group worker is essential and that groups would not be able to sustain themselves without professional or agency support. The group worker's role was to arrange a venue and other basic facilities, prepare and encourage potential participants to come along, help members to negotiate and agree an agenda for a programme of sessions or activities, and mediate relationships and conflict to ensure the group remains helpful.
50. Parents observed their child acquiring skills and therefore saw the centres as providing measurable support for themselves and their child and were more open to advice from staff whom they perceived as having experience and expertise. Moreover, family centres provided an opportunity to see how centre staff interacted with their children and encouraged learning and development and good behaviour. Parents described their children as being much better behaved at the family centre and this being generalised when they returned home.
51. Parents felt less threatened by the fear of their child's removal in family or child care centres. Most parents knew that staff contributed to assessments and would report any concerns about a child, or a parent's interaction with their child to their social worker. But they saw social workers or senior staff as responsible for decisions about registration, changing plans or removal of a child from their care. They felt that centre staff were more readily available and had more time to listen to them and treated them as an individual in their own right rather than merely a parent of a child.

There's a big difference in [my child] since he's been attending. I come once a week too, to see what he's doing and play with him. I have more patience with him.

The routines they get into in the centre help them get into routines at home too.

52. Both families and professionals found family centres offered great benefit but highlighted gaps in support for example at evenings and weekends.

Working in partnership with families

53. Parents rarely felt that they were equal partners in planning and making decisions with the professionals helping them. In some cases developing partnership working will be very difficult for example, when the parents have severe problems which prevent them from meeting their child(ren)'s core needs, the respective interests of parents and children may diverge. But even when not identical, the interests of children and their parents are inextricably linked. When an equal partnership is not possible and the local authority must act against parents' wishes, it is essential that parents are given the opportunity to contribute their views. Parents acknowledged that social workers could and did provide a great deal of help for families in difficulty and protection for children at risk. They did not always feel that their views were listened to or that they were respected as individuals. They felt that their own needs were dismissed by professionals 'putting children first' when they were sure that if their needs were met they could parent their children better. They felt that agencies did not work together in partnership either and reported very slow assessments and decisions.
54. Parent wanted more choice and control about what services they received and when. They valued sitter services and drop-in services because they could decide when to use them. They wanted more information about what was available in their area and wherever possible wanted to be able to choose which services to make use of.
55. National guidance sets out the requirements for effective working in partnership with parents. These guidelines apply to all professionals who work directly with families in which children may be in need. Achieving partnerships with parents and children in the planning and delivery of services to children requires that:
- they have sufficient information at an early stage both verbally and in writing to make informed choices;
 - they should be aware of the various consequences of the decisions they may take;
 - they should be actively involved wherever appropriate in assessments, decision-making meetings, care reviews and conferences;
 - they should be given help to express their views and wishes and to prepare written reports and statements for meetings where necessary;
 - professionals and other workers should listen to, and take account, of parents' and carers' views;

- families should be able to challenge decisions taken by professionals and make a complaint if necessary; and
 - families have access to independent advocacy when appropriate.
56. Less than one in five of the case files we looked at contained any form of written agreement with parents or information to families setting out the local authority's assessment and what support and services the local authority would provide. Many of these agreements were partial, focusing on one service or one aspect of support such as day care, arrangements for parents' contact with a child in foster care, or schedules of appointments. The extent to which these were joint agreements seemed limited. Where there were assessments and plans on case records it was often not clear whether these had been copied to parents. Many had not been reviewed or updated recently with some examples of the most recent plans or agreements over a year old.
57. One case record included a contract on file setting out the department's expectations that a parent would improve the cleanliness in her household and work to provide more reliable and consistent routines for her child, including regular attendance at nursery and for health care. Although all parties had signed the contract the wording gave little indication that the terms of the contract were agreed in a way which took account of the parent's views. There was little active support offered by the local authority. The contract noted that social work department staff would visit at an agreed frequency, but without prior arrangement on occasion. The contract was clear but the tone was severe and unsympathetic.
58. We found that little information was given to parents which was tailored to their needs. Where children were looked after or named on local Child Protection Registers families had more access to written information about the local authority's views, proposals and recommendations because they were provided with copies of reports for Children's Hearings, child protection case conferences or reviews. The local authority's assessments were usually contained in the body of these reports.
59. It was clear that social workers tried hard to talk to parents and provide them with full information and many case files contained accounts of discussions with families about the local authority's or professionals' worries about children. But it was also clear from case records and from interviews with parents that such discussions often occurred under stressful circumstances and that families sometimes found it difficult to understand or recall events or information clearly. There were examples of disagreements or disputes about factual information or the basis for professionals' concern. Families felt that social workers reports did not accurately reflect their own perspectives or points of view in their written reports. Although conference, Hearing and review reports should include information about families' and children's views these reports are for a particular purpose and not geared towards communication with families first and foremost, although they should be written with a range of audiences in mind.

60. Poor information and communication with health professionals also stemmed from a lack of attention to how best to communicate information under stressful circumstances. Few health professionals provided information in writing to parents, although this is improving in some areas with the introduction of parent-held records, which were welcomed by parents. Whilst an important development, we found that health visitors using parent-held records did not then retain any separate information or record of their contact or observations of the child. Where there are concerns about a child's welfare and development careful records of observations by all professionals involved with the family are essential.

Working with families in stressful situations

61. Families under stress do not always welcome professional attention especially when this is perceived as critical scrutiny or likely to lead to demands that the family feel unable to comply with. Angry and hostile parents arouse considerable anxiety and fear amongst the people trying to offer help. This may be compounded by knowledge of a history of violence within the family, or experience of threats or even assaults. The often complex and serious problems some families present also arouse anxiety in professionals who worry that they lack the skills or knowledge to really help. They may be very worried about young children's welfare or safety yet there is insufficient evidence to take protective action. Organisations are less likely to maintain contact with hostile and frightening families. They may withdraw services because of unacceptable behaviour and assessments may lack important information because it is so difficult for professionals to engage with families. Children in these families are left unsupported until there is sufficient evidence for child protection enquiries or compulsory measures of supervision.
62. This is not to say that all vulnerable families are threatening or violent. But stress will lead to situations in which families find control of their emotions and behaviour difficult. Misuse of drugs or alcohol will affect parents' behaviour and presentation. These factors pose real risks for both the children living in these families and the people working with them. The difficulty in attempting to develop a supportive and helping relationship with angry, intoxicated or resistant adults cannot be underestimated. Many local authority social workers are clearly very skilled and experienced in working with such people. However, local authorities' concentration on child protection sets the tone for a more confrontational kind of practice and increases the risks for those workers who might be required to challenge parents, perhaps in the presence of unknown strangers.

Whenever I go to visit mum and the baby, there are usually other adults there, her brothers I think. I don't know them. They don't say anything much, they are often stripped to the waist and they are all smoking over the baby who is only 6 weeks old. It's dark with the curtains drawn and the TV is on so it's hard to talk to mum. I feel intimidated and I just want to get out as soon as I can (Health visitor).

63. The majority of frontline professionals working in children's health and social services are women. Women professionals reported that many aspects of their work made them feel unsafe. For example midwives told us they felt vulnerable and sometimes afraid when visiting families in some communities. Few had access to personal alarms or mobile phones. Health visitors and community midwives said they were isolated and heavily reliant on informal support from peers. Off-site management was not readily accessible, clinical supervision was irregular and rarely focused on the relationship between the practitioner and her clients. Male social workers said that they would be asked to visit jointly with women colleagues when there were perceived threats. They felt unsure about their role in such circumstances. Across all agencies frontline staff described working with families who seemed to them to be dangerous with little explicit support from their agency. Line managers were often, though not always, supportive.
64. Staff in family centres and children's centres also experience difficulties and stresses associated with working with families under pressure. However, the combination of direct provision of a valued service, usually childcare, regular and routine, often daily, contact and direct access to a listening ear and some personal support in attractive family friendly surroundings can do much to alleviate the tensions surrounding families' contact with professionals. Even parents who had a long history of conflict with professionals found family centres welcoming and non-threatening places. In contrast the very poor condition of some of the social work offices we visited seemed likely to exacerbate feelings of alienation and poor self-esteem amongst vulnerable families. Reception and interview facilities were dingy, dilapidated and depressing, with grubby, dirty or broken furniture and fittings. There was a lack of toilet facilities, toys and games for children were in a poor condition and public information was often dated, scattered and poorly organised. We found other area offices which were clean, airy, bright and business-like. The atmosphere in these was much calmer. Reception and public areas in health, education and housing services were generally of a much higher standard than those in social work services. We concluded that the stigma attached to contact with social work area teams is intensified by the condition of the places in which they carry out their tasks, and to which families in difficulty have to come for help.

Working with extended families

65. When we asked parents where they obtained most help and support they most often referred to family and friends. Extended family and grandparents in particular provide a great deal of informal support, respite, advice and advocacy and many professionals across support agencies looked to extended family as a source of support for vulnerable children and parents. The presence of a consistent, supportive adult, interested in the child and his or her welfare is a significant protective factor, alleviating the effect of other disadvantage in vulnerable families. Extended family often provided security and compensatory experiences for children whose early experiences were poor. Birth parents reported that accepting help from extended family was more comfortable when there was some degree of reciprocal support and users did not feel too dependent.
66. Where children were not able to be cared for safely by their birth parents we found evidence that all the local authorities made good efforts to explore the possibility of placement with extended family members. Local authorities seldom considered the needs of these family carers separately unless they were perceived as an agency resource, akin to foster carers. In these circumstances the carers' own relationships and attachments, and their role both in the family's problems and in finding solutions, may be overlooked.
67. A significant number of children in our sample were being cared for away from home by extended family, usually grandparents or other immediate relatives such as aunts. Some of these placements were short term, to enable work with parents to resolve other problems, to provide respite, or before decisions about children's futures were reached. Others were clearly long term and in some cases likely to last throughout childhood and adolescence.
68. We found some cases in which the agency's commitment to children being looked after wherever possible in extended family rather than foster or residential care had led to placement without sufficient assessment and exploration of the family's capacity to meet the child's needs. Family carers described social workers placing children with them at times of family crisis, with no preparation for difficulties that emerged, little continuing contact and no apparent review of how this was working. Their commitment to the child in their care was not in doubt. Nevertheless they felt that professionals had left them to deal with often complex problems and difficult behaviours without taking into account the needs of their own families, or the often profound impact on their lifestyle and income. Where parents were opposed to, or contesting, removal of children from their care, this created additional stresses for family carers. Relatives may find it harder than ordinary foster carers to resist their family members' demands to return children. They rarely have the same access to training, advice and support from fostering services or link social workers available to local authority carers.

69. There was little consistency, even within authorities, about the status of, or support for, extended family placements. Some families received the equivalent of fostering allowances for the children they were caring for. Others received intermittent financial grants and some practical or material resources such as child care, clothing, furniture and bedding. Yet others appeared to receive no support at all. In some cases family carers were closely involved in planning for children; in others they were not sufficiently informed or involved in planning or decision making for the child, being consulted as 'carers' only on the child's progress in their care.
70. We found a lack of practical and financial support for family carers, usually grandparents, whom local authorities had made responsible for the permanent care of very young children. In many cases it was clear that a child could not return to their parent's care, that extended family would provide long term or permanent care for a child and that this was in the child's interests. Yet local authorities did not generally support family carers to acquire parental rights and responsibilities through, for example, assistance to the extended family in applying for section 11 orders, or adoption, with continuing financial support where this is necessary.
71. Two of the local authorities were piloting projects in family group conferencing, a method of involving birth parents, children where appropriate, and extended family and other significant adults in finding solutions to family problems, supported by professional mediation, with access to reasonable resources from the local authority and other services. The projects were located outwith mainstream services and relied on referral of suitable families from local area teams. We found little evidence of this approach having an impact on professionals' practice in these areas, with very low numbers of families referred to the projects. Field social workers perceived family group conferencing as inappropriate for families in which children were perceived to be at risk and were more likely to refer families with older children, particularly where their persistent offending could precipitate rejection and family breakdown. Other agencies had little involvement in the pilot projects.

Working with men

... encourage fathers to be more involved; it's harder for us to ask for help – it's not socially acceptable. Social workers should listen and accept a father's role.

72. Throughout the review it was apparent that professionals took insufficient account of the role and contribution of fathers and male partners in the safety and well being of the children and their families. In many case files there was little information about fathers and limited evidence of contact with them to assist assessment and planning even when fathers were perceived to be the main source of risk. In each of the local authority areas there were examples of fathers stepping in to provide support and care for their children, when mothers' difficulties affected the care of their children. These fathers reported that they found family support services almost entirely staffed and attended by women, and however welcoming the service or other users, they felt very isolated. Some of the professionals we interviewed were dismissive of the men they came into contact with, describing them as irresponsible and '*like babies themselves*', with little recognition of, or support for, their contribution to parenting. Both male parents and professionals acknowledged that the men present in vulnerable families can shape children's experiences for good or ill, and that services must find better ways to engage with them. But there is little dedicated work with men to support their care of children or enhance their family relationships.
73. Social workers and other professionals held considerable information about the incidence of violence towards or between partners in the families in our case sample. There was often little information about the circumstances in which violence occurred, the frequency or extent of injury and the attitude of the mother or father to this violence. Violent incidents were acknowledged but rarely explored with the families. Professionals seemed to assume that risk would be resolved if the source of the violence (usually although not exclusively the male partner) left the household or if the relationship ended, and apparently waited for this to occur. Sometimes they discussed the impact of domestic abuse on children and exhorted mothers to protect their children from the 'risky' parent. They expected mothers to leave or evict the violent parent without real consideration of the nature and quality of the parental or cohabiting relationship, and the practical and emotional investment which each partner may have in the relationship continuing. There were few examples of discussions with male partners, unless they initiated this themselves.

Keeping purposeful and effective records

74. We found that health visitors and field social workers had very limited access to information technology. This hampered effective record-keeping. The quality and organisation of family case records varied widely within each local authority. We found examples of high and low standards in each. There was no common format across authorities and staff did not follow local formats consistently. In many case files accurate records of contact were not easily retrievable. Records were incomplete or in summary form which did not identify when a family had been seen, who was present or the purpose of the contact. Only in one local authority was there evidence that line managers read case records periodically.
75. In three of the five local authorities there was little evidence of managerial staff using technology to assist information management and retrieval or to modernise professional practice. In these authorities social workers had no direct access to information technology. This hindered their recording practice and made potential contribution to evaluation and research very difficult. Practitioners in the other two local authorities had much better access to IT. Their case records were generally of a significantly higher standard. These records were well presented and usually well-organised, up to date and much more accessible.
76. We were able to review only a small sample of health visiting records in two authorities. The health professionals on our inspection team found that they varied dramatically. There was no standard content other than centile measurement of height and weight and reference to some developmental milestones. These records were selected to match social work records and family interviews and in some cases there had been extensive contact with families both from health and social work services. This was not always reflected in health visiting records. Vulnerability factors and risk were not reliably recorded and there were few examples of health visitors' assessment and plans in writing.

'It's everyone's job to make sure I'm alright.'

Integrated support for vulnerable families

4

Quality assurance and workload management

A focus on action

Clinical and professional supervision

Education and training

Quality assurance and workload management

1. Senior social work managers in each of the local authorities we visited had clear and specific expectations of what effective professional practice and case management should look like. They were not able to say definitively how far their expectations were currently being met in the areas for which they were responsible but thought that practice was likely to be variable with weaknesses attributable to workload pressures. In none of the local authorities were these expectations written down or available to staff, in the form of practice or operational standards. In the absence of clearly visible professional standards for their organisation, operational staff thought that management was concerned with productivity rather than quality. There were no consistent systems for quality assurance.

2. First line managers had more of a sense of strengths and weaknesses in local performance. But their perception of standards was intuitive, based on observation of some aspects of practice and content of supervision rather than any systematic attention to quality assurance. There was evidence in one local authority that some line managers had read some case records, but this was not common across the local authority fieldwork sites. Local managers did not have sufficient information to benchmark their teams' performance against that of other area teams in the local authority or say how consistent performance might be across the local authority. They knew about different local issues and pressures affecting responses and performance in different parts of their local authority.
3. Practitioners in local authorities and health services thought that senior management in their organisation was preoccupied by organisational and financial issues rather than management of the services. There had been management reviews and reorganisations in each local authority area within the last year. In some authorities there had been more than one reorganisation of senior management leaving frontline staff confused and uncertain about lines of accountability and decision making, and demoralised and cynical about effectiveness. In efforts to ensure effective financial management, control of resources was very centralised and few local managers were aware of how much their services cost. None had devolved control of financial resources other than small local budgets for limited financial assistance.
4. In health services strategic planners and senior managers also lacked information about the quality of local professional practice, and any systems for measuring this. We were struck by the differing perceptions of management and frontline practitioners about the quality, quantity and effectiveness of health care services.

A focus on action

5. We found that too often agencies and practitioners focused narrowly on their core function without taking account of the family's wider needs and the impact of other professionals.
6. On the whole however, where health, education and social work services were working together to support families, too much time and effort was spent on duplicating 'assessment' and 'monitoring' rather than remedial input. There was little evidence of focused work towards change with clear goals and regular review and evaluation of the effect of agencies' intervention.
7. Joint planning and liaison on a regular basis was limited to those cases in which there was a formal framework for inter-agency planning and review. These were cases in which there was an inter-agency child protection plan, children subject to compulsory measures of supervision, or looked after away from home by the local authority. **There were no means to ensure joint planning between the professionals in cases that fell short of these thresholds.**

8. We found evidence that in order to obtain social work intervention other services were increasingly making referrals framed in terms of risk to children and child protection. Framing referrals in this way may subject a larger number of families to the stress of compulsory intervention, with its attendant problems, than is warranted.

Clinical and professional supervision

9. All the local authority social work services have well established arrangements in place for supervision of field social workers. The frequency and content were tailored appropriately to the developmental needs of newly qualified and experienced staff and most reported that they were satisfied with the content and quality of supervision by first line managers. Supervision addressed review of casework, agency responsibilities and management requirements and staff development. Formal supervision was regular and reliable, although often liable to disruption in all the authorities.
10. We found some evidence that the introduction of nurse specialists in some areas had given health visitors greater access to clinical supervision. But these practitioners had few regular opportunities to review complex cases. Arrangements for clinical supervision were patchy and irregular. In some areas clinical supervision was based on peer review and support. Clinical supervision by supervisors was available on nurses' request and many staff were hesitant about appearing unconfident.
11. Many staff working directly with both parents and children most often, such as family aides, respite carers and childminders, home support workers and child care staff in family centres, were the least qualified and most junior in professional networks, with least access to training and supervision.

Education and training

12. Across health and social work services professions, but most consistently amongst field social workers, practitioners said that their pre-qualifying training had not equipped them to practice autonomously with confidence, and meet their agency's requirements with vulnerable children and families, particularly those with complex needs and problems. Paradoxically, other agencies perceived newly qualified and less experienced practitioners as more likely to work actively with families with complex needs. Children's Reporters described newly qualified social workers as more likely to maintain regular and frequent contact, more persistent in engaging families and more creative in identifying sources of help and providing emotional support for families. They suggested organisational constraints and workload pressures on more experienced staff were contributing to 'burn out' and cynicism.
13. All agencies highlighted the need for some mandatory element of shared training at pre-qualifying and post-qualifying level for health and social work staff working with children. We found some successful examples of joint training and inter-agency practice forums.

'It's everyone's job to make sure I'm alright.'



1. We set out to answer three key questions at the beginning of this review. We asked what support was currently provided to vulnerable families with young children, how well this support met their needs and how well organisations worked together, and with others, to deliver responsive, effective support to improve the health, development and welfare of children in need and their families.
2. We found an extensive range of services offering practical help, information, parenting education and advice, and emotional support to parents in difficulty in each local authority and health board area. Families generally found services helpful, particularly family centres and services that assisted both parents and children to improve their skills and development. Nevertheless, parents told us that frontline staff were not always able to offer the right kinds of help at the right time and could appear unsympathetic or unhelpful. They also found that gaining access to services was not easy.
3. We found many instances of excellent practice in social work and health care, with skilled and committed practitioners delivering intensive support in often difficult and sometimes frightening circumstances.

4. We found that the outcomes for vulnerable children were greatly improved by social work support when the support was consistently provided by a single, named social worker over a period of time. In such cases all aspects of the work – relationships with the family, assessments of needs and risk, and work to support the family were generally of a good quality and in many cases of a very high quality. These cases clearly demonstrated that social work services have a vital contribution to make in improving the welfare of children.
5. Such consistent support from a named, skilled social worker is too infrequently available. Too few families gain access to social work assistance and often only do so when problems have become acute or chronic and the children are identified as being at risk. Even then help may be only intermittently available from different social workers.
6. Prioritising enquiries and monitoring of child protection plans at the expense of active family support to address their needs and problems is false economy for local authorities. Providing a child protection service without integrated family support fails to deliver the best outcomes for these most vulnerable children. It minimises social workers' substantial contribution to social justice and social inclusion. It also erodes public and inter-agency support for these services.

What is needed

7. More decisive early action is needed to support families to provide good care for their children or to secure children's futures in suitable alternative families when this is needed. There should also be more commitment to direct work with parents separated from their children to prevent the same pattern being repeated. This will require all services to reshape their activity and responses.
8. Local authorities need to reinvest in their social work services and revitalise these core helping services. These must take their place alongside health, education and voluntary sector services in a partnership to deliver integrated family support for children in need as well as children at risk. In turn all services in touch with children or parents must give attention to child protection as a core responsibility essential to the delivery of care and support for all vulnerable children.
9. Health and education services should encourage and support the most vulnerable children and families to make best use of their universal and mainstream services. This will require new and creative approaches to service delivery, and depend on closer collaboration with social workers.
10. These matters are taken forward in the report and recommendations contained in *'It's everyone's job to make sure I'm alright'*.

'It's everyone's job to make sure I'm alright.'



Appendix A

Lay Members Report

Since 1995 SWSI has included lay people in its inspections and reviews. Marion McArdle and Margaret Allison are both parents interested in improving support to parents in difficulty. Marion is a parent of a child with special needs who regularly uses health and social work services. Margaret is a volunteer with her local Children's Panel.

We were asked to participate in this review as lay members in July 1999 and have since been major contributors in all aspects of the review. We took part in all aspects of fieldwork activity including interviews with service users, practitioners and managers and had access to all information gathered for the review.

In each of the five local authorities we visited the review took the form of two phases. During the first phase we read through case files and interviewed strategic authority management personnel. This was new territory for us and so it took us a few days to 'find our feet' and begin to recognise what was good both in recording and practice, and what needed to be looked at and improved. It was interesting to observe the differences in recording techniques used by the social work departments and the health services. As a Review Team we encountered some resistance from the Health Department in regard to accessing case files because of issues of confidentiality.

The second phase concentrated on interviews with social work, health and education professionals. We also interviewed professionals and service users in focus groups and individual family members. For us the most important aspect of this phase was meeting with parents, extended families and carers and finding out exactly what they thought of the services provided and how they felt they could be improved.

Support services for vulnerable families varied throughout the five local authorities but family centres were valued and appreciated across the board. These were seen as an important resource, without stigma, and seemed to us an ideal place to offer multi-agency support.

The areas where support services for vulnerable families did not do as well would also vary throughout the five local authorities. However, here there was a recurring theme, which needs to be addressed, regarding the difficulties agencies seem to have with working together – 'joined up working'. Often professionals were quite unclear about their own roles and that of professionals from other agencies. Confidentiality is important but sometimes it was seen as a barrier between agencies. We felt that families would welcome more sharing of information between professionals in order that they can receive the necessary help and support and perhaps access the appropriate resource much easier and quicker. One parent said, 'I'm fed up telling different professionals the same story, why don't they all get together and help me sort out the problem'.

Being involved in this review has given us a fascinating insight into services as users and providers see them. We have formed some conclusions about some of the aspects we feel could be improved.

We saw little evidence of managers being 'in touch' with what was happening at grass roots. This situation must improve to allow service users more say in how they would like to see services develop and to make managers more aware of the problems both for users and their professionals in the field.

Focus Groups consisting of professionals and, separately, service users, seemed to embrace this unique opportunity to air their views. They often had good ideas for improving services. This type of forum should be encouraged in the future.

The role of the social worker has to become more focused on effecting change. At present their skills appear to be misdirected, spending a great deal of their time assessing and monitoring rather than planning and developing strategies which will bring about changes in attitude and behaviour within families.

One parent said to us 'I have had a social worker for the past 15 years and nothing has changed, in fact things have got worse'.

We were very concerned at the lengths social work departments would sometimes go to maintain a child within the parental home when there was clear evidence that it was not in the child's best interest to remain there. There has to be a clear distinction between what social workers consider to be in the parents' best interests and what is considered to be in the child's best interest. *The best interest of the child has to be paramount.*

If we are to support vulnerable families with very young children it is essential that they receive medical help and advice right from the start. It is important, therefore, that every child is registered with a GP and is allocated a health visitor.

The role of the health visitor also needs to be looked at. A caseload of 250 children does not allow sufficient time for health visitors to identify and address the particular needs of vulnerable families. Reducing their caseload would enable them to spend more time working with vulnerable families and intervening when necessary at an early stage.

As stated above, family centres were universally considered by families to be an extremely useful resource. They offered support in various forms, from practical help on how to look after a very young child, dealing with behavioural problems, parenting groups, and mutual support groups where mums could meet other mums who had the same problems. We feel that family centres could be used as the main focus for providing initial support to vulnerable families by providing support from a trained health professional or social worker, who would make an initial assessment of the child's needs and refer families to the appropriate specialist. This kind of child support worker's remit would also include monitoring ongoing concerns and alerting specialists to intervene if necessary at an early stage.

If we are to help vulnerable families with young children it is important that this assessment is needs led and not budget led. It is vital that the appropriate resource is available at this stage in a young child's life if we want them to thrive and develop and take their place as valued members of our community.

The area which we highlighted as needing the most improvement in is that of inter-agency collaboration. We feel that this will require a whole new cultural change before any great improvements are made. The need for inter-agency training is extremely important if we are to begin to break down the barriers between various agencies as it is important that professionals value each other's role and therefore become more willing to work together, trust each other and share information.

Finally, during the course of this review we visited many different social work and health department offices. Health department offices were usually of a very high standard. This contrasted dramatically with the very dilapidated condition of some social work department offices. The poor condition of these premises needs to be improved in order that they are more welcoming to families and provide a better working environment for staff.

It took the review team four months to complete the fieldwork for the review. Sifting and analysing the information gathered and preparing the report has taken a long time. We are very glad the report is now published. As lay members we were impressed by the dedication, hard work and professionalism of the social work inspectors and the health and education reviewers with whom we worked most closely. The review was carried out in a fair, courteous and respectful manner.

As lay members we were very aware of the responsibility we had to the children, parents and families who took part in this review. We feel strongly that our task was to assure them that they were being listened to and their views and feelings would be reflected in our findings in this review. We are very grateful to everyone who shared and trusted us with their 'life stories' and experiences of these services. We hope that our presence as 'ordinary people' made them feel more at ease during the interviews.

To everyone who helped us – thank you.

Marion McArdle Margaret Allison

'It's everyone's job to make sure I'm alright.'



Appendix B

Summary of Fieldwork

Sample of social work case records selected for analysis – 147

Health visitor records reviewed – 20

Interviews with Local Authority Staff

Social work staff	Total
Head of Children's Services or equivalent	5
Strategic/operational/area managers	15
Senior social workers	24
Social workers: individual interviews	26
Social workers: focus groups	16

Visit to family centre	
Family centre manager interviews	7

Education services staff	
Heads of Service for children with special educational needs	5
Early years development officers/co-ordinators	4
Educational psychologist	1

Housing staff	
Assistant Director of Housing	1
Principal Officers/Housing Managers	6

Interviews with staff in Health Services

Health Board	
Commissioners of Children's Services	4

Nursing managers and staff	
Directors of Nursing	5
Directors/Managers for Women's and Child Health (ante-natal and midwifery services)	7
Health visitors: individual interviews	28
Health visitors: focus groups	42
Midwives: individual interviews	2
Midwives: focus groups	23
Community psychiatric nurses	4

Local Health Care Co-operatives	
LHCC Chairs	3
LHCC General Managers	5
Locality Nurse Managers	2

Acute or primary care NHS trusts	
Community paediatricians	5
Medical/Nursing directors of service	3
Child protection nurse specialists/advisers	3
Nursing or other staff	6

Child and Adolescent Mental Health Services	
Consultant psychiatrists	3
Nurse specialists	1
Psychiatric social worker	1
Psychologists	2

Specialist Drug & Alcohol Problem Services	
Consultant psychiatrists	2
Nurse specialists	3
Social workers	3
Service Manager	1

Voluntary Sector Services	
Family centre staff	3

Scottish Children's Reporters Administration	
SCRA – Reporter Manager	1
Children's Reporters	8

Interviews with users of services

Service users: individual interviews	28
Service users: focus groups	47

Total number of interviews

Service users	75
LA staff	110
Health service staff	158
Voluntary sector staff	3
SCRA	9
Total:	335

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Appendix C

Services for Vulnerable Families with Children aged 0-3 years: Evidence about Effectiveness

A Literature Review

by

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1. Introduction

The literature review

The Scottish Executive commissioned the writers to carry out a literature review of evidence concerning the effectiveness of interventions aimed at assisting vulnerable families with children aged under 3 years.

Funding was provided for work over two months. Given the time-scale, the review was necessarily partial in its coverage of topics and in its capacity to read and summarise the literature on any one topic. An initial structure was developed which covered holistic theoretical approaches; centre-based, professional and community initiatives; child protection and alternative family care. Consultation with the funders refined priorities. Thus, it was agreed not to give attention to childminders, day carers or playgroups, but to include material on 'routine' or 'mainstream' work by health visitors and social workers.

The context

For a long time the first few years of life have been seen as vital, both for the development and life-chances of the individuals concerned and for society's interest in optimising the positive contributions made by the next generation and minimising the problems and demands. Promoting parental skills and providing support at this stage of a child's life are of cardinal importance if children are to attain positive developmental outcomes in later years (Dunst *et al* 1988, Cochran *et al* 1990, Holden 1997). In recent years it has become apparent that the 'family' is not always the centre of nurturing and in some situations may have a more negative than positive affect, as when children are persistently abused or neglected.

The recurrent concerns with prevention and early intervention have become prominent again in the last few years across a range of areas (e.g. education, health, crime, poverty, and child protection). This has been a prominent element in government's plans to reduce social exclusion or increase social inclusion. Services may assist children directly through improving their learning, health or social development, for example. Children can also benefit indirectly if their parents' economic situation, employment opportunities or caring capacities are enhanced.

The current focus on the early years incorporates long-term issues related to child poverty, managing the work-care tensions in early parenthood and health and educational inequalities. It also reflects demographic, social and economic changes that have affected parenting processes for many, e.g. higher and more diverse expectations of parents, commercial pressures, reduced access to kin supports (Henderson 1999). On top of these, persisting structural and gender inequalities in society are making parenthood more difficult for disadvantaged groups (Middleton *et al* 1994). It has been suggested that in some cases ethnic minority families and those where the family is headed by a lone mother are more vulnerable to poverty and stress (Williams 1989, Glendinning and Millar 1992). Parents, especially mothers, who experience disability, marital breakdown or domestic abuse generally have to contend with low incomes, which in many households is less than half the average income (DoH 2000). According to Steinhauer (1996) poverty serves as a source of stress in its own right, but it also erodes parents' limited psychosocial resources and magnifies interpersonal and psychological problems. In addition to the effect poverty has on children it is also clear that other deprivations tend to coexist with poverty, which together undermine competency and resilience in parenting (Steinhauer 1995; Byrne *et al* 1996). Other factors such as poor health; substandard housing; alienation from the mainstream of society; and individual depression have also been identified as consequences of poverty, which also predispose families to vulnerability (DoH 1995).

Partly as a result of the demands of the job market many families are also living away from their original communities and have little support from extended family members and friends. In addition the change in community structures has also meant that some communities are less cohesive than they once were. Although in some areas assistance by neighbours remains strong or has developed new forms of support, in others where once neighbours

could rely on each other, they now hardly know each other (Hill 1987; Allan 1991). This has put increased pressure on the nuclear family and has deprived families of help and companionship from a wider source. According to Belsky (1984) these systems of support are one of the factors that can buffer the parent-child relation from stress. Others have also identified support from friends and family as an alternative to secondary and tertiary services within the community and as a means of coping more effectively (Belsky and Vondra 1989, Werner 1990, Monat and Lazarus 1991, DoH 2000). Holman (1988) advocates the development of non-coercive community-based support as an effective means for helping disadvantaged families to carry out their caring responsibilities.

Changes in other areas of social policy such as health and community care legislation have meant that parents with mental health problems for example, are likely to spend more time at home in acute stages of their illness, resulting in added stress for them and their children.

Current legislation and policies

A number of recent legislative measures and policy initiatives are relevant (Kirk and Hill, 2000). The UN Convention on the Rights of the Child has emphasised the universal entitlements of children to provision and protection, while recent British legislation has endorsed the view that parental rights towards children derive from a set of specific responsibilities for their long-term welfare and education. Among other things, the Children (Scotland) Act 1995 prescribed that each local authority has a *duty* to provide wider services for children of any age who are ‘in need’ and their families (S. 22(1)). Children in need are those whose health or development would be adversely affected without the provision of services, and children who are themselves disabled or who are ‘adversely’ affected by disability of a family member (S. 93(4)(a)). More specifically, local authorities have a *duty* to provide day care for ‘children in need’ who are under 5 (S. 27(1)). Authorities have a *power* to provide day care for young children not ‘in need’ (S. 27(1)).

In the last few years, the government in Scotland has developed a general Childcare Strategy, rooted in the principles of the UN Convention. The SureStart programme funds initiatives which are particularly targeted at very young children. This programme is explicitly based on evidence about the potential positive impact of early intervention programmes on young children living with vulnerable families. The review by Glass (1999:262) indicated that these might achieve:

- gains in emotional and cognitive development for the child, and improved parent-child relationships;
- improvements in health-related indicators;
- improvements in educational process and outcomes;
- increased economic self-sufficiency, initially for the parent; and later for the child; and
- reductions in criminality and teenage pregnancy.

Guidance issued in 1998 encourages inter-departmental co-operation in early years provision, while in July 2000 funding was announced to develop the training of child care workers. Nursery education places have been expanded. At the same time as aiming to improve services for all children and their parents, projects have been promoted which focus on particularly vulnerable groups or areas (e.g. Starting Well in Glasgow). These initiatives build on a range of existing provision, provided by a number of professions and types of organisation. Statutory services include health and various local authority departments (e.g. education, social work, housing, and recreation). Many kinds of service are provided by voluntary organisations, large and small; local, regional and national.

Coverage and format of the report

Given the time-limited nature and specific focus of the review, it has not been possible to examine fully the possible meanings of 'vulnerable', although certain indicators were mentioned briefly above. In any case, relevant publications adopt different approaches to this, depending on their professional or theoretical orientation and the time of writing. Loosely, vulnerability has been interpreted to correspond with the legal definition of children in need, i.e. the child's health or development is currently impaired or is likely to be so, as a result of economic, social or psychological problems affecting the family or owing to disability.

Given the huge number of studies relevant to this subject, we have often not been able to scrutinise original research reports and had to rely on overviews. Both specific studies and overviews, like early years provision itself, do not always confine themselves to vulnerable children so it has been relevant to report wider conclusions about the impact of services, highlighting where we can, findings particularly relevant to the most vulnerable. Similarly, services and research often cover a wider age span and do not identify under-3s as a particular group. Therefore we report results on all pre-school children where these include or have implications for children under 3.

The report begins with a brief summary of key approaches to early years services and a consideration of what counts as 'effectiveness' and evidence for it. The main body of the report considers particular types of service in turn, recognising that these often overlap.

2. Holistic frameworks

The theoretical models that underpin services for families with young children can take many forms. Given that legislation requires the child's welfare to be the paramount consideration, we outline here four primary frameworks that place children's development at the centre, though in different ways. These are:

- cumulative factors approaches;
- attachment theory;
- ecological models; and
- social construction approaches.

This is not intended to be an exhaustive account of relevant approaches. For example, attention to the gendered nature of family relations, child care and employment is also essential to a full understanding of the nature and impact of services. Conventional medical models of prevention are also relevant. Hardiker *et al* (1996) applied this framework to child protection and elaborated the usual three-fold levels by adding a quaternary level:

- *Primary prevention* – taking universal action to promote conditions so that problems do not arise;
- *Secondary prevention* – focusing on individuals or families who are at high risk, but may not yet have problems;
- *Tertiary prevention* – targeting individuals or families who have problems to minimise the adverse effects; and
- *Quaternary prevention* – optimising the prospects for children where family problems have resulted in their placement in substitute care.

Cumulative factors

This is an important orientation in the literature, which is often implicit rather than formulated into a coherent theory. The assumption is that children's lives and life chances are affected by various discrete factors which reinforce or offset each other. Hence interventions should seek to minimise children's exposure to negative factors or aim to overcome their consequences.

There is a wealth of mainly medical and psychological literature, based largely on quantitative surveys, which identify characteristics of children, their families or their environments which affect the chances of children achieving favourable or unfavourable outcomes. Risk factors are those characteristics that are statistically associated with poorer outcomes, while protective factors help shield children from difficulties. Resilience factors are those that appear to enable children to do well even though they have experienced adversity in early life (Rutter 1985). Sophisticated statistical analysis is possible, but in broad terms the assumption is that it is the balance in number and intensity of risk and preventive or resilience factors that largely determine outcomes (See section 3 for further discussion of the meaning of outcomes).

Among the risk factors that have been shown to be associated with higher proportions of health, behavioural or educational difficulties in children are: parents' physical or mental illness, parental substance or alcohol misuse, marital breakdown, lone parenthood and economic disadvantage (Rutter 1995; Rutter and Smith 1995; Steinhauer 1996). This does not mean that all children in such circumstances turn out poorly, but the chances of doing so are higher than average, sometimes markedly so. Rutter (1995) emphasises that the impact of risk factors depends on their interaction with protective and resilience factors in the individual and the environment. Even so, the methods used to identify so-called vulnerable populations have been criticised for producing inaccurate or misleading results, since vulnerability results from individual clusters of reasons (Upshur 1990).

The initial risks to very young children are biological and environmental, but the quality of their family environment becomes increasingly important (Rutter and Rutter 1993). For instance, evidence now indicates that brain damage can be a result of poor parenting, as nurturing is now thought to play an important part in healthy brain development and the capacity for learning and regulation of emotions (for more details see Keating 1992, Carnegie Corporation New York 1994, Norrie *et al* 1999.)

Long-term follow-up studies have identified a number of qualities that help children cope well despite being brought up in situations of poverty and family disruption (Werner *et al* 1982; Beardslee 1989; Garmezy 1991). These resilience factors may reside in the child (e.g. high IQ; equable temperament; positive orientation to problem-solving) and some are part of the environment (e.g. help of a supportive adult, good educational opportunities) (Fonagy *et al* 1994, Gilligan 1998). While some of these are relatively fixed, others can be modified, such as access to support.

The notion of resilience has gained considerable recent attention, partly because it focuses on the actual or potential strengths of vulnerable individuals and families, whereas the risk factor perspective has concentrated on 'pathology' and deficits. From this perspective Gilligan (2000) claims that through decisively exploring the strengths in families, positive experiences and resources issues can be built on and enhanced. However, Dingwall (1993) warns that staff working with families in this way should be careful not to adopt 'a rule of optimism', which discounts evidence of serious family malfunctioning.

Evidently, risk, protective and resilience factors can act at different points in a child's life and often they change over time. A *pathway or career perspective* helps take into account either the persistence of circumstances or significant alterations (Rutter 1989; Little *et al* 1996; Boushel *et al* 2000). A child's life-course may be characterised by both continuities and discontinuities of factors and outcomes. This is most evident when there are major changes in household composition or other life events, e.g. parental separation, remarriage, entering or leaving foster care. One advantage of the pathway approach is that it avoids a sense of inevitability about good or bad outcomes. It also helps to focus on crucial turning points or decisions, where great care is vital to ensure a child has supports and options which maximise the chance of a good outcome.

Attachment theory

Attachment theory provides a means of assessing the qualities needed by, or experienced by, young children in their relationships with parents and other carers. This theory has gone through several stages of development and some of the initial ideas have been rejected by critics and modified by proponents.

In the original formulation, Bowlby (1954; 1965; 1969) argued that infants have an inborn tendency to form a primary attachment to one individual, normally their mother or mother figure. The infant treated the attachment figure as a 'secure base', feeling comfortable and confident in their presence, but sad and disoriented when separated. The primary evidence for this was provided in studies of children's distress when separated short term in unfamiliar surroundings and the negative effects of long-term impersonal and inconsistent care in *residential* institutions. Initially Bowlby and others used these ideas to suggest that it was harmful for children to be placed in *day care*. Subsequent reviews of the evidence indicated that this was an inaccurate extrapolation on at least three counts (Rutter 1971). Children generally form multiple not sole strong attachments, though the number and types of attachment vary considerably depending on the cultural and household contexts (Schaffer and Emerson 1964; Hill 1987). They are usually not distressed if separated from parents in a familiar setting or with another familiar adult (Schaffer 1990). Children can thrive in day care, provided the care is stimulating and carers consistent (Hughes *et al* 1980).

Despite these major shortcomings in its initial formulation, some of the original concepts (like secure base or indicators of attachment) are useful. Later developments are also pertinent to understanding services that involve separation from parents, like nurseries and childminding. Classifications of infant-adult relationships into secure, avoidant, ambivalent and disorganised have been found to have wide applicability and extend into later childhood or even adulthood (for further details, see Appendix 1; Parkes and Stevenson-Hinde 1991; Howe 1995). Bowlby's later idea that children have an internal working model of relationships is also interesting. This suggests their early experiences dispose them to expect similar treatment from all or most adults. Thus children securely attached to their parents will expect trust, while others will anticipate (and perhaps therefore provoke) rejecting or inconsistent responses (Rutter and Rutter 1993).

Attachment theory has implications for parenting programmes too, since there is evidence that parents' bonding with their own children and treatment of them is affected by the nature of their own earlier attachment history and internal working models (Main 1995). Taking a broader view of attachment than is often the case, Howe *et al* (1999) classify four types of intervention, depending on the degree of focus on the child or parents and include one category where the target of work is broader (Type 4 in the table overleaf):

	HIGH FOCUS ON CHILD	LOW FOCUS ON CHILD
HIGH FOCUS ON PARENTS	<i>1. Joint-focused</i>	<i>2. Parent-focused</i>
LOW FOCUS ON PARENTS	<i>3. Child-focused</i>	<i>4. Family and community support</i>

The ecological approach

The ecological perspective to child development places much greater stress on the wider environment than cumulative factors or especially attachment theories. It identifies the complex interplay of influences, opportunities and stresses that affect children and influence their parents' ability to raise them. Ecological approaches examine the interaction of levels and contexts in the household, the neighbourhood and the wider world of work and society. Development in one setting (such as the family home or a family centre) is contingent on what is going on in other areas.

The most developed ecological analysis is probably still that developed by Bronfenbrenner (1979) who provides a more holistic view of child-parent dynamics and their relation to services, employment and social attitudes. He identified four concentric systems beginning with the microsystem of a child's immediate activity and extending via mesosystems and exosystems to the macrosystem of society as a whole. Opportunities for development and risks to development do not simply arise from a deficiency in parenting skills but as a result of the interaction between the make-up of the child (physical and genetic), the parent(s) and the child's social environment. Stresses on families and access to support services are affected not only by local factors, but structural inequalities related to gender, race and disability. Acheson (1988) used the example of low birth weight in poor neighbourhoods to illustrate this point. She indicates that babies born in poor areas often have lower than average birth weights. This is not the result of failures by individual parents, but the result of structural inequalities which result in limited access to services and resources and increased pressures on a group of society who have the least resources and abilities to cope. More generally, Garbarino (1980:81) stated that the quality of the carer-child microsystem is dependent on its ability to provide 'enduring, reciprocal, multi-faceted relationships that emphasise playing, working and loving'. If the quality is poor, development will be restricted. However, parents' or other carers' capacities to provide that quality are not simply due to their own characteristics but are much affected by external opportunities, supports and constraints. Policies related to employment such as hours of work and relocation may have a detrimental affect on the child-parent relationships. Similarly, writing in the context of child protection, Boushel (1994) noted that children's good and safe care depends not just on parents' behaviour, but the nature of family support and supervision, as well as general attitudes towards women and children.

Another model, which did not simply view the child in isolation, was proposed by Belsky (1984). He drew on aspects of the ecological approach by focusing on deficits of the micro and mesosystems, but made no comment on aspects of the wider systems. Belsky identified three determinants, in order of importance, which he believed affect parental functioning:

- personal psychological resources of parents;
- contextual sources of stress and support; and
- characteristics of the child.

This model puts most importance on the psychological resources of parents. Belsky argued that psychological developmental history and personality are most important in shaping the quality of parenting. He did consider external influences and emphasised that positive networks of social support help people act more effectively as parents. Unlike Bronfenbrenner, though, Belsky ignored the affect of structural and legislative variables that will inevitably affect families in different ways.

Social construction approaches

The terms parenthood, childhood and family life represent powerful socially constructed meanings that vary significantly according to culture, time, place and individual family process. For example care of young children in different cultures varies greatly. In some cultures a wide network of female carers undertakes the care of young children. This has been criticised in the West as critics have argued that it leads to less intense affection and loyalties. However, studies in Africa and the Pacific (Freeman 1983, Rashid 1996) have indicated that this type of care can be accompanied by close attachments. Whereas Western cultures foster and adopt children into families outside the kin network, other cultures would not consider this (Hill 1991; Dickens and Watts 1996). Similarly attitudes to care by siblings is very different in modern Britain compared with other places and times (Weisner and Gallimore 1987; Kosonen 1996).

Whereas other theories tend to write in terms of relatively fixed factors or characteristics, and describe quasi-universal accounts of child development and good parenting, social construction emphasises the fluidity of notions such as children's needs and the varied meanings attached to aspects of family life (Rogers and Rogers 1994; Rodger 1996; Woodhead 1998). Since the 1990s, the sociology of childhood has challenged traditional assumptions in much developmental psychology based on a universal unfolding of abilities and a tendency to judge children in terms of deficiencies compared with adults, instead of in their own right (Mayall 1996; James and Prout 1998). It has been argued that too often children have been judged largely in terms of who or what they will 'become', rather than for what they currently are (Shamgar-Handelman 1994).

Implications

The approaches outlined above are not necessarily in conflict or tension, but have different perspectives and emphases. They can help identify broad orientations to intervention and specific targets for action.

Interventions can reduce or compensate for risk factors by providing or enhancing protective and resilience factors. The aims will range from reducing poverty to promoting problem-solving skills. Attachment theory emphasises the importance of consistency in relationships and sensitive understanding of reactions to separation, loss and rejection. Ecological approaches suggest the need for comprehensive and co-ordinated programmes, since otherwise input to a child or parent may be undermined by other aspects of the environment (and vice versa). From the social construction perspective, it is important for interventions not simply to begin with professional or academic presumptions about the aims and nature of services, but to adopt a questioning approach to the goals of parenthood and child development and to engage in dialogue with parents and children about their particular perceptions. Although it is essential to be conscious of how early experiences may affect children's later prospects (including employment prospects, adult health and life expectancy), it is equally crucial not to neglect their needs here and now through an excessive focus on future development.

An example of a practice model that reflects an integration of at least the first three approaches outlined here is that of the Department of Health. Its 'Framework for the Assessment of Children in Need' (DoH 2000) is summarised in a triangle representing three domains which correspond roughly to three systems in the ecological approach. These are:

- the developmental needs of children;
- the capacities of parents or caregivers to respond appropriately to those needs; and
- the impact of wider family and environmental factors on parenting capacity and children.

Attachment is a central component of the child's needs, which comprise the seven dimensions devised by the Looking After Children programme (Parker *et al* 1991; Ward 1995):

- health;
- education;
- emotional and behavioural development;
- identity;
- family and social relationships;
- social presentation; and
- self-care.

The other two domains (parental capacities and the wider environment) incorporate many of the protective and risk factors that have been identified by research, such as stimulation and stability for parenting, income and community resources in the wider environment. According to the DoH document, the significance of understanding the child-parent relationship has long been a salient factor in child welfare practice, while the consequences of poverty are well known. However the interface between environmental factors and the child's development have been largely ignored, especially the influence of these factors on the parents' ability to parent effectively (DoH 2000).

3. The nature and evidence of effectiveness

It is apparent from the preceding sections and other evidence (Alderson *et al* 1995, Macdonald 1997, Newman and Roberts 1997) that the early years are critical for healthy future development, and that some families living in disadvantaged situations will need support from services other than those universally available in the community. In providing support for these families it is important to ascertain the effectiveness of the interventions, as it has been widely recognised that 'meaning well and doing good' are not the same thing, and good intentions may well have harmful effects (McNeish and Newman 1996:55). However, ascertaining what works is not always easy to achieve. In the first instance, there is a paucity of information on the quality and effectiveness of different types of support, particularly in Scotland (Henderson 1999). Secondly, the meaning of effectiveness is complex: establishing that something clearly works is less straightforward than appears at first sight. This review intends to provide evidence of the effectiveness of different kinds of support for vulnerable families who have children aged 0-3 years in the UK and where appropriate in other countries as well. In order to carry out this task it is important to explore briefly what is meant by the term 'effectiveness' (see Hill 1999 for a more full discussion).

In assessing effectiveness the achievement of desired goals is a primary consideration. Aims of intervention are often multiple or vague, however. It may be necessary to weigh up emotional, social and educational consequences, which may not all go in the same direction. Generally early years interventions are judged according to the impact on the child, but consequences for mothers, fathers and others can all be relevant. If the primary purpose is to assist parents (e.g. to work, have a break) then it may be sufficient that the children are not adversely affected, though usually it would be hoped that they have positive benefits.

Normally it is hoped that interventions achieve positive change and that the change(s) *would not otherwise have happened*. Thus research needs to demonstrate not only that change actually occurred (or deterioration was stemmed) but also that this change is a direct result of the intervention. This can be difficult to establish, since there is much evidence that children tend to progress except in extreme circumstances and may recover from difficulties without formal help (Rachman and Wilson 1980). In order to establish clearly that a change has resulted from an intervention, the ideal research method is a randomised control trial or RCT, where children or families are allocated to either a 'treatment' or 'non-treatment' group

at random. Comparisons are then made between those who received the service and those who did not. Since the random allocation should mean that both groups started with the same range of initial characteristics, any difference found (positive or negative) should be due to the service. Few studies use this approach for a combination of practical and ethical reasons (Fuller 1996).

Quasi-experimental designs can be used when random allocation of participants is not possible. A naturally occurring sample is taken of those who receive an intervention and compared with others who either receive a different intervention or none at all. The initial characteristics of both samples need to be very similar, as otherwise different starting points may account for different outcomes. Pre-tests and post-tests are carried out for both groups in order to establish a comparison of outcomes and thereby assess the effectiveness of the intervention. Such quantitative comparisons can provide strong indications, but often it is necessary to supplement these with a range of qualitative data (Cheetham and Kazi 1998). Projects, services and centres often have multiple functions and these tend to change over time. Even with a positive evaluation from a RCT or quasi-experimental comparison, it may be hard to specify which aspect(s) or stages of development or a programme or project were responsible for the good results.

A large amount of evaluation carried out in the area of child welfare does not fall into the category of experimental design. Macdonald and Roberts (1995:13) suggest that findings from studies employing other methods are 'at best suggestive'. However, when a number of studies produce similar findings, more confidence can be expressed in the results. Methods that do not use experimental designs include cohort studies, surveys and studies based on the views of service users. Studies based around user views provide useful information about the perceptions of those using a service. Sometimes feedback from service users and/or professionals is the only data available and it can provide valuable insights into the consequences of a service (Gribben 1992). Care should be taken when using the results of satisfaction surveys as a means of assessing effectiveness. Vulnerable families will have a tendency to view the intervention and professionals positively, whether or not it actually makes much difference to their wellbeing.

Even when change has been shown to occur as a result of a particular form of intervention, it is sometimes a matter of interpretation whether the change is good. For example it has been found that nursery attendance tends to encourage a greater peer-orientation among children (Moore 1975, Rubin 1980). Some (adults) see this as desirable independence, others as undesirable lower regard for authority.

With respect to generally agreed improvements, questions arise about how long they last and whether the input of resources (costs) is justified by the outcomes. Perhaps a cheaper method would work just as well? It is also necessary to look at whether there have been any unintended effects. In some cases the unintended consequences will outweigh the benefits of the planned outcomes and therefore the intervention loses its effectiveness. Hill (1999: 11)

gives the example of young offenders in institutions who make friends and learn skills which then assist in future law-breaking. In the early years, a short-term negative consequence of starting nursery early can be increased risk of infection.

In view of the frequent lack of experimental or quasi-experimental evidence, and the complexity of assessing effectiveness, this review has drawn on a wide range of evidence. We try to indicate the strength of support for any conclusion, depending on the rigour of evaluation or the number of studies that reach similar conclusions.

4. Early years provision: nurseries and family centres

Daytime group care of young children is a long-standing form of service for families with young children. The goals and functions are diverse; some are offered on a universal basis and some are aimed solely or primarily at vulnerable families. Among the purposes are:

- providing good quality care for children while one or both parents do something else (often paid employment);
- offering play and social contacts for children;
- initiating children's education;
- helping children prepare for school;
- providing 'respite' for families under stress or with a disabled child; and
- monitoring children who have been abused.

Many establishments seek to meet several of these aims, while for others there is one primary purpose. At one time, distinctions were sharper than today. Day nurseries or crèches provided extensive hours of daytime substitute care; nursery schools and classes offered pre-school education (usually for children aged 3 or over); playgroups enabled children to play and mix together for short periods. Increasingly the trend has been towards more integrated services, which not only provide direct care of children, but also offer services to parents (normally mothers) including support groups, classes and various kinds of therapeutic help. This led to the development of multi-purpose family centres. In addition, nurseries have often taken on more family support functions too. Most have now been renamed as children's centres or family centres, though some are still in practice largely day care facilities. When examining research evidence it is not always clear precisely what kind of service is being referred to. Most early research was about nurseries and pre-school education; recent studies often focus on 'family centres', although these are not always family centres in the fullest sense. Outcome studies of playgroups are rare.

Nursery care

The development of early years services, such as day care facilities has not occurred without criticism. In particular some have viewed it as having a negative impact on child outcomes (Bowlby 1951, Belsky 1992), whilst others have argued that it perpetuates the unequal power divide between men and women in families, whilst not addressing the responsibilities of fathers (Cannan 1992, Kirk 1990). In this section we concentrate on the evidence about the impact of day care on young children. Nevertheless gender remains an important issue since not only do mothers usually provide more direct care than fathers, but they also tend to make alternative care arrangements, while very few nursery staff or childminders are men.

Much policy and research about the effects of early nursery care have been framed by attachment theory (see section 2). Bowlby (1969) argued that infancy is a critical period when children are especially vulnerable to even short-term separation from an attachment figure. Therefore, according to Bowlby, children who were separated from their mothers in day care under the age of 3 were at serious risk of lasting psychological damage. Critics believe that his assertions about the effects of separation were fundamentally flawed. First, the negative effects, which he attributed to separation, were shown to be a result of a number of different factors that influenced the development and behaviour of children. In particular, children who showed linguistic and intellectual retardation were found to have a lack of stimulation in these areas, and children who exhibited conduct disorders and delinquent behaviour were thought to have experienced family discord (Rutter 1971; Holmes 1993). It was also found that separation from parents only had lasting negative effects when it was prolonged and there were additional adverse factors such as: absence of other people to whom the child is attached; a strange environment; the child is passed from one person to another; and no one person takes over the mothering role (Robertson and Robertson 1971).

Bowlby's early views both reflected and reinforced many public and political concerns about nursery care. Hence over the years, recurrent studies have tested the assumption that attending day care harms young children. On the whole the conclusions have been that children may experience initial distress, but this is short-lived. The greatest sensitivity to separation is experienced between about 6 and 18 months when young children have developed strong personal attachments to parents and others, but are not yet confident that absences can be temporary (Schaffer 1990). Systematic comparisons have repeatedly indicated that children in nursery care do just as well emotionally and socially as others (Rubenstein *et al* 1983; Scarr and Clarke-Stewart 1987). There are two provisos. It is necessary to compare comparable children, since many children attending day care come from disadvantaged backgrounds so tend to do less well than the average for that reason. Secondly, the nurseries must have adequate levels of staffing, resources and stimulation.

There is a wide body of evidence to suggest that children who enter day care develop normal attachments to both their mother and the day care staff, although some have argued

that these attachments are likely to be insecure (Ainsworth *et al* 1978). Clarke-Stewart (1981) reviewed 28 studies that compared maternal attachment in children who attended day care with those who did not. Only one study found that children who attended day care were 'anxiously attached or ambivalent to their mothers' (Tizard 1986:12). Clarke-Stewart believed that this finding could have been attributed to the fact that children in day care were less dependent on their mothers, rather than having a disturbed relationship with them. In fact there is no evidence to suggest that disturbed behaviour or developmental delay occurs as a *result* of day care. There is evidence, however, to indicate that children attending day care, especially in the UK, do display behavioural problems. This is thought to be because the majority of places taken up in day care are by children from vulnerable families. In these cases it is thought that there are many positive aspects of day care that affect both child and parent (Holman 1988, Gibbons 1990, Clarke-Stewart 1992, Glass 1999). There is also evidence to suggest there is a correlation between quality of parenting and social support such as that provided as a result of day care or family centres (Culbertson and Schellenbach 1992, Kirk 1999).

Family centres

The introduction of family centres saw the recognition of a partnership philosophy between parents and child care services. Some were established to provide a preventative service for children at risk of abuse or of being taken into public care, while others offered a wider community service. Much of the research on family centres has documented their functions, principles and usage, but not examined their impact on children or families.

Originally set up by voluntary agencies the legislation acknowledges them as providers of family support services, and they have therefore become part of a comprehensive range of formal provision that can be provided by local authorities. According to the Guidance to the Children Act (1989) they are 'Centres where family members may attend for occupational, social, cultural or recreational activities and for advice guidance or counselling'. De'Ath (1985) stated that services may include day care for young children, play groups, family therapy, health education and so on. In addition she also pointed out their diverse nature, but as indicated by Walker (1991) they tend to share three characteristics in common: a focus on the whole family unit; location in neighbourhoods displaying a high incidence of disadvantage; and a task of preventing family breakdown. However, according to Holman (1988) there are three individual models.

- *client model* – offering specialist services to social work clients in difficulties;
- *neighbourhood model* – providing support for a wider set of families in the locality; and
- *community development model* (very much in the minority) – used by anyone in the locality but with the aim of empowering local people to develop and run their own services.

The Children Act classification is slightly different and suggests three different types: therapeutic, community and self-help. The model along which the centre is organised does not strictly determine what type of families attend as there is overlap depending on the area and other resources available. Evidence does suggest that those attending the client- focused model tend to be families referred by social work, and according to Cannan (1992) these centres provide somewhere 'to contain, monitor and treat what appears to be increasing numbers of dangerous families'. Kirk (1995) in her study of one local authority's provision in a disadvantaged area of Scotland found a similar scenario of a variation in the needs of clients between centre types. Those using the client-focused model tended to be from the lowest income group with high levels of stress and ill health and the least sources of informal support. The neighbourhood centres catered for a more mixed group, but still catered for a number of very vulnerable families.

Evidence about types of family centre, access and stigma

Most commentators favour a proactive non-stigmatising, universal family support service, which they claim is more effective than a reactive, targeted, referral based professional service with a narrow child protection focus (Bachelor *et al* 1998: 206). However it would appear from the findings of a national survey (Warren 1990) that child protection was a predominant function in at least 70 per cent of family centres rather than a generic family support, or child-focused education or welfare. This can be seen as a form of targeting the most vulnerable families, but proponents of universal services argue that these not only overcome stigma (which may deter usage) but also transcend the child care debates on the provision of universal versus selective services, and primary preventative services versus reactive secondary and tertiary provision. However there remains a challenge in ensuring that those who are most vulnerable are engaged with such services without being stigmatised as a result of the referral process (Smith 1996).

Gibbons *et al* (1990) carried out a study in two local authority areas, which examined the use of neighbourhood family centres. They found that these centres were successful in attracting disadvantaged families as there was little stigma attached. Benefits from attending the centres included increased social networks and decreased social isolation. This study also reported differences in satisfaction between referred users and 'drop-in' users. The latter were more satisfied and also had more choice. Hence it could be that opportunities for participation and for the service to be responsive to people's expressed needs are important elements for a successful service.

Even though this model of family centre may be attractive to families who are disadvantaged but are concerned about being labelled and/or stigmatised, the problem still remains that other users may dislike being associated with those who are most vulnerable and disadvantaged. A study by Stones (1989) of a neighbourhood centre that catered for a mix of needs found that when the media made stigmatising references about the centre, the drop-in users blamed those with more severe problems.

A more recent study by Bachelor *et al* (1998) addressed these issues by carrying out an evaluation of an existing family centre to inform the development of a needs led policy. The study was undertaken using an integrated method case study, which used quantitative methods to measure the relationship between need and service provision and a qualitative approach for the collection and analysis of data from interviews, observations and documents. The study found many users disliked attending centres that were based on a referral system. Users regarded such a 'client-focused' centre as a 'dumping ground'. Based on the data from the needs assessment and the more qualitative data, the research team proposed 'an integrated cluster model, which aims to bridge the gap between existing intensive therapeutic provision provided by social services and user organised drop-in support' (Bachelor *et al* 1998:205).

Thus the evidence is not conclusive about which model(s) are preferable, but does indicate that open-access, non-stigmatising services are most likely to engage those disadvantaged families that need help and support but are not viewed as child protection cases. Bachelor *et al* (1998) suggest the necessity for 'multi-faceted needs assessment strategies' as a means of providing the most appropriate model of family centre provision. Smith (1993) concluded from a study of Children's Society Family Centres that project type was not the most important issue when examining effectiveness. He suggested that 'worker style, a mix of activities, an adult education approach and the provision of scarce resources and services in neighbourhoods lacking facilities are probably more important than project type'. McGuire and Richman (1986) indicated that a social mix amongst those attending such facilities is valuable as this will help to reduce any stigmatising effect.

Studies of the impact of family centres

In terms of providing effective services to vulnerable families, there have been a number of studies that have reported improvements in the lives of parents – (predominantly mothers) and their children (Tibbenham 1986, Cigno 1988, Kendrick 1987, Gibbons *et al* 1990, Smith 1993). However, as indicated by Kendrick, these studies have methodological limitations, as none used experimental designs and no longitudinal investigations were undertaken. The study carried out by Tibbenham was based on staff assessments of 38 families referred to a local authority client-focused centre. Over half of these families were on the child protection register. It was reported that 47 per cent of families 'kept their commitment to attend'. An examination of 14 families in more detail found that mothers had increased their social networks, were more able to manage their children and had more self-confidence. However, as Tibbenham himself suggests, the long-term effect is unclear, since mothers attended as 'a prerequisite to keep their children' and he questioned how long these gains would last if they stopped attending.

Another British study used the views of staff and users to assess the effectiveness of three different models of family centres (Smith 1996). Again, the findings from this study must be viewed with caution, as the study did not use any sort of experimental design. Participants' views are pertinent, but without external assessments or comparison groups it is hard to be

sure that gains can be attributed to the family centres. Mothers using the service in Smith's study reported an increase in the size of their social networks and gains in self-confidence. The most important outcome they identified for themselves was their increased knowledge of children's development and behaviour that helped them to cope with their child. Equally important, they believed their children benefited from learning to mix with others and having the opportunity to play in a safe environment with a wider variety of toys. Overall, parents and staff felt that the greatest impact had been on children rather than adults, apart from single parents who reported that the centres gave them 'time off', which they felt was highly beneficial. There were some differences in the perceived impacts in the different types of project. For example in the client-focused centres mothers gained in their understanding of child behaviour, whereas in the neighbourhood centres users identified the impact in terms of the effect on their self-confidence, learning new skills and feeling less isolated.

It is difficult and perhaps unwise to be prescriptive about the most effective type of family centre, as there is still relatively little reliable evidence to do this. However, evidence from a range of sources about various types of provision indicate that improvements in children's learning and development tend to be greater when their parents (mothers) are also involved (Kirk 1995). Goldshmid and Jackson (1993) provide descriptions of approaches that can be used with children under 3 years. Having reviewed relevant research, Yoshikawa (1994:44) indicates that in order for early years provision to be effective it should focus on both parents and child, last at least two years, have a strong educational emphasis in day care, and offer informational, health and emotional support to parents, as well as vocational and educational counselling where necessary.

Early educational interventions

Nursery schools and classes are largely restricted to children aged 3 or over, but now most group facilities for younger children also have educational components. Intensive structured programmes such as High/Scope and Head Start have been developed in North America and are now widely used in Britain. It is not always clear from research the extent to which under-3s were involved or whether the provision assessed was 'routine' or intensive.

In general pre-school educational experiences have been found to provide positive outcomes for children in terms of both cognitive and social development. The gains tend to be greatest for vulnerable families, especially when the parents participate, though the benefits can readily fade unless there is sustained follow up (Rutter 1971; Bronfenbrenner 1979). Most evidence has come from the US, but a study in an inner-city area of Dublin by Kellaghan and Greaney (1993) reported positive educational outcomes compared with a control group. Young people who attended a pre-school programme were followed up at 16 years of age and were found to have stayed on longer at school and attained more qualifications than the control group who had not attended pre-school groups. The ages when the children attended is not recorded.

The High/Scope programmes in the US have undergone rigorous experimental outcome research in the form of RCTs. These have demonstrated positive learning outcomes (Macdonald and Roberts 1995). Among the ingredients are a structured and active learning curriculum, specially trained staff and parent participation. The studies that have been undertaken indicate a number of positive outcomes for those attending the programmes (Schweinhart and Weikart 1993, cited in McDonald and Roberts 1995). A longitudinal follow-up indicated lasting differences between attenders and non-attenders across a surprising range. Graduates of the programme were followed up at age 27 years and it was found that, compared with non-attenders, they had significantly:

- higher average monthly earnings;
- a larger percentage of home ownership and second car ownership;
- a higher level of schooling completed;
- a lower percentage receiving social services at some time in the past 10 years; and
- fewer arrests for crimes of drug-taking or dealing.

It has been suggested that for children younger than 1 year the outcomes are less clear cut, although even then the trend reflects the outcomes found in older children. It has also been shown that as well as developing long-lasting academic, social and cognitive gains, the programme results in cost-effective outcomes (Sylva 1994). Similar programmes in the UK have helped improve children's self esteem, attitudes to learning and task orientation (Smith 1999).

Also in the US, the Head Start programme was developed as an early education intervention aimed at breaking the cycle of poverty. Again this programme has been rigorously evaluated using experimental methods (Macdonald and Roberts 1998). The early studies showed that the IQs of children attending improved, but the gains disappeared after entry into school. However by applying more sophisticated outcome measures it was reported that benefits in cognitive ability, self esteem, scholastic achievement, motivation and social behaviour were achieved as a result of attending the programme (McKey *et al* 1985). Head Start schemes particularly benefited children from the most disadvantaged families (Lee *et al* 1988).

It is evident that programmes such as High/Scope and Head Start provide good social and academic outcomes for children from disadvantaged families, but as indicated by Macdonald and Roberts (1995) the positive effect of such interventions on the 'here and now' quality of life for children in vulnerable families should not be forgotten.

5. Parenting education and group support

introduction: multiple interventions

As noted above, various forms of children's and family centres now provide support to parents, as well as care and stimulation for children. Other forms of intervention are almost exclusively focused on parents, usually with the aim that this will improve the quality of their care. These range from broad primary prevention programmes, which may benefit anyone, to those that particularly target vulnerable families. Some explicitly refer to parents or parenting. Others are couched more in terms of family support, although in many cases they directly involve the parents only. Family support also covers centre-based services, covered in the previous section (Gibbons *et al* 1990; Higgins 2000), and intensive home visiting programmes discussed in the next.

As we need to note recurrently, many programmes engage mainly or entirely with mothers. On the whole, parenting programmes focus on preparation for parenthood or early parenthood, though some cover a later family stage.

There are a wide variety of initiatives to support and provide training for parents who require additional help in raising their children and there is now extensive evidence to indicate that parental support provides a strategy, which prevents problems from escalating and minimises more 'intrusive' measures (Gilligan 1995). Family support can be provided through a range of naturally occurring sources, but when these are unavailable or insufficient, it is necessary for support to be provided formally by health, education or social services. In North America, evidence indicates that multi-method programmes are particularly effective (Gilligan 2000). One literature review by DePanfilis (1996) indicates that some degree of improvement in parenting behaviour results when programmes combine a range of direct services with efforts to enhance a family's support network (See also Fuchs 1995.) De Panfilis identified the following important components:

- specific assessment – with a focus on the availability and helpfulness of a family's social network;
- multi-service approach (including concrete help);
- intensive social contact with a volunteer, lay therapist or parent aide;
- use of modelling, coaching, rehearsing, and feedback, both on a one-to-one basis and in a support group, to improve social interactional skills;
- development of personal networks, mutual aid groups and connections to neighbourhood helpers; and
- structured parenting support groups for socialising, support and social parental skill building.

Thus the family receives several different kinds of help (practical assistance, information, learning of skills, emotional help, social support) from several sources (professional, volunteer and peers).

This literature review also suggests that individual support for certain neglectful parents may be required, as they tend to lack the skills needed to participate in a group. A review by Guterman (1997), which examined the effect of early prevention strategies for parents at risk of abuse and/or neglect, similarly showed that parental education and support that linked parents with both formal and informal support networks were effective preventative strategies. Guterman also examined the effect that the duration of interventions had on families and reported that long-term interventions with moderately frequent contact were most effective. In addition to these findings the study showed that professional support was not necessarily most effective, but a combination of paraprofessional support and professional provision produced the best results.

Parent education programmes

There is no sharp distinction between parenting education and parental support, but the former not only tends to have a learning focus and a more structured approach (a curriculum), but also tends to be based in centres where classes or groups meet. Parenting support has a more social and emotional emphasis, though often an advisory or informal teaching element is present. It is often provided to people in their own homes, but can also be group-based.

According to Pugh *et al* (1995) there has been an increase in the uptake of parent education programmes in the UK and it is estimated that approximately 4 per cent of the parent population has attended one of these at some time (Smith 1996). However, as indicated by Utting *et al* (1993) this is a small proportion of the total parent population and most of those attending appear to come from the middle classes, so that relatively few vulnerable families are likely to be reached.

Evidence of the effectiveness of parent education programmes has largely come from the US where the evaluations have mainly focused on parenting children with behavioural problems. The incidence and prevalence of such difficulties are not closely related to material disadvantage (Stewart-Brown 1998). Unfortunately there is limited evidence on the effectiveness of programmes that simply aim to improve family life and empower disadvantaged/vulnerable parents to care for their children (Lloyd 1999). This is somewhat surprising considering this type of programme has been identified as very important and as beneficial as the more problem-orientated programmes (Smith and Pugh 1996).

One example of relevant British research is an evaluation of a parenting project run by Barnardos Northern Ireland, although this project was not confined to the 0-3 age group. The aim of this project was to provide parenting education and support to parents with children in the early and middle years and adolescence. It was based on a community education and

development approach and focused on improving self-esteem and developing practical skills for parents in order to improve the parent-child relationship (Lloyd 1999). The evaluation did not use an experimental design but did adopt a longitudinal approach. It showed that parents experienced greater confidence, reported less stress and isolation, developed greater understanding and better management of children's behaviour and improved relationships with their children. These benefits also appeared to have been sustained after 12-18 months.

Grimshaw and McGuire (1998) obtained information from professionals and parents about 'open access' parenting programmes. Low awareness of the existence of the programmes reduced attendance, while lack of childcare facilities was another factor which deterred some from attending. About half of the parents who did attend said it was helpful. On the whole users preferred to have as leaders other parents rather than professionals.

It would appear that there is a lack of research regarding the effectiveness of formal parent education for vulnerable families with children age 0-3 years. The emphasis seems to be on education programmes for parents who have children with behavioural problems or for education programmes aimed at more affluent families. Whilst there are a number of studies examining user views and satisfaction of parenting programmes, there are a limited number of rigorous experimental studies that examine the impact of parent education for the group under discussion. Lloyd (1999) suggests that in order to develop effective programmes for this group it is necessary to assess how best parents can be supported in order to implement effective programmes specific to these needs. This is also echoed by others who have suggested that the reasons why vulnerable families do not attend parenting classes is due to the lack of services specific to their needs, the lack of transport and the lack of child care, which all act as barriers to attending (Pugh *et al* 1995).

6. Professional home visiting

Unlike *education* programmes there is considerably more information regarding the effectiveness of *support* for individual vulnerable parents. Often support programmes involve professionals or volunteers offering advice and support to parents (mothers) in their own homes, in contrast to family centres and parent education, which are mainly based on group activity or learning away from home. All families should receive this to some extent through routine midwifery and health visiting, but parenting support is more frequent and intensive. Most often the support is offered to particular types of family (in practice mothers), but occasionally intensive support is offered on a wider basis in a local area.

Targeted intensive programmes

A number of schemes have been established and evaluated where health visitors (or their equivalents in other countries) offer intensive help to mothers identified to have one or more high-risk factors as regards the quality of child care. These factors include low birth-weight and mental health problems, as well as suspected or proven child abuse (see section 10). The intensive support usually entails more frequent contact, easier availability out of normal office hours and, as a result, readier access to other services.

It has been well documented that vulnerable mothers are more likely to have low birth-weight babies as a result of poor diet and unfavourable environmental factors, and as a consequence these children are more at risk from developmental delays. A study using an experimental design illustrated the effectiveness of a programme that provided social support to women with a history of low birth-weight babies. One randomly selected group of women received the intervention and another group (the control group) received traditional ante-natal care. The intervention group received a range of additional support and were able to contact a midwife at any time of the day or night. The study showed that birth weight for the intervention group was slightly higher than the control group, and 41 per cent of the intervention group, as opposed to 52 per cent of the control group were admitted to hospital (Oakley *et al* 1996). In addition differences between the two groups continued throughout the follow-up period of the study. Oakley reported that at 7 years, children of the intervention group demonstrated fewer behavioural problems, and anxiety amongst the mothers in the group was less than those in the control group.

Parental mental illness has been identified as a significant risk factor for children and families. A study carried out by Holden *et al* (1989) in Edinburgh identified 60 mothers with post-natal depression through a screening process at 6 weeks post partum and a more specific psychiatric interview at 13 weeks. Women who were identified as depressed were randomly allocated to either a normal treatment programme or a programme of eight weekly counselling sessions carried out by specially trained health visitors. A total of five women chose not to participate in the study and another five dropped out. Based on follow-up interviews and a self-report scale, the findings showed that 69 per cent of the 26 women in the treatment group had fully recovered compared with only 38 per cent of the 24 women in the control group. The researchers thus concluded that the intervention provided by trained health visitors in the study was effective in managing non-psychotic post-natal depression.

Wider intensive programmes

A widely acknowledged social support initiative also involving health visitors is the Child Development Programme. This provides monthly visits by a health visitor, primarily to new parents, antenatally and for the first year of life. However, it does also provide visits to parents with more than one child who are experiencing particularly difficult problems in coping with their children. The programme aims to provide support for mothers, not just in their role as a mother but as women in their own right. The visits focus on health, development, diet (children and parent's), and self-esteem. Tasks are set around these areas, which the parent/s work on in the month following the visit. The evaluation reported that families who were part of the programme scored more highly on most of the main outcome measures compared with non-programme families, even though these were considerably less disadvantaged (Macdonald and Roberts 1998).

Research overviews of home visiting programmes

Recently two systematic reviews have been undertaken to examine the effectiveness of home visiting programmes (Hodnett and Roberts 1998, Kendrick *et al* 2000). The former looked at the effectiveness of programmes offering additional home-based support for recent mothers who are socially disadvantaged. The latter looked at the effectiveness of home visiting programmes on parenting and the quality of the home environment. Whilst the second analysis did not specifically focus on disadvantaged families, most of the studies included in the review were concerned with this group.

The review by Hodnett and Roberts includes a total of 11 studies, all of which adhered to the following inclusion criteria:

- experimental or quasi-experimental design;
- one or more post-natal home visits; and
- additional home-based support compared to usual care.

The authors noted that the majority of studies had methodological limitations, but they nonetheless assembled evidence that socially disadvantaged mothers did benefit. Bearing in mind the design issues, the authors did not reach firm conclusions about the effectiveness of intensive home visiting for the target group. They did conclude, however, that it had no risks and *may* lead to improvements for disadvantaged mothers.

The review carried out by Kendrick *et al* (2000) examined the effectiveness of home visiting programmes on parenting and quality of the home environment. A total of 34 studies were included in the review and 12 were entered into a meta-analysis. Of the 34 studies 26 were with participants considered to be at risk of adverse maternal or child health outcomes; two used pre-term or low birth weight infants and two used infants with 'failure to thrive'. Eight used participants not considered at risk.

The criteria for inclusion into the review were:

- use of experimental or quasi-experimental designs;
- home visiting programmes, which included at least one post-natal visit;
- the programmes included tasks that were within the remit of British health visiting;⁶ and
- the studies reported outcomes relevant to British health visiting.

The studies in the review used several outcome measures to examine parenting and the quality of the home environment. Seventeen used the Home Observation for Measurement of the Environment (HOME) (see Kendrick *et al* 2000 for more detail), 27 used other outcome measures and a further 10 used both the HOME and other measures. Of these studies only 12 were included in the meta-analysis, and these were all studies using the HOME. Five studies that used the HOME were excluded from the meta-analysis as they did not report certain key statistics.

⁶ This requirement was necessary, since most of the studies were North American

Results of the meta-analysis and the systematic review showed that home visiting programmes were effective, producing improvements in HOME scores and other outcome measures were evident. However, the authors of this review were clear in considering the limitations of the studies. In addition Kendrick *et al* suggest that due to the lack of theoretical frameworks in most of the studies it is difficult to assess exactly which elements of the interventions produced the improvements.

In terms of UK health visiting the study reported that it was difficult to extrapolate directly the results as only four of the studies under review concerned UK health visitors. It was also indicated that these studies were targeted at particularly high-risk families, whereas health visiting in the UK is a universal service. Nevertheless the results were positive in showing that home visiting programmes can improve parenting and the quality of the home environment.

Combining support groups and home visiting

The *Parents in Partnership: Parent Infant Network* (PIPPIN) is based on a sequence of connected education and support, using both individual and group methods. Parents attend ante-natal classes, then receive home visits by trained facilitators before and after the birth, with partners seen separately. A comparison was carried out between 49 families involved in the programme and 57 unwilling or unable to attend. The programme couples were shown to have greater confidence and less anxiety than the comparison group. They also appeared more 'child-centred' in their attitudes, but the research measures detected no difference between the two groups in their actual parenting behaviour (Little and Mount 1999).

Perceptions of routine health visiting interventions

Whilst there appears to be little experimental evidence to indicate the effectiveness of home visiting in the UK, there have been a number of non-experimental studies carried out to examine user views of health visiting. The following section focuses on this aspect. Although the evidence does not clearly indicate impact of the service, it does provide interesting material concerning the perceptions of those receiving services from health visitors.

Young single mothers have been identified as a particularly vulnerable group who are often in need of additional support in parenting their children. A study by Knott *et al* (1999) sought to examine the views of unsupported young mothers with children aged 9 to 21 months about their needs and the support they received from health visitors. This study was qualitative in nature and used semi-structured interviews to elicit the views of a sample of 12 young mothers. The study identified four main areas of concern to young mothers, which have been illuminated by other research too.

First, *participants felt that health visitors were not concerned with the health and welfare of mothers*, but concentrated on the children. The mothers felt uncomfortable initiating a discussion about their own problems or worries, so they all raised questions only about their child's health or development. The authors indicate that this perception was not in keeping

with the health visitors' own perception of their role. Other writers have suggested that it is important for clients to be aware of the health visitor role and what they can expect from them. When this is clear, communication and satisfaction with the service is enhanced (Watson 1986). When engaging with this particularly vulnerable group it has been suggested that professionals need to focus on environmental and social needs just as much as on the baby (Luker and Chalmers 1990).

Similarly a *lack of communication and unclear understanding of the role* of the health visitor resulted in missed opportunities for mothers to see health visitors when they attended clinics. As far as they were concerned, the clinic was for getting your baby weighed, and although health visitors were on hand at the clinic, mothers were not aware of this. Previous research has also shown that mothers perceive health visitor clinics as for weighing babies (Sefi and Macfarlane 1985, Watson 1986, Sherratt *et al* 1991, Sharpe and Lowenthal 1992). Mothers in this study also indicated that clinics lacked privacy and they found it was often difficult to explain a problem to someone in a crowded noisy situation, whereas if the health visitor came to their house it was much easier to do this. These findings reflected those from previous studies (Sharpe and Lowenthal, Machen 1996, Folkes-Skinner and Meredith 1997).

Young single mothers are often particularly vulnerable, and this was evident in the study conducted by Knott *et al*. *Young mothers believed they were treated differently by health visitors because they were young and single*. Comments made by health visitors regarding young mothers' inability to parent effectively were reported by several of the participants, which made them feel stigmatised and demoralised. The majority of those in the study lacked confidence and self-esteem. They felt that the health visitors did little to boost either of these. Previous studies (Clark 1984, Mayall and Grossmith 1985, Foster and Mayall 1990) also reported that health visitors' attitudes towards this group were somewhat judgemental. Simms and Smith (1984) indicate that a more positive type of approach in line with that of health promotion (Tones and Tilford 1994) would enable young mothers to develop autonomy and self-efficacy, which gives people the ability to change their behaviour. This approach also empowers vulnerable groups to take control over their own lives.

The final area identified by the Knott *et al* study was the level of help provided by health visitors. Seven out of the 12 mothers indicated that they had experienced specific problems with their babies, for which they had sought help from the health visitor. Only one reported that the help received was useful. In addition to this type of help eight of the respondents had also asked for general advice about the child, five of whom found it useful. These negative findings indicate a problem, but should not be generalised too far. Contrary to these results, other studies that did not focus on such vulnerable disadvantaged groups found much greater satisfaction with the help received from health visitors. Cowpe *et al* (1994) showed that 78 per cent of their sample were satisfied with the help they received from health visitors and in another study by Machen (1996) 19 out of 20 participants were largely positive about their health visitors.

Thus, the evidence is that health visitors are generally well regarded, but young single mothers tend to feel they are treated more negatively. Many mothers do not have a clear idea of health visitors' roles, especially in the clinic setting. The findings suggest that the training and practice of health visitors should take more account of the social and economic disadvantage of this group, as well as their feelings of vulnerability.

7. Community networking models and volunteer befriending schemes

Principles of enhancing informal support

Traditionally most interventions have relied on specialist or professional input to children, parents or families. Increasingly strategies are being used to strengthen the help and advice available to families informally, whether from their kin, neighbour and friendship networks or through linking families with a volunteer. Such help may be less expert than professional services, but it is often more acceptable, more flexible and more available.

Gilligan (2000) and others have argued that children's social and community networks are of vital importance when considering the development of effective interventions. This is no doubt true, but for the very young children being considered in this review it is somewhat difficult to do this. Therefore it is largely the networks of parents that need to be considered, though these do then impact on young children's own social networks (Hill 1989). Support networks can provide parents with the buffers from stress, information and confidence that allow them to parent more effectively. It is therefore important for professionals involved with vulnerable families to be aware of the importance of these networks and provide interventions that will complement them. Gilligan identifies nine ways that professionals can assist young people in keeping contact with existing social networks. Although not all are relevant for the group under discussion, most (seven) can be adapted to facilitate the development of community based social networks for vulnerable parents with very young children. Briefly they include:

- mapping the network by establishing who it incorporates;
- validating the network by pointing out to all involved the significance of the network;
- gathering relevant information from members of the network;
- negotiating and mediating between the focal member and other members of the network, especially if communications breakdown;
- negotiation and mediation between the focal member and other professionals;
- co-ordination of meetings and information sharing between focal member and other network members; and
- helping to reinforce the identity of the network through arranging celebrations and outings for special occasions.

A social network model of intervention

A good example of how effective support can be provided to vulnerable families through community support networks is the Neighbourhood Parenting Support Project carried out in two disadvantaged inner city areas of Winnipeg, Canada (Fuchs 1995). This project used an experimental design to test the effectiveness of ways to mesh formal services with informal support and helping networks to support parents and reduce the risk of child maltreatment. Parenting support was provided to a total of 100 parents in neighbourhood A, while neighbourhood B was used as a comparison.

The social network of each person was identified and mapped by the 'networker' and links were developed in a way that would provide the focal person with more support and resources. In addition the networker also worked with parents to help them identify stress factors, existing social supports and develop plans to improve their networks. Findings from the project were based on assessments carried out before and after the intervention. These showed that parents in Neighbourhood A had increased and diversified their social support networks. In addition a smaller group of residents in neighbourhood A who had more intense support had even lower levels of depression and family violence than the rest of neighbourhood A, and increased levels of social support. Neighbourhood A families showed higher levels of support than neighbourhood B over a two-year period, and the ratio of support to stress had increased slightly in neighbourhood A over the two years, but in neighbourhood B it had decreased by 13 per cent. Therefore the main findings showed that: i) social network intervention can assist in developing better parenting support networks for vulnerable families; ii) a trained 'networker' can help to mesh formal and informal networks; iii) social network intervention can reduce the risk of child maltreatment (Fuchs 1995:121).

Befriending

A more common approach to expanding the informal resources available to families, especially in the UK, has been the development of volunteer befriending schemes. One such example is Home Start. This is a voluntary organisation in which trained volunteers offer regular support, friendship and practical help to young families under stress in their own homes, helping to prevent family crisis and breakdown. Home Start provides a range of practical help, advice and support. A wide range of referrals are accepted, but most common are depressed or isolated young mothers. The aim of Home Start is to build on the existing resources of families and the communities they live in (for more information see Frost *et al* 1996).

Research has shown that volunteers help families with quite similar needs and risks to those in touch with social services. Parents were significantly more satisfied with the help from their volunteers than were social workers' clients with their more formal 'help' (Gibbons 1995). Part of the explanation appears to be the greater time that volunteers can spend with the family, though their independence from statutory agencies doubtless contributes too.

Home Start in Scotland undertook a retrospective evaluation of its services using questionnaires to collect the data from families, referrers and Home-Start co-ordinators. These were based on a number of selected outcome measures that were largely taken from the Family Outcomes Study being carried out in Northern Ireland. No experimental design was used due to ethical and practical constraints. The evaluation showed that all respondents felt the programme had benefited them, although views about specific benefits varied between families, referrers and co-ordinators. There was emphatic consensus among all groups that families experienced increased confidence and self-esteem (Kirkcaldy and Crispin 1999:33). Overall, the evaluation reported that vulnerable families could be helped by such schemes as Home Start when experiencing difficult times. The number of schemes operated by Home Start Scotland is expanding, particularly through local authority use of Sure Start funds.

The *New Parent Infant Network* (NEWPIN) provides another example of a community support programme based on befriending, but also giving access to a wider range of services. The initial programme was based in London, although it has now expanded to other areas. It is specifically targeted at vulnerable mothers where there is a danger of family breakdown. More specifically it is aimed at mothers with depression, social isolation and poverty (Oakley *et al* 1995). The majority of referrals come from health and social work, although a few are self-referrals. Most of the work is done through therapy, training and social involvement with a peer group who provide added support. Initially mothers are matched with a befriender who is an established NEWPIN user. In addition there is also the opportunity to attend a drop-in centre with crèche, and participate in training such as a personal development programme.

Two evaluations of NEWPIN have been carried out. The first in 1991 (Cox *et al* 1991) suggested that mothers had benefited, but extended involvement of 7-12 months was required in order to see improvement in mothers' mental health. Among the chief gains was a greater capacity to anticipate children's needs, increased warmth and sensitivity, and more effective control (Gibbons 1995; Smith 1999). The second evaluation was carried out in 1994 and looked at 214 referrals in 1992. The response rate (63 per cent) was thought to be adequate considering the type of population under investigation, although those who did respond were reported to be less disadvantaged and therefore more likely to engage with services (Oakley *et al.* 1995). The problems identified by the evaluation included social isolation, depression, relationship problems, problems with children's health and behaviour and housing problems. Despite this wide range of problems less than half those surveyed used the services available through NEWPIN, and the majority of users went less than five times. This indicated that a large proportion did not become regular users. However, 47 per cent of those surveyed reported that it was very or quite helpful, but those referrals who did not use it indicated that it did not meet their needs or they had access problems. There were a small group who used the personal development training and felt it was helpful, but most users indicated that the opportunity to meet other women was of most importance.

It was concluded from the evaluation that NEWPIN did provide a valuable service for a very vulnerable group of women. However, those who engaged with the service only represented a minority of the total number of mothers who were referred. Evidently this difficulty in take-up is a matter that requires further exploration.

The Community Mothers Project also helps young mothers by linking them with an experienced supporter. However, the emphasis in this scheme was more educational. Lay volunteer community mothers have been recruited to provide a child development programme to disadvantaged parents with children up to one year. An RCT was used to assess the impact of this non-professional intervention in parenting (Johnson *et al* 1993). The study showed that at the end of a year children in the intervention group were more likely to have had all their vaccinations, were more likely to be read to daily and were less likely to be given cows milk before 26 weeks. Mothers in the intervention group were also seen to have benefited more than the control group, with reports of more positive moods (Johnson *et al* 1993) and better diet (Macdonald and Roberts 1998).

It is therefore not disputed that personal and community networks can provide assistance to parents in ways that more formal support cannot. However, some appear inappropriate in view of low take-up or high drop-out rates.

8. Working and not working with men

The neglect of men in vulnerable families

In both research and practice, the role and influence of fathers and male partners has often been neglected or else loosely subsumed within consideration of parents. Even though the 1980s saw a surge of academic interest in fathers and child development (e.g. McKee and O'Brien 1982), this was not sustained. Likewise, practitioners have recognised the importance of fathers from time to time, but work is still predominantly with women (see e.g. Cleaver 2000) and few early years projects pay particular attention to men.

According to O'Hagan and Dillenberger (1995) there has been consistent marginalisation of fathers both as a potential asset and as a potential risk in family interventions. Hence some children miss out on the potential benefits from men's greater involvement, while in other cases risks posed by the man may be overlooked. There is also little policy or statutory guidance that gives a clear direction on how professionals should be engaging with fathers. This is largely due to the fact that fathers generally are viewed as a social problem rather than a social strength, in relation to many vulnerable families and especially situations of child abuse. In research fathers' effects on children have been considered mainly in terms of their absence, be it as a result of long working hours or their absence from the family home. At a policy level an economic perspective of fathering dominates the debate and as yet there has been little discussion about how professionals can support fathers so they can provide effective parenting (Lewis 2000).

The Children Act (1989) and The Children (Scotland) Act 1995 refer to ‘parental’ responsibilities as the key concept, without any distinction on the grounds of gender. Williams (1998) makes two salient comments regarding the Children Act 1989: first, that two parents are viewed as providing the optimum situation in caring for children and secondly, that parenting is always shared in an integral way. In practice, as indicated by Daniel and Taylor (2000) this is not always the case, so that male and female parents or parental figures need to be differentiated. It has been argued that the Child Support Act 1991 not only focuses on fathers as ‘bad’ or uncaring towards their children, but prioritises the economic responsibilities of fatherhood over the father-child relationship.

Consequently the mother inevitably becomes the focus of intervention (Taylor and Daniel 2000). This is apparent in the child protection literature, where it is seen as the mother’s role to protect children from abuse, particularly sexual abuse. With regard to neglect mothers have also been blamed and most commonly cited as ‘the perpetrators’ with little mention of fathers (Swift 1995). Men (not necessarily fathers) commit the majority of sexual abuse and over half of physical abuse (Cleaver and Freeman 1995), yet it appears there is little active working with fathers or male partners. Daniel and Taylor (1999) cite a study carried out by Munro (1988), which showed that social workers often overlooked the male partner in the overall functioning of the family. The study reported that this was due to social workers not making the link between domestic abuse and child abuse and the fact that they were frightened of interviewing potentially violent men.

In contrast to the father/male partner who poses a risk to the family, there are also men who can be an asset. Some studies (Edwards 1998) appear to indicate that an inclusive view of men in the family is largely overlooked by practitioners as they are still strongly influenced by the stereotypical view that women carry out all the care of children and domestic tasks in the house. In effect men, even when not at risk are still ‘invisible’ (Stanley 1977). This phenomenon not only excludes men who may wish to be more engaged, but fails to draw on potential valuable resources, which are often in short supply for vulnerable families (O’Hagan 1997, O’Hagan and Dillenberger 1995). This last point is of particular importance when considering the recent work on resilience, which has indicated that there are advantages for children who can draw support from a father even if he is not the primary carer (Gilligan 1997).

According to Daniel and Taylor (2000:17), men who are assets can fall into one of four categories:

- a ‘*partner*’ with the mother, either taking on the traditional division of labour with the father carrying out the provider role and the mother carrying out the nurturing role, or the less traditional role whereby both share the roles;
- an ‘*alternative mother*’ whereby the father is the primary carer;
- a ‘*luxury*’ where the father is ‘good’ to his children and supports the mother; and
- A ‘*unique father*’ role, where the man offers something that a mother cannot, such as a good male role model.

In order to assess whether men are a risk or an asset it is important for practitioners to engage with them and not simply focus on the mother. In vulnerable families, men may well combine elements of risk and resource. They can also provide access to other actual or potential supports for children, notably their own close relatives (Daniel and Taylor 1999).

Engaging men

A few writers have suggested ways in which fathers and other male figures in the family could be involved more by service providers, e.g. Daniel and Taylor 2000. Hardly any evidence is available about effectiveness in this area, but a qualitative study has been carried out to examine how family centres are working with fathers (Ghate *et al* 2000).

This study highlights how social and cultural attitudes make it hard to engage men in mainstream services that have traditionally been targeted at women. This reflects not only habits of thinking and working by professionals, but also fears by staff and female users about risks to the women and children in place that is for some a 'safe haven' from violence at home. Also men themselves are inhibited by preconceptions and anxieties about entering what have traditionally been seen as areas for women only.

Therefore a concerted effort is needed if men are to become more involved. The study showed that in centres where there was an identified strategy for working with fathers, more men attended more often than is typically the case. Interestingly centres that were 'gender blind' and centres that were 'gender differentiated' appeared to be equally successful in engaging men. It was the presence of a clear commitment that was important, rather than the particular approach. Two mechanisms which contributed to engagement were staff visiting men at home and persuasion by female partners. On the other hand, men who did participate regretted that activities were geared only to children or women in ways they found hard to identify with. They were often faced with the choice of being 'ghettoised' in separate men's groups or becoming 'one of the girls' (p. 45). Thus it seems family centres need to work at developing activities which are truly family or parental in nature.

9. Poverty and anti-poverty measures

Trends in child poverty

Poverty is a multi-faceted phenomenon but for the purposes of this review it is discussed in relation to social and material deprivation and exclusion. It is also measured in relative rather than absolute terms, as there is strong evidence to indicate that it is not simply having the means to survive that is important, but the ability to participate in society. Therefore poverty is defined relative to the prevailing living standards of society (Oppenheim 1995; Long 1995). In order to participate in society people require the means to be involved in social customs, activities and obligations, which for some are unaffordable or greatly restricted, resulting in high levels of social exclusion.

In the UK there is no official poverty line, but recent evidence based on 'socially perceived necessities'⁷ indicates that rates of poverty amongst households in the UK have risen sharply in the last 20 years. In 1983 14 per cent of households were classified as residing in poverty as they lacked three or more necessities due to lack of money. In 1999 the figure had increased to 26 per cent of households. In addition to these figures it has been estimated that 9.5 million people in the UK cannot afford adequate housing; almost 7.5 million are too poor to engage in common social activities; about 2 million children go without at least two things they need, such as meals, toys, out of school activities and clothes; and 17 per cent of the population considered themselves and their families to be living in absolute poverty as defined by the United Nations (Joseph Rowntree Foundation 1999). Previous studies carried out by Huby and Dix (1992) showed that out of 1,700 people who applied to the social fund in 1990, 87 per cent had not been able to find the money for essential items such as food, clothing and footwear for their children. Similarly a study carried out in 1991 by NCH showed that one in five parents and one in 10 parents in the preceding month had gone hungry, and a healthy diet for children was not achievable (Long 1995).

In the past most studies on poverty have been based on households and/or families. They have identified that early parenthood is a life-stage especially vulnerable to poverty, since household incomes tend to reduce while expenditure rises (Alcock 1993). However, children themselves have not been used as a unit of analysis. This has largely been due to the view that children have an effect on the welfare of the household, while their welfare as a result of poverty has been largely ignored until recently. The Joseph Rowntree Foundation indicates that poverty rates for children are highest amongst the following:

- households without any workers;
- lone parent families;
- families with a larger number of siblings;
- families where there was chronic illness;
- minority ethnic families; and
- families in local authority housing.

The study carried out by Gregg *et al* (1998) used children as the unit for analysis and examined the trends in child poverty rates and the relationship between childhood disadvantage and subsequent economic and social outcomes. The study showed that over recent decades (1968-1998) the number of children living in households with below the average income has tripled, even though there has been a general rise in living standards. The reasons for this have been attributed to the increase in workless families, especially among lone parent families.

⁷ Items defined as necessities are those that more than 50% of the population believes all adults should be able to afford and which they should not have to do without

The Impact of poverty on families and children

It is evident from the information provided that poverty is an ever-increasing factor in society. However, it is not simply important to examine the rates of poverty but the effect poverty has on those who experience it. For families living in poverty it is both children and adults who are affected. For parents poverty is destructive in terms of self-respect, it is socially excluding and a source of anxiety and depression. These factors have an affect on children, but children suffer in their own right as a result of poverty. They are more likely to experience ill health, they do less well at school and have lower expectations.

It has been well documented that health is adversely affected by poverty (Wilkinson 1994). More specifically for children, there is evidence to indicate that child mortality and morbidity rates are higher for those coming from the poorest backgrounds as a result of poor diet, accidents and poor social and environmental conditions (Cole-Hamilton 1991; CPRU 1994). The health consequences of poverty often extend into adulthood resulting in lower life expectancy for these groups of the population (Long 1995, Watt and Ecob 1992).

Negative long-term outcomes on other dimensions were documented by the National Child Development Study, which assessed the characteristics and progress of children born in 1958 at several subsequent points well into adulthood (Ferri, 1996; Gregg *et al* 1998). Allowing for various other factors, the study demonstrated that childhood poverty was the factor that had most impact on future social and economic outcomes for the individuals in the study.

Support for families in poverty

Policies to combat family poverty have often been developed at national level. They include some of the cornerstones of the welfare state, notably child benefit, as well as various forms of family benefits and tax credits, whose precise forms have varied greatly over the last five decades (Wasoff and Dey 2000). The present government's policies on social inclusion and exclusion have a strong emphasis on enabling more parents to work so that reliance on benefits is reduced and incomes increased (Burden 2000). The new Integrated Child Credit represents a major change in the way financial support is provided for children, too.

Neighbourhood and community development programmes have a long history of seeking to help individuals and families, through a range of measures including credit unions and food co-operatives. The effects of such projects have rarely been evaluated (Henderson 1999). One kind of success has been the multi-purpose family centre, which among its purposes may include enabling women to enhance their skills and improve their income or employment prospects (Cannan and Walker 1997). This may sometimes be linked in to wider community development, income generation or employment initiatives (Smith 1999). Long (1995) provides a description of such work carried out by Save the Children in a highly deprived area in the North East of Glasgow. Besides childcare, the Centre offered training for women, general support and opportunities for participation. Long's account focuses mainly on the training opportunities provided for women in line with an anti-poverty strategy.

A further measure to prevent poverty in the long-run is to promote children's educational achievements and skills, so their long-term prospects for securing an adequate income through earnings are increased. While this evidently requires input throughout childhood, we noted in Chapter 4 how intensive, structured pre-school programmes can lead to long-term gains for children with disadvantaged family backgrounds (Macdonald and Roberts 1995).

10. Child protection

Preventative approaches

Child protection has come to mean official responses aimed at protecting children from neglect, physical, sexual or emotional abuse within their homes or families. Abuse affects children of any age, though neglect and physical abuse are most likely to implicate younger children.

This section looks at the effectiveness of preventing child abuse/maltreatment in vulnerable families and, where it has occurred, ways of preventing reoccurrence and providing help to those concerned. Therefore we shall be examining the effectiveness of primary, secondary and tertiary prevention (see section 2). These three aspects of prevention operate at different ecological levels, although there is inevitably some overlap. Where primary and secondary prevention are concerned services are largely targeted at the community level. This may include a number of the interventions already reviewed in previous sections, such as helping to develop social support and community networks, education and the provision of social and day care facilities. In contrast tertiary prevention is more focused on the individual or family, addressing causal factors within the family, usually by seeking to improve competency and parenting skills.

One of the difficulties in assessing the effectiveness of child protection interventions is determining what the contributing factors to child abuse are. This appears to be largely dependent on the discipline or perspective that the study is based on e.g. sociology, genetics, medicine, psychology. However, it is rarely just one factor that provides the sole reason for the occurrence of child abuse. A number of studies have recognised this and have been designed so they can assess the impact of several specific factors and levels of causation, through adopting an integrative approach (Sameroff and Chandler 1975, Brofenbrenner 1979, Cicchetti and Rizley 1981). Macdonald and Winkley (1999:38) have summarised four core elements of the integrative approach. These provide a framework for developing an appropriate research process and using the findings to develop suitable social responses to social problems (in this case child abuse/maltreatment):

- the dynamic contribution of the different disciplines/perspectives and their cumulative impact over time;
- the fact that some factors increase the risk of abuse, whilst others have a protective effect, the cumulative factors approach (see section 1);

- the fact that some factors have an enduring effect and some are circumstantial or transient; and
- that the understanding of abuse requires that we examine the interplay of factors at different levels of analysis – the ecological approach (See section 1).

It is therefore increasingly apparent that child abuse/maltreatment is not the result of a single factor but is a multiply determined circumstance, event or in some cases a series of events – stress, poverty, psychological problems, parents' own poor childhood history, lack of social support, etc. (Olds and Henderson *et al* 1986).

Difficulties have been encountered when attempting to review the effectiveness of secondary and tertiary interventions in particular (Macdonald and Winkley 1999). The main problem has been the lack of 'purity' of the samples as a result of a blurred distinction between those at risk of abusing their children and those who have actually abused. Macdonald and Winkley suggest that this occurs as a result of the methods used to recruit participants to the study. Primarily they are recruited through referrals to and from child protection agencies, where the classification of families into one group or another is a difficult professional judgement. This is not to say that these studies are not valid or reliable, but caution should be adopted when interpreting the findings.

Primary prevention

Primary prevention is targeted at one or more stress factors that are known to have the capacity to provoke abuse. Tackling these stress factors, or enabling parents to cope with them in order to promote the general wellbeing of children are the characteristics of primary prevention. Aspects of primary prevention have been discussed in previous sections on social support, family centres and community networks, so we will not discuss them further at this stage. General strategies to tackle poverty or social exclusion also help create the conditions where family stress and hence child abuse become less likely.

Secondary prevention

In the context of child protection, secondary prevention is targeted at 'high risk' families who are sometimes identified through screening processes within health services. As a result of the increased knowledge around risk factors and the cumulative effect these have on families, it is believed that secondary prevention is an important facet of child protection, and can be more effective than the limited success that has been experienced with tertiary prevention. Not only does secondary prevention act as a preventive strategy to abuse and maltreatment, it also maximises the chances of good developmental outcomes for children. In addition it is sometimes possible to provide interventions that are not always part of child protection services, so stigma and labelling is reduced with positive consequences, as was also noted in relation to family centres in section 4 (Macdonald and Winkley 1999).

Effective intervention lies partly with the ability to identify groups or individuals at increased risk of abuse. Such groups include teenage mothers and parents who have been abused themselves. This identification of risk is important so that interventions can be provided to them. Likewise, in research terms, this may allow for random allocation to control and intervention groups which, over time, will provide evidence as to whether the intervention has been effective. It has been suggested that pre-natal screening provides an effective means of identifying at risk individuals.

A number of interventions have been identified as effective in providing support to parents thought to be at risk of abuse/maltreatment. In particular *home visiting by professionals, paraprofessionals and lay volunteers* pre- and post-natally to women in high-risk groups has been found to be effective with respect to child protection, as in relation to broader family tensions considered in section 6. Although there are a number of studies in this area, some are more methodologically rigorous than others and the strength of their findings varies accordingly (Olds and Kitzman 1993, Macmillan 1994a, Clemant and Tourginy 1997). Macdonald and Winkley identify the study by Macmillan *et al* as the most methodologically secure review to date. In summary Macmillan *et al* found that long-term home visiting programmes for parents with one or more risk factors (single parenthood, poverty, teenage parent status) was effective in the prevention of child physical abuse. However, the available evidence regarding the provision of short term home visiting schemes was inconclusive.

The impact of a RCT reported by Olds *et al* (1997) provides a good example of an effective long-term home visiting scheme. It was specifically designed to improve particular aspects of maternal and child functioning and therefore provided interventions that were directly related to known risk factors. The study consisted of 400 predominantly white women all first-time mothers. Those allocated to the control group received ante-natal care and screening only, and the intervention group received home visiting.

The following findings were reported by the study:

- The rate of abuse or neglect amongst poor, unmarried teenage mothers was considerably higher in the control group compared with the intervention group (19 per cent compared with 4 per cent).
- Children aged 1-2 years in the intervention group were 40 per cent less likely to have visited a physician for a physical injury or ingestion of a poisonous substance.
- No change occurred in the number of referrals for child maltreatment in the two years following the study, although the children in the intervention group had 87 per cent fewer visits to the physician for physical injury or ingestion of poisonous substances compared with the control group. The intervention group children also lived in better environments, which were more conducive to safety and intellectual and emotional development.

Although the study did prove effective in a number of ways it was evident that no change occurred in the rate of referrals for child maltreatment. As Olds *et al* indicated, this may be partly because child abuse could be over reported in the intervention group as they were under closer scrutiny than the comparison group. The authors suggest that a longer period of intervention is perhaps required to make any impact on this issue as different problems emerge as children get older, which parents may not have the capacity to deal with. In addition the environmental and socio-economic problems already faced by such families are long standing and may need constant attention over a longer period of time.

Tertiary prevention

This level of prevention refers to action taken with respect to families where abuse is known to have occurred. It would appear that there is limited reliable evidence regarding the effectiveness of tertiary prevention (Oates and Bross (1995)). After setting four methodological criteria they sought to identify studies that evaluated child and/or parent-centred interventions and only identified a total of 16 studies in this area. Five of these studies were child-centred interventions and the remaining 11 were parent interventions. An additional review by Oates and Bross, covering the period from 1983 to 1992 and using different criteria, showed a total of 25 studies. None of these addressed routine service provision, but focused on special interventions for helping abused children (13 studies) or interventions aimed at helping parents (12 studies) (Macdonald and Winkley 1999).

There appears to be little evidence to suggest what is *effective* in tertiary prevention by way of legal or administrative interventions, including investigations, case conferences, registration, court and children's hearings decisions. This is largely because studies lack methodological rigour as a result of a lack of experimental designs, small sample sizes, high rates of attrition and inadequate outcome indicators. On the other hand, considerable research has documented the *effects* of these processes on parents and (mainly older) children (DH 1995; Hill and Tisdall 1997). Among the immediate consequences are distress and anger by many parents, and emotional trauma by many children. A longitudinal study by Gibbons *et al* (1995) showed that (a) rates of re-abuse were high (25-30 per cent) and (b) children registered for neglect had poorer long-term outcomes than those registered for other reasons. It is in the nature of long-term follow-up studies, though, that they relate to past intervention, in this case during the first half of the 1980s. However, other studies of more recent investigations and registrations indicate similar rates of re-abuse (DH 1995).

More evidence is available regarding therapeutic interventions. These mostly show that behavioural and cognitive approaches are effective in helping to prevent abuse in high risk cases and prevent abuse from re-occurring in families where it has already been a problem. Through such approaches parents are taught skills, learn appropriate response and reinforcement patterns for dealing with a child's 'difficult' behaviour, understanding of children, develop anger management, and modify their attributions towards children (Gough 1999).

It should be noted that there appears to be a paucity of UK studies in this area, and the majority of studies found for this review have largely come from the US. Few are recent. For example a study carried out by Wolfe *et al* (1981) compared a cognitive behavioural assessment intervention with a standard service for a total of 16 families where parents had abused their children or were found to be at high risk of abusing. Parents were ordered by the court to attend or had been given the opportunity to attend rather than be taken to court by the child protection agency. The intervention group (eight families) received group-based and individual support. The group support consisted of all parents meeting for two hours per week over a period of eight weeks, and these sessions included: developing an understanding of child development; problem solving and modelling of appropriate child management; and self-control training. The individual support consisted of weekly home visits by the project co-ordinator who acted as a facilitator in building on the skills developed as a result of the group sessions. Other more specific work was also carried out. The control group (eight families) received bi-weekly visits from statutory services to monitor the safety of the child in the home and also received community resources.

The results showed that none of the families in the intervention group had been reported or suspected of abuse during treatment, and a year after the programme had finished all cases had been closed as parents were thought to be functioning appropriately (Macdonald and Winkley 1999). In the control group only two families had not had their cases closed. One had a further report of abuse and the other remained under supervision. In addition to a higher rate of case closure, the families in the intervention group were also reported to have improved child management skills, fewer child behavioural problems and caseworkers observed there were fewer problems generally.

Macdonald and Winkley cite other studies which reported similar findings, although they indicate that few are RCTs (Crimmins *et al* 1984, Egan 1983, Wolfe and Sandler 1981, Wolfe *et al* 1981). The few British studies in this area that have been reviewed do not show any conclusive evidence regarding effectiveness (Smith and Rachman 1984, Nicol *et al* 1988).

Other cognitive approaches have been identified, which focus on the wider issues that are often problematic for families where abuse has occurred or there is a high risk of it occurring. Macdonald and Winkley (1999:112) provide a comprehensive overview of two approaches – behavioural family therapy and ecobehavioural approaches. The latter approach was developed as ‘Project 12 Ways’, which provided assessment and 12 core services to families where abuse had occurred. The project ran from 1979-1985 and catered for 50-100 families per year. A five-year follow-up was undertaken of 700 families, 352 of which attended the project and the rest were allocated into a comparison group with no project intervention. The study showed that families who attended the project had lower rates of abuse over all years apart from one year when the rate was similar to that of the comparison

group. This was particularly interesting considering the intervention group were thought to have more severe problems than the comparison group (Lutzker and Rice 1987). Although these results appeared impressive the researchers found that over time the gap in incidence between the intervention and comparison group became less, even though it was still statistically significant. This is attributed to several factors – families dropped out of the programme and/or they did not receive adequate help in resolving existing problems. As we have seen a number of times in this report, research on different types of service suggests that prolonged or additional support is needed so that improvements made early on can be maintained.

Social network interventions

Moving away from the area of therapeutic intervention, the final part of this chapter examines the effectiveness of social network interventions, already briefly discussed in section 7. Although intense professional support is required for families who abuse or are suspected of abuse, there is evidence that a combination of formal and informal support can provide an effective intervention, especially in terms of preventing the re-occurrence of abuse.

Evidence comes from work carried out in the US by Gaudin *et al* (1990) who undertook a RCT of 88 families who had been identified as neglecting their children. Participants were recruited on a voluntary basis from the caseloads of social workers at the Department of Children's Services. Those who were allocated to the control group continued to receive standard services. Those allocated to the intervention group received 'holistic care management' from a project social worker who took on the role of case manager, which included advocacy and brokering of formal services, as well as facilitating the development of supportive social contacts.

The study showed significant improvements in several aspects for families in the intervention group at both six and 12 months. These results were obtained using three well validated tools (Edington *et al* 1980, Halper and Jones 1981, Polanski *et al* 1981). Families in the intervention group showed an increase in the size of support networks compared with the initial baseline measures, but no change was reported in the control group. At 12 months both groups' respondents reported a significant increase in the perceived supportiveness of their networks, but this change was bigger in the intervention group. There were significant improvements in age-appropriate expectations of parents in the intervention group and use of corporal punishment had decreased compared with baseline measures. However, the authors do point out that these improvements still remained below that of average non-neglectful parents. Using standardised parenting measures, it was reported that after nine months of participating, parents in the intervention group improved their parenting from neglectful or severely neglectful to marginally adequate parenting and almost 60 per cent of cases were closed as a result of these improvements. These results were undoubtedly positive, but as

pointed out by the authors, those who participated in the study did so voluntarily, thereby indicating a will to address their parenting deficits. The findings, although significant would need to be carefully applied to parents who were not so compliant and easy to engage. As noted in section 6, a Canadian study also showed that work in a small neighbourhood aimed at improving the linkages of vulnerable mainly young mothers to informal support was linked with a reduction in known abuse in the locality (Fuchs 1995).

11. Social work and vulnerable families

By its nature, most of social work with children and their families is focused on those who are vulnerable. Quite a few studies have taken place which are relevant and have systematic measures of outcome. In the British context, much of the recent research has been carried out under the broad umbrella of child protection or family support (formerly prevention), so the contents of this section overlap with those in previous chapters. In North America, the term 'family preservation' has been quite common to describe interventions aimed at keeping together families where there is a high risk of the children having to move into public care.

Mainstream practice

Evidence from England and Wales indicated that, in the 1990s, much statutory work with children and families was concerned with investigations of suspected child abuse. Following investigation, many families were found not to have ill-treated their children but needed help which they did not receive (Department of Health 1995; Farmer and Owen 1995; Gibbons *et al* 1995). There is some evidence that in Scotland families were more likely to gain access to supportive services (Freeman 1996).

More evidence is available about the effects of special programmes than about routine services or indeed innovations within mainstream services. Some studies have pointed to the quality or competence of social workers as factors in success, but the details of what this means are not always spelled out (e.g. Bullock *et al* 1998). Other work has shown that typically 'packages' of assistance are multiple and differ widely according to the perceived needs of the families, so it is hard to disentangle statistically which parts contribute to success. For instance, in their study of maltreated children, Brandon *et al* (1999) did not find that features of 'good practice' (e.g. seeking to work collaboratively, frequent supervision) or particular methods were associated with good outcomes. High satisfaction with the service did correlate with good outcomes, however. The earlier work by Farmer and Owen (1995) suggested that children were helped best when direct multi-professional input was accompanied by assistance from within the extended family.

The literature suggests that interventions at two levels are particularly effective: micro-skills work and improving material and/or social supports (Hill 1999). The former requires detailed individual work with parents, while the latter is based on an understanding of formal and

informal resources in the local neighbourhood and a capacity to use and enhance these supports. As we shall see below, some projects manage to do both at the same time. A further important quality was revealed in early studies of client feedback on social workers (Rees and Wallace 1982) and has been confirmed in later work. Parents do want direct, practical help, but they also value social workers who give respect and attention to their viewpoints (Cleaver 2000). Also vital is the provision of clear and honest information about social workers' concerns, plans, procedures and powers, as well as parents' rights (Thoburn *et al* 1995; Cleaver and Freeman 1995).

In order for intervention to be effective, it is necessary for workers to be able to engage well with families. Communication skills are vital for this (Shulman 1992). Many studies have shown that the ability of social workers to gain the trust of parents and include them in decision making is closely associated with good outcomes (e.g. Bullock *et al* 1993; Thoburn *et al* 1995), though unfortunately the most 'difficult' and disadvantaged are often the hardest to engage with (Farmer and Owen 1995; Hill 1999).

Skills and social learning approaches

In social work, as in other areas, interventions based on social learning theories have been repeatedly shown to help parents acquire desired skills and to modify behaviour problems in their children (Sheldon 1987; Herbert 1998; Iwaniec and Herbert 1999). Important elements include: use of contracts, precise definitions of targets and application of learning principles (Cigno and Bourn 1998, Gough 1999). Parents with young children are helped to expand their repertoire of techniques for responding to stress or conflict and to avoid angry, negative approaches (Bourn 1998). With respect to children who fail to thrive, careful monitoring is necessary of weight, height and other aspects of development, both to assess progress and provide feedback to the family and professionals (Iwaniec 1996; 1998).

Intensive, multiple interventions

Several careful comparative studies in both Britain and North America have shown that specialist, intensive projects tend to produce better results than routine social work interventions. However, it is not always easy to discern which particular factors have made the difference: indeed it may be that a whole combination of ingredients is needed. They may include better staff resources, higher motivation and a more focused programme, in addition to any particular feature of the different approach. American family preservation programmes have typically sought to produce change at individual, family and community resource levels, using a combination of practical support and skill-based or therapeutic work. They have been found to have low rates of admission to foster and residential care, despite dealing with high risk families (Pecora *et al* 1992; Rosenburg and Holden 1992; Downs *et al* 1996). Dutch work also shows that targeting parental skills alongside attention to material needs can be successful. However, it can be difficult to engage the most difficult and mobile families (Little and Mount 1999).

A particular model which has been developed for very disadvantaged families is the 'wraparound' process, which develops individualised programmes tailored to the expressed wishes and identified strengths of families. A vital component is the worker's ability to purchase services in a flexible way. Although primarily used for families with older children, the model is applicable to all family stages and has been shown to be effective in preventing moves into residential or foster care, with financial savings as a result (Brown and Debicki 2000).

In the UK, Iwaniec (2000) has shown that services targeted at infants who fail to thrive for non-organic reasons enable them to progress significantly better than a control group. Key elements are parenting skills training, support with maternal depression and practical help and support. For the cohort followed up over 20 years by Iwaniec herself, the benefits were evident into adulthood for those who received help *in the first year of life*, whereas the outcomes were much less good for those who received help when they were older.

The British study of Family Support by Gibbons *et al* (1990) analysed a project where social workers were based in family centres and sought to mobilise informal and voluntary sector supports. The researchers concluded that a combination of network support and day care was essential to the success of the project.

Duration of intervention

Quite often the length of social work involvement is influenced by outside bodies (such as children's hearings) and considerations other than effectiveness, but it is nevertheless important to know whether similar or better results can be achieved from shorter intervention, since that will be cheaper. Unfortunately, the evidence is not consistent. Certainly, some research has shown that brief interventions can achieve as good results as longer-term contacts (Reid and Shyne 1969; Quick 1998). However, other studies have shown that sustained intervention is necessary since otherwise short-term benefits fade. Berrick (1997) concluded that families where abuse or neglect was an issue gained best from services lasting 6-18 months. This supports the view of Guterman (1997) about the need for sustained input, which was cited in section 5.

12. Inter-agency issues

Many types of agency and professional group have a part to play in services for vulnerable families. The chief sectors are local government (notably education, social work and housing services), the NHS (health boards and trusts) and the voluntary sector, with the Benefits Agency, Employment Services and Inland Revenue having a major impact on family incomes. Research has identified that a number of issues need to be dealt with to achieve satisfactory partnerships. These include different expectations about child rearing and employment conditions (Penn 2000; Fawcett 2000).

Despite the fact that inter-agency co-ordination is widely advocated by policy makers it has been difficult to achieve, not only in the delivery of services to children and families, but across health and welfare services generally. With regard to inter-agency collaboration within child and family services, the majority of the literature has focused on child protection, therefore for the purposes of this review we shall be largely looking at inter-agency co-ordination in this area. In addition there is a paucity of experimental research to demonstrate clearly that inter-agency collaboration results in positive outcomes for children and families (Mulford and Rogers 1982) or to assess which kinds of collaboration work better for children's services. This reflects in part an oversimplified view of co-operation, with a failure to distinguish different types and levels of co-operation (Hallett and Birchall 1992; Tisdall *et al* 2000). Also studies have tended to focus more on 'performance against expectations' (Widner 1973), and on 'policy and administrative purposes' (Challis *et al* 1988). However, there is evidence from professionals to indicate improvements in certain aspects of the child protection process (Hallett and Birchall 1995).

Inter-agency collaboration, be it in child protection or community care is something which has been largely directed by central government, and although also advocated by those in the field, is not always easily achieved. Challis *et al* (1988:267) suggest that this is because in practice good co-ordination is extremely difficult to achieve, and others have made similar comments regarding co-ordination across the spectrum of health and social care (Wilson and Akana 1987). According to some (Hallett 1995, Weiss 1981, Scharpf 1978), the difficulties can be explained using organisational theory. This suggests that organisations tend to want to preserve their own autonomy, and the change to a more collaborative approach is costly, not only in terms of money but in terms of effort and morale. Therefore organisations are unlikely to change unless they can be persuaded that it is in their interests, or that it is their duty to do so (Scharpf 1978). Also a number of studies have pointed to the differences in professional values and outlooks which need to be reconciled or 'worked through' in order to reach shared understandings.

In a study by Hallett and Birchall (1995) a case study approach was used in two different areas of England to look at co-ordination policy and practice in child protection. This was carried out retrospectively in a purposive sample of cases of child abuse. Although this study did not use an experimental design, the findings provide an interesting description of the views of those working in this area. These views are particularly interesting, considering the literature suggests that barriers to co-ordination are located at an interpersonal level. Participants were asked about their experiences of inter-agency working and in particular were asked whether they agreed with the observation; 'given the opportunity, professionals would probably work better alone' (Blyth and Milner 1990:195). In addition they were asked scaled questions about:

- the ease of co-operation with particular professions;
- preferences as to collaborative partners;

- role clarity and role overlap;
- the extent of agreement about child abuse;
- the degree of urgency with which various professions approached the task;
- the importance of professions involved; and
- perceptions of competence in respect of child protection in various professions (Hallett 1995:295).

The study showed that the majority of participants were in favour of inter-agency working and positive about their experiences of it (Birchall and Hallett 1995). Reflecting the findings from a previous literature review (Hallett and Birchall 1992), the respondents indicated that inter-disciplinary work in child protection allowed an important aggregation of skills and resources.

A key issue in many of the discussions of inter-agency co-ordination has been the blurring of roles. In many areas of health and welfare the blurring of roles within teams has been advocated, but in the area of child protection, where the team approach is less often used this is not a practical approach. Hallett and Birchall found that most professionals were able to identify distinctive roles for themselves and others. They also welcomed role clarity. However, there was some degree of overlap particularly between social workers and health visitors, although this was not something that is particularly advocated by either profession. Health visitors were keen to specify and adhere to their role in child protection. Managers reported that the role of the health visitor was a preventative one and they should not be involved in the support of families, which was largely seen as the role of social work. However, in reality there was overlap. Health visitors did work supportively with families when the need arose, primarily as a result of limited resources in social work. Interestingly it was these two groups who appeared to collaborate most closely. Hallett and Birchall suggest that this possibly reflects the fact that they have most contact with each other in the child protection process and the familiarity of each other's role as well as frequent personal contact creates a preference for working with what is familiar. The other professions involved in the study did appear to have clearer roles where overlap was less likely.

In keeping with previous findings on inter-agency work (Challis *et al* 1988, Broussine *et al* 1988) the proximity of workers helped in developing good inter-agency working. Coterminous boundaries between health, education and social work proved to be an important factor in fostering good collaborative work, as well as small professional networks at a practice level. However, it was also found that personalities were a critical factor in the success or failure of inter-agency work. In particular those in senior positions had significant influence on the way in which professionals worked.

Overall the work carried out by Birchall and Hallett (1995) showed that professionals accepted the need for inter-agency co-operation and were mostly satisfied with it. They saw little need for more intense forms of joint work that blurred the roles of the different professions. Information exchange and joint planning were thought to work well.

Inter-agency co-ordination has been a key feature of early years planning and reviews. We have not come across systematic evaluations of the processes involved. There is evidence that some local authorities have sought to build their children's services plans on early years organisational networks (Wheelaghan *et al* 1999). Voluntary agencies have at times been marginalised as different parts of the statutory sector have sought to overcome some of the traditional barriers among themselves.

13. Fostering and adoption of young children

When families are under stress or parents are unable to care for their children, whether temporarily or long term, then the children may be placed with foster carers or adopters. Not so long ago in Britain young children were placed in residential nurseries, as still occurs in many parts of the world. Nowadays it is extremely rare in the UK for a child under 3 to be placed in any kind of residential institution, except in a hospital when inpatient medical care is required.

For the most part, children in foster care return to their original families, often soon, but sometimes later. Currently, short-term placements in particular tend to be viewed more in terms of respite, shared care or family support, rather than substitute care (Aldgate and Bradley 1999). In contrast, adoption is a permanent alternative, as can sometimes be the case with foster care.

The evidence is that both foster care and adoption tend to be more successful for young children than older ones. This accords with attachment theory and common sense, since young children have had less time for problems in their original family to affect them and are more able to re-attach to new carers or parental figures. Both prospective foster carers and adopters are carefully assessed and so are likely to be particularly suited to looking after children. Despite the current emphasis in adoption practice that adopters can come from diverse backgrounds, the majority of baby adopters still appear to be 'middle class' (Castle *et al* 2000).

Fostering young children

Studies of fostering outcomes have often focused on the type or duration of the fostering (e.g. short term, long term, permanent, specialist), rather than particular age groups. Nevertheless, considerable information is available about placements of young children.

Most young children in foster care stay for short periods (up to 6 months, but often only a few days or weeks) before returning home or in a minority of cases moving on to another placement or adoption (Rowe *et al* 1989). Over three-quarters of such placements are successful, using a range of criteria. Children who are fostered and return home before they are 2 are more likely than older children to have a successful return (Sellick and Thoburn

1996). Multiple moves in care have been found to affect children's attachments and behaviour adversely, though a single move can be helpful (Millham *et al* 1986; Cleaver 2000).

The evidence about longer-term placements is that the younger the child at placement and the fewer the identified behaviour difficulties, the greater the chance of the arrangement proceeding as planned. Indeed, there may be a greater risk of placements going on beyond their planned duration than ending prematurely (Berridge and Cleaver 1987; Kelly 2000). In the study by Rowe *et al* 1989, only 4 per cent of planned long-term placements for children under 4 years 'broke down' within a year, compared with over one-third of the placements of 14-15 year olds.

Adoption of young children

From the 1950s to the 1970s most children who were adopted were aged under 2, but this is no longer the case. The numbers of babies placed for adoption has fallen markedly, while a smaller increase in the placements of older children has occurred, so the latter are now in the majority (Hill and Shaw 1998). Evidence from the period when baby adoptions were common indicates that the vast majority have formed good attachments with their adoptive parents and turned out very well in many respects. The NCDS follow-up of children born in 1958 showed that those who were adopted had good outcomes as regards physical and cognitive development. They quite rapidly overcame generally poor ante-natal and early histories to do as well as other children in advantaged material circumstances (Seglow *et al* 1972; Maughan *et al* 1998). Other studies have shown that the majority of children adopted as babies do well, but an above average minority develop behavioural or psycho-social problems, particularly in adolescence (Bagley 1993; 1998).

Adoption breakdown rates tend to be low compared with those in residential and foster care (Triseliotis *et al* 1997). Moreover, disruption of placements are much less for children placed at an early age. Around 5 per cent of infants placed for adoption are likely to have to leave their home during childhood, though rather more will have unhappy experiences (Sellick and Thoburn 1996). A recent study of 52 children adopted as infants found that all were still living with their adoptive parents at 6 years (Castle *et al* 2000). As earlier research had shown, the children were above average in cognitive assessments and socially well adjusted. Adoptive parents were nearly all well satisfied. The great majority of adoptive placements that do break down do so before an Order is granted (DH 1999).

Age at placement and pre-placement appears to affect outcomes. The retrospective study by Howe (1997) indicated that young adults who had the best outcomes and most settled experiences of growing up in the adoptive family had been placed before 6 months and had

not experienced instability or rejection in early life. Similarly the long-term follow-up study of Romanian children has shown that outcomes are almost invariably positive in the first few years, but those who arrived after the age of 24 months have done less well (Groothues *et al* 1998; DH 1999).

Quaternary prevention

According to the scheme of prevention developed by Hardiker *et al* (1996) outlined in section 2, one of the primary aims of shared and substitute family care arrangements is to 'prevent' or minimise negative consequences arising from the separation of children from their birth families. Research has identified a range of factors which appear to affect children's experiences. Careful recruitment, preparation and the availability of adequate and sensitive post-placement social work support have been identified as key factors (Triseliotis *et al* 1995; Sellick and Thoburn 1996). Contact with birth relatives is generally helpful for children's current wellbeing, self-esteem and identity, as well as the prospects of return home, though in situations of extreme rejection or abuse this does not apply (Cleaver 2000). When parent-child relationships are poor, sibling relationships can often mitigate children's sense of loss and isolation (Kosonen 1994).

14. Key points and concluding remarks

Summary of key points

We have indicated at the beginning of this review that the early years are crucial in developing healthy developmental outcomes in later life. The term vulnerability can be interpreted in various ways, as it can refer to material deprivation, family malfunctioning or a combination of the two. Evidence indicates that children most at risk of ill-treatment, neglect or separation are in families where both poverty and some kind of serious parental or family difficulties co-exist, but of course children can also suffer in households with no material disadvantage.

Four holistic frameworks were described in section 2. These help clarify principles, aims and targets for intervention:

- cumulative risk, protective and resilience factors;
- attachment theory;
- ecological models; and
- social construction approaches to parenting and childhood.

Children living in vulnerable families are more at risk from poor parenting and therefore have a more than average chance of incurring negative biological, emotional and psychological consequences. They are less likely to form positive attachments while protective factors (such as family stability, good education) are less likely to feature in their lives, so they will be less resilient in later years. From a broader perspective the ecological approach to child

development has sought to place more emphasis on the wider environment and the availability and extent of support networks as an important factor in contributing to the wellbeing of the parent and child. Social construction theories indicate that a critical and open approach should be adopted to assumptions about children's needs and family relationships.

With these issues in mind, it is apparent that some families will need support from specialist or targeted services, though many will benefit from services universally available in the community. In providing these services it is important to ascertain the effectiveness of the interventions. This review has drawn on some of the available literature in this area to try and provide evidence of what is effective in supporting vulnerable families with very young children. However, this has not been a simple task as the availability of rigorous outcome research has been lacking in several areas and often we have quoted research carried out in the US as opposed to the UK. This is not to say that lessons cannot be learnt from this research and in some cases similar programmes have been imported and implemented. Due to the lack of experimental studies we have included a number of different designs in this review, but have warned where necessary that caution may need to be taken when interpreting certain results. In addition the limited time scale has meant that we have been unable to carry out in depth literature searches, so there are gaps in some of the areas in this review.

Family centres and early educational interventions

Family centres provide a large amount of support to vulnerable families with children under 3 and most commentators favour a non-stigmatising universal support service. However, it would appear from a national survey (Warren 1990) that most largely provide child protection services to families who are referred by statutory services. Critics of this targeted model of provision argue that by adopting a universal approach a more preventative service can be implemented that reduces stigma and encourages usage. On the other hand, engaging the most vulnerable without a referral process is problematic. It was also found that drop-in users do not like being associated with those who have been referred. Thus there is no conclusive evidence regarding the most effective or even preferable models of family centres, although the studies reviewed in this work do advocate open access, non-stigmatising services.

A number of studies provided evidence that indicated positive gains for mothers and their children as a result of attending family centres. These studies were based on the views of staff and users. This is a valid method of investigation, but without external assessments or comparisons it is difficult to be certain that any gains can be attributed to the family centres. Evidence from a range of sources does suggest that in order to provide effective early years provision, both child and parent need to be actively involved in a range of activities over a sustained period of time. Centres can help mothers' self-esteem and prospects for increased family income by promoting skills and contacts that can lead on to employment. Concerted efforts and adapted activities are needed to encourage men to engage with family centres.

More rigorous studies were available from the US regarding early educational interventions and findings from these studies showed that there were positive social, economic and educational gains in later years. Vital elements appear to be structured programmes, intensive help, parental inclusion and sustained involvement.

Professional early parenting support and training

There is limited evidence from the UK to indicate the effectiveness of parent education and evidence from the US has largely focused on the parents of children with behavioural problems. Most studies carried out in the UK seem to have included mainly affluent individuals. Although they may include some with serious parenting difficulties, it appears that services are not targeted to the needs of vulnerable families and are not made accessible to them. However, the limited research in this area, which used non-experimental methods of evaluation, did report sustained benefits to parents. They appeared to experience improved levels of confidence, less reported stress and isolation, greater understanding and better management of their children's behaviour.

Unlike education programmes there is considerably more information regarding the effectiveness of support for vulnerable families. A number of studies using experimental designs have reported positive results for a range of interventions for particularly vulnerable groups of mothers and parents in the community.

Both extra specialist input from health visitors or midwives and support from experienced volunteers has been shown to help mothers in the early stages of parenthood. Improvements have been documented in parent-child interaction, rate of immunisations, nutrition and mothers' mental health. The routine service provided by health visitors is generally valued by mothers as helpful, but many are unclear about health visitors roles and some single mothers feel judged and stigmatised.

Community networking models and volunteer befriending schemes

Peers are very important for young children and centre-based interventions help promote social skills and confidence. On the other hand, both centre and neighbourhood approaches have been shown to help isolated parents (mainly mothers) develop their links to existing community networks (Kirk 1999). The development of community networks can also provide flexible and acceptable support in ways that more formal support cannot. Some evidence indicates that workers who understand and engage with informal networks can reduce child abuse (Fuchs 1995; Henderson 1999).

Studies carried out in the UK have pointed to the benefits parents report from being befriended by a volunteer, in such programmes as Home Start and NEWPIN, sometimes alongside others kinds of support. However, some schemes have high non-engagement or drop-out rates, so arguable those most in need may not be assisted.

Child protection

This review has looked at the effectiveness of interventions aimed at prevention of child abuse/maltreatment as well as the prevention of the reoccurrence of abuse/maltreatment.

Studies into secondary prevention have identified long-term home visiting for women pre- and post-natally by professionals, lay professionals or volunteers as most effective, although evidence on the effectiveness of short-term programmes was inconclusive. It was reported that there is limited reliable evidence regarding the effectiveness of tertiary prevention in legal and administrative interventions (Oates and Bross 1995). The multiple and often compulsory nature of responses make quasi-experimental studies difficult. More evidence is available regarding therapeutic interventions, although this is largely from the US. Rigorous studies using good outcome measures have reported a decrease in the recurrence of abuse as a result of programmes, especially those with a cognitive-behavioural orientation.

There is also evidence to suggest that social network intervention is also effective in preventing the reoccurrence of abuse/maltreatment. Evidence from work carried out in the US (Gaudin 1990) showed that significant improvements were found in several aspects for families who were subjected to intensive case management which included the development of supportive social contacts.

Social work and inter-agency activities

Parents want social workers to be clear and honest about their intentions and respect their viewpoints, especially when there is a conflict of perspective about what is best for the child. Both practical help and emotional support is valued. Similarly, well structured multiple interventions have been shown to work well. Social and cognitive learning approaches are effective.

Both in relation to child protection and family support, this indicates that often a 'package' of services is beneficial which tackles individual, family, neighbourhood and practical issues, in accordance with ecological principles.

Inter-professional co-operation has been examined most closely in relation to child protection. Most of those involved are reasonably satisfied with the type and degree of collaboration.

Fostering and adoption

If young children are placed in foster care, this is normally for a short period and the experience is usually a brief and satisfactory experience unless it is a prelude to multiple placements away from home. Adoptions of children under 2 have very low risks of breakdown.

Children from disadvantaged backgrounds who are adopted soon reach or exceed normal physical and cognitive achievements, but a minority develop psycho-social difficulties.

Concluding comments

This report was prepared in eight weeks and so is inevitably partial and provisional. Nevertheless, from the limited evidence provided in this review it seems there are a number of options and methods for enhancing the healthy development of children. Their success has been demonstrated to varying degrees, but certain key messages emerge from the most systematic research or are supported by several studies. These are set out below:

- multi-level and multi-method approaches have most impact;
- nurseries and family centres have long-term benefits for children and parents from vulnerable families when they are well structured, involve mothers and continue for some time;
- intensive home visiting by professionals or experienced befrienders is helpful, though attitudes are more clearly affected than behaviour;
- parenting is helped when professionals seek to enhance informal network support;
- skills-based and social or cognitive learning approaches are valuable in work with both individual parents and groups;
- interventions mainly focus on mothers: concerted efforts are needed to engage fathers and male partners;
- usually input needs to last months, if not years, to have lasting effects on families with serious multiple difficulties; and
- much care is required to access families with the most serious difficulties or alienation and to keep them involved.

Appendix 1:

Patterns of attachment

It has been widely acknowledged that secure attachments provide protective experiences and promote social competence, resilience and good mental health. In this appendix we briefly discuss patterns of attachment. For the purposes of this review these are only discussed in relation to the 0-3 years age group, although there are consequences across the life span (Parkes and Stevenson-Hinde 1991; Howe 1997).

It should be noted that much of the theorising about attachment patterns is based on research carried out in limited circumstances – in relation to mothers and in controversial experimental situations (Burman 1994; Woodhead and Faulkner 2000). Nevertheless, the ideas have been found to have considerable applicability in understanding the development and behaviour of children growing up in vulnerable circumstances.

Secure patterns of attachment

A young child who is securely attached to a parent or carer tends to display a number of behaviours (Fahlberg 1994). These include:

- liking for physical proximity to the 'attachment figure(s)' and intimate interaction;
- distress when separated unexpectedly;
- feelings of comfort and relaxation on reunion or when upset; and
- freedom to explore in the presence of the attachment figure.

These features are often summed up by saying that an attachment figure acts as a 'secure base' for the child. Although Bowlby emphasised the primacy of secure attachment to a single adult (usually the mother), subsequent work has shown that young children typically have a small number of attachment figures, which may include two parents, siblings, grandparents and other people they see regularly (Hill 1987; Schaffer 1990).

Secure attachments generally promote protective and resilience factors and are associated with good mental health (Rutter and Rutter 1993; Howe 1995). Most research on secure attachments had focused on mothers, who are usually the people who have most contact with infants. Howe (1999:47) has indicated that mothers of secure infants demonstrate a number of similar characteristics and most of the time are sensitive, accepting, co-operative, available, accessible and dependable. In addition the mother-child relationship appears to be harmonious, with high levels of empathy displayed by the mother, which results in appropriate interactions that are reciprocated by the child, resulting in a rewarding relationship between the two. It is believed that this type of relationship allows the infant to explore their own world more freely as they are not constrained by constant emotional arousal that is often present in insecure patterns of attachment (Mains 1995, Crittenden

1992b). This type of relationship also allows the infant to develop the means to help them understand emotions, mental states, behaviours and interactional styles. This allows cognition and affect to develop together rather than in a state of conflict and confusion (Howe 1999), which leads to healthy psychosocial development. Goleman (1996) refers to this as emotional intelligence.

It has been suggested that strategies for managing anger are directly related to patterns of attachment. Those children with secure attachment are thought to experience less intense anger over a shorter duration than insecure children. This occurs as a result of the way in which mothers react to the child's expressions of anger. In secure children the mother will react quickly, which protects the child from over exposure to prolonged distress.

As a result of the mother's quick and sensitive responses particularly in times of angst, the child perceives others as emotionally available and dependable especially in times of distress. This in turn makes children feel lovable and worthwhile and, over time, allows them to view themselves and others in a positive manner. Secure attachment therefore allows children to develop high self-esteem and resilience in the face of adversity. Walden and Garber (1994:428) found that children aged 3-9 months showed positive emotionality when their parents were psychologically healthier, enjoyed stable relationships, interacted harmoniously with their baby and had higher levels of engagement.

Insecure patterns of attachment

Insecure attachments can be classified into three different patterns (Howe 1995; 1999), often referred to as avoidant, ambivalent and disorganised.

Avoidant, defended and dismissing patterns

This type of insecure attachment is characterised by a wariness of entering into close relationships. Intimacy is desired, but the children do not have confidence that it will be forthcoming. Consequently, people who behave in this way tend to detach themselves from others in order to feel secure and place a greater reliance on themselves rather than on other people.

Avoidant attachment patterns are associated with mothers or caregivers who are hostile towards the child and do not provide the child with the response and comfort that is required. When a child becomes anxious, distressed or upset their attachment behavioural systems are activated and they look for comfort from the carer and become increasingly more demanding and emotionally needy. The mother/caregiver copes with the distressed child by perceiving the behaviour as an attack or intrusion, so responds in a way that suits her needs, rather than the child's (Howe 1999). This results in her being less available and psychologically distant when the child's attachment needs are greatest.

Consequently, the child learns to minimise and restrict expression of emotions such as anger or upset, for fear of upsetting the mother/caregiver (Grossman 1993). When they interact

with other carers or individuals outside the family or with other carer, the child tends to behave in a manner which is aimed to avoid hostile rejection but has not learnt how to elicit warm, caring relationships.

Ambivalent, dependent and pre-occupied patterns

Ambivalent attachment is usually characterised by low self-esteem and a tendency to become involved in complex emotional relationships. The child seeks intimacy and finds it hard to act autonomously, but is fearful that relationships will be lost or turn sour. He or she may well become 'clingy', reluctant to separate or act independently, yet the preoccupation to stay close may itself invoke rejection since other parties can feel overwhelmed by the demands (Fahlberg 1994; Howe 1999).

Ambivalent attachment is created when there is inconsistency in the way the caregiver responds to the needs of the child. Often the caregiver is under involved with the child and therefore fails to recognise signs of physical and psychological distress. Consequently, the child seeks ways in which to gain the attention of the mother/caregiver (Howe *et al* 1999:89). This is achieved through crying, shouting, clinging or similar behaviour. The mother sometimes responds with varying degrees of warmth and concern, but just as likely her response is passive and lacking in interest or attention to the child. The result of this pattern of attachment is that young children doubt their entitlement to love and care and so develop a low sense of their own worth or ability to command positive types of attention. Children displaying this pattern of insecure attachment are very demanding, with displays of anger and dependence, which can lead to exasperation and in extreme cases abuse by parents.

Disorganised, controlling and unresolved patterns

This pattern of attachment is characterised by its inconsistency. For much of the time, the child may appear securely attached or passively distant, but at times of stress become extremely fearful or angry. This in turn reflects experience of inconsistent parenting, which is by turns loving and hostile or rejecting. Children with these characteristics have parents who are abusive or have mental health problems or a drug or alcohol addiction. The children are deeply affected by the fact that the persons they are closest to and rely on for care are also the people who intermittently behave very negatively towards them.

The significance of different patterns

The research and theory on attachment help to identify the kinds of parent-child interaction which have negative effects. Therefore they can help inform parent preparation, education and support programmes aiming to prevent the kinds of parental behaviour which result in extreme forms of insecurity. Understanding of the different patterns can also help in devising different strategies to help children directly or to guide carers, when these negative patterns have already developed (see e.g. Downes, 1992; Fahlberg 1994; Howe 1996).

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Appendix D:

Membership of Review Steering Group

CHAIR: Dr Sandra Grant – Chief Executive, Scottish Health Advisory Service (SHAS)

Margaret Allison – lay member

John Bishop – Assistant Chief Inspector, Core team

Stuart Bond – Inspector, SWSI

Anne Burgham – Child Protection Nurse Advisor, Dundee Primary Care Trust

Liz Jordan – Senior Medical Officer, Primary Care Unit, SEHD

Anne-Marie Knox – Child Protection Nurse Advisor, Lomond and Argyll Primary Care Trust

Marion McArdle – lay member

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Michael Proctor – Nursing Officer, Primary Care Directorate, SEHD

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