C4EO for the sector from the sector

FAMILIES, PARENTS AND CARERS

KNOWLEDGE REVIEW 1

Improving children's outcomes by supporting parental physical and mental health

Centre for Excellence and Outcomes in Children and Young People's Services

The Centre for Excellence and Outcomes in Children and Young People's Services (C4EO) identifies and coordinates local, regional and national evidence of 'what works', to create a single and comprehensive picture of effective practice in delivering children's services. Using this information, C4EO offers support to local authorities and their partners, working with them to improve outcomes for children, young people and their families.

It is focusing its work on nine themes:

- Early Years
- Disability
- Vulnerable (looked-after) Children
- Child Poverty
- Safeguarding
- Schools and Communities
- Youth
- Families, Parents and Carers
- Early intervention, prevention and integrated delivery

C4EO works with a consortium of leading national organisations: National Children's Bureau, National Foundation for Educational Research, Research in Practice and the Social Care Institute for Excellence.

The Centre is also supported by a number of strategic partners, including Local Government Improvement and Development, the Family and Parenting Institute, the National Youth Agency and the Institute of Education.

There is close and ongoing cooperation with the Association of Directors of Children's Services, the Local Government Association, the NHS Confederation, the Children's Services Network, the Society of Local Authority Chief Executives and Ofsted.

C4EO is funded by the Department for Education.

Improving children's outcomes by supporting parental physical and mental health

James Blewett
Janet Noble
Jane Tunstill
(King's College, London)

Data annexe by Karen White
(National Foundation for Educational Research)

Contents

Summary

This knowledge review tells us what works in improving the safety, health and wellbeing of children through improving the physical and mental health of mothers, fathers and carers. It is based on a rapid review of the research literature involving systematic searching of literature, analysis of key data, validated local practice examples, views from service providers and the users of services. It summarises the best available evidence that will help service providers to improve services and, ultimately, outcomes for children, young people and their families.

Reviews on 'the impact of parenting and family support strategies on children and young people's outcomes' and on 'improving children's outcomes by supporting couple relationships, reducing family conflict and addressing domestic violence' are also available on the C4EO website.

King's College London carried out this review on behalf of the Centre for Excellence and Outcomes in Children and Young People's Services (C4EO). The National Foundation for Educational Research conducted the data work.

Key messages

The prevalence of health difficulties

- A range of central and local government departments shares responsibility for maximising the safety, health and wellbeing of children through improving the physical and mental health of mothers, fathers and carers. Implementation at the local level is by a wide group of professional and non-professional staff in the community.

- While there is no single source of purposely collected national data for identifying parents with either physical or mental health conditions, data collected in the context of government labour surveys suggest that 1.7 million (12 per cent) of parents in the UK have a disability as defined under the *Disability Discrimination Act 1995* (GB. Statutes 1995).

- There are estimated to be: 150,000 young carers in the UK, 30 per cent of who are believed to be caring for adults with mental health needs; 200,000 to 300,000 children and young people living with a parent whose drug use is problematic; and 1.4 million children are living with at least one parent who drinks excessively.

- Much health-related data fails to identify the fact that patients also have a role as parents, so that the needs of children in these families often remain invisible (even if most of this group manage with the support of universal services and informal networks). Better data would facilitate better understanding of their needs. Services across the spectrum of need must be sensitive to the circumstances of the children and families using them, especially with regard to poverty, ethnicity and disability.

The relationship between parental difficulties and children's wellbeing

- There is an association between parental health difficulties and children's safety, health and wellbeing, but the exact mechanisms involved are only partially understood. As causal relationships are difficult to establish, it cannot be said that negative outcomes are inevitable and care needs to be taken in assessing the impact on children of

parental health difficulties. Both the characteristics of the parents/carers **and** the characteristics of children/young people themselves can play a role in determining outcomes.

- Resilience in children has been identified as a key factor in mediating poor outcomes for them, even in circumstances which might appear to be adverse. Although it is not yet fully understood as a concept, building on both parental and child resilience clearly pays dividends

Services and interventions

- A strong message from providers consulted during this review was that the current service configuration – especially the split between adult and children's services – poses a key challenge to the effective delivery of services that can meet the needs of both children and their families.

- Adult services can provide valuable examples of providing a **personalised** approach to problems in order to produce personalised outcomes, so that targeted support is not seen as stigmatising by parents, children and young people.

- Access to services by family members is impeded by the current system of gate-keeping by means of thresholds; i.e. an access point at which access to one or more service/s is judged necessary, or not, on the basis of perceived risk or need.

- Service usage is likely to be influenced by the real and perceived characteristics of the services, especially in relation to the fear of stigma, a deterrent most obvious in respect of those who are referred for services against their wishes, rather than those who either self-refer or are in agreement with a referral to a service.

- It is essential that services are provided for children and their families at each of the tiers of need. Furthermore, it is crucial that 'bridges to access' exist, both between the levels of need; and between the different services on offer from a number of professions and agencies.

- It is important to offer parents and carers potential access to services at different points in time, and over a sustained period, so that early access to services can be made possible at whatever stage of the problem. 'Episodic' access to services can be an important resource in periods of increased parental stress.

- There is a positive association between early intervention and better outcomes, but late intervention is better than no intervention at all.

- Positive outcomes for the parents whose spectrum of need is covered by this review include: physical and psychological wellbeing; self-esteem; cultural and ethnic identity; improved adult/child and partner relationships; and improvement in parenting competence.

- The Think Family Pathfinders and the related Family Intervention Projects have begun to show some encouraging results. The flexible personalised way in which they respond to the needs of both children and adults is viewed extremely positively by families; and by the professionals working with them. Evaluations of the programmes stress the value of flexible working with adult services; information sharing; and joint

commissioning towards the aim of delivering a more cohesive service for vulnerable families.

- A number of validated local practice examples carried out as part of this review highlight the value of services which offer a mixture of practical, therapeutic and emotional support to families; they have identified some very encouraging results in terms of outcomes. The quality of the relationship between professionals and the families they supported was found to be a crucial lever for change.

Who are the key stakeholders?

- mothers, father and carers who use services
- those with responsibility for designing /commissioning services (policy-makers at national and local level, commissioners at local and strategic level)
- those who work in children's social care services (children's social workers and social care staff, family support workers, children's centre managers, foster carers, kinship carers, residential establishment staff)
- those who deliver services through education (school-based support staff, teachers, special educational needs coordinators)
- those who work in adult services (adult social workers and social care staff, domestic violence workers, youth offending teams)
- those who work in the adult /youth justice system (police and community safety workers)
- those who work in health services (primary care staff including health visitors, midwives and antenatal services, mental health professionals and GPs; acute sector staff who might refer to services, for example A&E staff).

Their contributions are valuable in the process of improvement

Those who have used, currently use, or may use services

Parents and carers face a number of obstacles in accessing timely services likely to benefit their children. Some of these will be relatively 'tangible ones', perhaps the result of barriers to accessing services such as lack of publicity; lack of proactive outreach; others will be less obvious, such as a sense of stigma/fear of the consequences of seeking help. In relation to the latter, we know from research that problems such as poverty, poor housing and unemployment often occur alongside issues around both physical and mental health, and especially in relation to substance misuse issues. However, research over many years also highlights the consistent commitment of the majority of parents/carers to do their very best for their children, even in the face of adversity.

As children and young people will be the prime beneficiaries of improvements in services, it is important that they are encouraged to feel a key sense of interest in, engagement with, and entitlement to, services on offer. All conventional strategies have a part to play as

does publicity linked to the UN Convention on the Rights of the Child, which includes, of course, the right to family life.

Those with responsibility for designing/commissioning services

The challenge facing those designing services at both the national and local level is to create a system that can respond to the needs of the whole family, simultaneously addressing the needs of children; and parents and carers with additional difficulties; while taking into account the stresses in their lives. To do so requires some recognition of the need to build bridges between the different levels of need; and active effort to improve the cohesion between adult and children's services. It may well not be either desirable or realistic to create new organisational structures, but barriers to partnership working across children's and adult services can and should be addressed.

Those who work in children's social care services

Staff in children's social care will work with a range of families where parents have health difficulties, including those with the most acute problems. Staff in these services will be focused on the needs of the children. This review reinforces the need to recognise that the most effective way of supporting children in such circumstances is usually to support their parents. Therefore it is important that staff in these services assess parents' needs and are prepared to provide services that address these needs. In some cases, although not all, this will involve close liaison with colleagues in adult services.

Those who work in education services

It is clear from this review that we have only a partial understanding of how children are affected when their parents have health difficulties. Therefore, a significant number of children will still be living with parents with health difficulties, who are in receipt of little or no support. While teachers and other support staff need training and support in order to best assist families, schools nevertheless play a vital role in identifying those children whose families are under stress. In some cases it may simply be necessary for school staff to take account of the overall needs of the children with whom they work. However, for those children who are experiencing greater difficulties, the eliciting of further support through the use of the Common Assessment Framework; and the making of referrals will be an important extra step for education staff to take.

Those who work in adult services

Practitioners in adult services will be focused on the needs of the adult. However, it is important that they also recognise that many of these adults are also parents and that as workers in adult services, they share a responsibility for safeguarding the wellbeing of those children. This means that being aware of the impact on children of any parental difficulties is crucial. However, practitioners in these services can also play an important role in ensuring that colleagues in children's services fully understand the needs of the parents **as adults** – and the value to children of meeting those needs.

Those who deliver services in the adult/youth justice system

In some instances where problems – particularly those related to substance misuse – are more entrenched, parents may come into contact with the youth justice system. Also, there

is a correlation between problematic substance misuse, mental health difficulties and domestic abuse. Workers in these services therefore need high-quality training and the services require clear protocols to enable practitioners to be sensitive to the impact of such problems on children; they must also know how to act decisively if/when they have concerns.

Those who work in health services

There will be many practitioners working across the health system who will have a key role in meeting the needs of children and their parents who have health problems. Practitioners – such as GPs and health visitors – in primary healthcare settings will be crucial in identifying those parents who need extra support. At the more specialist level, like workers in other adult services, they need to be aware of those patients who are also parents. Health workers focused on children need to be aware that some childhood problems, such as those related to behaviour, may be symptomatic of parental stress caused by health problems.

What data is available to inform the way forward?

There are many publicly available data sources about the prevalence of physical and mental health problems among adults and children, and the characteristics of those who are affected by these issues. However, there is limited local data on children's emotional wellbeing. Also, most of the data sources do not identify whether adults are parents or carers; nor do they link parents' health to their children's outcomes. The sources available can be used by local authorities and the NHS to inform their Joint Strategic Needs Assessments of adults' and children's health in their area and to plan their future priorities and interventions.

C4EO's interactive data site enables local authority managers to evaluate their current position in relation to a range of key national indicators and to easily access publicly available comparative data on adults' and children's health and wellbeing.

The evidence base

The reviewed evidence focused on mental rather than physical illness, most commonly maternal depression, and parental substance abuse. However, very few of the items reviewed directly addressed the role of substance abuse in parents' or carers' mental and physical health. Most sources referred to the effect of parental substance abuse on children's psychopathological development and on family wellbeing. Where the focus was on the mental health of parents and carers, in many cases the focus was determined by the nature of the mental illness. In terms of national data, data is available on the prevalence of mental illness and some other health conditions such as obesity (a theme that was identified as being of particular interest to this review by the Theme Advisory Group (TAG).) Nevertheless, the data annexe reinforces the lack of data that is currently available about the physical and mental health needs of parents and carers. Such data is particularly difficult to isolate as the NHS does not currently identify patients as parents.

Knowledge review methods

This knowledge review is the culmination of an extensive knowledge gathering process. It builds on a scoping study and research review. The research review is available on the C4EO website.

Research literature was identified through systematic searches of relevant databases and websites, recommendations from the TAG, and considering studies cited in identified literature ('reference harvesting'). The review team used a 'best evidence' approach to systematically select literature of the greatest relevance and quality to include in the review. This approach attempts to eliminate bias in the selection of literature, to ensure that the review's findings are as objective as possible.

Data contained within the data annexe was obtained by a combination of search methods but primarily by obtaining online access to known government publications and access to data published by the Office for National Statistics.

The review also contains examples of local practice generated by the sector, which have been assessed and validated on the basis of agreed criteria by specialists in the area of families, parents and carers. The full versions of all the practice examples contained within this review – and those published since the review was written – are available on the C4EO website. Evidence has also been gathered from service providers during discussion groups at C4EO training events, while evidence from the users of service was collected via C4EO's Parents and Carers Panel and from various young people's networks. Service providers and users are also contributors to some of the published studies and consultations included within the review.

1.   Introduction

This review is unusually wide in its scope, and is intended to be a key reference document for professionals. By addressing, in one document, the implications for children of a number of parental circumstances, the review aims to draw out the key 'what works?' messages on improving the safety, health and wellbeing of children through improving the physical and mental health of mothers, fathers and carers. It addresses three questions that were set by the C4EO Theme Advisory Group (TAG), a group of experts in families, parents and carers' policy, research and practice. These questions are:

- What proportion of mothers, fathers and carers experience mental and/or physical health problems and what are their characteristics?

- What is the relationship between mothers', fathers' and carers' mental and physical health and their children's safety, health and wellbeing?

- What interventions and support mechanisms are most effective in increasing children's safety, health and wellbeing through improving mothers', fathers' and carers' a) physical and b) mental health?

Reviews on 'the impact of parenting and family support strategies on children and young people's outcomes' and on 'improving children's outcomes by supporting couple relationships, reducing family conflict and addressing domestic violence' are also available on the C4EO website.

The reviews are based on:

- the best research evidence from the UK – and where relevant from abroad – on what works in improving services and outcomes for children and young people

- the best quantitative data with which to establish baselines and assess progress in improving outcomes

- the best validated local experience and practice on the strategies and interventions that have already proved to be the most powerful in helping services improve outcomes, and why this is so

- the views of users of services and providers on 'what works' in terms of providing services and outcomes.

C4EO will use this review to underpin the support it provides to professionals working in children's services to help them improve service delivery and, ultimately, outcomes for children and young people.

Definitions of key terms

The TAG provided the following definitions:

Wellbeing – in the context of this review, this term is taken to relate to children's emotional, behavioural, economic/material, physical/health and educational wellbeing.

Mental health issues – to include depression and anxiety disorders, psychoses and personality disorders. In this context, mental health also includes alcohol and drug misuse.

Physical health issues – to include limiting longstanding illness and disability in parents and children (with the group expressing a particular interest in obesity).

Types of evidence used

The research included in this review was identified through systematic searching of key databases, reference harvesting or recommendations from the TAG. All research included has been appraised to ensure that the evidence presented is the most robust available.

The review also contains examples of local practice that have been gathered from the sector and assessed as having a positive impact on outcomes by specialists in the Families, Parents and Carers area. (See Appendix 5 for C4EO's validated local practice assessment criteria). The 'validated local practice' examples included in this knowledge review are supplemented by a range of 'promising practice' examples, which are published on the Families, Parents and Carers pages of the C4EO website. These promising practice examples include, for example, the Barnardo's Community Mums and Dads project in Reading, and Action for Children's Intensive Family Support project in Exeter.

Evidence has also been gathered from service providers during discussion groups at C4EO training events. Meanwhile, evidence from parents and carers has been collected via C4EO's Parents and Carers' Panel and through published consultation documents, and from children and young people through C4EO's Young People's Network, and also through published consultation documents (see Appendix 6 for more details of the process).

Data contained within the data annexe was obtained by a combination of search methods but primarily by obtaining online access to known government publications and access to data published by the Office for National Statistics.

Strengths and limitations of the review

The strengths of the review include the provision of a set of available evidence identified in advance for us by the scoping review team. This included both individual research and national datasets that have informed specific questions; and was derived from a search which took account of the relevance of **information**, as well as the **quality and strength of evidence**. We have also been able to draw on guidance from the TAG in order to ensure focus on issues of key importance in early childhood research, policy and practice.

The wide range of parental challenges covered in this review means that many of its findings relate to areas also covered by other C4EO reviews. This review therefore addresses complementary and potentially overlapping research knowledge, especially in the areas of: family support; safeguarding children; and the improvement of outcomes for children and young people in the looked-after system. (Indeed, the latter category of children and young people may be extremely important in understanding the impact of previous parenting and educational experiences.)

Limitations of the review include the very tight deadlines which the review had to meet. This has inevitably limited the ability of the team to extend and develop the evidence base through reference harvesting and hand searching. Other challenges included the aspiration to meet the knowledge needs of a very diverse group of practitioners. In the context of children's services, these staff will have professional backgrounds spanning a number of clinical disciplines within health, social care, education, youth and adult justice, and, in some cases, as with volunteers, community-based skills but having undertaken no professional training. This wide range of knowledge needs would, in an ideal world, be met by a range of reviews, tailored to individual roles and backgrounds.

Finally, we should acknowledge that the review was limited to English-speaking countries only.

2.   Context

Since May 2010 a new Coalition Government has come into being, stating freedom, fairness and responsibility as its central aims. The Coalition believes that strong and stable families of all kinds are the bedrock of a strong and stable society and has set out, in its Programme for Government, an aim to make society more family-friendly (HM Government 2010).

The government believes that it is important to ensure that policy and services are designed around parents' lives and work patterns, evolving roles and financial pressures. However the Coalition also believes that the government's role is to give power and opportunity to people rather than to assume the State has the answers, and to provide centrally prescribed solutions. The government cannot create resilient happy families but it can listen to their concerns and understand the barriers they face in their day-to-day lives. Working together with communities and families, the government states that it wishes to empower families to make choices that are right for them and to enable their children to fulfil their full potential.

The Coalition Government's aim to make society more family-friendly has been underpinned by a series of recent commitments intended to remove the barriers – which it believes include unnecessary bureaucracy – that can prevent families from flourishing, and to create the right environment for families to support themselves. The Coalition has also signalled that effort and resource should be directed, especially in times of financial uncertainty and constraint, at protecting the most vulnerable by ensuring help is available early to prevent problems escalating, and by generating opportunities for genuine social mobility.

The Coalition Government has set in motion a series of reforms and measures to meet these commitments, as outlined below. It has also commissioned three reviews, which have all recently reported. These are the review of poverty and life chances by Frank Field MP, the Munro Review of child protection, and the review by Graham Allen MP into early intervention (Field 2010; Allen 2011; Munro 2011). A review of Family Justice is also taking place with an Interim Report due in spring 2011. These reviews provide an opportunity to take a fresh look at some of the biggest challenges faced in family policy.

Recent reforms

The early years is being reformed by the Coalition Government to ensure that Sure Start Children's Centres remain accessible to all, while providing more focused support to families most in need through evidence-based early interventions. This is being reinforced by expanding the health-visiting workforce with an additional 4,200 health visitors. Fifteen hours a week of free early learning and care will continue for all three- and four-year-olds and this will be expanded to two-year-olds from the most disadvantaged households.

In recognition of strong evidence of the importance of relationships in the home and their impact on children's outcomes, the Prime Minister announced, in December 2010, that £7.5 million a year, over the four years 2011–2015, will be dedicated to funding for

relationship support – a total figure of £30 million. This is a significant increase on current levels of funding. The majority of the £7.5m a year will be allocated to voluntary and community sector organisations as grants by the Department for Education. In addition, up to another £500,000 a year could be dedicated to training practitioners in Sure Start Children's Centres and up to £1m a year for contracting with helpline and online family relationship support services.

Some families need extra help, particularly the small number of families who experience multiple problems. The government has committed to introducing a new approach to supporting these families and has launched a national programme designed to help turn around their lives, improve outcomes and reduce costs to welfare and public services. The programme is underpinned by the Community Budgets initiative. Community Budgets will initially be established in 16 areas to give areas greater flexibility to pool together funding from a range of different streams; and to identify and tackle barriers to doing this; as well as the trialling of new and innovative ways of working in some exemplar areas which will be shared widely across the country.

These reforms are complemented with reforms to funding. The new Early Intervention Grant (EIG) will provide funding to enable local authorities to act more strategically and target investment early, where it will have greatest impact. The EIG brings together funding for early intervention and preventative services for the most disadvantaged and vulnerable in society: for example, Sure Start Children's Centres, short breaks for disabled children, families with multiple problems and targeted support for young people. It is not ring-fenced and gives local authorities the freedom and flexibility they need to make savings while protecting the services that are most important to their residents.

The government is also providing direct funding to the voluntary sector to continue to provide services online and by telephone. This decision is driven by the belief that these forms of assistance can be convenient for families, are designed to build parents' confidence in their own abilities to handle times of change, challenge or crisis and strengthen their parenting skills.

The desire to make Britain more family-friendly is not unique to the new government. Over the last twenty years, a key policy goal has been to support all parents, especially in the context of the growing awareness of the needs and rights of disabled people generally, and of disabled parents, in particular. This was reflected in the disability discrimination legislation of 1995 (GB. Statutes 1995), the *Human Rights Act 1998* (GB. Statutes 1998) and the evolving personalisation agenda. The Coalition Government has taken forward the vision for more personalised, responsive adult services with the publication of a vision for adult social care (DH 2010b)

Even though there have been changes in the political parties in government over the last twenty years, since the passing (with all party support) of the *Children Act 1989* (GB. Statutes 1989), governments have been in agreement about the need for policy and organisational structures that facilitate the achievement of better outcomes for all children and young people. This aspiration has remained a clear and consistent theme in child and family policy across the period. Key shared assumptions include the fact that:

- While some parents will need help and support at points in their lives most children will, with such support, thrive in their families

- all children have the potential to succeed and should go as far as their talents can take them

- children and young people need to be safe, healthy and enjoy their childhood, as well needing to grow up prepared for adult life.

Strategies likely to achieve these ends include: services that work together to meet individual needs; and intervening early in problems, spotting those who need extra help and making sure they get it. The aim has been to break down the barriers for accessing services between levels of need and also between different agencies, communication and collaboration (Munro 2005; C4EO 2010).

In recent years, the previous government was aware of the need for adult and children's services to work more closely together – particularly with the most vulnerable families – and launched the Think Family Pathfinders projects, with a view to promoting cohesive whole family approaches (DCSF 2010b). In the UK – building on the 'prevention typology' concept, developed primarily in public health services – the delivery of agency services for children and their families is organised across the operational concept of 'the four Tiers of Need', namely universal services: those targeted at vulnerable children; those targeted at children with complex needs; and specialist services for children in acute need.

The Coalition Government states that it aims to empower frontline professionals to have the skills, knowledge, confidence and freedom to exercise their own judgement and focus on the best interests of the child.

3. The evidence base

The evidence base addressed in this overview inevitably reflects the different research traditions within the disciplines of health, social care and education: all of whose service provision plays a key role in meeting the needs of vulnerable parents and carers and children. For example, health researchers have tended to attach more weight to the findings of research studies that have been based on methodologies such as random controlled trials. In social care/family support research, fewer studies have relied solely on this particular approach and have valued a variety of quantitative, qualitative and mixed methods approaches – including surveys, interviews and case studies – to capture outcome data (SCIE 2005).

The review questions highlight issues that have been addressed through a systematic search of an extensive range of data, including:

- administrative data sources
- national/cross national surveys that address service access
- summative data using experimental methodologies including randomised controlled trials
- process and outcome evaluation studies
- exploring in more depth, data that is routinely kept in the course of providing services
- qualitative methods.

This broad approach to evidence is essential since a number of researchers (Coote *et al* 2004; Pawson 2006) have argued that the complex, changing organisational structures in the child and family service systems will always limit the use of true experimental designs. It should also be acknowledged that the cultures and characteristics of policy, practice and research and evaluations differ from country to country, as does the means of dissemination to policy-makers, practitioners and those who use services. Consequently, in order to arrive at conclusions of optimum relevance to practitioners and policy-makers, we have taken account of each of these factors to identify and reflect the findings of most relevance to strategic managers working in children's services.

Accordingly, we drew extensively on the initial scoping document (Twist *et al* 2009), whose authors had reviewed a total of 671 sources and selected 252 sources as relevant (based on information available in the abstracts).We finally selected 54 items as key items for the review on the basis of the scoping phase outlined above, feedback from the Theme Advisory Group (TAG) and peer reviewing process. These items comprise literature reviews/evidence syntheses or empirical research, as well as a small number of practice guides. Over half of the key items are from England or Australia. The table below shows the number of relevant items by Review Question number – highlighting the fact that more evidence was available for Review Questions 2 and 3 than for Review Question 1. The review questions are as follows:

1. What proportion of mothers, fathers and carers experience mental and/or physical health problems and what are their characteristics?

2. What is the relationship between mothers', fathers' and carers' mental and physical health and their children's safety, health and wellbeing?

3. What interventions and support mechanisms are most effective in increasing children's safety, health and wellbeing through improving mothers', fathers' and carers' a) physical and b) mental health?

Review question	Number of key items
Review Question 1	16
Review Question 2	38
Review Question 3	32

Note: The total number exceeds 54 as some of the items were relevant to more than one review question.

We acknowledge that many of the items are relevant for at least one other review question, but hope we have avoided too much repetition and/or overlap.

In addition to drawing on the considerable evidence base made available to us, we adopted two additional complementary strategies:

- In order to minimise the negative impact of variations in the respective **depth** of research literature relating to specific areas, we 'mined' the 'relevant' articles and reviews. Some additional references have been selected on this basis which were not flagged up in the initial evidence base identified (this process is often know as 'reference harvesting').

- Mindful of the end target that this review be capable of informing both local agency **policy implementation** and **individual day-to-day practice**, we included a number of key government generated sources. Two main types of literature fell into this category: first, published government commissioned research overviews, not already identified in the original search, for example Quinton's (2004) analysis of fourteen research studies of various aspects of family support; second, and bearing in mind the **on-going/on the ground** implementation of a number of practice strategies, such as the *Framework for the assessment of children's needs* (DH *et al* 2000), empirical sources for practitioners that have already been widely disseminated by central government. References that fall into this category include Ward and Rose (2001) and Aldgate *et al* (2006).

4.   What do service users and providers tell us about what works?

C4EO recognises that knowledge gained from empirically based research is only one source and if we are to understand 'what works' we also need to take account of the experience and expressed views of those who use and work in services for children and their families. In this section we consider the messages from users and providers of services that have emerged from a variety of sources (for further details, see Appendix 6). Specifically, as part of the knowledge review process, separate consultations were carried out with young people and with parents/carers. The National Children's Bureau held a number of consultation events with 71 young people. The Family and Parenting Institute gathered the views of parents and carers through a Parents' Panel that meets regularly. The data from these consultations is supplemented by national and local evaluations that have captured the voices of users of services. Provider perspectives were obtained from four national training events which were carried out by C4EO in different regions of England. While we need to be mindful that the stakeholder views reflected here will not be representative of all stakeholders, they nevertheless give an important flavour of the current views and priorities of those who use and provide services for families. The messages emerging from this variety of sources are presented within the following four major themes.

Accessing services and how can the deterrent impact of stigma be reduced?

Both carers and young people were asked how they would access help if they were to face difficulties. For both groups, the informal support of family and friends featured strongly with the caveat that they needed to be trustworthy, particularly with regard to confidentiality. One young person commented that 'I like people who listen but won't do anything...you know let me get things off my chest but not make things worse'. Professional support would only be sought if the problem was either sensitive or 'embarrassing' or serious and complex. The young people also recognised that the wellbeing of their parents directly affected them, in both practical and emotional ways.

In terms of the routes for **accessing** help, the Internet featured very prominently. Many providers formally acknowledge the importance of accessible websites, but perhaps they have not fully grasped how central it is as a medium, not only to young people but also increasingly to their parents. However, accessibility of information was seen to comprise more than simply access to the Internet, and user-friendly leaflets were mentioned by several of the respondents in the consultation groups. When asked which professionals could provide support, a wide variety was cited, ranging from teachers and doctors to social workers and Connexions workers. In the first instance, both the young people and also the carers indicated they would seek to access help through universal services. Approachable, respectful staff were cited as key in this process. There was, however, a sense of 'wariness' about the consequences of seeking help. For example one parent stated:

> You have to be careful... I mean if I was depressed or something I could go and talk to my GP. However I would be worried about what they would write down about me and what might then happen....

When asked to elaborate on what was meant by 'negative consequences of seeking help', issues of stigma emerged as prominent. The fear among both young people and their parents was that they would be seen as 'not coping' and as being inadequate in some way. As one respondent commented, 'I have always been brought up to keep things in the family... A family member would say "leave it" if anyone thought about talking to an outsider.'

However the concern was not simply about the family being regarded negatively by services. Many cited a fear of 'social services involvement'. As one young person stated: 'If anyone who works in public services gets a sniff of it then you'll lose your parent.' This fear is echoed in much of the research into parents' experiences. For example, a study carried out by the Children's Commissioner (2010) into families' experiences of safeguarding systems reiterated the fear that social worker involvement in family life could very quickly lead to the loss of children to the care system. The challenge for providers is that this fear extended to families whose problems were relatively minor and would never lead to formal child protection processes let alone care proceedings.

In terms of overcoming this fear, accessible and approachable staff in universal services were yet again cited as important. This is a message reaffirmed in guidance for schools on working inclusively with disabled parents (Brunner *et al* 2009). One parent stated how teachers being available in the playground represented an important and straightforward means of access. Parents in the same guidance cited concerns about confidentiality in such circumstances but described how with skilled and sensitive practice these concerns could be overcome.

> … I do have a sort of feeling of being ashamed of having difficulties. It's not something I talk about… so it's quite good that somebody understands when I'm not being chatty, or if I don't turn up why I'm not there. It's having that understanding and [parent support adviser] giving a wee phone call and saying oh how are you.'
>
> (p 11)

In terms of research-based literature, much of the feedback from the users of services relates, perhaps unsurprisingly, to parents with physical health difficulties and disabilities. Olsen and Tyers (2004) articulate from a perspective that reflects a social model of disability, a view of services that is congruent with much of what has been written in relation to *Think family* (Social Exclusion Task Force 2008). That is, that all too often there has been a one-size-fits-all approach to service design and delivery, and that the aspirations of disabled parents very much reflects the personalisation agenda that is transforming adult services. This vision is one of a responsive individualised package of culturally sensitive support that is developed on the basis of the strengths and the resources they offer their children, rather than simply a source of unmet needs.

A positive development has been that as part of the previous government's *Aiming high for disabled children (*HM Treasury and DfES 2007) parental satisfaction with services is now recognised as an important performance indicator.

More recent policy-related literature regarding learning disability has reflected the view that the personalisation agenda needs further development in this particular area of disability, and, in particular, in the parental role of adults with learning disabilities (DH 2009). The latter group of parents, like those parents with mental health and substance misuse needs, face the additional barrier of stigma that may exist alongside other areas of discrimination and challenge, such as poverty and racism. Safeguarding concerns will almost inevitably arise for some parents with the more serious health difficulties but the feedback from those who use, for example, mental health services and substance misuse services, is that these are best addressed in an environment that attempts to take a strength-based, individualised approach, addressing the difficulties they face across the different areas of their lives (Morris and Wates 2006).

The importance of relationships

In the young people's consultations, the importance of relationships was a recurring theme. Indeed it was the perceived personal qualities of the professional that were valued rather than their formal job title. 'Trust' was identified as a key factor by many of the young people, as well as professionals not behaving patronisingly towards them. As one young person stated, 'Professionals are all like "so tell me how you feel", talk to us like normal people! They're patronising.' Nevertheless, the young people did want professionals to be authoritative and recognised that on occasions this might entail them challenging their behaviour. One young person requested that, in the context of preparing for adulthood he should be 'made' to participate in 'more compulsory activities made to do stuff even if you don't want to'.

The importance of relationships with professionals was also a key theme in the consultation with parents. Home-Start, which involves using trained volunteers to support parents, was particularly positively regarded in this respect.

Providers also recognised that building relationships is both key to the experience of services but also not always easy to do. Barriers can include conditions involving disability (and therefore adequate worker time is needed); appropriate resources; and the existence of the 'right staff with the right attitudes'.

The role of thresholds

Making time to build high-quality relationships, however, is more than just about the commitment and values of staff. Thresholds emerged as a major obstacle to accessing help in both the consultations with users of services and providers. Many of the providers expressed concern that in a period in which resources would be scarce, higher thresholds for specialist services could act as a deterrent to families seeking help. This concern was echoed by the parents and young people. The young people, in particular, expressed some pessimism as to whether the help they needed was likely to be available in the community.

The recurring theme among providers, particularly with regard to parental mental health, was that problems would be not deemed serious enough for parents to receive assistance, until they had become entrenched, with the likelihood that services would be provided too late.

Facilitating and improving professional collaboration

In a period where there will be a pressure on resources, making the most of what is available becomes crucial, and such a context makes cohesive inter-agency input all the more important. A major theme highlighted by the providers was the poor quality of the relationship between adult and children's services. This was seen to have been aggravated by the earlier reorganisational developments, linked to policy changes in adult and children's services. A representative from one local authority argued that bridging posts between adult and children's services had played a crucial role in her area to facilitate better service access.

Some parents who were consulted stressed the importance of 'good signposting' by professionals so that if, for example, a children's centre could not provide a service, centre staff might put the parent in touch with someone who would be able to help.

The Common Assessment Framework (CAF) was cited as both problematic and a success story by providers. Indeed some of the parents who were interviewed as part of the consultation and who also worked as volunteers described it as 'brilliant'. The providers recognised that services have not historically been very 'joined up' and this has impacted both on their effectiveness and on users' experiences of seeking assistance. As with the parents, provider opinions were divided as to how effectively the CAF had facilitated professional collaboration. In some areas it had clearly become embedded and contributed to a culture change in terms of integrated working. In other areas it appeared to constitute little more than an inconsistently used referral form.

Applying the concept of resilience to understanding outcomes for children and young people?

The young people, in particular, cited their appreciation of services that treated them as 'human beings and not a collection of problems.' In the process of realising their aspirations, most young people, however, cited their parents and carers as delivering the most important source of support. Likewise, parents saw professionals as very much **supporting** their role as parents. It is perhaps easy for professionals who work with families experiencing difficulties to fail to appreciate the hopes and aspirations parents have for their children. This comes across strongly in work undertaken by the Family and Parenting Institute (Virgo 2010) which reinforces the role of families in supporting the resilience of children and young people.

That is not to say, however, that on occasions services need to be provided directly to the young people themselves, and in the consultation young people said they wanted very practical help with education and life skills development. However, in terms of **supporting resilience**, for the majority of children and young people this will entail providers

continuing to develop services that 'join up' both between individual agencies and across the many agencies that support children, young people and their parents and carers.

5. What proportion of mothers, fathers and carers experience mental and/or physical health problems and what are their characteristics?

Key findings

- While there is no single source of purposely collected national data for identifying parents with either physical or mental health conditions, data collected in the context of government labour surveys suggest that 1.7 million (12 per cent) parents in the UK have a disability as defined under the *Disability Discrimination Act 1995* (GB. Statutes 1995). (For a definition, see Data annexe).

- Of that 1.7 million, a total of at least 64 per cent, have a disability related to a physical condition.

- Obesity levels for both genders are approximately 25 per cent of the population.

- Estimates vary but the labour surveys suggest 26 per cent of disabled parents have a disability by virtue of a mental health condition.

- There are estimated to be 150,000 young carers in the UK, 30 per cent of who are believed to be caring for adults with mental health needs.

- In the UK, 2.2 per cent of the population are identified as having a significant learning disability, with a further 6.7 per cent recognised as having mild and borderline learning disability.

- Approximately, 9 to 10 per cent of women and 5 to 6 per cent of men in the UK are suffering from **diagnosed** mental health difficulties at any one time. Given the intermittent nature of many such difficulties this means a considerably wide spectrum of the UK population experiences mental health difficulties at some point in their lives. Most of these difficulties are mild in nature with only a small minority experiencing serious mental health illness.

- It is estimated that 200,000 to 300,000 children and young people are living with a parent whose drug use is problematic.

- An estimated 1.4 million children live with at least one parent who binge drinks.

- Some black and minority ethnic (BME) groups are over represented in diagnostic terms in the mental health system, in particular African and African Caribbean men are twice as likely to be diagnosed as suffering from schizophrenia as their white UK counterparts, while only half as likely to be diagnosed with depression.

Although there is a lack of clear consensus around some of the key terminology in this priority and the sources of data are dispersed, it is nevertheless still surprisingly difficult to quantify the number of children and young people living with parents who are experiencing physical and mental health problems. For the purposes of this review, discussion will be considered in four sections:

- physical health and disability

- learning disability

- mental health

- substance misuse.

The rationale for analysing the data in this way is that it will enable the authors to focus on the issues prioritised at both the scoping phase of this review and of the discussion within the Theme Advisory Group.

Before looking at each area in turn, however, it is important to recognise that the picture is further complicated by the overlapping nature of the populations under discussion. For example, those with physical disability are more likely to experience mental health difficulties, and there is a well-established inter-connection between mental health difficulties and substance misuse (Morris and Wates 2006). Likewise, there is much evidence that people with learning disabilities are more likely to experience a range of difficulties in their lives, often stemming from the way multiple stressors and stigma associated with social exclusion exacerbate physical and mental health difficulties (DH 2007a).

Physical health difficulties and physical disability

The scoping phase of this review revealed that this is the area in which there is least robust data, and yet the available evidence suggests that these types of difficulties are the most common among parents and carers. As the data annexe explains, one of the difficulties is that data regarding adults derived from health systems often does not differentiate between parents and non-parents. Morris and Wates (2006) drew on two large-scale studies commissioned by the Department for Work and Pensions, the *Labour force survey* and *Families and children study*. Using the definitions of disability in the *Disability Discrimination Act 1995* (GB. Statutes 1995), they report that 12 per cent (1.7 million) of the 14 million parents in the UK are disabled, with 1.1 million households with dependent children having at least one disabled parent. From the same survey, 47 per cent of the respondents who identified themselves as 'disabled' cited problems in relation to their arms, legs, hands, feet, neck or back, including arthritis. A further 17 per cent reported chest or breathing problems such as asthma. A further 26 per cent reported mental health difficulties with the remaining 20 per cent citing 'other problems', some of which may well have been physically related.

The research review undertaken by the SCIE (2005) with regard to young carers can also offer some insights. On the basis of an analysis of the 2001 census data it identifies up to 150,000 young carers in the UK but offers a qualification in terms of the subjective nature of such a definition. In the context of this discussion, it unhelpfully only disaggregates those caring for parents with mental health difficulties, citing a figure of 30 per cent of the total. However, it is reasonable to surmise from this that a substantial proportion of the remaining 70 per cent are caring for parents with physical disabilities and health conditions, ranging from conditions such as multiple sclerosis (MS) to hearing or visual impairment. Many of those who write from a disability rights perspective and adopt a social model of disability challenge an assumption that it is possible to deduce the number of

young carers from the incidence of a condition that occurs primarily in adults of child-rearing ages such as MS. As we go on to argue, the relationship between parental health difficulties (particularly with regard to physical health) is complex. Care should be taken not to assume all parents with certain health conditions or disabilities will inevitably have problems (Olsen and Tyers 2004).

One area of public health in which there has been growing interest, and indeed concern, is that of adult obesity. From the data annexe it is clear that rates have grown substantially over the last 15 years, with 24 per cent of men now clinically obese and 25 per cent of women. Rates among women are greater than men and there is an association with low socio-economic status and obesity. However, it is important to recognise that diagnosing obesity is not straightforward, as obesity exists on a continuum. Any association with difficulties in parenting are most likely to relate to severe or morbid obesity, as opposed to clinical obesity, or being generally overweight.

Learning disability

The scoping phase of this review produced surprisingly few sources of data with regard to parental learning disability. However, the Department of Health (2007a) reports that 2.2 per cent of the UK population has a learning disability with a further 6.7 per cent recognised as having 'borderline learning disability'. Identifying those with learning disabilities is not straightforward and the term itself is contested to the point where some authors have concluded that there is no clear line between those with or without a learning disability (Morris and Wates 2006). Estimates have, therefore, ranged extremely widely from 26,000 to 250,000 (Booth and Booth 2004).

Mental health difficulties

More data on parents with mental health difficulties was captured during the scoping phase of this review. In a major review for SCIE, Parker *et al* (2008) report that much of the data is variable in quality. They also argue that many practitioners in different agencies are not well attuned to identifying parental mental health difficulties among those who use their services. Therefore, as is the case with learning disability, while they may well work with parents with mental health difficulties they would not recognise them as such. What emerges from across the different sources is that mental health, like other health issues, needs to be understood on a continuum. Nevertheless, large-scale high-quality surveys conclude that in the non-elderly population in the UK, 9 to10 per cent of women and 5 to 6 per cent of men may be experiencing mental health difficulties (Parker *et al* 2008). However, given the episodic nature of mental health difficulties, a much greater percentage of the UK population will experience mental health problems at some point in their lives.

Tunnard (2004), summarising similarly large-scale survey-based studies, reports that 14.2 per cent of parents in the UK experience some sort of minor mental health problem normally associated with depression or anxiety. McManus *et al* (2009; see Data annexe) suggest the rate has been gradually rising so it is now more than 20 per cent for 'common mental disorders'. The same authors also found that over 70 per cent of these parents received no treatment at all for these conditions (see Data annexe). It is important not to minimise how distressing and debilitating these 'minor' or 'common' ailments may be to

parents. Indeed, the lack of treatment perhaps reflects a failing of mental health services to engage with these parents rather than indicating that these problems are in any sense trivial. More serious mental health difficulties, and in particular psychotic illness, are much rarer with only 2.5 per cent of parents experiencing such problems.

Morris and Wates (2006) reported that 26 per cent of parents in the UK recognised as having a disability or long-term health problem have some sort of mental illness. Of the 150,000 to 175,000 young people identified in the 2001 census as possible young carers, 30 per cent (or up to 50,000) were caring for parents with mental health difficulties (SCIE 2009). Morris and Wates (2006) reported that between 33 per cent and 50 per cent of children who use young carers' projects do so on the basis that their parents have mental health problems.

Many of these problems will fall into the category of what may be seen as 'relatively common disorders' such as depression or anxiety; and only relatively small numbers experience psychotic illness. Nevertheless, care should be taken to minimise the impact that such 'common' problems can have on parents and, as a result, on the lives of their children.

There is limited international data, but Maybery *et al* (2009a) calculate that 23 per cent of children in Australia live with parents who have experienced mental health difficulties at some time. Tobias *et al* (2009) report from the General Household survey in New Zealand that 19.2 per cent of parents (some of whom had more than one child) had experienced a mental health problem in the last 12 months. In both of these studies the incidence of serious mental difficulties was at a similar level to that reported by Tunnard (2004) in the UK, at between 2 and 3 per cent.

In terms of those who are identified as having mental health problems, the findings about those who are parents are consistently high. Falkov (1998) reports that 20 to 25 per cent are parents but Fowler *et al* (2009) conclude that the figure could be as high as 50 per cent. The point (or **threshold**, as discussed earlier) at which an adult comes to the attention of service agencies – having been formally or informally identified as 'an adult with mental health difficulties' – is high enough for these parents, in general, to have serious and/or enduring mental health difficulties. However, eliciting the number of patients who are parents is not always easy. For example, Scott *et al* (2007) describe in their study of 10 mental health trusts in England, including an audit of 100 case files, that in 70 of the files, no data whatsoever was recorded on the parental status of the adult. A further difficulty in interpreting the statistics is that it is not always clear whether the mentally ill person referred for treatment currently lives with (or entered hospital from) the household in which his/her children live.

In terms of gender there is a consistent finding that mental health difficulties are more prevalent among mothers than fathers (Smith 2004; Tunnard 2004; Maybery *et al* 2009b; Tobias *et al* 2009). For some time, there has been recognition of the significant number of women who experience post-natal depression. Goodman (2004) reports that 13 per cent of women suffer from this condition. However, she cites other literature, which suggests considerable variation in the estimates of researchers. Some community-based studies report the incidence of maternal depression to be 1.2 per cent in the first year after birth,

while others estimate this figure to be as high as 25 per cent. Some researchers whose work Goodman reviewed estimate the incidence of post-birth **paternal** depression, for men whose partners were suffering post-natal depression, as being as high as 50 per cent.

There was also a consistent association found between lone parenthood and increased risk of poor mental health. Tobias *et al* (2009) report that 42.5 per cent of lone parents, as opposed to 19.2 per cent of partnered parents, experience mental health difficulties.

Ethnicity

Greene *et al* (2008) report that there are higher rates of hospital admission and compulsory detention for some BME communities – especially people of Black Caribbean, Black African, white/Black African mixed heritage – than for other groups in the population. African-Caribbean people are twice as likely as white people to be diagnosed with a mental health problem. People from African and African-Caribbean groups are more likely to be diagnosed with schizophrenia and less likely to be diagnosed with depression.

Behind these figures there are, however, some key associations with two sets of issues between:

- structural factors and mental health problems
- the absence of ethnic-sensitive services and access, especially prompt access, to services.

The overall prevalence data outlined above highlights the link between socio-economic characteristics such as poverty, unemployment and insecure housing and inequality and social exclusion. While there are differences between different BME groups, associated with individual as well as structural factors, some social problems such as poverty and discrimination are more commonly experienced. There are also shared difficulties in accessing effective and appropriate mental health services so that mental health problems among BME parents, compounded by lack of treatment and support can have implications for the wellbeing of their children and contribute to the over-representation of the latter in the looked-after system.

In terms of substance misuse McManus *et al* (2009) (see Data annexe) found some correlation between ethnicity and the type of use. White males, for example, were more likely to misuse alcohol, while Black African Caribbean men were more likely to misuse cannabis.

Substance misuse

Like mental health, parental substance misuse is an area that has attracted considerable attention from both researchers and policy-makers. Much of the literature considers illegal drugs misuse and alcohol misuse together. However, it is important to acknowledge that a wide body of policy- and research-related literature also consider them separately. For example, *Hidden Harm*, the report of an inquiry of the Advisory Council on the Misuse of Drugs (2003), recognised the impact of both heavy drinking and heavy smoking but considered this beyond the remit of its report. In terms of illegal drug misuse, this report concluded that there were between 200,000 to 300,000 children affected by drug use,

which correlates with one for every problem-drug-using adult in England and Wales. Drawing on the data from drug-treatment services (of which there was parenthood data available on 71 per cent) the report further concluded that 43 per cent of problem drug users had dependent children, a figure that had grown significantly over the preceding five years. Only 46 per cent had their children living with them, with most living with relatives and a minority in care (9 per cent). Mothers (64 per cent) were far more likely than fathers (37 per cent) to be living with their parents. This data relating to both incidence and gender correlates with the more recent data provided in the data annexe of this report. Heroin and stimulant use (including crack cocaine) were most strongly associated with problem drug use, although it is the pattern of use rather than nature of substance itself that is the greatest risk factor.

It is increasingly recognised that there can be a complex inter-relationship between substance misuse and mental health difficulties for some parents (Schulte *et al* 2008). However, the collection of prevalence data is patchy across the regions of England and Wales and therefore both the nature and extent of this problem are not fully understood. In terms of alcohol misuse it is perhaps surprising, given the prevalence of drinking in our society, that the problem is not more widely reported by researchers. It has been argued by some researchers (Bancroft *et al* 2004) that problematic use remains under-recognised. In particular, its impact on parenting remains to be fully understood. Drawing on the Health Survey for England and the General Household survey, Manning *et al* (2009) conclude that 30 per cent of children in the UK (3.3 to 3.5 million) live with at least one binge-drinking parent and that 8 per cent live with two. Care should be taken with this figure as the definition of 'binge drinking' is contested by the National Alcohol Strategy who – using their higher threshold – estimate that 1.4 million children live with a parent who binge drinks. Four per cent live with a lone binge-drinking parent. They further reported that 3.6 per cent of children live with at least one parent who both misused drugs and alcohol.

It is clear from this discussion that substantial numbers of children are living in families where parents and carers have additional health needs of one sort or another. It is perhaps a reflection of how commonplace many of these difficulties are that the data on prevalence remains uneven and in some areas inconclusive and contested.

6. What is the relationship between mothers', fathers' and carers' mental and physical health and their children's safety, health and wellbeing?

Key findings

- There is an increasingly wide cross-disciplinary acknowledgement of an association between parental health difficulties and children's safety, health and wellbeing, but similar agreement that a comprehensive and precise understanding of the exact mechanisms involved has yet to be reached.

- The **ecological conceptual framework** developed by Bronfenbenner (1979); and the concept of **resilience** developed by Rutter (1999) have both been crucial in showing how multiple factors, both external and internal to family members, may impact on their risk status over time, including mitigating adverse outcomes for children, even in what might appear to be adverse circumstances.

- Understanding this inter-relationship is complicated by the relative absence of knowledge available around the impact on some aspects of child wellbeing, given that in some cases parents will have assessed needs which fail to meet the **thresholds** for services.

- Research suggests that both the characteristics of the parents/carers **and** the characteristics of children/young people themselves can play a role in determining outcomes.

- Children who have provided a significant amount of care to parents while growing up may be more vulnerable to unemployment, poverty and isolation in adulthood.

- Poorer outcomes have been identified across a range of research for children growing up in circumstances where there are:
  - poor parenting skills
  - parental mental health problems
  - parental substance use
  - violence between adult family members
  - parents who were themselves abused or neglected as children
  - social isolation.

The inter-relationship between children's and young people's needs, their chances of achieving optimum outcomes, and the physical, emotional and social characteristics and circumstances of their parents and carers has been widely and consistently acknowledged and highlighted by researchers over a long period. The research contexts in which this inter-relationship has been explored vary in aims, size and methodology. At one end of the spectrum there are the five large-scale, longitudinal British birth cohort studies, which now cover a 64-year period. From repeated data collections in childhood and adolescence, each study has information on the health and physical development of its subjects, their cognitive and educational development, behavioural styles and personality. Adulthood

data collection includes occupation, income, family formation, health and social participation.[1] The cohort studies have been important in facilitating the identification of inter-relationships between physical and mental health problems in both adults and children, even if they, as yet, cannot answer all the questions as to **which** risk factors will be **most** implicated in a negative outcome for **any one** individual at **any one** point in time.

Recent research on resilience (Schoon and Bartley 2008) recognises the interaction between individual development and context, including social and economic factors such as poverty, deprivation, family environment and community resources. These authors also acknowledge the positive paradigm shift from a 'pathogenic or deficit model' to the observation of 'positive outcomes in the face of adversity' (op. cit. p 24).

This prevalence data is further illuminated by data which has been collected in some specific service outcome evaluations (Horwath 2001; Olds *et al* 2004; Quinton 2004; Barlow and Underdown 2007; Belsky *et al* 2007). These authors echo the earlier work of Conger *et al* (2002), and in particular are agreed that **parental stress** is a key factor in the emergence of negative child outcomes. They point out the high possibility of it being linked to parental illness, poverty, child behaviour problems, and its relationship to almost all other likely disruptions to parenting.

This expanding knowledge base has underpinned approaches to assessment by those working in the child welfare field (Velleman 2004; Cleaver *et al* 2007). Many of these professionals have for some years recognised that living with parents with significant health difficulties can cause difficulties for children and young people in both the short and long term. Their approach was reinforced more widely in 2000 when findings from a range of studies were distilled to design a framework for helping practitioners better understand the interventions and supports that may be helpful for parents in maximising child outcomes (DH *et al* 2000). This research-based framework, designed to be applicable to all parents and carers, identifies six dimensions to the task of parenting:

- basic care
- ensuring safety
- emotional warmth
- stimulation
- guidance and boundaries
- stability.

However, our understanding of the process whereby the successful undertaking of these tasks by parents can be hindered or supported is still partial. For example, questions remain as to how individual parental and child characteristics interact (Aldgate *et al* 2006; Beresford *et al* 2008). In particular, research studies from a range of disciplines have

---

1. MRC National Survey of Health and Development, www.nshd.mrc.ac.uk; National Child Development Study, www.cls.ioe.ac.uk; British Cohort Study 1970, *www.ioe.ac.uk*; Avon Longitudinal Study of Parents & Children, www.bristol.ac/alspac; Millennium Birth Cohort Study, *www.cls.ioe.ac.uk*.

continued to explore the exact nature of the relationship between children's and young people's safety, health and wellbeing and their mothers', fathers' and carers' mental and physical health, including substance abuse. It should also be noted that there are imbalances in the literature, so, for example, we have more knowledge about the impact of parents' and carers' mental health on their children's wellbeing, than on parental physical health. We do know that children who have provided a significant amount of care to parents while growing up may be more vulnerable in adulthood to unemployment, poverty and isolation (Aldridge and Becker 2003; Gorin 2004; Finkelstein *et al* 2005).

We also know that parental characteristics and circumstances can impact – for better or worse – on the ability of parents to respond to the needs of children and young people for whom they have responsibility, and both policy and practice literature address this topic (Cowling 2004; Tunnard 2004; Beresford *et al* 2008). This knowledge has been central to the design of both policy and practice. Of particular relevance to parents and children with health problems have been the Family Intervention Projects (now known as Intensive Family Interventions) which are currently being evaluated (National Centre for Social Research). Evidence for the families who received interventions between 2006 and March 2010 shows that there have been significant improvements in a range of areas including reductions in mental health problems and drug and alcohol misuse (Gowland 2008). This evaluation also found that the longer the family received the intervention, the better the outcome. Central to their way of working is a 'team around the family', led by a lead key worker for the whole family:

> The primary responsibility for a family's welfare will always rest with parents. The task of public services is to provide the best possible support to enable parents to fulfil that responsibility.
>
> (Social Exclusion Task Force 2008 p 4)

> Parents may be experiencing their own problems which may have an impact through their behaviour on their capacity to respond to their child's need.
>
> (DH *et al* 2000 p 25)

> A parent's mental ill-health can have an effect on the mental health and development of their child.
>
> (DCSF 2006 p 76)

Despite these policy aspirations to support parents in order to facilitate better outcomes for children, the 'definitive understanding' of the nature of any relationship between children's safety, health and wellbeing, and their mothers', fathers' and carers' physical and mental health remains elusive. Even if we can identify the crucial **range** of adverse circumstances (Gorin 2004; Tunnard 2004), we still lack the ability to draw categoric conclusions as to whether a specific outcome will have **definitely** been produced by a single circumstance or set of circumstances; or whether those circumstances should, more usefully, be regarded as an early-warning sign of **possible** later problems (Darlington *et al* 2005; Finkelstein *et al* 2005).

We recognise, however, that a number of overseas interventions have presented strong evidence of improving child outcomes (Dawe and Harnett 2007; Lam *et al* 2008). These interventions have been assessed through the use of randomised control trials and other

rigorous evaluation designs. There may be features of these programmes that could be replicated in a UK context. Details of studies that have used such designs are provided in the 'Further reading' section of the review.

In terms of the literature that has been incorporated in this review, there remain gaps in knowledge about the factors that can mediate, even in adverse circumstances, against damage to the outcomes for children and young people. The way in which practitioners handle this tension lies at the heart of good practice.

What are the key factors that impact on outcomes?

In a study of the needs of children of problem drug users (Social Exclusion Task Force 2008 p 30) a threefold typology for studying a process of growth and developmental needs for children and young people was developed. It is relevant **across a range of parental needs** and highlights the areas within which negative outcomes can have their roots:

- conception and pregnancy

- parenting

- the wider family and environment.

Along with the conclusions of other research overviews (Gorin 2004; Tunnard 2004) a picture emerges of poorer outcomes overall for children in home circumstances where there are:

- poor parenting skills

- parental mental health problems

- parental substance use

- violence between adult family members

- parents who were themselves abused or neglected as children

- social isolation.

The range of parental characteristics that might be said to characterise the circumstances of children at risk (Social Exclusion Task Force 2008 p 4) is diverse. The potential interplay within this diversity (comprising socio-economic as well as psycho-social and physical characteristics) is further amplified in the basket of indicators used by a 2005 Cabinet Office study (Cabinet Office 2005) as outlined below:

- no parent in family in work

- family living in poor or overcrowded accommodation

- no parent has any qualifications

- mother has mental health problems

- at least one parent has a longstanding limiting illness

- disability or infirmity

- family has low income (below 60 per cent of the median or cannot afford a number of food and clothing items).

However, there are still a number of gaps in what we know about parental characteristics, for which the reasons are in part methodological. For example, both research findings and practice knowledge frequently derive from the identification of families through serious case reviews (Rose and Barnes 2008; Brandon *et al* 2009) and core assessments in which levels of both child and parental need will be consistently high. This may well generate knowledge and understanding of the needs and potential of the **most seriously incapacitated** parents. This could apply across physical or mental health problems, including where family members no longer live together. At the same time, there may be less knowledge available around the impact on child wellbeing of the needs of those parents whose assessed needs fail to meet the thresholds described in Section 1 of this report, where negative outcomes may take place 'imperceptibly' (Aldridge and Becker 2003; Beresford *et al* 2008).

How far do we currently understand the complexity of the inter-relationship?

Perhaps most importantly for the focus of policy and practice, a picture emerges across the literature of a complex relationship between the needs of parents – whether unmet or met – and the probability of positive and/or negative short-, medium- and long-term outcomes for their children. To further increase the complexity of this relationship, research suggests that both the characteristics of the parents/carers **and** the characteristics of children/young people themselves can play a role in determining outcomes (Mowbray and Oyserman 2003; Nicholson *et al* 2007).

While there are no crude formulae available for calculating the impact of parenting style on outcomes for children, there are clear pointers in the research, of which the phenomenon of **parental stress**, as highlighted above, is probably the most crucial. It provides one thread through the path of understanding data, both in relation to 'singular factors' such as parental problems, including substance misuse and mental disorder, as well as multiple challenges, including poverty, parental health problems, isolation and exclusion from the labour force.

The impact of post-natal depression has been found to have an effect on a child's risk of displaying violent behaviour:

> What is clear… is that the mother's mental health state after childbirth is an easily identifiable risk factor for her child's intellectual and social development... what is not clear is the mechanism whereby this risk factor exerts its influence.
>
> (Hay *et al* 2003 p 1092)

Exposure to maternal depression had an effect on adolescent IQ, especially for boys. It did not predict some emotional and behavioural difficulties, although maternal depression did lead to higher incidences of some conduct disorders particularly with regard to violent behaviour by boys (Hay *et al* 2008). In addition, postnatal depression in women can have an effect on fathers too, and has been found to have important implications for overall family health and wellbeing (Goodman 2004).

The systemic impact of conditions such as mental disorders and substance abuse – in and on different family members – is also highlighted by Townsend *et al* (2006). They draw on stress-process theory to propose a conceptual framework for understanding how such problems impact in and on different family members; and describe how the care givers (for example, parents) can impede family member outcomes in the longer term as well as in the present.

Brandon *et al* (2009) in their analysis of serious case reviews demonstrated the association between parental substance misuse, parental mental health difficulties and domestic violence. However, simplistic causal relationships cannot be inferred – a number of authors (Powdthavee and Vignoles 2008; Pretis and Dimova 2008; Scaife 2008) caution against this temptation. This caveat applies across parental characteristics, including parental disability such as mental illness, as well as maternal and paternal drug misuse:

> It cannot be assumed that parental drug misuse automatically leads to poor outcomes for children...
>
> (Scaife 2008 p 55)

> The increasing prevalence of mental illness among parents always represents a stressor affecting the bio-psychosocial [physical, cognitive, emotional and social] development of a child. However not all children are affected to the same extent...
>
> (Pretis and Dimova 2008 p 152)

Gender differences recur through the literature with boys apparently somewhat less able to withstand stress engendered by maternal alcohol abuse (Snow Jones 2007) and more likely to achieve higher behavioural problem scores. Using a fivefold model of illness (identity; causes; duration; consequences; and curability), Fox *et al* (2007) found that there were gender differences with girls showing greater social acceptance and more compassion than boys.

Considerable gaps remain in our understanding of ethnic variations, although Dogra *et al* (2005) in a study of Gujarati young people and parents found neither group had a consistent understanding of either mental health or mental illness. Greene *et al* (2008) focused on the experiences of black and minority ethnic groups in the UK. Gorin (2004) emphasises the different approaches to seeking support which characterise children in different ethnic groups, with Asian children preferring to seek help within the family.

Almost all researchers reject the notion that negative outcomes are inevitable throughout childhood, and indeed into adulthood and seek to highlight the potential of a range of interventions to minimise or erase the harmful impacts of parental deficit, even at the stage of pre-natal influences.

> Whilst early childhood mental health is significantly affected by pre-natal events in addition to the child's later environment… interventions targeting adverse pre-natal, pre-natal and post-natal influences can be expected to improve mental health outcomes for children in the early years...
>
> (Robinson *et al* 2008 p 1118)

What may be the possible pathways?

A picture emerges across the literature of a complex relationship between the circumstances and needs of parents. For example, in the context of **parental mental distress**, some studies suggest a parent's heightened mental distress may have a direct impact on the child's wellbeing, including maternal withdrawal, tense interactions and transmitted anger. However, even then some groups of mothers were more skilled at handling emotions and there is little known about longitudinal relationships (Powdthavee and Vignoles 2008). Despite the suggestion of associations between parental stress, parents' overall health and wellbeing and children's safety and wellbeing, this association is far from conclusive or simplistic. There are obvious examples. Smith (2004) draws on earlier work by Duncan and Reder (2000) on the impact on children of behaviours associated with parental psychiatric disorder. She conceptualises these pathways as 'disruptions to parenting'. So, for example, self-preoccupation can result in a child being neglected; frequent separations in a child becoming anxious, perplexed, angry and neglected.

There are many complexities to this relationship. For example, the perceptions of mental illness articulated by children and young people themselves appear to be a potential 'active ingredient' in their own outcomes (i.e. the likelihood of surviving undamaged, or minimally so). Some work has focused on the way in which children and young people perceive their parents' behaviours (Rusch *et al* 2005). There is a suggestion that where children and young people were best able to understand their parent's mental illness as a 'set of behaviours' (as distinct to being synonymous with their parent's **personality overall**), the better it was for their ability to cope with challenging responses and the less damaging to their developmental outcomes.

The pathways by which these circumstances impact on child outcomes, i.e. how they affect children's lives, are complex, and again not fully understood. In essence, the literature suggests that there are five main routes that have been established:

- physical changes in the developing brain as a consequence of stress or trauma
- difficulties in forming and maintaining relationships linked to insecure attachment as infants
- mental health-related responses to stress and trauma, including depression, anxiety, post-traumatic stress disorder and behavioural disorders (and subsequent physical health responses to behaviours such as smoking which are more likely among those with mental health problems)
- the development of adult behaviour patterns based on those observed at home
- the disruption to education and social relationships caused by family disruption experienced as a consequence of parental behaviours.

Given the range of adverse outcomes for children that have been identified, inevitably the relationship between some will be easier to understand than others. For example, physical health problems sometimes arise directly from injuries received as a result of abuse. Neglect can also result in immediate physical health problems. However, there are more subtle impacts where the links will be less immediately obvious, such as: poor educational

performance; offending; substance use; or impaired physical health (Clark *et al* 2004). Childhood mental health problems – including anxiety, depression, disorder and conduct disorders – can reflect problems such as parental mental health and substance use problems (Marmorstein *et al* 2009).

Resilience

Building on earlier work by Garmezy (1983) and Werner and Smith (1982), the concept of **resilience** was best and most widely highlighted and developed by Rutter (1985). It is described as: 'the capacity of a person to develop positively, and in a socially acceptable way, inspite of adversity'.

Schoon and Bartley (2008) draw attention to the fact that much of the literature on resilience has emphasised individual characteristics, many aspects which can be seen as part of a **structural** context and are related to outcomes in later life. They found that individuals growing up in poverty are generally less likely to develop these resources to survive adversity than their more privileged peers. Furthermore, even if they demonstrated capabilities to overcome external adversity, in respect of educational, health-related or occupational outcomes in later life, they were still not achieving to the same level as more privileged peers:

> Having a parent with a mental health problem has associated risks for children, but some families seem very resilient and do not always suffer these difficulties...
>
> (Walsh 2009 p 115)

In other words, children's safety, health and wellbeing is not just determined by whether their parents have mental or physical health problems; they are active agents in determining their own life courses. This should not be confused with children displaying artificial levels of social maturity that in effect are masking a lack of parenting and neglect. Rather, as the literature around young carers in particular illustrates (SCIE 2009), children are not simply the passive recipients of the circumstances in which they find themselves. In some, albeit not all, situations the sense of self-efficacy that results from coping with adversity will promote their resilience. The adaptation of individuals to adversity, including maltreatment, results from interactive processes among the resilience factors located within the child, family and community.

While resilience has increasingly been seen as important in understanding the relationship between parental difficulties and child outcomes, it is important to recognise that its impact on specific child/parent behaviours and interactions is not as yet fully understood. Nevertheless, it does appear that resilience can help maximise children's outcomes by providing a more positive family or wider environment. Resilience and better child outcomes, however, can also be related to certain characteristics of the individual child. However as Schoon and Bartley (2008) caution: 'there is not one major factor that enables individuals to cope with adversity, but rather a combination of influences and measures making a difference…' (p27)

In summary, the research studies reviewed provide a consistent picture of the challenges posed by a range of diverse circumstances, which undermine the ability of parents and

carers to meet the needs of children and young people. These circumstances include physical and mental health problems, as well as substance abuse. In some cases, as a result of the impact of these issues, the development of children will be affected. In others there appear to be family and individual child-level factors which mean this harm is avoided, a relationship that is still insufficiently understood. However, the variation in adverse circumstances and the differences between individual child and parent characteristics is likely to require a similar diversity across services designed to support parents in their parenting roles.

7. What interventions and support mechanisms are most effective in increasing children's safety, health and wellbeing through improving mothers', fathers' and carers' a) physical and b) mental health?

Key findings

- Measuring the effectiveness of interventions is a complex task which involves outcomes at three levels: family level; parent/carer level; and child level.

- Key outcomes of effective support interventions for each of the three groups (parental physical health, mental health and substance misuse problems) include: physical and psychological wellbeing; self-esteem; cultural and ethnic identity; improved adult/child and partner relationships; improvement in parenting competence.

- Services which combine direct support for children but also work with their parents within a framework of flexible and tailored support are positively evaluated, both within the research-based literature and the validated local practice identified as part of this review. The quality of the relationship between professionals and the families they supported was found to be a crucial lever for change in a range of services such as Home-Start and the Family Nurse Partnerships.

- The Think Family Pathfinders and the related Family Intervention projects have also begun to show some encouraging results. The flexible personalised way in which they respond to both the needs of children and adults is viewed extremely positively by families and the professionals working with them. Evaluations of the programmes stress the value of flexible working from adult services, information sharing and joint commissioning in delivering a more cohesive service for vulnerable families.

- Service usage is likely to be influenced by the characteristics of the services, notably whether they are seen as stigmatising or not, a hazard which particularly relates to involuntary rather than voluntary service use.

- Services across the spectrum of need must be sensitive to the circumstances of the children and families using them especially with regard to poverty, ethnicity and disability.

- It is essential that services are provided at each of the tiers of need and that bridges to access are constructed both between the levels of need and between the different professional groups and systems.

- There is a positive association between early intervention and better outcomes, but late intervention is better than no intervention at all.

As highlighted in Section 6, because there is no straightforward association between parental wellbeing and child wellbeing, measuring the effectiveness of interventions is by definition a challenging task. Nevertheless, a range of interventions have been demonstrated to make a positive difference in addressing these difficulties, which are identified in the 'Further reading' section of this review (see Cicchetti 2002; Sidebotham *et al* 2010; Stewart-Brown and MacMillan 2010). In order to capture the most helpful

messages for practice we have drawn on evidence collected from a range of research methods, including explorations of the views of people who use services.

The outcomes reported across the studies reviewed include three levels: family level; parent/carer level; and child level. The outcome measures reported by the different studies vary and may include physical and psychological wellbeing; self-esteem; cultural and ethnic identity; improved adult/child and partner relationships; and improvement in parenting competence. There is considerable overlap between the three levels, but data on the specific impact of services for adults on the health of children is relatively limited. Areas explored typically include the value of a range of health, educational and family support services in helping families to deal with mental health problems. Both in services for parents and children where parental stress has been shown to be linked to their child's behaviour and/or mental health problems. Interventions aimed at reducing the parents' stress as well as working with the child were positively associated with improvement in the child's behaviour (Kurtz and James 2005).

We know from the literature (Barlow *et al* 2008; Beresford *et al* 2008; Asmussen and Weizel 2009; Fowler *et al* 2009) that many of the parents and carers facing serious challenges in their role as parents are confronting multiple and simultaneous difficulties in their own lives. Mindful of the breadth and co-existence of mental and physical health challenges for parents, ranging from stress to alcohol misuse (Cleaver *et al* 2004), we have selected the following framework based on the fourfold typology of tiers of child need, referred to in Section 2 above.

The four tiers: implications for understanding service efficacy

The 'four tier' framework can facilitate understanding of the relationship between 'severity of problem' at the point of referral and 'measurable outcomes of services' at the point of delivery.

The current knowledge base means that we tend to know most about Tier 1 and Tier 2 interventions. At this level it is important to note that **no one intervention** is likely to be sufficient on its own. Even with tight targeting, some parents will take up offers of support, others, for a range of reasons, including stigma, will be deterred from using services, or drop out early on. For families where parents have health difficulties, the tier of intervention will, as with all families experiencing difficulties, depend on the type and severity of ill health, the composition of the family, for example, extent of support from a parent or relative, and whether the health problem is compounded by other difficulties in other family members. If in the latter group, parents are likely to be in need of Tier 3 and Tier 4 services, especially if there are mental health problems and addictions.

We know rather less about the effectiveness of services at Tiers 3 and 4; in large part because the complexity of issues which 'referred' families face almost invariably means that several services are provided consecutively or concurrently. Deciding whether a particular service or therapeutic method has led to a particular outcome is a major difficulty for summative research (Thoburn 2010). For some, a high-intensity multi-method approach will help. The model of home visiting, developed by Olds in the US, looking at the intensive individualised support provided by trained nurses to teenagers through

pregnancy and infancy is currently being piloted and evaluated in a government-commissioned study called the Family-Nurse-Partnership in England (Olds *et al* 2004).

Using the tiers model to review our knowledge of service outcomes can potentially inform useful service delivery strategies best able to support parents with a range of needs. For example, 'looking through the lens of the tiers' can highlight the likely consequences of some more complex services only being offered after a certain threshold of need has been met (Smith 2004; Tunnard 2004; Social Exclusion Task Force 2008). In other words, if even potentially successful specialist services are offered too late when problems are entrenched, then outcomes are likely to be poorer.

What do we know about Tier 1 interventions?

Tier 1 services are universal services and, as well as assuming access to adequate housing and income levels, will include community-based provision ranging from GP services to public libraries. Their role in a specific intervention outcome is crucial as the earlier in the development of a problem that help can be offered, the greater the chances of better outcomes later. To maximise access for all groups, provision has to be sensitive to the circumstances of all who want to use them (Beresford *et al* 2008; Parker *et al* 2008), including people in a particular need group, for example, midwifery services for expectant mothers (Barlow *et al* 2003). Most of the parents who have physical disabilities would be using services at this level. Quinton (2004) demonstrates how many of these parents did not need targeted or specialist provision; rather they required universal services that were sensitised to their needs as disabled parents. Services must, in line with disability discrimination, be accessible to people with impairments (Olsen and Tyers 2004). Greene *et al* (2008) highlight the fact that black and minority ethnic parents with mental health problems are often reluctant to use existing services because they are not culturally sensitive to their needs, a challenge yet to be fully addressed.

What do we know about Tier 2 interventions?

Some of these also target vulnerable groups, for example, when health visitors, or extended schools, Sure Start children's centres or community centres provide additional services to families under stress. Some 'referred' families receive an enhanced service and have a 'lead professional' allocated to them to coordinate the 'team around the child and family', or child development centres for disabled children and their families. The two most common, and currently the most comprehensively evaluated service delivery strategies at this level, are home-visiting and parent education programmes, both of which have been used to complement routinely available universal services.

Home visiting

Home-visiting programmes emphasise the role of improving parents' knowledge of good parenting practice, boosting their confidence, building on their strengths and improving parenting skills and behaviour. The underlying assumption is often that resources to address these issues via social networks are not available, so the visitor (who may be a professional or someone from the local community) fills the void. Home visitors are usually trained to enable parents to make contact with other more specialist sources of help if necessary, although some professional home visitors provide services directly.

A meta-analysis, which combined the results of evaluation data from 60 home-visiting programmes, found that parenting behaviour and attitudes generally improved as a result of home-visiting programmes (Sweet and Appelbaum 2004). Children enrolled in home-visiting programmes generally fared better than those in the control group. Within the set of child outcomes; healthcare, maternal self-sufficiency and maternal self-help yielded effect sizes significantly greater than zero. However, there was no discernible impact on either the incidence of child abuse or on child stress and, with respect to this review, they tend not to specifically report on outcomes for children whose parents have different health problems.

One of the difficulties of drawing conclusions for Britain from US-based home-visiting studies is that parents in the US do not have access to universal health-visiting services. Thus, the support provided by the home visitor is being compared with no organised support. In Britain, parents have access to health visitors, and evaluations comparing more intensive or additional home visiting (in particular First Parent and Home-Start, two UK-based home-visiting programmes using volunteers) with standard health visiting have found few substantive differences in either child or parent outcomes. The most recent evaluation of Home-Start (unusually for a UK evaluation using a comparison group design) found that parents had less stress and better social support, and children's development was better, but the Home-Start parents used more services than the comparison parents, and there were no net savings in the short term. In many ways this illustrates the challenge facing those developing interventions. Home-Start **might** make a major difference to children's life chances, and with long-term follow-up might have benefits that significantly exceed the costs, but in the short-term planning environment it does not appear to be cost-effective.

There was, however, some evidence to suggest that programmes that used workers (under professional supervision) who did not possess professional qualifications or who were unqualified as home visitors, had a greater impact in potentially abusive families than either those using nurses or those using volunteers (Sweet and Applebaum 2004). Individual studies raise issues favouring different groups. Health professionals tend to be better at referring parents to specialist services. Members of the community can encourage greater empathy and openness, but can also raise issues of confidentiality and privacy. However, other evidence suggests that it is the quality of the relationship between the parent (almost always the mother) and the visitor that matters, not whether the visitor is a professional or a parent.

The most often-cited home-visiting scheme is the Nurse-Family Partnership developed by Professor David Olds of the University of Denver. This was implemented in three sites: Elmira, Memphis and Denver. The follow-up process differed between sites. Long-term follow up of mothers in Elmira showed that the incidence of verified maltreatment was significantly reduced (an average of 29 per cent of mothers compared with 51 per cent in the control group). The effect was most pronounced for poor teenage mothers. There were no similar effects in either the Memphis or the Denver trials, although there were fewer injuries to Memphis children (Olds *et al* 2004). Overall, outside the Nurse-Family Partnership, which targets a specific group (disadvantaged first-time teenage mothers), the evidence to support home-visiting schemes beyond universal health visiting is limited. A randomised controlled trial of the Nurse-Family Partnership is underway in England and

this will provide evidence as to how effective it is in the context of a universal health service. These programmes have positive outcomes for both parents and children, so their impact on child maltreatment is not their only justification and they offer the opportunity for earlier detection of maltreatment, particularly neglect. The programme will be expanded from 30 to 70 sites by 2011, with a view to rolling out this support for the most vulnerable mothers across England over the next decade.

Other evaluations (Barlow and Svanberg 2009) provide some support for the idea that within the relationship developed via intensive home visiting, it is possible to improve parents' understanding and parenting practice and to build parents' confidence. This can in turn contribute to better family relationships and potentially reduce rates of maltreatment as children become older. In comparison to routine health visiting, home visiting was perceived as allowing health visitors to work more to a preventive model of care versus 'crisis management'. This approach allowed visitors to focus on change, focus on the family needs and relationship building and understand the decision-making process of families.

Parenting skills programmes

These programmes, about which we have increasingly helpful data (C4EO 2010) represent a means of enhancing the capacity of universal services to meet the need of more vulnerable families, including as a means of addressing mental and physical health needs of parents/carers. In some cases this has meant including services for some identified families by health visitors. In others it has involved the provision of parenting skills programmes, the latter delivered on an open-access as well as targeted basis. They can be delivered on a group basis or a one-to-one basis in the family home. There is some evidence from the Family Intervention Project evaluations that this approach is more acceptable – especially if delivered intensively by an outreach worker – to families with mental health or addiction problems (DCSF 2009).

Parental stress may derive from a range of sources including: parental physical or learning disabilities; poverty; tensions within adult relationships; mental health difficulties; and substance misuse problems. Each of these **may** lead to the reduction of parenting skills, impulse control and stress management issues. Helping parents in these circumstances to 'do their best as parents' is one aim of parenting skills programmes. There are many such programmes, developed by a wide range of organisations and individuals (Barlow *et al* 2008; Barlow and Svanberg 2009). However, there are four well-developed manualised programmes whose use is widespread and whose impacts have been measured: Mellow Parenting (developed in Scotland); Webster-Stratton (also known as Incredible Years developed in the US); Triple P (also known as the Positive Parenting Programme developed in Australia); and Parenting Matters (developed in England). These programmes usually provide group sessions for parents over a period of weeks and offer a combination of skill development and social support. Parents share their experience, with some of the programmes videoing parent–child interactions which are then used as a basis for discussion.

Evaluations have shown that these interventions lead to:

- reductions in harsh, negative, inconsistent and ineffective parenting and increases in supportive and positive parenting (Webster-Stratton)

- reductions in ineffective commands by parents (Webster-Stratton)

- improvements in parents' self-esteem (Parenting Matters; Mellow Parenting)

- improvements in parent–child relationships (Mellow Parenting, Parenting Matters, Triple P)

- reductions in parental anger and blame of children (Triple P).

Evaluations of other programmes tend to show similar effects. The evaluation of the Parent Support Advisor Pilot (Lindsay *et al* 2009), for example, demonstrated the benefits of a flexible, school-based parenting support programme in which the relationships and 'style' of the adviser was valued by parents. The Children's Workforce Development Council host a Commissioning Toolkit, which is a searchable database of parenting interventions designed to provide information and guidance for commissioners, service managers and programme developers on the quality and effectiveness of parenting programmes/approaches. It can be found at: www.commissioningtoolkit.org/

A common theme in the evaluations has been in relation to access and in particular the importance of high-quality assessments ensuring access to the **right programme at the right time**. The following example from Hertfordshire highlights an innovative multi-agency approach to this issue

---

Validated local practice example
The Right Response, by the right service, at the right time

What is it?
The Right Response is a multi- agency project, set up in July 2010, in Hertfordshire by the local authority in order to embed multi-agency working and ensure the best use of available resources.

What does it do?
The Right Response project has established a Targeted Advice Service. This service works closely with referrers in order to maximise the allocation of services so that they are matched closely to need via the Common Assessment Framework (CAF) process. 'Virtual' multi-agency teams then work with families across the spectrum of need.

Why is it different?
This project has reflected a rigorous and multi-agency based approach to managing referrals, in a timely and effective manner, ensuring that services are allocated appropriately.

> *What has been achieved?*
> The project has been able to demonstrate an apparent increase in CAF activity in the local authority and a decrease in referrals to social care. This reflects the benefits of earlier more targeted support.
>
> Find out more about this project on the [website](#).

What do we know about what works at levels 3 and 4?

The following validated local practice examples that have been identified within this knowledge review process relate to interventions at these higher levels of need. They provide excellent examples of messages which are reflected in the wider literature

> **Validated local practice example**
> **Holding Families**
>
> *What is it?*
> This is a multi-agency project that developed across the Children's Trust in order to reduce the harm of parental substance misuse on children and family life
>
> *What does it do?*
> The integrated team offers 'whole family support' through a 16-week programme. The nature of the programme is tailored to the needs of individual families but involves both individual and group sessions with parents and their children. Childcare specialists work with the children and adult substance misuse workers with the parents. Family work is carried out at regular intervals through the programme.
>
> *Why is it different?*
> This service uses existing services in a new and innovative way through the creation of an integrated, multi-disciplinary service. In the past families would have been offered a series of separate interventions.
>
> *What has been achieved?*
> The project has been independently evaluated by Salford University and has reported positive outcomes. Most importantly, there is evidence of families benefiting from the service through improved relationships within the family, reduced parental substance misuse (in some cases abstinence) and an appreciation by the children of the desire by practitioners to understand their perspectives and experiences. Practitioners report much improved inter-professional and inter-agency collaboration.
>
> Find out more about this project on the [website](#).

Validated local practice example
Building Bridges

What is it?
Family Action's Building Bridges service has been delivered in eight local authorities since 1999. It seeks to address and alleviate concerns arising from the impact of parental mental health difficulties on children and young people.

What does it do?
The service is provided by family support workers who, on the basis of an assessment that focuses on the impact of parents' mental health difficulties, offer a tailored package of support. This package can include direct work with parents and children, support in helping families access other services such as children's centres and practical assistance with issues associated with poverty.

Why is it different?
This service is different in that it specialises in parental mental health but builds on the strengths of other manualised parenting programmes, such as Webster Stratton and Triple P, by offering an additional tailored case-work-based service. (Manualised programmes place an important emphasis on 'programme fidelity', i.e. **doing the same thing in the same way**).

What has been achieved?
The service has been independently evaluated using validated research instruments and this has shown evidence of a reduced number of children subject to child protection plans, and of their parents on the Care Programme Approach. Evidence from health visitors in one area suggested a significant reduction of vulnerable children on their caseload.

In terms of cost benefits, 40 families were supported between 2009 and 2010 at a cost of £3,500 per family. The cost per family per week was £73. The return on investment was £1.37 for every £1 invested. Estimated savings to education services over two years were £114,000. Estimated savings from reduction in benefit claims over two years was £158,000 and estimated savings to health services over two years was £67,200.

Find out more information about this project on the [website](#).

Validated local practice example
Shelter, Keys to the Future

What is it?
This is a 'ground-based service', provided in six locations across the country that provides support to homeless young people and their parents.

What does it do?
This project helps homeless young people and their families to find settled accommodation and provides ongoing practical and emotional support. Workers assess and broker multi-agency support for the young people via the CAF process. However, workers also work with parents to help address parental difficulties such as parental mental health problems.

Why is it different?
This project has been innovative in that it has promoted positive working relationships between housing providers and child welfare agencies. The project has also sought to meet young people's needs through the delivery of additional support for their parents.

What has been achieved?
The project has been evaluated by Birmingham University who report that improved outcomes have occurred for the majority of families across all of the Every Child Matters outcomes. For example, they highlighted many examples of families who had received a service that met, through tailored support, a range of needs ranging from the practical and educational to the emotional. Overall this reflects how fundamental housing issues are to family life, as well as the inter-related nature of the outcomes, and therefore the benefit of a holistic approach.

Find out more about this project on the website.

Validated local practice example
The Multi-Agency Adolescent Support Service (AMASS)

What is it?
AMASS is a multi-agency project established in Islington by the local authority in response to the fact that, historically, the authority has a high number of looked-after young people.

What does it do?
This service offers intensive community-based interventions to young people and their families where there are significant risks posed to and by them with regard to issues such as offending, school exclusion, substance misuse and gang membership. The service works with the whole family recognising that the parent is the 'main agent of change' and that many parents have their own, often health-related, difficulties. Contacts can occur between three and five times a week for periods of up to six months.

Why is it different?
This project is innovative in that it has brought together a range of different agencies and professionals to work both with each other and more intensively with a vulnerable group of families.

What has been achieved?
The project has been externally evaluated by the University of Bedfordshire who reported that not only did parents and young people positively evaluate the service but that it was possible to identify positive outcomes as a result of the intervention of AMASS in the following areas:

- offending
- gang-related and anti-social behaviour
- school exclusions and poor attendance
- self-injurious behaviours
- substance misuse.

In terms of cost benefit, 22 families with a young person exhibiting challenging behaviour benefited from the service between 2009 and 2010 at a cost of £780,000. This equates to £739 per family a week. The social return on investment is £1.46 for every £1 invested. Estimated savings to the local authority/Department for Education over two years is £336,932; to the local authority/Department of Health is £161,356; and to the local authority/Ministry of Justice is £624,000.

Find out more about this project on the website.

As the above research evidence, and indeed these practice examples, indicate, it is difficult to devise rigid boundaries across understandings of respective interventions (Ostler 2009; SCIE 2009), not least because of the interlocking system of thresholds to services. For example, a child may not be assessed as being in sufficiently high need (often equated with being at sufficiently high risk of maltreatment) to access family support services. This may well be on the basis that these more specialist services need to be prioritised for those families most at need. However, the evidence suggests that access to appropriate services, i.e. earlier or later in the trajectory of a problem (or not at all) will have an impact on long-term child and family welfare outcomes (Sheppard 2004).

Even though some interventions will be helpful early on, this is less likely in cases where problems have become more entrenched or are more acute (Parker *et al* 2008). More intensive programmes developed in the US and evaluated as either 'effective' or 'promising' with specific groups are being piloted in the UK and other countries in Europe. Multi-systemic therapy (MST) was found to be a promising intervention in the US with teenagers with challenging behaviour or involved in the criminal justice system and their families. MST is an intensive targeted programme for young people with acute problems and evidence shows that it is most successful when fidelity to the programme's requirements is followed in implementation. It has been found to be less effective when service providers make adaptations to suit local populations and legislative and service delivery arrangements. A recent experimental (random control) evaluation in Sweden surprisingly reported no difference in outcomes (at 7 and 24 months after treatment) between the MST families and the 'service as usual' families. However, one hypothesis is that this less positive result is a consequence, not so much from any deficit in the MST service, but rather from the higher quality 'service as usual' provided in Sweden (at a lower cost than the MST project) than the 'service as usual' available to the control group in the US (Sundell *et al* 2009). MST is reviewed in more depth within another of the research reviews undertaken by C4EO, related to vulnerable children (Dickson *et al* 2009).

A recent randomised controlled trial of MST for young people in England referred to the Brandon Centre (a voluntary sector provider in North London) through youth offending services, indicates that MST was more effective and more cost-effective than usual

services in reducing young people's offending (National Mental Health Development Unit (2010). A larger randomised controlled trial of MST, led by Professor Peter Fonagy at University College London, is currently underway across nine MST sites in England. This trial looks at young people and families referred to MST where the young person (aged 11 to 17) is at risk of out-of-home placement in care or custody, due to serious behaviour problems or offending and will look at outcomes for both young people and their parents

Evidence from a range of UK longitudinal and mixed methods research studies (Quinton 2004) shows that around half of families referred for an assessment of need to local authority social care services are not referred specifically for a child protection service, but have a **range of needs,** many of which will be in relation to the health of the parents, be that mental, or less commonly, physical health. If not appropriately met, these will lead in many cases to deterioration in the health and wellbeing of the children in the family. The majority will need a short-term (though possibly high-intensity) service after which time the universal services will be able to meet the ongoing needs. A proportion – around 40 per cent of all those referred for an 'in need' or 'child protection' service (Thoburn *et al* 2000) and around 40 per cent of children where actual or likely significant harm is identified (Brandon 1999) – have long-standing and multiple problems, and will need long-term monitoring and 'episodic' social casework and family support services that are readily accessible at times of increased stress. Brandon found that two thirds had had a long-term service, and 38 per cent were continuously or intermittently open cases in the eighth year after the identification of significant harm.

High-quality assessments are therefore crucial in identifying those families that are in effect moving to Tier 4, and will require the use of child protection plans and in some cases the use of the courts; and those children in families that are at the upper level of Tier 3 and will respond to the more short-term intensive interventions.

In terms of interventions at Tier 3, Tunstill *et al* (2007) note that a particular advantage of neighbourhood family centres is that families can enter and leave the service as stresses in the family become manageable or escalate. Being able to access services at different points in time over a sustained period is viewed by parents as very helpful in their parenting tasks. A key issue for commissioners in the coming period of contracting budgets will be targeting children's centre provision in such a way that it is able to respond to families with this level of need. The potential of this model of working is reinforced by Morris (2007) in an evaluation of Family Action projects that were designed to meet the needs of families where parents had mental health difficulties. Morris reports that the development of these services was to a large extent a response to the disparity in thresholds between adult mental health services and children's services. The largest number of referrals (29 per cent) came from children's social care, which identified a group of families that needed support because of the adult's mental health needs. However, these health needs were not serious enough to trigger intensive input from adult mental health services (and only 11 per cent of referrals came from adult mental health services).

Childcare practitioners were therefore faced with children who were clearly in need of additional services and, indeed, some were in need of protection, but with no service directly that could meet the parental health difficulties that underpinned this need. The projects offered a package of services, some of which were focused on working with the

parent, some on supporting the child and some family work. They offered a mixture of practical, therapeutic and emotional support. The projects attempted to use a number of standardised intervention tools and, while Morris noted the merits of the aspiration of such an 'evidence-based' approach, she nevertheless questioned the practicality in terms of capacity (of parents and support workers) in using such methods. While a relatively small-scale evaluation, Morris nevertheless did identify some very encouraging results in terms of outcomes. The quality of the relationship as a lever for change was crucial:

> The overwhelming message from parents was their appreciation of practical support, support to their children, and in particular the warmth and understanding of Family Support projects.
>
> (Morris 2007 p 20)

Two other important messages emerged from this evaluation. First, a strength of the projects was the skills' mix that they employed within their services, in particular the use they made of high-quality but unqualified family support workers. However, Morris noted that these unqualified workers are closely supervised by a qualified social worker. Second, although many of the children's needs were at Tier 3 and in some cases Tier 4, the services retained many features of lower-tier services discussed above, thereby minimising issues of stigma and blame.

These examples of good practice and effective service design are reinforced in *Good practice guidance* published by SCIE (2009). This guidance itself drew on the existing research and practice-based knowledge base and supported many of the messages in this section. For example, it made the case for early intervention and effective screening at the lower-tier services. At Tier 3 it similarly reinforced the importance of services that meet the needs of **both** the adult and the child, and the importance of a **package** of services being provided. The authors stressed the importance in this case of such a package of services being provided by a range of agencies.

In terms of services at this tier for parental substance misuse, similar messages emerge. The *Hidden harm* report (Advisory Council on the Misuse of Drugs 2003) emphasised that if the potential damage of parental drug misuse is to be minimised then effective treatment for the parent is the key. Cognitive behavioural approaches have been identified as an effective intervention for many who misuse drugs and alcohol, as well as increasingly the use of motivational interviewing (Forrester *et al* 2008). Nevertheless, in terms of meeting the needs of the child, relying solely on treatment is insufficient and a similar multi-agency package of services is required.

Tier 4 services are 'remedial' or 'rehabilitative' support and/or therapy services for referred families, and sometimes involve court orders or an element of compulsion (such as a child protection inquiry; a young person convicted of an offence being placed in a treatment foster family; a health service placement in an addiction treatment unit; or a residential unit for a family evicted as a consequence of anti-social behaviour).[2] Many of the children who require services at this level do so because of parental mental health difficulties and/or

---

2. Services for severely disabled children are usually also at Tier 3 or Tier 4.

parental substance misuse difficulties. Brandon *et al* (2009) in a review of serious case reviews noted the co-morbidity of parental mental health and substance misuse problems, alongside domestic abuse. However, she also warned against a mechanistic, overly deterministic approach. Forrester and Harwin (2008) also noted that in 62 per cent of cases which progressed to care proceedings, parental substance misuse was a factor.

One of the challenges of working with children and their families where parental difficulties have become this serious is that they are often very entrenched and hard to shift. The danger is that in areas where thresholds are very high, cases will only receive sustained casework that can coordinate a package of services when they are on the cusp of Tier 4 and requiring a formal statutory, involuntary intervention. If Tier 3 or 4 services are considered necessary, it is likely that parental health problems, disabilities or addictions will be compounded by challenging behaviour or criminality of parents or children and by serious relationship difficulties, including violence and child protection concerns. At Tier 4 children's social care will almost always be involved and will be coordinating a package of services, often through a child protection plan that involves ongoing assessment and support. In cases where children need to be placed in substitute care, Farmer and Moyers (2008) and Hunt *et al* (2008) both argue for the potential of family and friends care.

Thoburn (2010) provides an overview of the summative and formative research on services to families with complex problems, including those with mental health problems and addictions. She notes that they may be 'hard to reach/engage' and/or 'hard to help/change' and concludes with other researchers cited above, that a combination of practical assistance, supportive and educative casework, and therapy has the best chance of securing positive outcomes for the children. Particularly when parents have chronic health conditions or mental illness, it is likely that long-term services will be needed, although these may be low intensity or provided episodically as health problems increase or are in remission. She cites Stanley and Cox (2009) who 'emphasise that with parents who have a chronic or recurring mental illness, and with those where there is domestic abuse or addictions, fear that contact with statutory services will result in children being removed from their care frequently creates a barrier to engaging with services for parents as well as for children who have taken on a caring role' (Thoburn 2010 p 15). She concludes that neighbourhood family centres, a feature of which is 'permeable boundaries' that allow family members to enter and leave services as pressures mount and abate, are particularly well placed to provide this sort of relationship-based service (Tunstill *et al* 2007).

Role of adult services

By adult services we mean adult mental health and adult substance misuse, and inevitably there is an artificial division between these and overall family-focused services.

A recurring theme that emerges throughout the literature in terms of intervening effectively across the range of health difficulties that parents face is the importance of coordinated approaches from adult and children's services. *Think family* (Social Exclusion Task Force 2008) was a direct response from the former government to this and attempted to promote a holistic understanding of families' needs in the context of the trajectory of welfare policy in adult and children's services moving them in different directions. Research carried out in all areas of parenting difficulty (Olsen and Clarke 2003; Moran *et al* 2004; Asmussen and

Weizel 2009; SCIE 2009) warn both adult and children's services against the dangers of not working together in a coordinated way to meet the family's needs and also cite the positive impact of such collaboration.

There are for a number of reasons, including the separation of adult and children's services and limited resources, barriers to be overcome in order to create an environment that fosters effective service delivery and practice across the interface between adult and children's services. The initiatives that have arisen from *Think family* such as the Think Family Pathfinders and the related Family Intervention Projects have, however, begun to show some encouraging results (DCSF 2010a; NATCEN 2010). Although many are still relatively new, the flexible personalised approach in which they respond to both the needs of children and adults is being viewed extremely positively by family members and the professionals working with groups of families. These families have multiple difficulties and have been identified as consistently hard to help, with some of the most complex needs. The concept of a team around the family building on the established notion of a team around the child would seem to be a positive example of the growing understanding of the relevance of the personalisation agenda in children's services. The most recent findings from the evaluations have reinforced the early positive messages and have stressed the value in flexible working from adult services and the role that information sharing and joint commissioning can play in delivering a more cohesive service for this vulnerable group of families (DCSF 2010b).

In summary, the diversity and range of parents' health needs are reflected in a similarly broad range of services and interventions that are required to adequately meet those needs. While there are some common characteristics of successful interventions, especially with regard to the features that parents value, the challenge for service providers is to be able to deliver a range of services across the spectrum of need.

8.   Conclusions and main messages

> Many individuals are crushed by the experience of poverty and disadvantage, and it is always the most vulnerable who suffer the consequences. Even the most resilient child from poverty stricken circumstances is finding it more difficult to do well in life than a more ordinary child from a wealthy background. To witness these inequalities one has to ask, what would that resilient child or person have been able to do, what would their contribution to the community or the economy have been if they never had to overcome disadvantage? A society that maximises opportunities for all citizens is also one that makes best use of the many assets for well-being, social and economic development.   (Schoon and Bartley 2008 p 27)

Having undertaken this review we have identified six key themes that emerge across the extensive research and practice literature, alongside feedback from users of services and service providers, in respect of the relationship between the safety, health and wellbeing of children and improvements in the physical and mental health of mothers, fathers and carers. What is striking from both user and provider feedback is that it reinforces many of the messages from the literature. In particular, it has been very helpful in illustrating and 'bringing to life' issues such as access and stigma. We have redefined the six themes that we identified as broad questions. They are deliberately broad in scope and are relevant, in different respects, to all the stakeholders who are addressed in this review. We believe that they can throw some light on the challenges that currently exist and, perhaps, optimistically, that they **can** point to solutions in the future for mitigating the most obvious impediments to better child outcomes.

- What are the key structural obstacles?
- How can we improve the scope and relevance of the knowledge base?
- How can professional collaboration be facilitated and improved?
- How, as a matter of urgency, can we start building better bridges across and between services?
- How can we keep a focus on the concept of resilience to understanding outcomes for children and young people?
- How can the deterrent impact of stigma be reduced?

What are the key structural obstacles?

The guarantee of access to services at the right time and for the right family member is made less likely by the current organisational configuration of adult and children's services. Both the carers and young people consulted, described some of the practical barriers to getting access to help, including in relation to referral systems, high thresholds and a lack of resources. Children's services departments, introduced as one of the Every Child Matters reforms, have sought, it might be argued with some success, to create better 'joined up' services between social care and education. However, this has been at the cost of introducing a new potential divide between adult services and children's services (Social Exclusion Task Force 2008). Given that all stakeholders are in agreement that the key influence on, and inputs into children' s lives will, in almost every case, be exerted by their parents and carers, this new division is far from helpful. This is because it can exacerbate

the already well-documented reluctance of adult service providers to recognise adults as parents. This failure can potentially lead to all or many of their adult/parent needs being unmet. In addition, it can also fail to identify children's needs if they fall below a child protection threshold. Indeed there is an exciting potential for cross-service learning. Adult services can and do provide valuable examples of providing a personalised approach to problems in order to produce personalised outcomes, so that targeted support will not be seen as stigmatising by parents, children and young people.

How can we improve the scope and relevance of the knowledge base?

This point links in closely to the issue above, in that the building block of any useful policy and service design is a comprehensive knowledge base. One key element in this is the collection by central government of relevant and comprehensive data on need, which can facilitate the planning of appropriate services that deliver value for money. While there is evidence to suggest significant numbers of children are cared for by parents with physical disabilities and health needs, the adequacy of national data in this respect is currently questionable, given that much of the health agency collected data fails to identify patients as parents.

In addition, the literature we reviewed – while deploying a number of rigorous methodologies to explore aspects of parental mental and physical health – tends, with some exceptions, to focus on the outcomes of respective services, rather than on the overall impact on parenting of various phenomena, such as substance abuse problems. There is a need for more empirical work to be undertaken, starting from a point such as Smith's concept of 'disruptions to parenting', in order to facilitate increased understanding of the inter-relationship between child, parent and carer need.

How can professional collaboration be facilitated and improved?

Support for achieving better outcomes for children and young people growing up in vulnerable family settings is often undermined by the inter-professional rivalries that can sometimes characterise collaboration between clinicians: GPs; social care staff such as social workers; and those tasked to provide purely involuntary services, for example the justice system. There was evidence in some of the evaluations covered by this review that service configurations that brought together professionals from different backgrounds paid dividends, particularly with regard to how the service was experienced by those who used it. Although they are still relatively new, evaluations of Think Family Pathfinders and Family Intervention Projects have yielded some encouraging early findings. Such ways of working offer helpful practical ways forward in developing the potential of greater collaboration across the adult/children's services divide. However, given the complexity and diversity of services for families, there are other service models – as the Family Action projects demonstrated – that promote inter-agency and inter-professional collaboration besides fully integrated services.

How, as a matter of urgency, can we start building better bridges across and between services?

The literature reviewed, while highlighting promising lines of intervention, fails to identify any one service that could be seen to constitute a 'silver bullet' in its own right, and if delivered in isolation from other services and supports. An 'easy win' for service commissioners at work in the current challenging period, where resources are limited, and where value for money issues will be central, is to ensure that clear routes are available between all individual services; and especially between services for adults and children. These 'bridges' will require improvements both to service access systems; and the nurturing of inter-professional trust and collaborative working.

The last 10 years or so in the UK have been particularly characterised by the adoption of some of the approaches to interventions which have been developed in North America, including community-based targeted services, home visiting and parent education programmes. However, in the UK access to such services for the majority of parents is through a series of interlocking thresholds and, in particular, on the basis of professionals having acknowledged that a child or young person's needs meet a specific tier. This gate-keeping of services has produced two sets of negative consequences. As well as delaying the provision of services to a later stage in the 'history of a problem' it consolidates barriers between service providers. So, for example, a GP or health visitor may be required to make a referral to a parent education programme. The referral process should ensure the provision of helpful information about a family, but can also deter collaboration between services as it takes time, and will not necessarily guarantee timely access. Children's services could do far more than has been the case to solve this problem, by **downgrading** the need for a 'formal referral' (in many cases) and reconceptualising it as a duty to maximise publicity for parents about services available, as well as to ensure supportive structures are in place for the more wary or ambivalent parents. It is also essential to offer access to services at different points in time over a sustained period in order to facilitate early access at whatever stage of the problem. Both *Keys to the future* and *Building bridges* provide good examples of successful projects (see validated local practice examples in Section 7).

How can we keep a focus on the concept of resilience to understanding outcomes for children and young people?

The outcome framework introduced by the Every Child Matters reforms has been useful in concentrating service planners' minds on the need to know why a service is being commissioned and what might be the intention in offering it to parents in a community. However, there has been an unintended consequence in that it has tended to privilege the sorts of interventions, often time-limited, which can be more easily evaluated in a way that delivers **early** and **visible** improved outcomes. Obvious examples include the Webster Stratton and Triple P programmes that have been extensively experimentally evaluated in the UK and found to be both popular with parents and capable of delivering such promising early outcomes.

It is equally important that service commissioners do not restrict the menu of services on offer locally to these sorts of approaches, as we know from other aspects of the research

literature that variables such as **child resilience** play a large part in the emergence at a later stage in life of positive overall outcomes. However, less is known about the nature of the associations between resilience and family/community/individual characteristics. There is some indication in the literature that supports in the wider community underpin resilience. These may include access to supportive adults in the wider community/kinship network, or more purposively designed input through, for example, school support workers. (Newman 2005)

Either way, commissioners need to ensure that a set of community supports and services is in place to allow the green shoots of resilience to survive, and that adequate account is taken of the role of less formally identifiable services. The awareness of such impact might be captured in a number of ways, including for example through self-report mechanisms Just as importantly, the children's workforce should be empowered to share and celebrate a wider approach to understanding/interpreting better outcomes. Procedurally driven, overly mechanical 'tick-box' mechanisms that record progress in a systematised way will risk overlooking the (often) small steps forward that signal progress to better outcomes.

How can the deterrent impact of stigma be reduced?

Many of the parents and carers whose circumstances are described in this review face significant levels of social exclusion and discrimination in their lives. This can be exacerbated if they feel that by using services they will be seen by the wider community to have 'failed in their role as parents'. The danger of service use being associated with such a sense of 'stigma' is consistently highlighted in the literature, and regularly articulated by those who use services. An additional bonus of taking a more integrated whole family approach is that it can help minimise the risk of such a fear acting as an impediment to individual parents and carers, when they are considering whether to access services that could be helpful. Parents and carers were clear that services which met their overall needs, beyond a narrow definition of 'parenting support' made a positive difference to their lives. Such an integrated approach can support both a strength-based perspective by practitioners and help build resilience in families. It is an approach that can be applied in different ways, at each of the tiers of need.

At the lower tiers there have been many innovations around extended schools, within primary health and in children's services, of providing services that meet adult as well as children's needs. At the higher tiers there was evidence that some elements of such an approach could be replicated and this could help address the issue of stigma. For example, family centres that retained some features of children's centres emerged as a helpful way of working and all five of the validated local practice case studies (see Section 7 of this review) constitute examples of good practice in this area. Nevertheless, a cross-cutting theme with regard to addressing stigma was the significance of the quality of relationships between those who use services and professionals. In this review it was the values that individual practitioners held as opposed to their job title that determined their success in addressing stigma and maximising engagement with the service in which they worked.

This research review has covered a range of challenges that face parents with health difficulties. It reinforces both the wide and specific definition of key terms in relation to 'in need' in the *Children Act 1989* (GB. Statutes 1989). For example, Section 17(11) requires

that in Part 3 of the Act 'development means physical, intellectual, emotional, social or behavioural development, health means physical or mental'. For these aspirations to be achieved in respect of children and young people, parallel account must be taken of the equivalent needs of parents. The findings of the review highlight that there are areas of parental health where the data is much stronger than others but that overall there is no proven causal link between parental difficulties and outcomes for children and young people. Faced with such a diversity of need both in its nature and degree, it is clear that commissioners of services and practitioners need to respond with a range of services and interventions that are located across the continuum of need. In particular, there needs to be an emphasis within services on a strength-based approach that builds child and parental resilience. In other words, services will seek to enhance the protective factors in families while minimising those that place the child at increased risk

Data annexe

Key messages

- There is much data available on adults' and children's physical and mental health and the characteristics of those who are affected by these issues. Most of these data sources, however, do not identify whether adults are parents or carers or link parents' health to their children's outcomes.

- Many of these data sources can be used by local authorities and primary care trusts to inform their Joint Strategic Needs Assessments of adults' and children's health needs in their area and to plan their future priorities and interventions.

- The data available shows that both adult and child obesity have increased over time, although obesity among children has levelled off over the past few years. Generally, adults living in lower-income households were the most affected by poorer health. Drug and alcohol dependency were more prevalent among men than women, while a greater proportion of women than men had poorer mental health.

- Children's mental health and physical health were linked to their family backgrounds and their parents' health. In particular, mental health disorders were more prevalent among children living in families that had experienced marital breakdown.

Introduction and availability of data

The main focus of this priority is 'improving the safety, health and wellbeing of children through improving the physical and mental health of mothers, fathers and carers'. Part of the aim of this review is to identify the proportion of parents and carers who experience mental or physical health problems and their characteristics, as well as how parents' physical and mental health is related to children's outcomes; these are the areas that we mainly focus on in this annexe. While we can gain an insight into the prevalence of mental and physical health problems among adults and children, most datasets do not identify whether respondents are parents or carers and do not link children's outcomes to parents' health or characteristics.

This data annexe presents further discussion about the data currently available relating to adults' and children's physical and mental health. It provides:

- a summary of the search strategy for identifying data

- an overview of the nature and scope of the data that was found, with a brief commentary on the quality of this data, and any gaps that have been identified

- charts on the prevalence of mental and physical health problems among adults and children, including obesity, mental health disorders and alcohol and drug dependency, produced from selected publicly available data, along with a brief commentary on these.

A summary table of the data sources of readily available, published data relating to the health, safety and wellbeing of adults and children and young people at a national, regional and/or local authority level is presented in Appendix 4. Some of the data refers to disability. Under the *Equality Act 2010* (GB. Statutes 2010)*,* a person is defined as having a disability if:

> The person has a physical or mental impairment, and the impairment has a substantial and long-term adverse effect on [their] ability to carry out normal day-to-day activities.

Data search strategy

There are a number of archival databases in the UK, such as the National Digital Archive of Datasets and the UK data archive, some of which have services that facilitate searching or access to macro- and micro-datasets (including ESDS International). Even so, searching for current and recently published data cannot yet be conducted in the same way as searching for published research findings. Access to newly published data is not supported by comprehensive searchable databases in the same way that literature searches are supported.

Data for this annexe was obtained by a combination of search methods including obtaining online access to known government publications (such as the Statistical First Releases from the Department for Education (DfE[3]); access to data published by the Office for National Statistics, the Department of Health and other government departments; data published by the National Health Service and other national, regional and local bodies; and online searches following leads emerging from these publications, research funding council summaries and other literature searches. It should be noted that links to statistical sources that were live at the time of searching may not remain live after publication.

Nature and scope of the data

There are a number of data sources that provide information about the proportion of adults in England who experience mental and physical health issues. This data, however, does not usually identify whether adults are parents or carers. Furthermore, most of the data on children's outcomes at local level does not link these to their parents' characteristics or health, although some data available at the national level offers insight into how children's family backgrounds and their parents' health behaviours are associated with their own health. The data available does, however, enable local authorities and primary care trusts to identify where and to

---

3. Formally the Department for Children, Schools and Families (DCSF).

whom intervention might be targeted to improve health and can be used to inform their Joint Strategic Needs Assessments (JSNA) of the needs in their areas to plan their future priorities, as they are now required to do as part of the *Local Government and Public Involvement in Health Act 2007* (DH 2007b). Data that can be used for this can be accessed on C4EO's interactive data site. The Association for Public Health Observatories and Department of Health (2008) has also compiled a list of the data sources that can be used to measure national indicators and Vital Signs (the NHS version of national indicators) in *The JSNA core dataset*.

For this review, the term 'wellbeing' incorporates a diverse range of children's outcomes, including their emotional and behavioural health, economic wellbeing, physical health and educational achievement. There are a large range of datasets available that local authorities can use to assess their progress towards improving children's wellbeing in their area, including progress towards public service agreement (PSA) 12 'improve the health and wellbeing of children and young people', PSA 13 'improve child and young people's safety', and PSA 10 'raise the educational achievement of all children and young people'. The DfE,[4] for instance, publishes a wide range of statistics about children's educational achievement based on data collected through the School Census. It also collates data on the number of children and young people who have been referred to social services and who have been subject to child protection plans through the Children in Need census (previously, up until 2008/09, this information was collated from Child Protection and Referrals 3 (CPR 3) statistical returns; see Fauth *et al* 2010 for more information). Further data on children's safety is also available from the Hospital Episode Statistics warehouse,[5] which records information about all hospital admissions in England. The latter is the official measure of local authorities' progress towards national indicator 70, regarding hospital admissions caused by unintentional and deliberate injuries to children and young people.

It should be noted that the new Coalition Government abolished national indicators in March 2011, as part of its aim to offer local authorities more freedom . Some data collections are continuing as part of the proposed Single Data List for Local Government. The Audit Commission's website[6] contains information about the ongoing work on this and provides a regular update on the national indicators that have been so far abolished. In this data annexe, we refer only to national indicators that were retained as of November 2010.

Given the wide range of outcomes for children that this priority encompasses, we have focused on children and young people's physical health (in terms of obesity) and mental health in this annexe. Interested readers are referred to other C4EO reviews for an overview of data relating to safeguarding children (Fauth *et al* 2010) and improving children's educational outcomes (O'Mara *et al* 2010).

---

4. www.dcsf.gov.uk/rsgateway/

5. www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937

6 www.audit-commission.gov.uk/localgov/audit/nis/pages/guidance.aspx

Data on the prevalence of obesity among children is collected by the National Child Measurement Programme (NHS Information Centre 2009) and this is also the formal measure of local authorities' progress towards national indicators 55 and 56 regarding reducing the proportion of primary school children who are obese. Weight and height measurements of children are collected by trained staff in schools which enables a robust measure of obesity in terms of body mass index (BMI) to be calculated. Data has been collected since 2005/06, so there is currently only limited trend data available. The Health Survey for England (Craig *et al* 2009), however, has been collecting data over a longer period and provides a good overview of national trends over time.

The TellUs survey (Chamberlain *et al* 2010; DCSF 2010a) previously measured local authorities' progress towards improving the emotional wellbeing of children and young people. In August 2010, the government decommissioned the TellUs survey and local authorities were no longer required to measure progress towards the formal national indicator for this (national indicator 50).[7] Therefore the latest data available from TellUs is for 2009. Apart from the TellUs survey, there is little data at a local level about children's mental wellbeing. Furthermore, although useful, some caution should be exercised when interpreting the TellUs data, as its measurement is limited to children and young people's perceptions of whether they have good friends and whether they can talk to people about their worries. It does not take into account other factors that can also influence wellbeing, such as positive effects or self-esteem. More comprehensive data on children and young people's mental health, at a national and government office region level, is available in The Mental Health of Children and Young People in Great Britain survey (Green *et al* 2005). This source provides information on the prevalence of mental disorders among children aged five to 16 in 2004. The classification of mental disorders used is based on the ICD-10 diagnostic criteria and so the statistics on the prevalence of each disorder reflect cases where symptoms reach a clinical level of distress or dysfunction. Furthermore, the Children's Society,[8] in collaboration with the University of York, is developing a new index to measure children's subjective wellbeing in England (known as the 'Good Childhood Index'). The index will be used to gain insight into children's feelings of satisfaction with their lives generally and also with specific aspects of their lives on a quarterly basis. Practitioners will be able to use the index with groups of children and then compare the results against the national findings.

There is also a wide range of data on aspects of adults' physical and mental health. In this annexe, we have focused on data about the prevalence of obesity, alcohol and drug dependency and mental health disorders among adults, and the characteristics of adults who are particularly vulnerable to these issues. Data on the prevalence of adult mental health problems, both common mental disorders such as depression and anxiety and more severe disorders, at a national and government office region level is available in the Adult Psychiatric Morbidity in England, 2007 survey (McManus *et al* 2009). Detailed data at local level is currently sparser. The

---

7. www.audit-commission.gov.uk/localgov/audit/nis/pages/guidance.aspx

8. www.childrenssociety.org.uk/whats_happening/media_office/latest_news/22240_pr.html

MINI, MINI2000 and National Psychiatric Morbidity Survey (NPMS) indices[9] record hospital admissions due to severe disorders and the proportion of people predicted to have a common mental disorder in an area. We have drawn on data from the Health Survey for England (Craig *et al* 2009) to look at adult obesity and trends in the prevalence of this over time, but local authorities can access data at a local level on obesity rates from *Healthy lifestyle behaviours* (Scholes *et al* 2008) published by the Information Centre for Health and Social Care. Data collected through the Quality and Outcomes Framework (DH 2010a) is also available at primary care trust level, but due to methodological limitations the Association for Public Health Observatories and Department of Health (2008) recommends that this data is not used to assess the prevalence of obesity.

Charts showing the prevalence of physical and mental health issues among adults and children

This section contains information about the prevalence of obesity and mental health disorders among adults and children, as well as alcohol and drug dependency among adults, and the characteristics of those affected by these issues.

Adult obesity

The rise in both adult and child obesity in the UK has been a topic of much discourse in the media over the past few years. The data presented here refers to general obesity which is, in itself, an important public health issue. Nevertheless, it is important to recognise that in terms of the extent to which obesity can be considered a disability, or significantly impacts on parenting, it is severe or morbid obesity that is of greatest relevance. Data from the Health Survey for England (Craig *et al* 2009) shows that in 2008 around a quarter of adults in England (24 per cent for men and 25 per cent for women) were classed as obese, based on their BMI measurement[10] (see Figure 1). The proportion of adults in this category increased steadily between 1993 and 2008 by 9 per cent for women and 11 per cent for men. Over this period, generally a greater proportion of women than men were classed as obese, but by 2008 the proportion of men and women who were obese was similar.

---

9. www.mentalhealthobservatory.org.uk/mho/mini

10. BMI is a measure of whether or not a person's weight is ideal according to their height. It is calculated by dividing a person's weight in kilograms (kg) by their height in metres squared (m^2). In the Health Survey for England, people were classed as obese if their BMI was $30kg/m^2$ or more.

Figure 1:   Trends in the prevalence of obesity among adults between 1993 and 2007: by gender

Source: Craig *et al* 2009

Women living in poverty seemed to be particularly at risk of being obese (see Figure 2). Among men, however, obesity was not related to income. Interventions that aim to improve the physical health of parents or carers might therefore benefit from targeting mothers or female carers in poorer families.

Figure 2:   Prevalence of obesity among adults in 2008: by household income and gender
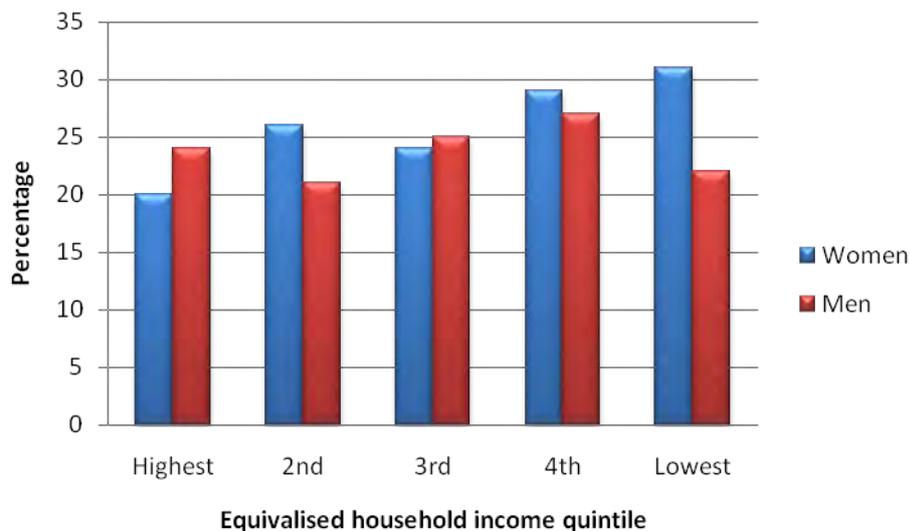
Source: Craig *et al* 2009

Obesity among children and young people

Data from 2006/07 to 2008/09 from the National Child Measurement Programme (which measures progress towards national indicators 55 and 56 regarding the prevalence of obesity among primary school age) (The NHS Information Centre 2009) suggests that little progress has been made nationally in reducing childhood obesity over this period (see Figure 3). This data also shows that the proportion of children who were obese increased with age, with around twice the proportion of children in Year 6 being obese than those in Reception Year.

Data on children's obesity has been collected for a longer period by the Health Survey for England (Craig *et al* 2009). This shows that, in line with the increase in adult obesity, the proportion of obese children in England increased between 1995 and 2008 (see Figure 4). Obesity rates for boys and girls peaked at around 2005 when about one in five boys (18 per cent) and girls (19 per cent) aged two to 15 was classed as obese. Between 2005 and 2008, the proportion of girls who were obese reduced slightly by 4 per cent, while among boys it only decreased by 1 per cent. It is not possible to say why this may be the case from this data, but national efforts to improve the health of children and young people, such as improvements to school dinners, may have had more impact on outcomes for girls. Indeed, the most recent evaluation of the School Fruit and Vegetable Scheme[11] in primary schools in England (Teeman *et al* 2010) found evidence that this initiative may have had more effect on improving the diets of girls than those of boys.

Figure 3:   Proportion of primary school children who were obese, 2006/07 to 2008/09: by year group (national indicators 55 and 56)
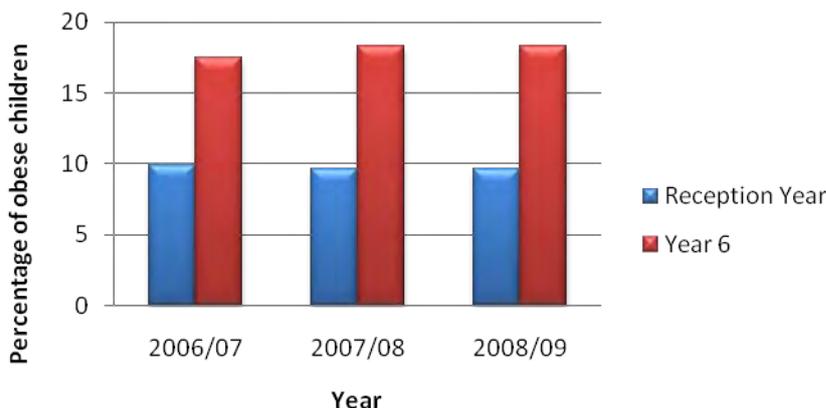
Source: The NHS Information Centre 2009

---

11. This is a national scheme in which children in Year 1 and 2 in primary school are given a free piece of fruit or vegetable to eat at break time every school day.
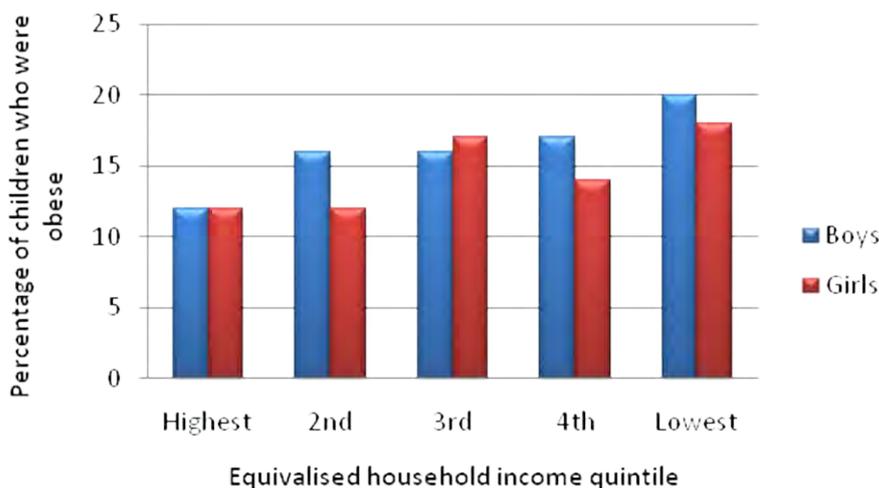
Figure 4:   **Trends in proportion of children aged 2 to15 years who were obese between 1995 and 2008: by gender**


Source: Craig *et al* 2009

Data from the Health Survey for England (Craig and Mindell 2008; Craig *et al* 2009) offers some insight into how children and young people's families and their backgrounds are associated with their weight. In line with the prevalence of obesity among adult women, a greater proportion of children and young people in the lowest income households were obese than those in the highest income households (see Figure 5). Furthermore, Figure 6 shows that parents' weight was associated with whether or not their child was obese, especially for girls. Around two in five girls (37 per cent) who lived in households where both parents were obese were also obese compared with only 16 per cent of girls living with parents who were both of normal weight. Among girls, their mother's weight seemed to be more associated with whether or not they were obese than their father's weight. A third of girls (33 per cent) living with obese mothers were also obese compared with a fifth or girls (20 per cent) living with obese fathers. This suggests that interventions which aim to improve physical health of children might improve obesity outcomes for girls by including a component that also improves mothers' weight.

Figure 5: **Proportion of children aged 2 to15 years who were obese in 2008: by household income and gender**

Source: Craig *et al* 2009

Figure 6: **Proportion of children aged 2 to 15 years who were overweight or obese in 2006: by parental BMI**
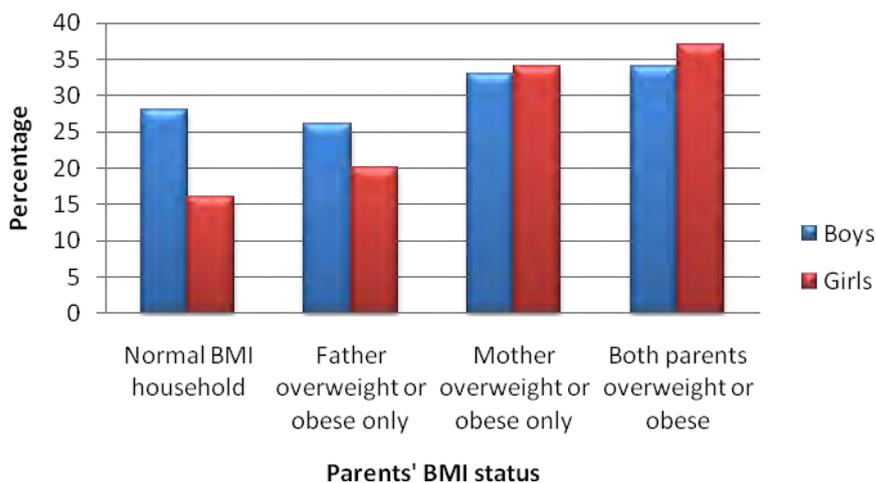
Source: Craig and Mindell 2008

Adult mental health

In 2007 just under one in five (18 per cent) adults reported experiencing symptoms of a common mental disorder (CMD),[12] such as depression or anxiety, over the past week (see Figure 7). Women were at greater risk of experiencing a CMD than men, with one in five women (20 per cent) showing signs of having a CMD compared with around one in 10 men (13 per cent). CMDs were especially prevalent among men and women in age groups where adults are particularly likely to be caring for a child (aged 16 to 54), with comparatively fewer older adults aged 55 years or over experiencing a CMD. Figure 8 shows that the proportion of adults experiencing a CMD increased slightly between 1993 and 2007, by about 2 per cent for both genders.

Figure 7:   Proportion of adults who had experienced symptoms of a common mental disorder in the past week in 2007: by gender and age
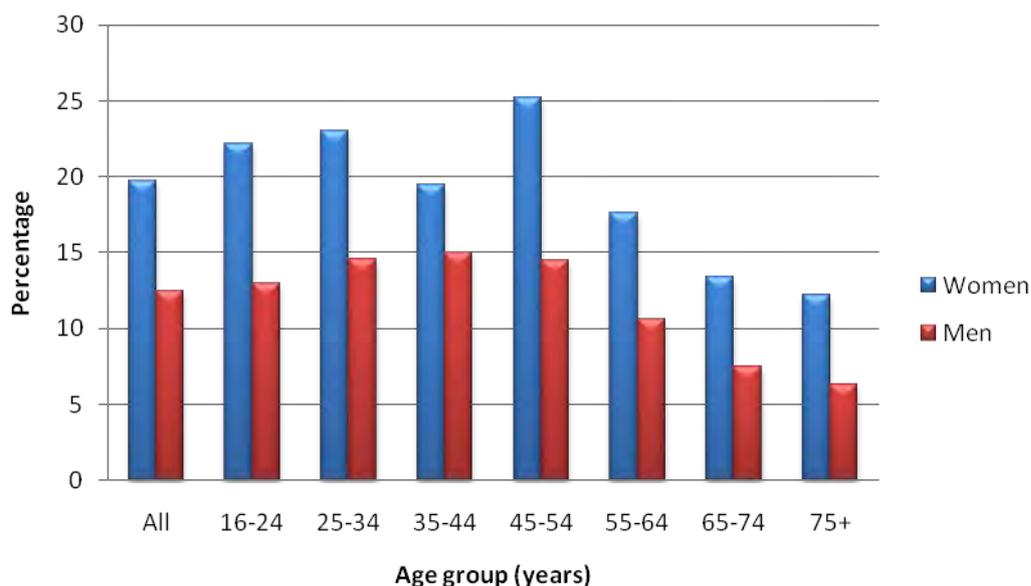
Source: McManus *et al* 2009

___

12. The Adult Psychiatric Morbidity in England survey measures the prevalence of six common mental disorders. Specifically it measures mixed anxiety and depression, generalised anxiety disorder (GAD), depression, phobia, obsessional compulsive disorder (OCD) and panic disorder.

Figure 8: **Proportion of adults who had experienced symptoms of a common mental disorder in the past week in 1993, 2000 and 2007: by gender**
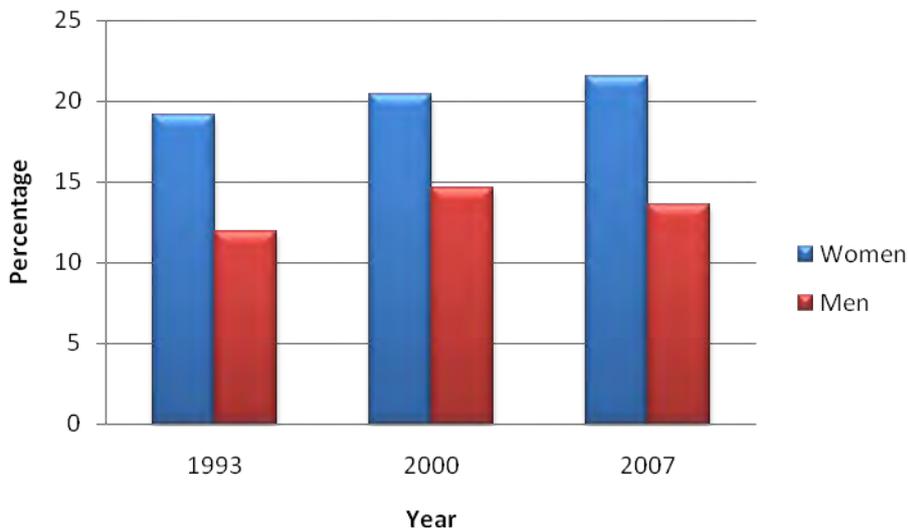
Source: McManus *et al* 2009

The prevalence of CMD differed by people's ethnic background, income and marital status (see Figure 9):

- A slightly greater proportion of women from a black ethnic minority background had experienced symptoms of a CMD in the past week than women from other ethnic backgrounds.

- A greater proportion of adults in households with a lower income experienced a CMD than those in higher income groups, and this was especially marked among men.

- Mental health difficulties were the least prevalent among people who were married, while those who were divorced or separated had the greatest prevalence of difficulties, especially separated women.

- Although we cannot tell from this data whether these individuals were parents or carers, this suggests that marital breakdown may be a particular risk factor for emotional difficulties and that mental health problems may be more prevalent among parents in families that have experienced marital breakdown.

Figure 9:   Proportion of adults who had experienced symptoms of a common mental disorder in the past week in 2007: by gender and background characteristics
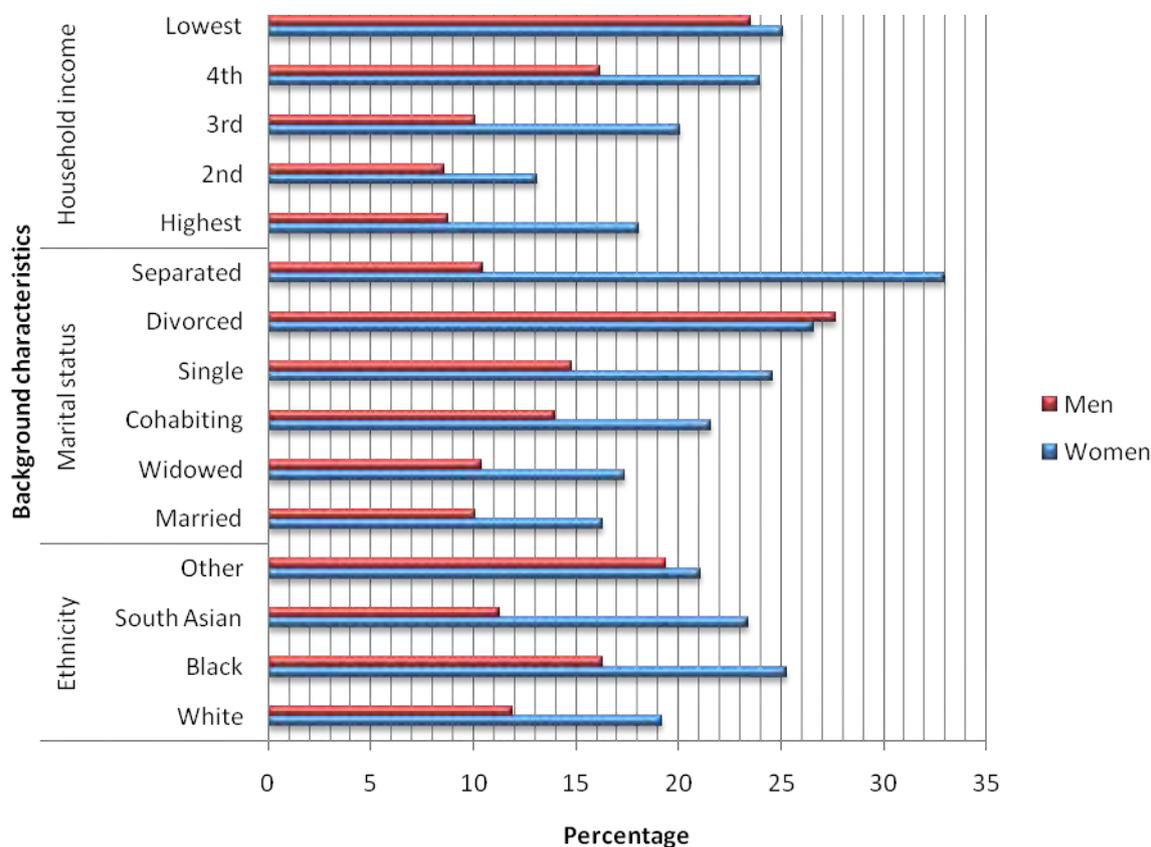

Source: McManus *et al* 2009

The majority of people experiencing a CMD were not currently receiving any treatment for it (76 per cent) (see Figure 10). The Department of Health's (2008) *Operational Plans 2008/09–2010/11* set out that one local priority (Vital Sign) that primary care trusts can choose to improve in their area is access to psychological therapies for people with depression and anxiety. The data in Figure 10 suggests that nationally few people experiencing these disorders receive counselling or therapy, with only one in 10 (10 per cent) reporting that they received this as part of their treatment. By comparison 14 per cent were receiving medication only. This suggests that the provision of these services to people experiencing mental health problems could be improved.

More severe mental health problems, such as personality disorder or psychosis, were rarer among adults than CMD. The Adult Psychiatric Morbidity in England survey (McManus *et al* 2009) found that 0.4 per cent of adults had experienced psychotic disorder in the past year and, similarly, 0.3 and 0.4 per cent of adults had experienced antisocial or borderline personality disorder, respectively. Similarly to CMD, psychosis was more prevalent among adults living in the two lowest income groups (0.9 per cent for both) than the highest income group (0.1 per cent). Also in line with the prevalence of CMD, proportionally more adults who were divorced (0.9 per cent) had experienced a psychotic disorder than those who were married (0.2 per cent).

Figure 10:   Proportion of adults who had experienced symptoms of a common mental disorder (CMD) in the past week in 2007 who were receiving treatment for a CMD
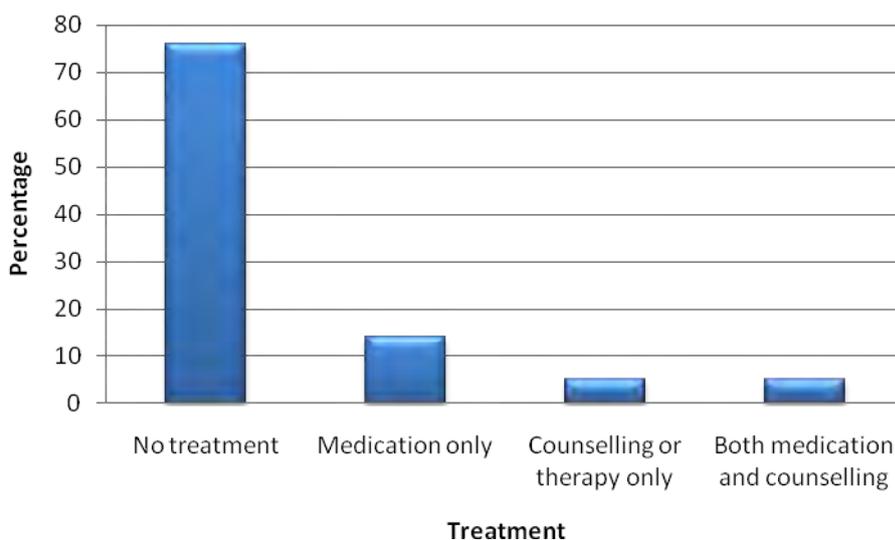
Source: McManus *et al* 2009

Children and young people's emotional wellbeing

Data from the *TellUs survey* (DCSF 2010a) shows that the proportion of children and young people showing 'good' emotional wellbeing reduced across England and all government office regions in between 2008 and 2009 (see Figure 11). According to the TellUs report, this was mainly due to a reduction in the number of children and young people who felt that they could talk to an adult other than their parents about their problems.

Figure 11:   Proportion of children and young people aged 10 to 15 years who showed good emotional wellbeing, 2008 and 2009
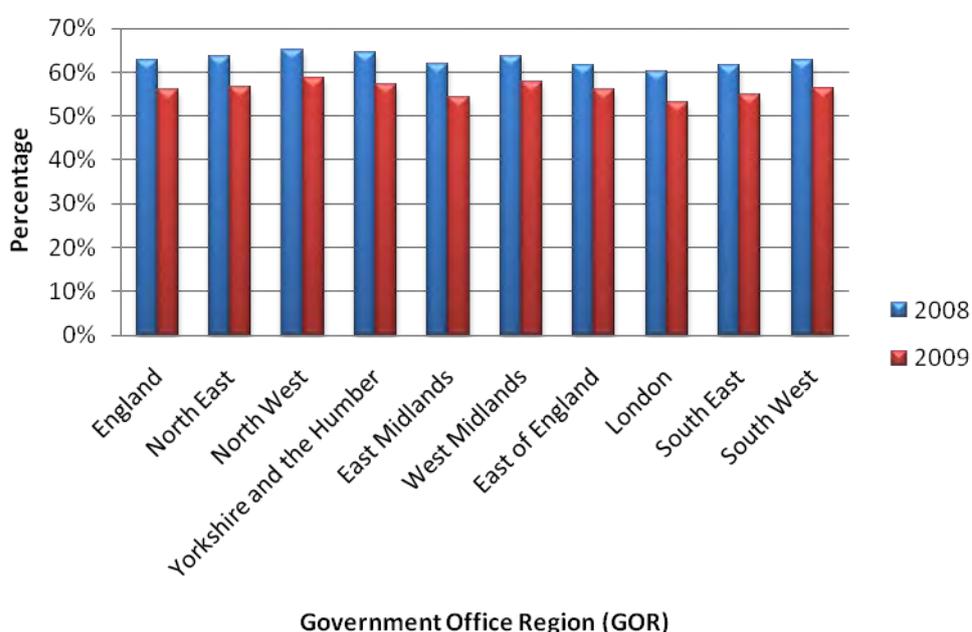
Source: DCSF 2010a

Although TellUs data allowed local authorities to monitor outcomes and progress in their own area (up until 2009), as mentioned earlier, its measure of children and young people's emotional wellbeing is limited as it only measures some aspects of wellbeing and does not breakdown the indicator by background characteristics, such as gender and ethnic group. The Mental Health of Children and Young People in Great Britain survey (Green *et al* 2005) provides a more comprehensive overview of children and young people's mental health nationally and at government office region level.

Figure 12 shows that in 2004 only a minority of children and young people had an identifiable mental health disorder. Generally, proportionally more girls than boys experienced an emotional disorder,[13] while conduct disorders tended to be more common among boys. The prevalence of mental health disorders increased with age, with proportionally more young people aged 11 to 15 experiencing an emotional or conduct disorder than children aged 5 to 10.

Figure 12:   Proportion of children and young people who experienced a mental disorder in 2004: by age and gender
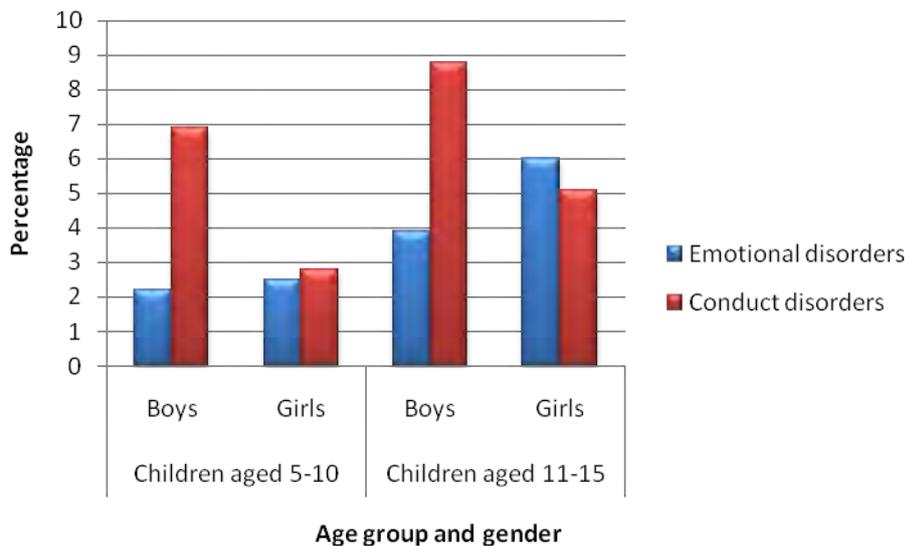
Source: Green *et al* 2005

In line with obesity outcomes, children's mental health was related to their family backgrounds and their parents' own mental wellbeing. A higher proportion of families with children with emotional disorders were assessed as having unhealthy functioning[14] in comparison with families where no child had an emotional disorder (see Figure 13). This was especially the case for families with a child who had depression. Furthermore, over half of the parents (50 per cent) who had children with an emotional disorder, except for children with a specific phobia, were identified as having poorer mental health[15] themselves (see Figure 14). Again, mental health was especially poorer among parents of children with depression.

---

13. Emotional disorders include anxiety disorders, such as social phobia and generalised anxiety disorder, and depression.

14. Family functioning was measured by a scale that assesses family relationships.

15. Parents' mental health was assessed by administration of the General Health Questionnaire (GHQ-12) to the parent who reported on their child's behaviour as part of the survey. This was usually the mother.

In line with the relationship between adult mental health and marital status, children and young people from families with married parents were the least likely to have a mental disorder (see Figure 15). Twice the proportion of children and young people living in lone parent families (either widowed, divorced, separated or single; 16 per cent) as those living with parents who were a couple (either cohabiting or married; 8 per cent) had a mental disorder. Children and young people in a lone parent family where the parent had experienced death of a spouse, divorce or separation were the most likely to experience a mental disorder. When the data was analysed further taking into account other factors that might impact the likelihood of a child having a mental disorder, living with a single parent *per se* did not increase the likelihood of having a disorder, but living with a parent that had experienced death of a spouse, divorce or separation did. This suggests, along with the data on adult mental health above, that marital breakdown may be a risk factor for poorer mental health among both parents and their children.

Figure 13:   Proportion of families with a child with a mental disorder who were assessed as having unhealthy functioning, 2007
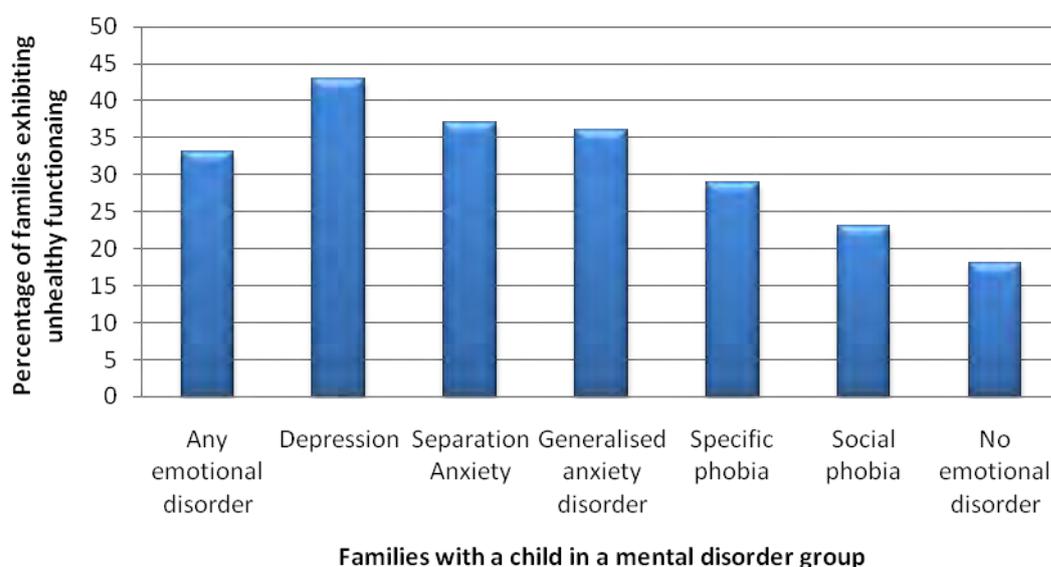
Source: Green *et al* 2005

Figure 14: **Proportion of parents with a child with a mental disorder who also were experiencing symptoms of an emotional problem (1999 and 2004 data combined)**
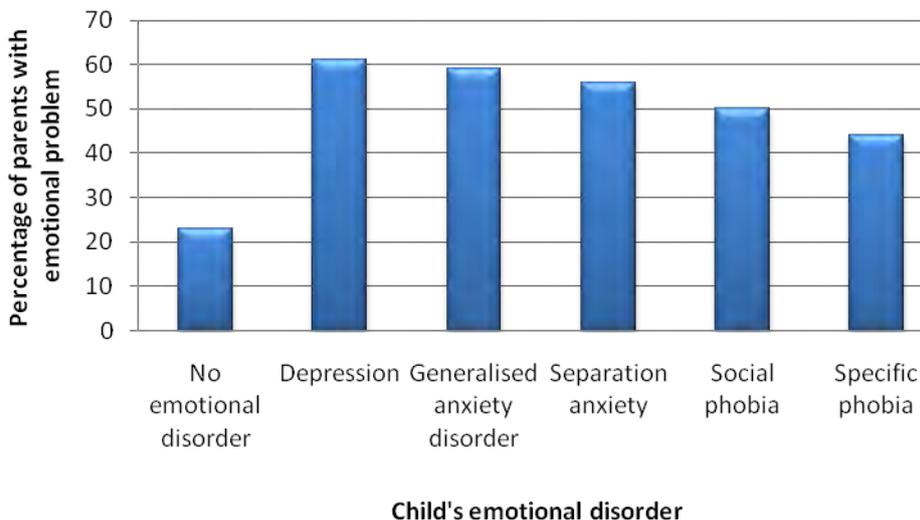
Source: Green *et al* 2005

Figure 15: **Proportion of children and young people who experienced a mental disorder in 2004: by family type**
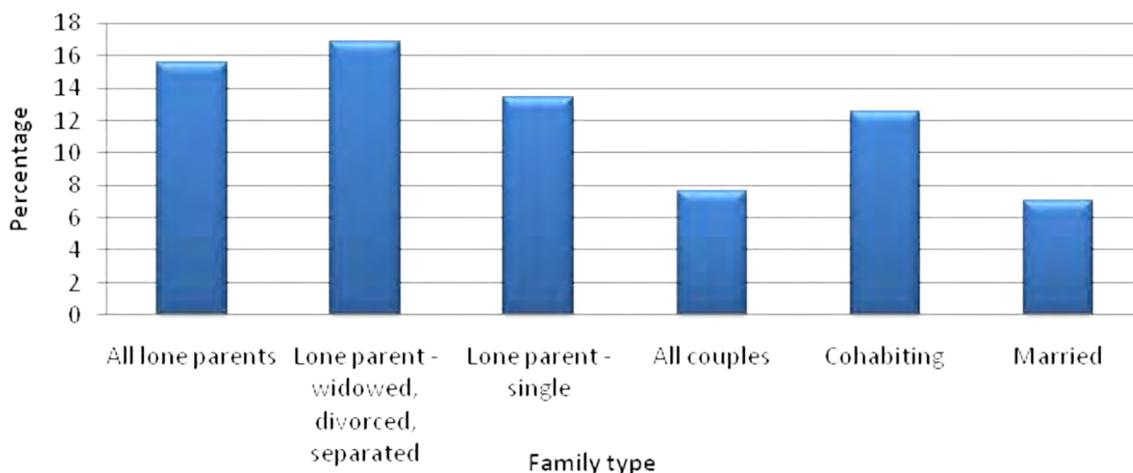
Source: Green *et al* 2005

Alcohol and dependency among adults

In 2007 nearly a quarter of adults (24 per cent) reported drinking alcohol in the past year to a degree that it was of potential risk to their physical health and psychological wellbeing (McManus *et al* 2009). This level of consumption was almost twice as prevalent among men (33 per cent) as women (16 per cent). Dependency on alcohol, however, was rarer, with only around one in 20 adults (6 per cent) identified as dependent on alcohol. Again this was more prevalent among men (9 per cent) than women (3 per cent). Furthermore, a greater proportion of adults from white ethnic backgrounds (10 per cent of men and 4 per cent of women) were dependent on alcohol than any other ethnic group. Figure 16 shows that alcohol dependency was also more prevalent among men and women in the highest income than the lowest income households, but this difference was only marginal. However, some care needs to be taken when interpreting this data. In some communities, for example, significant proportions of adults may abstain from alcohol masking the minority who drink excessively.

Figure 16:   **Proportion of adults who were dependent on alcohol in 2007: by household income and gender**
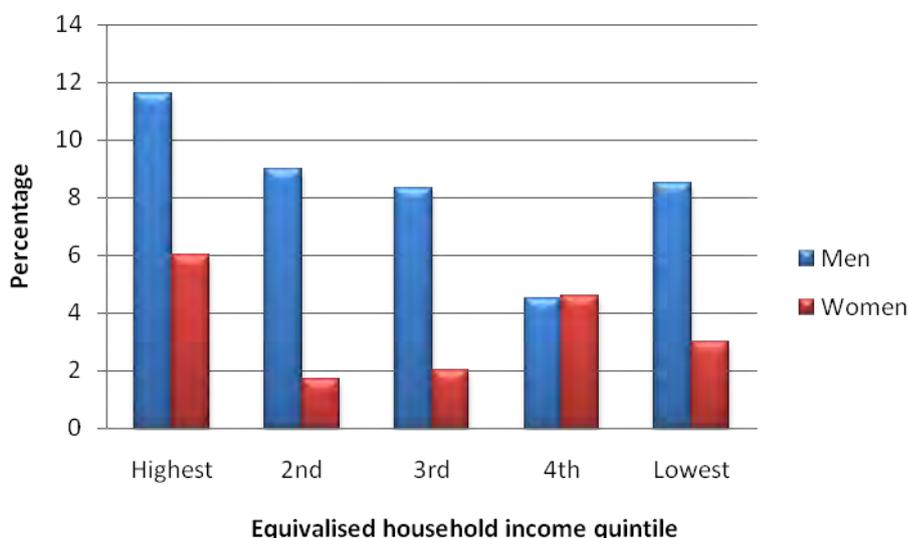
Source: McManus *et al* 2009

Dependency on drugs was rarer than on alcohol, with only 3 per cent of all adults showing signs of drug dependency (McManus *et al* 2009). Most commonly, adults showed signs of dependency on cannabis rather than higher class drugs. Similarly to alcohol misuse, drug dependency was more prevalent among men (5 per cent) than women (2 per cent). In contrast to alcohol dependency, though, which was most prevalent among white males, males from a black ethnic minority background were most likely to show signs of drug dependency: 12 per cent of black males showed signs of drug dependency in comparison to 5 per cent of white males and 2 per cent of South Asian males (see Figure 17). It was

also particularly prevalent among men in the lowest income category (see Figure 18). Although we cannot relate this data to whether or not these respondents were a parent or carer, this suggests that children in low-income families or from a black ethnic minority background may be particularly likely to be exposed to parents, and perhaps especially fathers, experiencing drug dependency.

Figure 17: **Proportion of adults who showed signs of dependency on drugs in 2007: by ethnicity and gender**
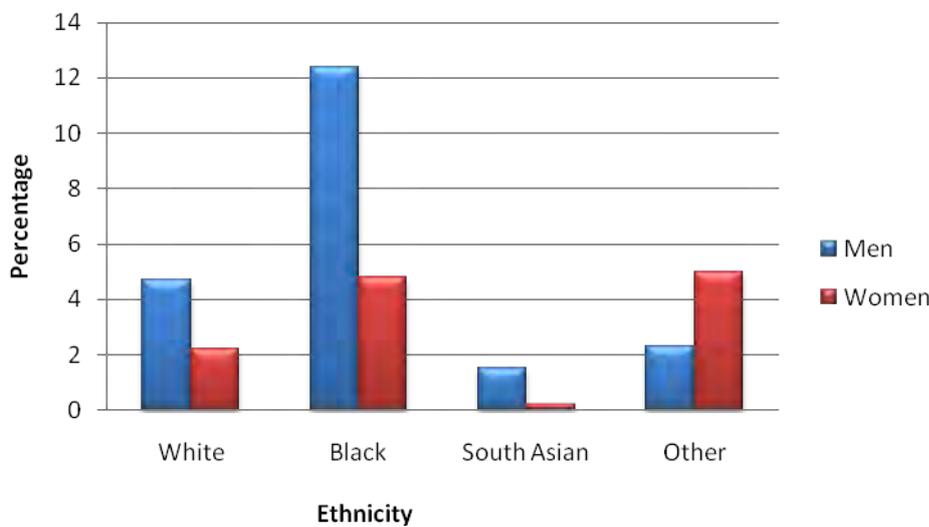
Source: McManus *et al* 2009

Figure 18: **Proportion of adults who showed signs of dependency on drugs in 2007: by household income and gender**

Source: McManus *et al* 2009

76
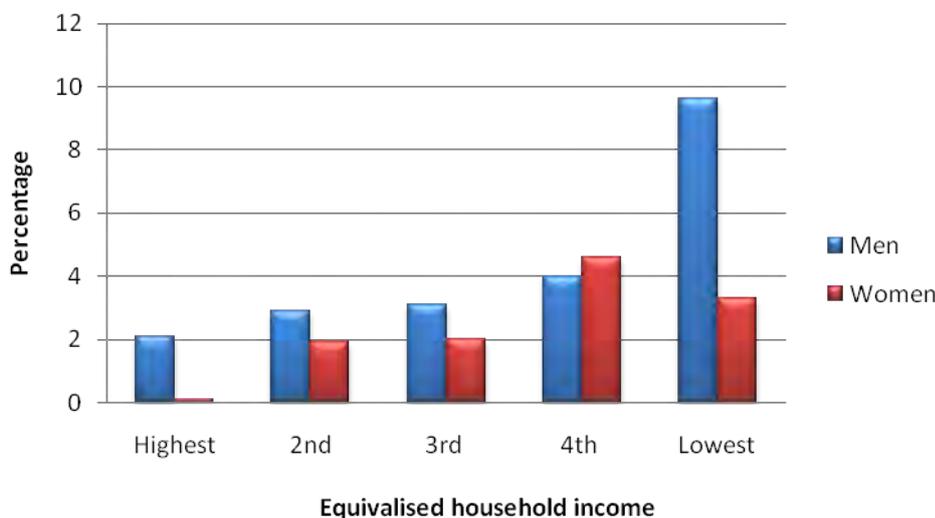
References

Advisory Council on the Misuse of Drugs (2003) *Hidden harm: responding to the needs of children of problem drug users,* London: Home Office (available at www.drugsandalcohol.ie/5456/1/1737-1660A.pdf, accessed 4 February 2011).

Aldgate, J. Jones, D., Rose, W. and Jeffery, C. (eds) (2006) *The developing world of the child*, London: Jessica Kingsley Publishers.

Aldridge, J. and Becker, S. (2003) *Children caring for parents with mental illness*, Bristol: The Policy Press.

Allen, G. (2011) *Early intervention: the next steps*, London: Cabinet Office (available at http://media.education.gov.uk/assets/files/pdf/g/graham%20allens%20review%20of%20early%20intervention.pdf, accessed 2 February).

Asmussen, K. and Weizel, K. (2009) *Evaluating the evidence: what works in supporting parents who misuse drugs and alcohol*, London: National Academy for Parenting Practitioners (available at www.pupprogram.net.au/media/8998/napp_briefing_substance_misuse.pdf, accessed 4 February 2011).

Association for Public Health Observatories and Department of Health (2008) *The JSNA core data set*, (available at www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_099262.pdf, accessed 4 February 2011).

Bancroft, A., Wilson, S., Cunningham-Burley, S., Backett-Milburn, K. and Masters, H. (2004) *Parental drug and alcohol misuse: resilience and transition among young people*, York: Joseph Rowntree Foundation (available at www.jrf.org.uk/sites/files/jrf/1859352499.pdf, accessed 4 February 2011).

Barlow, J., Coren, E. and Stewart-Brown, S. (2003) 'Parent-training programmes for improving maternal psychosocial health', *Cochrane database of systematic reviews*, issue 4 (available at http://mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD002020/frame.html, accessed 4 February 2011).

Barlow, J., Schrader McMillan, A., Kirkpatrick, S., Ghate, D., Smith, M. and Barnes, J. (2008) *Health-led parenting interventions in pregnancy and early years* (DCSF research report RW070), London: DCSF (available at www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-RW070, accessed 4 February 2011).

Barlow, J. and Svanberg, P.O. (2009) *Keeping the baby in mind: infant mental health in practice*, London: Routledge.

Barlow, J. and Underdown, A. (2007) 'The transition to parenthood: the role of the health visitor', in Bannon, M. and Carter, Y. (eds) *Practical paediatric problems in primary care*, Oxford: Oxford University Press.

Belsky, J., Barnes, B. and Melhuish, E. (2007) *The national evaluation of Sure Start*, Bristol: Policy Press.

Beresford, B., Clarke, S., Gridley, K., Parker, G., Pitman, R., Spiers, G. and Light, K. (2008) *Technical report for SCIE research review on access, acceptability and outcomes of services/interventions to support parents with mental health problems and their families* (working paper no. SCIE 2255), York: University of York, Social Policy Research Unit (available at www.york.ac.uk/inst/spru/research/pdf/SCIEReview2.pdf, accessed 4 February 2011).

Booth, T. and Booth, W. (2004) 'A family at risk: multiple perspectives on parenting and child protection', *British journal of learning disabilities,* vol 32, no 1 pp 9–15.

Brandon, M. (1999) *Safeguarding children with the Children Act 1989. Studies in evaluating the Children Act 1989*, London: Stationery Office.

Brandon, M., Belderson, P., Warren, C., Howe, D., Gardner, R., Dodsworth, J. and Black, J. (2009) *Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003–2005,* London: DCSF (available at www.education.gov.uk/research/data/uploadfiles/DCSF-RR023.pdf, accessed 4 February 2011).

Bronfenbenner, U. (1979) *The ecology of human development: experiments by nature and design*, Cambridge, MA: Harvard University.

Brunner, R., Maguire, R., Stalker, K. and Mitchell, J. (2009) *Supporting disabled parents' involvement in their children's education: good practice guidance for schools*, Reading: CfBT Education Trust (available at http://www.leeds.ac.uk/disability-studies/archiveuk/maguire/2500_Guidance_5.pdf, accessed 15 March 2011).

Cabinet Office (2005) *The multidimensional analysis of social exclusion bibliography*, London: Cabinet Office (available at www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/research/chapters/2.pdf, accessed 29 September 2010).

Centre for Excellence and Outcomes in Children and Young People's Services (2010) *Grasping the nettle: early intervention for children, families and communities*. London: C4EO (available at http://www.c4eo.org.uk/themes/earlyintervention/files/early_intervention_grasping_the_nettle_full_report.pdf, accessed 2 February 2011).

Chamberlain, T., George, N., Golden, S., Walker, F. and Benton, T. (2010) *Tellus4 national report* (DCSF research report 218), London: DCSF (available at http://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-RR218, accessed 4 February 2011).

Children's Commissioner (2010) *Family perspectives on safeguarding and on relationships with children's services*, London: Office of the Children's Commissioner.

Cicchetti, D. (2002). 'The impact of social experience on neurobiological systems: illustration from a constructivist view of child maltreatment', *Cognitive development*, vol 17, pp 1407–1428.

Clark, D.B., Cornelius, J., Wood, D.S. and Vanyukov, M. (2004) 'Psychopathology risk transmission in children of parents with substance use disorders', *The American journal of psychiatry*, vol 161, no 4, pp 685–691.

Cleaver, H., Walker, S. with Meadows, P. (2004) *Assessing children's needs and circumstances: the impact of the assessment framework*, London: Jessica Kingsley Publishers.

Cleaver, H., Nicholson, D., Tarr, S. and Cleaver, D. (2007) *Child protection, domestic violence and parental substance misuse: family experiences and effective practice*, London: Jessica Kingsley Publishers.

Conger, R.D., Wallace, L., Sun, Y., Simons, R.L., McLoyd, V.C. and Brody, G.H. (2002) 'Economic pressure in African American families: a replication and extension of the family stress model', *Developmental psychology*, vol 38, no 2, pp 179–193.

Coote, A., Allen, J. and Woodhead, D. (2004) *Finding out what works: understanding complex, community-based initiatives*, London: The King's Fund.

Cowling, V. (ed) (2004) *Children of parents with mental illness 2: personal and clinical perspectives*, Camberwell, VIC: ACER Press.

Craig, R. and Mindell, J. (eds) (2008) *Health survey for England 2006. Volume 2: obesity and other risk factors in children,* Leeds: The NHS Information Centre for Health and Social Care (available at www.ic.nhs.uk/webfiles/publications/HSE06/HSE06_VOL2.pdf, accessed 4 February 2011).

Craig, R., Mindell, J. and Hirani, V. (eds) (2009) *Health survey for England 2008. Volume 1: physical activity and fitness,* Leeds: The NHS Information Centre for Health and Social Care (available at www.ic.nhs.uk/webfiles/publications/HSE/HSE08/Volume_1_Physical_activity_and_fitness_revised.pdf, accessed 4 February 2011).

Darlington, Y., Feeney, J. and Rixon, K. (2005) 'Practice challenges at the intersection of child protection and mental health', *Child & family social work*, vol 10, pp 239–247.

Dawe, S. and Harnett, P. (2007) 'Reducing potential for child abuse among methadone-maintained parents: results from a randomized controlled trial', *Journal of substance abuse treatment*, vol 32, no 4, pp 381–390.

Department for Children, Schools and Families (2006) *Sure Start children's centre practice guidance*, London: DCSF (available at www.ypsh.net/tp_suffolk/docs/sure%20start%20childrens%20centre%20guidance.pdf, accessed 4 February 2011).

Department for Children, Schools and Families (2007) *The children's plan: building brighter futures* (Cm. 7280), London: The Stationery Office.

Department for Children, Schools and Families (2009) *Think family tool-kit: improving support for families at risk. Strategic overview*, London: DCSF (available at http://publications.education.gov.uk/eOrderingDownload/Think-Family.pdf, accessed 4 February 2011).

Department for Children, Schools and Families (2010a) *DCSF: Local authority measures for national indicators supported by the Tellus4 Survey 2009–10* (statistical release 04/10), London: DCSF
(available at http://www.dcsf.gov.uk/rsgateway/DB/STR/d000908/OSF04_2010.pdf, accessed 4 February 2011).

Department for Children, Schools and Families (2010b) *Think family pathfinders: research update,* London: DCSF.

Department for Children, Schools and Families, The Home Office and Department of Health (2008) *Youth alcohol action plan* (Cm. 7387), London: The Stationery Office (available at http://publications.education.gov.uk/eOrderingDownload/Cm%207387.pdf, accessed 4 February 2011).

Department for Education and Skills and Department of Health (2004) *National service framework for children, young people and maternity services*, London: DH (available at www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4090523.pdf, accessed 4 February 2011).

Department of Health (2007a) *Good practice guidance on working with parents with a learning disability*, London: DH (available at www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_075118.pdf, accessed 4 February 2011).

Department of Health (2007b) *Guidance on joint strategic needs assessment*, London: DH (available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097, accessed 4 February 2011).

Department of Health (2008) *Operational plans 2008/09–2010/11* (implementing the 2008/09 operating framework), London: DH (available at www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_082560.pdf, accessed 4 February 2011).

Department of Health (2009) *Valuing people now: a new three-year strategy for people with learning disabilities*, London: DH (available at www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093375.pdf, accessed 4 February 2011).

Department of Health (2010a) *Statistical release: smoking at delivery, GP recorded smoking and GP recorded obesity,* London: DH (available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_116059, accessed 4 February 2011).

Department of Health (2010b) *A vision for adult social care: capable communities and active citizens*, London: DH (available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508, accessed 4 February 2011).

Department of Health, Department for Education and Employment and Home Office (2000) *Framework for the assessment of children in need and their families*, London: The Stationery Office (available at www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4014430.pdf, accessed 4 February 2011).

Dickson, K., Sutcliffe, K., Gough, D., Statham, J. and Morris, M. (2009) *Improving the emotional and behavioural health of looked-after children and young people (LACYP)* (C4EO vulnerable/looked-after children research review 2), London: C4EO (available at www.c4eo.org.uk/themes/vulnerablechildren/emotionalbehavioural/files/improving_emotional_behavioural_health_research_review_2.pdf, accessed 4 February 2011).

Dogra, N., Vostanis, P., Abuateya, H. and Jewson, N. (2005) 'Understanding of mental health and mental illness by Gujarati young people and their parents', *Diversity in health and social care*, vol 2, pp 91–98.

Duncan, S. and Reder, P. (2000) 'Children's experience of major psychiatric disorder in their parent: an overview' in Reder, P., McClure, M. and Jolley, A. (eds) *Family matters: interfaces between child and adult mental health*, London: Routledge, pp 83–95.

Falkov, A. (ed) (1998) *Crossing bridges: training resources for working with mentally ill parents and their children*, London: Department of Health. Cited in Morris, J. and Wates, M. (2007) Working together to support disabled parents (adult services resource guide 9), London: SCIE (available at www.scie.org.uk/publications/guides/guide19/files/guide19.pdf, accessed 4 February 2011).

Farmer, E.R.G. and Moyers, S. (2008) *Kinship care: fostering effective family and friends placements*, London: Jessica Kingsley Publishers.

Farrington, D., Gottfredson, D., Sherman, L. and Welsh, B. (2002) 'The Maryland Scientific Methods Scale', in Farrington, D., MacKenzie, D., Sherman, L. and Welsh, L (eds) *Evidence-based crime prevention*, London: Routledge.

Fauth, R., Jelicic, H., Hart, D., Burton, S., Shemmings, D., Bergeron, C., White, K. and Morris, M. (2010) *Effective practice to protect children living in 'highly resistant' families* (C4EO safeguarding knowledge review 1), London: C4EO (available at www.c4eo.org.uk/themes/safeguarding/files/safeguarding_knowledge_review.pdf, accessed 4 February 2011).

Field, F. (2010) *The foundation years: preventing poor children becoming poor adults*, London: Cabinet Office (available at. http://povertyreview.independent.gov.uk/media/20254/poverty-report.pdf, accessed 3 February 2011).

Finkelstein, N., Rechberger, E., Russell, L., VanDeMark, N., Noether, C., O'Keefe, M., Gould, K., Mockus, S. and Rael, M. (2005) 'Building resilience in children of mothers who have co-occurring disorders and histories of violence: intervention model and implementation issues'. *Behavioural health services and research*, vol 32, no 2, pp 141–154.

Forrester, D., McCambridge, J., Waissbein, C., Emlyn-Jones, R. and Rollnick, S. (2008) 'Child risk and parental resistance: can motivational interviewing improve the practice of child and family social workers in working with parental alcohol misuse?, *British journal of social work*, vol 38, no 7, pp 1302–1319.

Forrester, D. and Harwin, J. (2008) 'Parental substance misuse and child welfare: outcomes for children two years after referral', *British journal of social work*, vol 38, no 8, pp 1518–1535.

Fowler, R., Robinson, B. and Scott, S. (2009) *Improving opportunities and outcomes for parents with mental health needs and their children: a review of the implementation of Action 16 of the Mental Health and Social Exclusion Action Plan 2005–2008* (available at www.pmhcwn.org.uk/documents/Action16report.pdf, accessed 4 February 2011).

Fox, C., Buchanan-Barrow, E. and Barrett, M. (2007) 'Children's understanding of mental illness: an exploratory study', *Child: care, health and development*, vol 34**,** no 1, pp 10–18.

Garmezy, N. (1983) 'Stressors of childhood', in Garmezy, N. and Rutter, M. (eds) *Stress, coping, and development in children*, New York, NY: McGraw-Hill, pp 43–84.

Goodman, J.H. (2004) 'Paternal postpartum depression, its relationship to maternal postpartum depression, and implications for family health', *Advanced nursing*, vol 45, no 1, pp 26–35.

Gorin, S. (2004) *Understanding what children say about living with domestic violence, parental substance misuse or parental health problems*, York: Joseph Rowntree Foundation.

Gowland, S. (2008) *Anti-social behaviour family intervention project: findings*, London: National Centre for Social Research (available at www.natcen.ac.uk/study/anti-social-behaviour-family-intervention-project, accessed 15 March 2011) .

Great Britain. Statutes (1989) *Children Act 1989. Chapter 41*, London: HMSO.

Great Britain. Statutes (1995) *Disability Discrimination Act 1995*. Chapter 50, London: HMSO.

Great Britain. Statutes (1998) *Human Rights Act 1998*, London: HMSO.

Great Britain. Statutes (2010) *Equality Act 2010. Part 2, Chapter 1.* London: TSO (available at www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf, accessed 4 February 2011).

Green, H., McGinnity, A., Meltzer, H., Ford, T. And Goodman, R. (2005) *Mental health of children and young people in Great Britain, 2004.* Basingstoke: Palgrave Macmillan (available at www.statistics.gov.uk/downloads/theme_health/GB2004.pdf, accessed 4 February 2011).

Greene, R., Pugh, R. and Roberts, D. (2008) *Black and minority ethnic parents with mental health problems and their children* (SCIE research briefing 29), London: SCIE (available at www.scie.org.uk/publications/briefings/files/briefing29.pdf, accessed 4 February 2011).

Hay, D.F., Pawlby, S., Angold, A., Harold, G.T. and Sharp, D. (2003) 'Pathways to violence in the children of mothers who were depressed postpartum', *Developmental psychology*, vol 39, no 6, pp 1083–1094.

Hay, D.F., Pawlby, S., Waters, C.S. and Sharp, D. (2008) 'Antepartum and postpartum exposure to maternal depression: different effects on different adolescent outcomes', *Child psychology and psychiatry*, vol 49, no 10, pp 1079–1088.

HM Government (2010) *The coalition: our programme for government*, London: Cabinet Office (available at www.cabinetoffice.gov.uk/sites/default/files/resources/coalition_programme_for_government.pdf, accessed 15 March 2011).

HM Treasury (2003). *Every child matters* (Cm. 5860), London: The Stationery Office.

HM Treasury and Department for Education and Skills (2007) *Aiming high for disabled children: better support for families*, London: HM Treasury (available at www.hm-treasury.gov.uk/d/cyp_disabledchildren180507.pdf, accessed 4 February 2011).

Horwath, J. (2001) 'Assessing the world of the child in need: background and context', in Horwath, J. (ed) *The child's world: assessing children in need and their families*, London: Department of Health, NSPCC and University of Sheffield, pp 19–28.

Hunt, J.**,** Waterhouse, S. and, Lutman, E. (2008) *Keeping them in the family: children placed in kinship care through care proceedings*, London: British Association for Adoption & Fostering.

Kurtz, Z. and James, C. (2005) 'Creative practice and innovation in child and adolescent mental health services', in Williams, R. and Kerfoot, M. (eds) *Strategic approaches to planning and delivering child and adolescent mental health services*, Oxford: Oxford Medical Publications, pp 534–544.

Lam, W.K., Fals-Stewart, W. and Kelley, M.L. (2008) 'Effects of parent skills training with behavioral couples therapy for alcoholism on children: a randomized clinical pilot trial', *Addictive behaviours*, vol 33, no 8, pp 1076–1080.

Lindsay, G., Davis, H., Strand, S., Cullen, M.A., Band, S., Cullen, S., Davis, L., Hasluck, C., Evans, R. and Stewart-Brown, S. (2009) *Parent support advisor pilot evaluation: final report* (DCSF research report 151). London: DCSF (available at www.education.gov.uk/publications/eOrderingDownload/DCSF-RR151.pdf, accessed 3 February 2011).

Manning, V., Best, D.W., Faulkner, N. and Titherington, E. (2009) 'New estimates of the number of children living with substance misusing parents: results from UK national household surveys', *BMC public health*, vol 9, p 377.

Marmorstein, N.R., Iacono, W.G. and McGue, M. (2009) 'Alcohol and illicit drug dependence among parents: associations with offspring externalizing disorders', *Psychological medicine*, vol 39, no 1, pp 149–155.

Maybery, D., Reupert, A., Goodyear, M., Ritchie, R. and Brann, P. (2009a) 'Investigating the strengths and difficulties of children from families with a parental mental illness', *Australian e-journal for the advancement of mental health*, vol 8, no 2, pp 1–10.

Maybery, D.J., Reupert, A.E., Patrick, K., Goodyear, M. and Craze, L. (2009b) 'Prevalence of parental mental illness in Australian families', *Psychiatric bulletin*, vol 33, no 1, pp 22–26.

McManus, S., Meltzer, H., Brugha, T., Bebbington, P. and Jenkins R. (eds) (2009) *Adult psychiatric morbidity in England, 2007: results of a household survey*, London: The Information Centre for Health and Social Care (available at www.ic.nhs.uk/webfiles/publications/mental%20health/other%20mental%20health%20publications/Adult%20psychiatric%20morbidity%202007/APMS%2007%20%28FINAL%29%20Standard.pdf, accessed 4 February 2011).

Moran, P., Ghate, D. and van der Merwe, A. (2004) *What works in parenting support? A review of the international evidence* (DfES research report 574), London: DfES (available at www.prb.org.uk/wwiparenting/RR574.pdf, accessed 4 February 2011).

Morris, J. (2007) *Building bridges evaluation*, London: Family Action (available at www.family-action.org.uk/uploads/documents/FA%20Building%20Bridges%20Evaluation.pdf, accessed 4 February 2011).

Morris, J. and Wates, M. (2006) *Supporting disabled parents and parents with additional support needs* (adult services knowledge review 11), London: SCIE (available at www.scie.org.uk/publications/knowledgereviews/kr11.pdf, accessed 4 February 2011).

Mowbray, C.T. and Oyserman, D. (2003) 'Substance abuse in children of parents with mental illness: risks, resiliency, and best prevention practices', *Primary prevention*, vol 23 no 4, pp 451–483.

Munro E. (2005) 'What tools do we need to improve identification of child abuse?' *Child abuse review*, vol 14, pp 374–388.

Munro, E. (2011) *The Munro review of child protection: interim report: the child's journey,* London: Department for Education (available at www.education.gov.uk/munroreview/downloads/Munrointerimreport.pdf, accessed 4 February 2011).

National Mental Health Development Unit (2010) *Multisystemic Therapy-New therapy brings results for troubled young people* (available at: http://www.nmhdu.org.uk/news/multi-systemic-therapy-new-therapy-brings-results-for-troubled-young-people/, accessed 20 March 2011).

Newman, T. (2004) *What works in building resilience?* London: Barnardos
The NHS Information Centre (2009) *National Child Measurement Programme: England, 2008/09 school year*, London: The Health and Social Care Information Centre (available at www.ic.nhs.uk/webfiles/publications/ncmp/ncmp0809/NCMP_England_2008_09_school_year_report_2.pdf, accessed 4 February 2011).

Nicholson, J., Hinden, B.R., Biebel, K., Henry, A.D. and Katz-Leavy, J. (2007). 'A qualitative study of programs for parents with serious mental illness and their children: building practice-based evidence', *Behavioral health services & research*, vol 34, no 4, pp 395–413.

Olds, D.L., Kitzman, H., Cole, R., Robinson, J., Sidora, K., Luckey, D.W., Pettit, L, Luckey, Henderson, C.R.Jr, Hanks, C., Bondy, J. and D.W. and Holmberg, J., (2004) 'Effects of nurse home visiting on maternal life course and child development: age 6 follow-up results of a randomized trial', *Pediatrics*, vol 114, pp 1550–1559.

Olsen, R. and Clarke, H. (2003) *Parenting and disability: disabled parents' experiences of raising children*, Bristol: Policy Press.

Olsen, R. and Tyers, H. (2004) *Supporting disabled adults as parents*, York: Joseph Rowntree Foundation.

O'Mara, A., Jamal, F., Llewellyn, A., Lehmann, A., Cooper, C. and Bergeron, C. (2010) *Improving children's and young people's outcomes through support for mothers, fathers and carers* (C4EO families, parents, and carers research review 3), London: C4EO (available at
http://www.c4eo.org.uk/themes/families/default.aspx?themeid=4&accesstypeid=1 , accessed 4 February 2011).

Ostler, T. (2009) 'Mental illness in the postpartum period', *Zero to three*, vol 29, no 5, pp 4–9 (available at www.zerotothree.org/site/DocServer/29-5_TOC.pdf?docID=8505, accessed 4 February 2011).

Parker, G., Beresford, B., Clarke, S., Gridley, K., Pitman, R., Spiers, G. and Light, K. (2008) *Technical report for SCIE research review on the prevalence and incidence of parental mental health problems and the detection, screening and reporting of parental mental health problems* (working paper no. SCIE 2247), York: University of York, Social Policy Research Unit (available at
www.york.ac.uk/inst/spru/research/pdf/SCIEReview1.pdf, accessed 4 February 2011).

Pawson R. (2006) *Evidence-based policy: a realistic perspective*. London: Sage.

Powdthavee, N. and Vignoles, A. (2008) 'Mental health of parents and life satisfaction of children: a within-family analysis of intergenerational transmission of well-being', *Social indicators research*, vol 88, no 3, pp 397–422.

Pretis, M. and Dimova, A. (2008) 'Vulnerable children of mentally ill parents: towards evidence-based support for improving resilience', *Support for learning*, vol 23, no 3, pp 152–159.

Prime Minister's Strategy Unit (2004) *Alcohol harm reduction strategy for England*, London: Cabinet Office (available at www.newcastle-staffs.gov.uk/documents/community%20and%20living/community%20safety/caboffce%20alcoholhar%20pdf.pdf, accessed 4 February 2011).

Quinton, D (2004) *Supporting parents*, London: Jessica Kingsley Publishers.

Robinson, M., Oddy, W.H., Li. J., Kendall, G.E., de Klerk, N.H., Silburn, S.R., Zubrick, S.R., Newnham, J.P., Stanley, F.J. and Mattes, E. (2008) 'Pre- and postnatal influences on preschool mental health: a large-scale cohort study', *Child psychology and psychiatry*, vol 49, no 10, pp 1118–1128.

Rose, W. and Barnes, J. (2008) *Improving safeguarding practice: study of serious case reviews 2001–2003* (DCSF research report 022), London: DCSF (available at www.knowsleyspace.co.uk/Resources/k/j/q/Improving%20Safeguarding%20Practice.pdf, accessed 4 February 2011).

Rusch, N., Angeymeyer, M.C., and Corrigan, P.W. (2005) 'Mental illness stigma: concepts, consequences, and initiatives to reduce stigma', *European psychiatry*, vol 20, pp 529–539.

Rutter, M. (1985) 'Resilience in the face of adversity: protective factors and resistance to psychiatric disorder', *British journal of psychiatry*, vol 147, pp 598–691.

Rutter, M. (1999) 'Resilience concepts and findings: implications for family therapy', *Journal of family therapy*, vol 21, pp 119–144

Scaife, V.H. (2008) 'Maternal and paternal drug misuse and outcomes for children: identifying risk and protective factors', *Children & society*, vol 22, no 1, pp 53–62.

Scholes, S., Pickering, K. and Rayat, P. (2008) *Healthy lifestyle behaviours: model based estimates for middle layer super output areas and local authorities in England, 2003–2005:user guide* (available at www.ic.nhs.uk/webfiles/Popgeog/PCO%20User%20Guide.pdf, accessed 4 February 2011).

Schoon, I. and Bartley, M. (2008) 'The role of human capability and resilience' *The psychologist*, vol 21, no 1, pp 24–27.

Schulte, S., Meier, P.S., Stirling, J. and Berry, M. (2008) 'Treatment approaches for dual diagnosis clients in England', *Drug and alcohol review*, vol 27, no 6, pp 650–658.

Scott, S., Robinson, B. and Day, C. (2007) *Parents in hospital: how mental health services can best promote family contact when a parent is in hospital. Final report July 2007*, Barkingside: Barnardo's (available at www.barnardos.org.uk/parents_in_hospital_summary_report_july_2007.pdf, accessed 4 February 2011).

Sheppard, M. (2004) 'An evaluation of social support intervention with depressed mothers in child and family care', *British journal of social work*, vol 34, no 7, pp 939–960.

Sidebotham, P., Brandon, M., Powell, C., Solebo, C., Koistinen, J. and Ellis, C. (2010) *Learning from serious case reviews: Report of a research study on the methods of learning lessons nationally from serious case reviews* (DfE research report 037), London: DfE (available at http://www.education.gov.uk/publications/eOrderingDownload/DFE-RR037.pdf, accessed 21 March 2011).

Smith, M. (2004) 'Parental mental health: disruptions to parenting and outcomes for children', *Child & family social work*, vol 9, no 1, pp 3–11.

Snow Jones, A. (2007) 'Maternal alcohol abuse/dependence, children's behavior problems, and home environment: estimates from the national longitudinal survey of youth using propensity score matching', *Journal of studies on alcohol and drugs*, vol 68, no 2, pp 266–275.

Social Care Institute for Excellence (2005) *The health and wellbeing of young carers* (SCIE research briefing 11), London: SCIE (available at www.scie.org.uk/publications/briefings/briefing11/index.asp, accessed 4 February 2011).

Social Care Institute for Excellence (2009) *Think child, think parent, think family: a guide to parental mental health and child welfare* (SCIE guide 30), London: SCIE (available at www.scie.org.uk/publications/guides/guide30/index.asp, accessed 4 February 2011).

Social Exclusion Task Force (2007) *Reaching out: think family. Analysis and themes from the families at risk review*, London: Cabinet Office.

Social Exclusion Task Force (2008) *Think family: improving the life chances of families at risk*, London: Cabinet Office (available at www.aft.org.uk/home/documents/think_family_life_chances_report.pdf , accessed 4 February 2011).

Spencer, L., Ritchie, J., Lewis, J. and Dillon, L. (2003) *Quality in qualitative evaluation: a framework for assessing research evidence. A quality framework*, London: Cabinet Office, Strategy Unit.

Stanley, N. and Cox, P. (2009) *Parental mental health and child welfare: reviews of policy and mental health education*, London: SCIE (available at www.scie.org.uk/publications/guides/guide30/files/FullResearchReview.pdf, accessed 4 February 2011).

Stewart-Brown, S.L. and Macmillan, A.S. (2010). *Home and community based parenting support programmes and interventions: report of workpackage 2 of the DataPrev project*, Coventry: University of Warwick, Medical School.

Sundell, K., Hansson, K., Lofholm, C.A., Olsson, M., Gustle, L-H. and Kadesjo, C. (2008) *The transportability of MST to Sweden: short-term results from a randomized trial with conduct disordered youth*. Journal of Family Psychology, 3: 550–560.

Sweet, M., and Appelbaum, M. (2004) 'Is home visiting an effective strategy? A meta-analytic review of home visiting programs for families with young children', *Child development*, vol 75, no 5, pp 1435–1456.

Teeman, D., Ransley, J., Lynch, S., White, K., Scott, E., Waldman, J., Cade, J., Benton, T., Thomas, J., Shamsan, Y. and Stoddart, S. (2010) *The third evaluation of the school fruit and vegetable scheme*, London: Department of Health (available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114343, accessed 4 February 2011).

Thoburn, J. (2010) 'Towards knowledge-based practice in complex child protection cases: a research based expert briefing', *Journal of children's services*, vol 5, no 1, pp 9–24.

Thoburn, J., Wilding, J. and Watson, J. (2000) *Family support in cases of emotional ... understanding and justice*, London: Sage Publications.

Tobias, M., Gerritsen, S., Kokaua, J. and Templeton, R. (2009) 'Psychiatric illness among a nationally representative sample of sole and partnered parents in New Zealand', *Australian and New Zealand journal of psychiatry*, vol 43, no 2, pp 136–144.

Townsend, A.L., Biegel, D.E, Ishler, K.J., Wieder, B. and Rini, A. (2006) 'Families of persons with substance use and mental disorders: a literature review and conceptual framework', *Family relations*, vol 55, no 4, pp 473–486.

Tunnard, J. (2004) *Parental mental health problems: messages from research, policy and practice*, Dartington: Research in Practice.

Tunstill, J., Aldgate, J. and Hughes, M. (2007) *Improving children's service networks: lessons from family centres*. London: Jessica Kingsley Publishers.

Twist, L., Wheater, R. and Wilkinson, K. (2009) *Improving the safety, health and wellbeing of children through improving the physical and mental health of mothers, fathers and carers*, London: C4EO.

Velleman, R. (2004) 'Alcohol and drug problems in parents: an overview of the impact on children and implications for practice', in Gopfert, M., Webster, J. and Seeman, M.V. (eds) *Parental psychiatric disorders: distressed parents and their families*, Cambridge: Cambridge University Press, pp 185–202.

Virgo, S. (2010) *Young people and families talk about future choices*, London: The Family and Parenting Institute.

Walsh, J. (2009). 'Children's understanding of mental ill health: implications for risk and resilience in relationships', *Child & family social work*, vol 14, no 1, pp 115–122.

Ward, H. and Rose, W. (eds) (2001) *Approaches to needs assessment in children's services.* London: Jessica Kingsley Publishers.

Werner, E.E. and Smith, R.S. (1982). *Vulnerable but invincible: a longitudinal study of resilient children and youth*, New York, NY: McGraw-Hill.

Further reading

Alakus, C., Conwell, R., Gilbert, M., Buist, A. and Castle, D. (2007) 'The needs of parents with a mental illness who have young children: an Australian perspective on service delivery options', *International journal of social psychiatry*, vol 53 no 4, pp 333–339.

Barnes, J., Ball, M., Meadows, P., McLeish, M. and Belsky, J. (2008) *Nurse-family partnership programme: first year pilot sites implementation in England; pregnancy and the post-partum period* (DCSF research report RW051), London: DCSF (available at www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-RW051, accessed 4 February 2011).

Department of Health (2001) *Valuing people*, London: DH.

Department of Health (2005) *Independence, well-being and choice: our vision for the future of social care for adults in England*, London: DH (available at www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4106478.pdf, accessed 4 February 2011).
England and Wales. Statutes (2005) *Disability Discrimination Act 2005. Chapter 13*, London: The Stationery Office.

England and Wales. Statutes (2007) *Local Government and Public Involvement in Health Act 2007. Chapter 28.* London: The Stationery Office (available at www.legislation.gov.uk/ukpga/2007/28/contents/enacted, accessed 4 February 2011).

Family Action (n.d.) *Families affected by parental mental health difficulties*, London: Family Action (available at www.family-action.org.uk/uploads/documents/Mental%20health%20briefing%231%23.pdf, accessed 4 February 2011).

Frank, R.G. and Meara, E. (2009) *The effect of maternal depression and substance abuse on child human capital development* (NBER working paper no. 15314), Cambridge: MA: National Bureau of Economic Research.

Fudge, E. (2003) 'Children of parents with a mental illness: the COPMI Project', *Australian journal of guidance and counselling*, vol 13, no 1, pp 99–105.

Fudge, E. and Mason, P. (2004) 'Consulting with young people about service guidelines relating to parental mental illness', *Australian e-journal for the advancement of mental health*, vol 3, no 2, pp 7–15.

Garbers, C., Tunstill, J., Allnock, D. and Akhurst, S. (2006) 'Facilitating access to services for children and families: lessons from Sure Start local programmes,' *Child & family social work*, vol 11, pp 287–296.

Great Britain. Statutes (1998) *Human Rights Act. Chapter 42*, London: The Stationery Office.

Hanson, R.F., Self-Brown, S., Fricker-Elhai, A., Kilpatrick, D.G., Saunders, B.E. and Resnick, H. (2006) 'Relations among parental substance use, violence exposure and mental health: the national survey of adolescents', *Addictive behaviours*, vol 31, no 11, pp 1988–2001.

HM Government (2004) *Every child matters: change for children*, London: DfES (available at www.everychildmatters.gov.uk/_files/F9E3F941DC8D4580539EE4C743E9371D.pdf, accessed 5 October 2010).

HM Treasury (2010). *Spending review 2010* (Cm. 7942). London: TSO (available at http://cdn.hm-treasury.gov.uk/sr2010_completereport.pdf, accessed 16 November 2010).

Jones, A.S. (2007) 'Maternal alcohol abuse/dependence, children's behavior problems, and home environment: estimates from the national longitudinal survey of youth using propensity score matching', *Studies on alcohol and drugs,* vol 68, no 2, pp 266–275.

Jones, D., Macias, R.L., Gold, P.B., Barreira, P. and Fisher, W. (2008) 'When parents with severe mental illness lose contact with their children: are psychiatric symptoms or substance use to blame?' *Loss and trauma*, vol 13, no 4, pp 261–287.

Laming, H. (2003) *The Victoria Climbie Inquiry report* (Cm. 5730), London: The Stationery Office.

Morris, J. and Wates, M. (2007) *Working together to support disabled parents* (adult services resource guide 9), London: SCIE (available at www.scie.org.uk/publications/guides/guide19/files/guide19.pdf, accessed 4 February 2011).

Morris, P.A. (2008) 'Welfare program implementation and parents' depression', *Social services review*, vol 82, no 4, pp 579–614.

National Centre for Social Research (2010) *ASB family intervention projects monitoring and evaluation* (DCSF research report 215), London: DCSF (available at www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-RR215, accessed 4 February 2011)

Ohannessian, C.M., Hesselbrock, V.M., Kramer, J., Bucholz, K.K., Schuckit, M.A., Kuperman, S. and Nurnberger, J.I. (2004) 'Parental substance use consequences and adolescent psychopathology', *Studies on alcohol and drugs*, vol 65, no 6, pp 725–730.

Osborne, C. and Berger, L.M. (2009) 'Parental substance abuse and child well-being: a consideration of parents' gender and co-residence', *Journal of family issues*, vol 30, no 3, pp 341–370.

Owen, S. (2009) 'Organisational systems and services for children of parents with mental illness and their families: processes of change and sustainability', *Administration and policy in mental health and mental health services research*, vol 37, no 5, pp 399–407.

Pawlby, S. and Fernyhough, C. (2009) 'Enhancing the relationship between mothers with severe mental illness and their infants', in Barlow, P. and Svenburg, P.O. (eds) *Keeping the baby in mind,* New York, NY: Routledge, pp 164–172.

Phelan, R., Lee, L., Howe, D. and Walter, G. (2006) 'Parenting and mental illness: a pilot group programme for parents', *Australasian psychiatry*, vol 14, no 4, pp 399–402.

Ramchandani, P.G., O'Connor, T.G., Evans, J., Heron, J., Murray, L. and Stein, A. (2008) 'The effects of pre- and postnatal depression in fathers: a natural experiment comparing the effects of exposure to depression on offspring', *Child psychology and psychiatry*, vol 49, no 10, pp 1069–1078.

Reupert, A.E., Green, K.T. and Maybery, D.J. (2008) 'Care plans for families affected by parental mental illness', *Families in society,* vol 89, no 1, pp 39–43.

Sidebotham, P. and Heron, J. (2006) 'Child maltreatment in the children of the nineties. A cohort study of risk factors', *Child abuse and neglect*, vol 30, no 5, pp 497–522.

Tunstill, J (2003) 'Political and technical issues facing evaluators of family support' in Katz, I. and Pinkerton, J. (eds) *Evaluating family support: thinking internationally, thinking critically,* Chichester: Wiley, pp 23–43.

Williams, A.S. and Cowling, V. (eds) (2008) *Infants of parents with mental illness: developmental, clinical, cultural and personal perspectives*, Bowen Hills, QLD: Australian Academic Press.

Appendix 1: Knowledge review methods

The review includes literature identified by a C4EO scoping study 'Improving the safety, health and wellbeing of children through improving the physical and mental health of mothers, fathers and carers' (Twist *et al* 2009) as being relevant to the review questions. The scoping study used systematic searching of key databases and other sources to identify literature that was then screened and coded (see Appendix 3 for the parameters document, search strategy and coding frame). Apart from reference harvesting, no further searching for material other than that located by the scoping review was undertaken for this review.

The review team used a 'best evidence' approach to select literature of the greatest relevance and quality for the review. This entailed identifying:

- the items of greatest relevance to the review questions
- the items that came closest to providing an ideal design to answer the review questions
- the quality of the research methods, execution and reporting.

The team reviewed all priority items and summarised their findings in relation to the review questions. The reviewer also assessed the quality of the evidence in each case. In judging the quality of studies, the team was guided by principles established to assess quantitative research (Farrington *et al* 2002) and qualitative studies (Spencer *et al* 2003).

There were six phases in the review method undertaken:

1. The research team undertook an initial review of the study titles of items of literature cited in the scoping study 'Improving the safety, health and wellbeing of children through improving the physical and mental health of mothers, fathers and carers' (Twist *et al* 2009). They then, following face-to-face discussion, taking the review title as parameters for this discussion, eliminated all but those which were most obviously relevant, on the basis of study title/publication abstract.

2. The remaining publications were then subjected to a second phase of coding on the basis of their abstracts. Coding at this stage took account of key study features – including research design, relevance to the scoping review questions and country of origin – to identify the key items to be included in the forthcoming main review. Subject topics were identified as relevant for inclusion in the design of the template.

3. A draft template was designed and circulated by the lead author, which was designed to record data on all or most of the following:

   o Appropriateness of the methodology in answering this question, and judgement as to the weight of evidence provided by the item in respect to the review questions.

   o Evidence on prevalence of problems such as mental and physical illness; incidence of child-level problems; and data on the outcomes of interventions.

4. In order to check for consistency, at the start of the project all team members read the same four pieces of evidence and then completed the template for each. This enabled us to check for consistency of approach across all team members.

5. A draft overview was produced on each of the sections, by the allocated researcher.

6. Completed review templates were collated and analysed thematically, so that writing could begin.

Appendix 2: Scoping study process

This appendix contains details of the search results and search strategy undertaken for the scoping study. The first stage in the process was for the Theme Lead to set the key review questions and search parameters and agree them with the National Foundation for Educational Research team who undertook the scoping study. The list of databases and sources to be searched, and keywords to be used, were also agreed with the Theme Lead.

The keywords comprised sets addressing the range of mental and physical health problems which were then combined with a set of keywords covering parents and carers. This comprised our core search. This new set was then combined with a range of keywords covering substance abuse, intervention and wellbeing, answering all three priorities.

Members of the Theme Advisory Group were invited to suggest relevant keywords, documents and websites. Websites were searched on main keywords and/or the publications/research/policy sections of each website were browsed as appropriate.

The next stage in the process was to carry out searching across the specified databases and web resources. The database and web searches were conducted by an information specialist at the National Foundation for Educational Research.

The records selected from the searches were then loaded into the EPPI-Reviewer database and duplicates were removed. The review team members used information from the abstract to assess the relevance of each piece of literature in addressing the key questions for the review. They also noted the characteristics of the text, such as the type of literature, country of origin and relevance to the review question. The first set of items was coded jointly by the team and there was a review of the coding of a randomly selected subset of items throughout the coding process.

The numbers of items found by the initial search, and subsequently selected, can be found in the following table. The three columns represent:

- items found in the initial searches
- items selected for further consideration (that is those complying with the search parameters after the removal of duplicates)
- items considered relevant to the study by a researcher who had read the abstract and/or accessed the full document.

Table A2.1. Overview of searches

Source	Items found	Items selected for consideration	Items identified as relevant to this study
Databases			
Applied Social Sciences Index and Abstracts (ASSIA)	606	58	
Australian Education Index (AEI)	624	62	
British Education Index (BEI)	487	54	
The Educational Resources Information Center (ERIC)	5990	207	
PsycINFO	5298	148	
Social Policy and Practice	2803	52	
Internet databases/portals			
British Education Internet Resource Catalogue (BEIRC)	15	6	
CERUKplus	54	1	
Educational Evidence Portal (EEP)	60	2	
Research in Practice (RiP)	40	4	
Research Register for Social Care	68	1	
Social Care Online	246	20	

Search strategy

The key words used in the searches, together with a brief description of each of the databases searched, are outlined below. Throughout, (ft) has been used to denote free-text search terms and * to denote truncation of terms.

Applied Social Sciences Index and Abstracts (ASSIA)

ASSIA is an index of articles from over 600 international English language social science journals.

Families/parents/carers

#1	Families
#2	Adolescent mothers
#3	Disabled mothers
#4	Learning disabled mothers
#5	Mentally ill mothers
#6	Adolescent fathers
#7	Alcoholic fathers
#8	Single fathers
#9	Adolescent parents
#10	Disabled parents
#11	Learning disabled parents
#12	Mentally ill parents
#13	Sick parents
#14	Single parents
#15	Teenage parents
#16	Carers
#17	Young carers
#18	Caregivers
#19	Parents in prison (ft)
#20	Single parent families
#21	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20

Mental health

#22	Anxiety
#23	Depression
#24	Parental depression
#25	Paternal depression
#26	Postnatal depression
#27	Mental illness
#28	Psychoticism
#29	Mental health
#30	Personality disorders

#31   Personality problems
#32   Antenatal depression
#33   Psychoses
#34   Emotional disturbance
#35   Emotional problems
#36   Psychiatric disorders
#37   Mental disorders
#38   #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29 or #30 or #31 or #32 or #33 or #34 or #35 or #36 or #37

Physical health

#39   Physical health (ft)
#40   Physical disability (ft)
#41   Disability
#42   Functional impairment
#43   Learning disabilities
#44   Perceptual impairment
#45   Sensory impairment
#46   Intellectual impairments
#47   Learning disabilities
#48   Mental retardation
#49   Learning difficulties
#50   Learning disorders
#51   Visual impairment
#52   Hearing impairment
#53   Obesity
#54   #39 or #40 or #41 or #42 or #43 or #44 or #45 or #46 or #47 or #48 or #49 or #50 or #51 or #52 or #53

Substance abuse

#55   Drug abuse
#56   Substance abuse
#57   Alcohol abuse
#58   Drug
#59   Drug dependency
#60   Drug misuse
#61   Drug addiction
#62   Addiction
#63   Drug dependency
#64   Hazardous drinking
#65   Alcohol abuse
#66   Problem drinking
#67   Alcoholism
#68   Alcohol dependence
#69   Alcohol consumption
#70   Drinking
#71   Binge drinking

#72   Heavy drinking
#73   #55 or #56 or #57 or #58 or #59 or #60 or #61 or #62 or #63 or #64 or #65 or #66
        or #67 or #68 or #69 or #70 or #71 or #72

Wellbeing

#74   Child welfare
#75   Welfare
#76   Wellbeing
#77   Quality of life
#78   Childrens safety (ft)
#79   Child safety (ft)
#80   Childrens health (ft)
#81   Pupil welfare (ft)
#82   Student welfare (ft)
#83   Child accidents (ft)
#84   Life satisfaction
#85   Life quality (ft)
#86   Home environment (ft)
#87   #74 or #75 or #76 or #77 or #78 or #79 or #80 or #81 or #82 or #83 or #84 or #85
        or #86

Interventions

#88   Intervention
#89   Support mechanism (ft)
#90   Evaluation
#91   Outcome* (ft)
#92   Programme* (ft)
#93   Support programme (ft)
#94   Support (ft)
#95   Value for money (ft)
#96   #88 or #89 or #90 or #91 or #92 or #93 or #94 or #95
#97   #38 or #54
#98   #21 and #97
#99   #98 and #73
#100   #98 and #87
#101   #98 and #96

Australian Education Index (AEI)

AEI is Australia's largest source of education information covering reports, books, journal articles, online resources, conference papers and book chapters.

Families/parents/carers

#1	Famil* (ft)
#2	Mothers
#3	Fathers
#4	Parents
#5	Parent (ft)
#6	Parenting (ft)
#7	Carers (ft)
#8	Young carers (ft)
#9	Child carers (ft)
#10	Caregivers
#11	Child caregivers
#12	Single parents (ft)
#13	Single mothers (ft)
#14	Single fathers (ft)
#15	One parent family (ft)
#16	Teenage parents (ft)
#17	Parents in prison (ft)
#18	#1 or #2 or #3 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17

Mental health

#19	Mental health
#20	Mental illness (ft)
#21	Mental disorder
#22	Mental retardation
#23	Mental disabil* (ft)
#24	Anxiety
#25	Depression (ft)
#26	Personality disorder (ft)
#27	Personality problem* (ft)
#28	Antenatal depression (ft)
#29	Postnatal depression (ft)
#30	Psychoses (ft)
#31	Emotional disturbances
#32	Emotional problem* (ft)
#33	#19 or #20 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29 or #30 or #31 or #32

Physical health

#34	Physical health
#35	Physical disability (ft)
#36	Disability (ft)
#37	Disabilities
#38	Intellectual impairment (ft)

#39   Learning disabilities
#40   Learning difficulties (ft)
#41   Learning disorders (ft)
#42   Multiple disabilities (ft)
#43   Sensory impairment (ft)
#44   Hearing disorders (ft)
#45   Vision disorders (ft)
#46   Hearing impairment (ft)
#47   Vision impairment (ft)
#48   Obesity
#49   #34 or #35 or #36 or #37 or #38 or #39 or #40 or #41 or #42 or #43 or #44 or #45 or #46 or #47 or #48

Substance abuse

#50   Substance abuse
#51   Drug* (ft)
#52   Drug abuse
#53   Drug use
#54   Drug misuse (ft)
#55   Drug dependency (ft)
#56   Drug addiction
#57   Drug education (ft)
#58   Hazardous drink* (ft)
#59   Alcohol abuse
#60   Alcohol use (ft)
#61   Alcohol MISUSE (ft)
#62   Alcohol dependency (ft)
#63   Alcohol addiction (ft)
#64   Alcohol education (ft)
#65   Alcoholism (ft)
#66   Alcohol (ft)
#67   Binge* (ft)
#68   Drinking
#69   #50 or #51 or #52 or #53 or #54 or #55 or #56 or #57 or #58 or #59 or #60 or #61 or #62 or #63 or #64 or #65 or #66 or #67 or #68

Wellbeing

#70   Childrens safety (ft)
#71   Child safety (ft)
#72   Childrens health (ft)
#73   Child welfare (ft)
#74   Pupil welfare (ft)
#75   Student health and welfare (ft)
#76   Health
#77   Child accidents (ft)
#78   Quality of life (ft)
#79   Life quality (ft)

#80   Home environment (ft)
#81   Wellbeing (ft)
#82   #70 or #71 or #72 or #73 or #74 or #75 or #76 or #77 or #78 or #79 or #80 or #81

Interventions

#83   Intervention* (ft)
#84   Support mechanism (ft)
#85   Outcome
#86   Programm* (ft)
#87   Support programme (ft)
#88   Support
#89   Evalua* (ft)
#90   Value for money (ft)
#91   #83 or #84 or #85 or #86 or #87 or #88 or #89 or #90
#92   #33 or #49
#93   #18 and #92
#94   #93 and #69
#95   #93 and #82
#96   #93 and #91

British Education Index (BEI)

BEI provides information on research, policy and practice in education and training in the UK. Sources include over 300 journals, mostly published in the UK, plus other material including reports, series and conference papers.

Families/parents/carers

#1   Famil* (ft)
#2   Mothers
#3   Fathers
#4   Parents
#5   Parent (ft)
#6   One parent family
#7   Teenage parent* (ft)
#8   Carers (ft)
#9   Parenting (ft)
#10   Young carers (ft)
#11   Child carers (ft)
#12   Caregivers
#13   Child caregivers
#14   Parents in prison (ft)
#15   Single parents (ft)
#16   #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15

Mental health

#17   Mental health
#18   Mental illness (ft)
#19   Mental disorder
#20   Mental retardation
#21   Mental disabil* (ft)
#22   Anxiety
#23   Depression (ft)
#24   Personality disorder (ft)
#25   Personality problem* (ft)
#26   Antenatal depression (ft)
#27   Postnatal depression (ft)
#28   Psychoses (ft)
#29   Emotional disturbances
#30   Emotional problem* (ft)
#31   #17 or #18 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29 or #30

Physical health

#32   Physical health
#33   Physical disabil* (ft)
#34   Disabil* (ft)
#35   Disabilities
#36   Intellectual impairment (ft)
#37   Learning disabilities
#38   Learning difficulties (ft)
#39   Learning disorders (ft)
#40   Multiple disorders (ft)
#41   Multiple disabil* (ft)
#42   Sensory impairment (ft)
#43   Hearing disorder* (ft)
#44   Vision disorder (ft)
#45   Hearing impairments
#46   Visual impairments
#47   Obesity
#48   #32 or #33 or #34 or #35 or #36 or #37 or #38 or #39 or #40 or #41 or #42 or #43 or #44 or #45 or #46 or #47

Substance abuse

#49   Substance abuse
#50   Drug* (ft)
#51   Drug abuse
#52   Drug misuse (ft)
#53   Drug dependency (ft)
#54   Drug addiction
#55   Drug education (ft)
#56   Hazardous drink* (ft)
#57   Alcohol abuse
#58   Alcohol misuse (ft)
#59   Alcohol dependency (ft)
#60   Alcohol addiction (ft)
#61   Alcohol education (ft)
#62   Alcoholism
#63   Alcohol (ft)
#64   Binge* (ft)
#65   #49 or #50 or #51 or #52 or #53 or #54 or #55 or #56 or #57 or #58 or #59 or #60 or #61 or #62 or #63 or #64

Wellbeing

#66   Well being
#67   Childrens safety (ft)
#68   Child safety (ft)
#69   Childrens health (ft)
#70   Child welfare
#71   Pupil welfare (ft)
#72   Student health and welfare
#73   Student health and welfare (ft)
#74   Health
#75   Child accidents (ft)
#76   Quality of life (ft)
#77   Life quality (ft)
#78   Home environment (ft)
#79   #66 or #67 or #68 or #69 or #70 or #71 or #72 or #73 or #74 or #75 or #76 or #78

Interventions

#80   Support mechanism (ft)
#81   Outcomes
#82   Programme
#83   Support programme (ft)
#84   Support
#85   Evaluation
#86   Intervention
#87   Value for money (ft)
#88   #80 or #81 or #82 or #83 or #84 or #85 or #86 or #87

#89   #31 or #48
#90   #16 and #89
#91   #90 and #65
#92   #90 and #79
#93   #90 and #88

British Education Index Free Collections

The free collections search interface of the British Education Index (BEI) (formerly the British Education Internet Resource Catalogue) includes access to a range of freely available internet resources as well as records for the most recently indexed journal articles not yet included in the full BEI subscription database.

Families/parents/carers

#1   Parents (ft)
#2   Caregivers
#3   Child caregivers
#4   Fathers
#5   Mothers
#6   Parents
#7   #1 or #2 or #3 or #4 or #5 or #6

Mental and physical health

#8   Emotional disturbances
#9   Emotional problems
#10   Mental disorders
#11   Anxiety
#12   Depression
#13   Personality problems
#14   Physical disabilities
#15   Physical health
#16   #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15

Substance abuse

#17   Alcohol abuse
#18   Drug abuse
#19   Drug addiction
#20   Drug education
#21   Solvent abuse
#22   Substance abuse
#23   #17 or #18 or #19 or #20 or #21 or #22
#24   #7 and #16
#25   #24 and #2

CERUK*plus*

The CERUK*plus* database provides access to information about current and recently completed research, PhD level work and practitioner research in the field of education and children's services.

Freetext search

    #1   Parent
    #2   Mother
    #3   Father
    #4   Carer
    #5   Mental health
    #6   Mental health problems
    #7   Mental well being
    #8   Physical health
    #9   Physical wellbeing
    #10   Physical disability
    #11   Depression
    #12   Anxiety
    #13   Substance abuse
    #14   Drug abuse
    #15   Alcohol abuse
    #16   Drug education
    #17   Drugs

Educational Evidence Portal (EEP)

EEP provides access to educational evidence from a range of reputable UK sources using a single search.

Freetext search

    #1   Parents
    #2   Mothers
    #3   Fathers (ft)
    #4   Carers (ft)
    #5   Mental health
    #6   Depression (ft)
    #7   Disabilities
    #8   Physical health
    #9   Physical disabilities
    #10   Learning disabilities
    #11   Learning difficulties
    #12   Alcohol education
    #13   Alcohol abuse (ft)
    #14   Alcohol use (ft)
    #15   Drug abuse
    #16   Drug education

#17   Drug use

Education Resources Information Center (ERIC)

ERIC is sponsored by the United States Department of Education and is the largest education database in the world. Coverage includes research documents, journal articles, technical reports, program descriptions and evaluations and curricula material.

Families/parents/carers

#1   Famil* (ft)
#2   Mothers
#3   Fathers
#4   Parents
#5   Parent (ft)
#7   Carers (ft)
#8   Parenting (ft)
#9   Young carers (ft)
#10   Child carers (ft)
#11   Caregivers
#12   Child caregivers
#13   Single parents (ft)
#14   One parent family
#15   Fatherless families (ft)
#16   Motherless families (ft)
#17   Single mothers (ft)
#18   Single fathers (ft)
#19   Teenage parents (ft)
#20   Adolescent parents (ft)
#21   Early parenthood
#22   Parents in prison (ft)
#23   #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22

Mental health

#24   Mental health
#25   Mental illness (ft)
#26   Mental disorders
#27   Mental retardation
#28   Mental disabil* (ft)
#29   Anxiety
#30   Depression (ft)
#31   Personality disorder (ft)
#32   Personality problems
#33   Antenatal depression (ft)
#34   Postnatal depression (ft)
#35   Psychoses (ft)
#36   Psychosis

#37   Emotional disturbances
#38   Emotional problem (ft)
#39   #24 or #25 or #26 or #27 or #28 or #29 or #30 or #31 or #32 or #33 or #34 or #35
      or #36 or #37 or #38

Physical health

#40   Physical health
#41   Physical disabilities
#42   Disabilities
#43   Intellectual disabilities (ft)
#44   Learning difficulties (ft)
#45   Learning disorders (ft)
#46   Multiple disorders (ft)
#47   Multiple disabilities (ft)
#48   Sensory impairment (ft)
#49   Hearing impairment (ft)
#50   Hearing impairment
#51   Vision impairment (ft)
#52   Obesity
#53   #40 or #41 or #42 or #43 or #44 or #45 or #46 or #47 or #48 or #49 or #50 or #51
      or #52

Substance abuse

#54   Substance abuse
#55   Drug (ft)
#56   Drug abuse
#57   Drug use
#58   Drug misuse (ft)
#59   Drug dependency (ft)
#60   Drug addiction
#61   Drug education
#62   Hazardous drink* (ft)
#63   Alcohol abuse
#64   Alcohol misuse (ft)
#65   Alcohol dependency (ft)
#66   Alcohol addiction (ft)
#67   Alcohol education (ft)
#68   Alcohol intoxication
#69   Alcoholism
#70   Alcohol (ft)
#71   Alcohol use
#72   Binge* (ft)
#73   Drink* (ft)
#74   #54 pr #55 or #56 or #57 or #58 or #59 or #60 or #61 or #62 or #63 or #64 or #65
      or #66 or #67 or #68 or #69 or #70 or #71 or #72 or #73

Wellbeing

    #75   Childrens safety
    #76   Child safety (ft)
    #77   Childrens health (ft)
    #78   Child welfare
    #79   Pupil welfare (ft)
    #80   Student health and welfare (ft)
    #81   Child accidents (ft)
    #82   Quality of life (ft)
    #83   Life quality (ft)
    #84   Home environment (ft)
    #85   Wellbeing
    #86   Wellness
    #87   Child health
    #88   Life satisfaction
    #89   #75 or #76 or #77 or #78 or #79 or #80 or #81 or #82 or #83 or #84 or #85 or #86 or #87 or #88

Interventions

    #90   Intervention* (ft)
    #91   Support mechanism (ft)
    #92   Intervention
    #93   Outcomes
    #94   Programme
    #95   Support programme (ft)
    #96   Support
    #97   Evaluation
    #98   Value for money (ft)
    #99   #90 or #91 or #93 or #95 or #96 or #97 or #98
    #100 #39 or #53
    #101 #23 and #100
    #102 #101 and #74
    #103 #101 and #89
    #104 #101 and #99

PsycINFO

PsycINFO contains references to the psychological literature including articles from over 1,300 journals in psychology and related fields, chapters and books, dissertations and technical reports.

Families/parents/carers

#1	Family
#2	Mothers
#3	Adolescent mothers
#4	Single mothers
#5	Fathers
#6	Adolescent fathers
#7	Single fathers
#8	Parents
#9	Parenting (ft)
#10	Single parents
#11	One parent families (ft)
#12	Carers (ft)
#13	Caregivers
#14	Young carers (ft)
#15	Teenage parents (ft)
#16	Adolescent parents (ft)
#17	Parents in prison (ft)
#18	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17

Mental health

#19	Mental health
#20	Mental disorders
#21	Mental retardation
#22	Mental disability (ft)
#23	Chronic Mental illness
#24	Chronic illness
#25	Behavior disorders
#26	Emotional disturbances
#27	Learning disorders
#28	Anxiety disorders
#29	Emotional problems (ft)
#30	Psychosis
#31	Personality disorders
#32	Depression
#33	Postpartum depression
#34	Antenatal depression (ft)

#35   #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29 or #30 or #31 or #32 or #33 or #34

Physical health

#36   Physical disorders
#37   Physical Health
#38   Physical disability
#39   Disabilities
#40   Multiple disabilities
#41   Learning disabilities
#42   Learning difficulties (ft)
#43   Learning disorders
#44   Intellectual impairment (ft)
#45   Vision
#46   Vision disorders
#47   Partially hearing impaired
#48   Hearing disorders (ft)
#49   Obesity
#50   #36 or #37 or #38 or #39 or #40 or #41 or #42 or #43 or #44 or #45 or #46 or #47 or #48 or #49

Substance abuse

#51   Drug abuse
#52   Drug usage
#53   Alcohol abuse
#54   Drug dependency
#55   Drug addiction
#56   Drug overdoses
#57   Drugs
#58   Drug education (ft)
#59   Drug misuse (ft)
#60   Alcoholism
#61   Alcohol misuse (ft)
#62   Alcohol dependency (ft)
#63   Alcohol addiction (ft)
#64   Alcohol (ft)
#65   Alcohol intoxication
#66   Binge drinking
#67   Hazardous drinking (ft)
#68   #51 or #52 or #53 or #54 or #55 or #56 or #57 or #58 or #59 or #60 or #61 or #62 or #63 or #64 or #65 or #66 or #67

Wellbeing

#69   Well being
#70   Life satisfaction
#71   Quality of life
#72   Life quality (ft)
#73   Child welfare
#74   Childrens safety (ft)
#75   Child safety (ft)
#76   Childrens health (ft)
#77   Child health (ft)
#78   Child accidents (ft)
#79   Pupil welfare (ft)
#80   Student health (ft)
#81   Student welfare (ft)
#82   Home environment (ft)
#83   #69 or #70 or #71 or #72 or #73 or #74 or #75 or #76 or #77 or #78 or #79 or #80 or #81 or #82

Interventions

#84   Intervention
#85   Evaluation
#86   Support mechanism (ft)
#87   Outcome* (ft)
#88   Programme* (ft)
#89   Support programme (ft)
#90   Support (ft)
#91   Value for money (ft)
#92   #84 or #85 or #86 or #87 or #88 or #89 or #90 or #91
#93   #35 or #50
#94   #18 and #93
#95   #94 and #68
#96   #94 and #83
#97   #94 and #92

Research in Practice

Research in Practice is the largest children and families research implementation project in England and Wales. It is a department of the Dartington Hall Trust run in collaboration with the Association of Directors of Children's Services, the University of Sheffield and a network of over 100 participating agencies in the UK

#1   Disability
#2   Family support and intervention
#3   Families
#4   Health | Physical
#5   Health | Mental

#6   Parenting
#7   Substance misuse

Research Register for Social Care (RRSC)

The RRSC provides access to information about ongoing and completed social care research that has been subject to independent ethical and scientific review.

#1   Families
#2   Parenting
#3   Mothers
#4   Fathers
#5   Carers
#6   Depression
#7   Mental health
#8   Physical health
#9   Disabilities
#10   Substance abuse
#11   Drug abuse
#12   Alcohol abuse

Social Care Online

Social Care Online is the Social Care Institute for Excellence's database covering an extensive range of information and research on all aspects of social care. Content is drawn from a range of sources including journal articles, websites, research reviews, legislation and government documents and service user knowledge.

#1   Families (ft)
#2   Mothers (ft)
#3   Fathers (ft)
#4   Parents (ft)
#5   Parenting (ft)
#6   Carers
#7   #1 or #2 or #3 or #4 or #5 or #6
#8   Anxiety (ft)
#9   Depression (ft)
#10   Post natal depression (ft)
#11   Learning disabilities (ft)
#12   Behaviour problems (ft)
#13   Behaviour problems (ft)
#14   Mental health
#15   Physical health
#16   #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15
#17   Substance abuse (ft)
#18   Drug abuse (ft)

#19   Alcohol abuse (ft)
#20   #17 or #18 or #19
#21   #7 and #16
#22   #21 and #20

Social Policy and Practice

Social Policy and Practice is a bibliographic database with abstracts covering evidence-based social policy, public health, social services, and mental and community health. Content is from the UK with some material from the US and Europe.

Families/parents/carers

#1   Family
#2   Mothers
#3   Single mother
#4   Single motherhood
#5   Single mothers
#6   Adolescent mothers
#7   Fathers
#8   Single father
#9   Adolescent fathers
#10   Parents
#11   Single parent
#12   Single parent families
#13   Single parent family
#14   Single parents
#15   Teenage parents
#16   Adolescent parents
#17   Carer
#18   Carers
#19   Caregivers
#20   Parents in prison (ft)
#21   #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or
       #14 or #15 or #16 or #17 or #18 or #19 or #20

Mental health

#22   Anxiety
#23   Anxiety disorder
#24   Depression
#25   Mental illness
#26   Mental health
#27   Mental disorder
#28   Mental disorders
#29   Personality
#30   Personality disorders
#31   Psychoses

#32   Emotional difficulties
#33   Emotional disorder
#34   Emotional disorders
#35   Emotional problem
#36   Emotional problems
#37   #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29 or #30 or #31 or #32 or #33 or #34 or #35 or #36

Physical health

#38   Learning
#39   Learning difficulties
#40   Learning disabilities
#41   Learning disorders
#42   Hearing
#43   Hearing difficulty
#44   Hearing disability
#45   Hearing impairment
#46   Vision impairment (ft)
#47   Vision disability (ft)
#48   Obesity
#49   Disability
#50   Physical disabilities
#51   Physical disability
#52   Physical health
#53   Physical illness
#54   #38 or #39 or #40 or #41 or #42 or #43 or #44 or #45 or #46 or #47 or #48 or #49 or #50 or #51 or #52 or #53

Substance abuse

#55   Drug
#56   Drug abuse
#57   Drug abuser
#58   Drug addict
#59   Drug addiction
#60   Drug addicts
#61   Drug dependency
#62   Drug education
#63   Drug misuse
#64   Substance abuse
#65   Substance dependence
#66   Substance misuse
#67   Substance use
#68   Alcohol abuse
#69   Alcohol addiction
#70   Alcohol dependence
#71   Alcohol dependency

#72   Alcohol education
#73   Alcohol misuse
#74   Alcohol problem
#75   Alcohol use
#76   Alcohol use
#77   Abuse
#78   Alcoholic
#79   Alcoholics
#80   Alcoholism
#81   Binge
#82   Binge drinking
#83   #55 or #56 or #57 or #58 or #59 or #60 or #61 or #62 or #63 or #64 or #65 or #66
        or #67 or #68 or #69 or #70 or #71 or #72 or #73 or #74 or #75 or #76 or #77 or
        #78 or #79 or #80 or #81 or #82

Wellbeing

#84   Childrens safety
#85   Childrens welfare
#86   Childrens health
#87   Child health
#88   Child safety
#89   Child welfare
#90   Pupil welfare (ft)
#91   Student welfare (ft)
#92   Child accidents (ft)
#93   Life satisfaction
#94   Quality of life
#95   Wellbeing
#96   Wellness
#97   #84 or #85 or #86 or #87 or #88 or #89 or #90 or #91 or #92 or #93 or #94 or #95
        or #96

Interventions

#98   Intervention
#99   Support mechanism
#100   Outcome or outcomes
#101   Programmes
#102   Support
#103   Evaluation
#104   Value for money
#105   Support programmes (ft)
#106   #98 or #99 or #100 or #101 or #102 or #103 or #104 or #105
#107   #37 or #54
#108   #21 and #107
#109   #108 and #54
#110   #108 and #97
#111   #108 and #106

Website		Number of results
Centre for Excellence and Outcomes (C4EO)	www.c4eo.org.uk	0
Think Family programme	www.dcsf.gov.uk/everychildmatters/strategy/parents/ID91askclient/thinkfamily/tf/	8
DCSF Family Pathfinders Programme Parental Mental Health and Child Welfare Network	www.pmhcwn.org.uk/resources_index.asp	11
Department of Health	www.dh.gov.uk/en/index.htm	1
DCSF	www.dcsf.gov.uk	3
National Academy of Parenting Practitioners	www.parentingacademy.org/	4
Joseph Rowntree Foundation	www.jrf.org.uk/	5
NICE	www.nice.org.uk/	0
Child and Maternal Health Observatory	www.chimat.org.uk/	11
National Treatment Agency, NTA	www.nta.nhs.uk/	0
Home Office	www.homeoffice.gov.uk/	4
NHS Evidence	www.evidence.nhs.uk/default.aspx	29
NHS Evidence – Mental Health	www.library.nhs.uk/Mentalhealth/	9
NHS Information Centre for Social Care	www.ic.nhs.uk/	0
King's Fund	www.kingsfund.org.uk/	0
MIND (Mental health charity)	www.mind.org.uk/campaigns_and_issues/report_and_resources	2
Mental Health Foundation	www.Mentalhealth.org.uk	3
Every Child Matters website	www.everychildmatters.gov.uk/	0
Social Exclusion Unit (Cabinet Office)	www.cabinetoffice.gov.uk/social_exclusion_task_force/families_at_risk.aspx	2
Family Action	www.family-action.org.uk/	5
Children of Parents with a Mental Illness	www.copmi.net.au	3
Barnardo's	www.barnardos.org.uk/	7

Appendix 3: Parameters document

1. C4EO Theme: Families, Parents and Carers

2. Priority 1

Improving the safety, health and wellbeing of children through improving the physical and mental health of mothers, fathers and carers

3. Context for this priority

Parenting capacity is critically affected by the physical and mental health of those providing care. Problems such as alcohol dependency and substance misuse, in particular, can reduce parents' ability to be responsive to their children's physical safety and emotional needs. Outcomes of serious case reviews show the clear link between parental mental health difficulties (for example, depression, drug and alcohol use) and placing children at risk or harm. Every Child Matters (HM Treasury 2003), Reaching Out: Think Family (Social Exclusion Task Force 2007), the Children's Plan (DCSF 2007), the National Alcohol Harm Reduction Strategy for England (Prime Minister's Strategy Unit 2004), the National Service Framework for Children, Young People and Maternity Services (DfES and DH 2004), the Government's 10-Year Drug strategy (2008), and Youth Alcohol Action Plan (DCSF *et al* 2008) all address the need to support parents and carers with additional physical, mental and behavioural health problems that impact on parenting. Since 2008, primary care trusts and local authorities have been required to undertake joint strategic needs assessments of the future health and wellbeing of their local populations to plan future services.

4. Main review questions[16] to be addressed in this scoping study (no more than five; preferably fewer)

1) What proportion of mothers, fathers and carers experience mental and/or physical health problems and what are their characteristics?

- Include consideration of substance abuse as a contributory factor to mothers', fathers' and carers' health.

2) What is the relationship between children's safety, health and wellbeing and their mothers', fathers' and carers' a) mental and b) physical health?

- Include consideration of substance abuse as a contributory factor to mothers', fathers' and carers' health.

---

16. See guidance note on setting review questions at the end of this form.

3) What interventions and support mechanisms are most effective in increasing children's safety, health and wellbeing through improving mothers', fathers' and carers' a) physical and b) mental health?

- Include consideration of substance abuse interventions where they aim to improve parents' and carers' mental and/or physical health.

- Include consideration of parental outcomes (in parenting role) as well as children's outcomes, though the latter are the main focus.

- Include consideration of barriers and how they are overcome.

- Include consideration of value for money.

5. Which cross-cutting issues should be included? (Child poverty: equality and diversity; disability; workforce development; change management; leadership; learning organisations)? **Please specify the review questions for cross-cutting issues in this scope.**
Child poverty, Workforce development, Equality and diversity, Disability

6. Definitions for any terms used in the review questions
Wellbeing – In the context of this review, this term is taken to relate to children's emotional, behavioural, economic/material, physical/health and educational wellbeing.

Mental health issues – to include depression and anxiety disorders, psychoses, personality disorders.

Drug and alcohol misuse/drug and alcohol dependency/substance misuse.

Physical health issues – to include limiting longstanding illness, disability, obesity in parents and children.

7. What will be the likely geographical scope of the searches?
(Work conducted in/including the following countries)
English-speaking countries.

8. Age range for CYP:
 0-19

9. Literature search dates
Start year
2003

10. Suggestions for key words to be used for searching the literature.
alcohol dependency, drug misuse, substance abuse, anxiety, depression, mental illness, personality disorder, parental disability, young carers, child carers, antenatal and postnatal mental health, substance misuse, obesity, hazardous drinking, harmful drinking, criminality, parents in prison, child accidents

11. Suggestions for websites, databases, networks and experts to be searched or included as key sources.

Think Family programme -
www.dcsf.gov.uk/everychildmatters/strategy/parents/ID91askclient/thinkfamily/tf/
DCSF Family Pathfinders programme
Parental Mental Health and Child Welfare Network
www.pmhcwn.org.uk/resources_index.asp
Department of Health
SCIE/Social Care Online
DCSF
National Academy of Parenting Practitioners
Joseph Rowntree Foundation
NICE
Child and Maternal Health Observatory
National Treatment Agency, NTA
Home Office

12. Any key texts/books/seminal works that you wish to see included?

Social Care Institute for Excellence (2009) *Think child, think parent, think family: a guide to parental mental health and child welfare* (SCIE guide 30), London: SCIE (available at www.scie.org.uk/publications/guides/guide30/files/guide30.pdf, accessed 28 January 2010).

Social Exclusion Task Force (2008) *Think family: improving the life chances of families at risk*, London: Cabinet Office (available at www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/think_families/think_family_life_chances_report.pdf, accessed 29 January 2010).

Advisory Council on the Misuse of Drugs (2003) *Hidden harm: responding to the needs of children of problem drug users,* London: Home Office (available at www.drugsandalcohol.ie/5456/1/1737-1660A.pdf, accessed 29 January 2010).

Fowler, R., Robinson, B. and Scott, S. (2009). *Improving opportunities and outcomes for parents with mental health needs and their children: a review of the implementation of Action 16 of the Mental Health and Social Exclusion Action Plan 2005–2008,* (available at www.pmhcwn.org.uk/documents/Action16report.pdf, accessed 29 January 2010).

Gorin, S. (2004) *Understanding what children say about living with domestic violence, parental substance misuse or parental health problems*, York: Joseph Rowntree Foundation (available at www.jrf.org.uk/publications/understanding-what-children-say-about-living-with-domestic-violence-parental-substance-, accessed 28 January 2010).

Smith, M. (2004) 'Parental mental health: disruptions to parenting and outcomes for children', *Child & family social work*, vol 9, no 1, pp 3–11.

Tunnard, J. (2004) *Parental mental health problems: messages from research, policy and practice*, Dartington: Research in Practice.

Social Care Institute for Excellence (2005) *The health and wellbeing of young carers* (SCIE research briefing 11), London: SCIE (available at www.scie.org.uk/publications/briefings/briefing11/index.asp, accessed 29 January 2010).

Morris, J. (2007) *Building bridges evaluation*, London: Family Action (available at www.family-action.org.uk/uploads/documents/FA%20Building%20Bridges%20Evaluation.pdf, accessed 28 January 2010).

Bancroft, A., Wilson, S., Cunningham-Burley, S., Backett-Milburn, K. and Masters, H. (2004) *The effect of parental substance abuse on young people*, York: Joseph Rowntree Foundation (available at www.jrf.org.uk/publications/effect-parental-substance-abuse-young-people, accessed 28 January 2010).

13. Anything else that should be included or taken into account?
Review to identify issues around diversity and parental health, for example, age, gender, ethnicity, social class.

Review to explore issues around joint commissioning between children and adult services.

Review authors to consider (where evidence on these exists) interventions that have been proved to be successful in improving the mental and physical health of mothers, fathers and carers over time.

Note on setting review questions

The review questions are important because the scoping team will use these to assess the available literature. Review questions need to be clear, specific and answerable. For example, the questions addressed in a scoping study might identify the following questions:

1. What is the evidence of different outcomes (in relation to ECM outcomes) for children and young people from diverse backgrounds and with different characteristics?

2. What do we know about the causes and correlates of these outcomes?

3. What works – what do we know about specific strategies, approaches and systems that help all children and young people to achieve good outcomes?

In addition to suggesting review questions, it is important to provide definitions of key terms and concepts (for example, for 'outcomes' in the above example).

Appendix 4: National indicators and key data sources

Improving the safety, health and wellbeing of children through improving the physical and mental health of mothers, fathers and carers

National indicator (NI) number	NI detail	Source (published information)	Scale	Frequency of data collection	Latest data collection	First data collection	Link
Be healthy							
Additional indicators	Emotional health and wellbeing – children and young people user perception	DCSF: Local authority measures for national indicators supported by the Tellus4 Survey 2009/10	National, regional and local authority	Annual	2009	2007	www.dcsf.gov.uk/rsgateway/DB/STR/d000908/index.shtml
Additional indicators	Emotional health and wellbeing – children and young people user perception	Mental health of children and young people in Great Britain	National	Ad hoc (1999, 2004 and 2007)	2007	1999	www.statistics.gov.uk/downloads/theme_health/GB2004.pdf www.statistics.gov.uk/articles/nojournal/child_development_mental_health.pdf
NI 51	Effectiveness of child and adolescent mental health (CAMHS) services	DCSF: Effectiveness of CAMHS as at December 2009	National, government office region and local authority	Annual	2009	2008	www.dcsf.gov.uk/rsgateway/DB/STR/d000932/index.shtml

National indicator (NI) number	NI detail	Source (published information)	Scale	Frequency of data collection	Latest data collection	First data collection	Link
NI 55/56	Obesity among primary school age children in Reception Year/Year 6	The Health Survey for England – 2008: Physical Activity and Fitness	National and strategic health authority	Annual	2008	1994	www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/health-survey-for-england/health-survey-for-england--2008-physical-activity-and-fitness
NI 55/56	Obesity among primary school age children in Reception Year / Year 6	Health Survey for England 2006. Volume 2. Obesity and Other Risk Factors in Children	National, government office region and strategic health authority	Annual	2006	1994	www.ic.nhs.uk/webfiles/publications/HSE06/HSE06_VOL2.pdf
NI 55/56	Obesity among primary school age children in Reception Year/Year 6	National Child Measurement Programme: England, 2008/09 school year	National, regional, local authority and local authority district. Also, strategic health authority and primary care trust.	Annual	2008/09	2006/07	www.ic.nhs.uk/ncmp
Additional indicators	A compilation of data sources that can aid Joint Strategic Needs Assessments (JSNA)	JSNA Core Dataset	Various	Various	Various	Various	www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_099262.pdf
Additional indicators	Adult obesity	The Health Survey for England – 2008: Physical Activity and	National and strategic health authority	Annual	2008	1994	www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-

National indicator (NI) number	NI detail	Source (published information)	Scale	Frequency of data collection	Latest data collection	First data collection	Link
		Fitness					surveys/health-survey-for-england/health-survey-for-england--2008-physical-activity-and-fitness
Additional indicators	Adult mental health and substance misuse	Adult Psychiatric Morbidity in England, 2007: Results of a Household Survey	England and government office region	Around every five years	2007	1993	www.ic.nhs.uk/webfiles/publications/mental%20health/other%20mental%20health%20publications/Adult%20psychiatric%20morbidity%202007/APMS%202007%20%28FINAL%29%20Standard.pdf
Additional indicators	Adult hospital admissions due to severe mental health conditions	The MINI and MINI2000 indices	Local authority ward	Unknown	Unknown	Unknown	www.mentalhealthobservatory.org.uk/mho/mini
Additional indicators	Adult obesity	Healthy Lifestyle Behaviours: Model Based Estimates for Middle Layer Super Output Areas and Local Authorities in England, 2003-2005: User Guide	Local authority and middle layer super output areas	Unknown	2003/2005	2003/2005	www.ic.nhs.uk/statistics-and-data-collections/population-and-geography/neighbourhood-statistics/neighbourhood-statistics:-model-based-estimates-of-healthy-lifestyles-behaviours-at-la-level-2003-05

National indicator (NI) number	NI detail	Source (published information)	Scale	Frequency of data collection	Latest data collection	First data collection	Link
Additional indicators	Adult obesity	Statistical Release. Smoking at Delivery, GP Recorded Smoking and GP Recorded Obesity (BMI), Quarter 2, 2010/11	National, strategic health authority and primary care trust	Quarterly	2010/11	2005/06	www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_116059
Additional indicators	Live and still births	Birth Statistics: Births and Patterns of Family Building in England and Wales	National, government office region and unitary authorities	Annual	2008	1998	www.statistics.gov.uk/statbase/Product.asp?vlnk=5768
Additional indicators	Adult health	General Lifestyle Survey (formerly the General Household Survey)	National and government office region	Annual	2008	1971	www.statistics.gov.uk/STATBASE/Product.asp?vlnk=5756
Additional indicators	Proportion of adults with a disability	DWP: Family Resources Survey 2008/09	National and government office region	Annual	2008/09	1992	http://research.dwp.gov.uk/asd/frs/

National indicator (NI) number	NI detail	Source (published information)	Scale	Frequency of data collection	Latest data collection	First data collection	Link
Additional indicators	Characteristics of Sure Start Local Programme areas between 2000/01 and 2004/05	National Evaluation of Sure Start	England and Sure Start Areas	Annual from 2000 to 2005	2005	2000	www.dcsf.gov.uk/everychild matters/publications/0/1908/
Enjoy and achieve							
NI 73	Proportion of pupils achieving Level 4 or above in both English and maths at Key Stage 2	DCSF: Key Stage 2 Attainment by Pupil Characteristics, in England 2009/10	National, regional and local authority	Annual	2010	Trend data from 2006 onwards available	www.education.gov.uk/rsgat eway/DB/SFR/s000972/inde x.shtml
NI 75	Proportion of pupils achieving 5 or more A*-C GCSEs (or equivalent) including English and maths	DCSF: GCSE Attainment by Pupil Characteristics, in England 2008/09	National, regional and local authority	Annual	2009	Trend data from 2006 onwards available	www.dcsf.gov.uk/rsgateway/ DB/SFR/s000900/index.shtm l

National indicator (NI) number	NI detail	Source (published information)	Scale	Frequency of data collection	Latest data collection	First data collection	Link
Staying safe							
NI 59	Percentage of initial assessments for children's social care carried out within seven working days of referral	DfE: Children In Need in England, including their characteristics and further information on children who were the subject of a child protection plan (2009-10 Children in Need census, Final)	National, government office region and local authority	Annual until 2010.	2009/10	2002/03	www.education.gov.uk/rsgateway/DB/STR/d000970/index.shtml
NI 70	Hospital admissions caused by unintentional and deliberate injuries to children and young people	Hospital Episode Statistics	National and primary care trust/NHS Foundation Trust	Monthly	January 2010	1989/90	www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937
Additional indicators	Infant mortality	Unexplained deaths in infancy, England and Wales, 2007	National and government office region	Annual	2007	Unknown	www.statistics.gov.uk/StatBase/Product.asp?vlnk=14127

National indicator (NI) number	NI detail	Source (published information)	Scale	Frequency of data collection	Latest data collection	First data collection	Link
Additional indicators	Infant mortality	Births, Perinatal and Infant Mortality Statistics, England and Wales and government office regions and strategic health authorities in England, 2008: Health Statistics Quarterly	National, government office region and strategic health authority	Quarterly	2008	Unknown	www.statistics.gov.uk/statbase/ssdataset.asp?vlnk=9886&More=Y

Appendix 5: Validated local practice process and assessment criteria

What is validated local practice?

Validated local practice examples describe how local authorities and their partners have successfully tackled key challenges and improved outcomes for children and young people. Their success in achieving improved outcomes has been assessed as being sufficiently well evidenced to merit inclusion within the review.

Collection methods

C4EO collected practice examples by sending invitations to local authorities and services to submit promising or proven practice examples to C4EO relevant to each theme. The 'call' for local practice examples was also advertised at the Families, Parents and Carers training event, placed on the C4EO website and publicised through various publications. Members of the Theme Advisory Group were also asked to use their own contacts and networks to publicise the call for practice examples. Respondents submitted examples in hard copy, online via the C4EO website or via email.

Validation process

Local authorities and their partners were asked to submit their practice examples in a form that was designed to encourage them to fully describe their practice and to provide evidence of how it had improved outcomes. The forms were then assessed by a validation panel made up of a small group of sector specialists, professionals drawn from across the children's sector who have an expertise and a track record of achievement in working with families, parents and carers. Two sector specialists assessed each example against the following validation criteria:

Adequacy of the information supplied. Is there enough to apply the validation process?

Strength of the rationale. Was the intervention/practice fit for purpose and based upon a clear and sound rationale? Was it based on prior and good quality evidence of need and what works in similar contexts?

Sufficiency of impact and outcome evidence. Is there sufficient external and/or internal evaluation evidence that the practice/intervention has made a difference and led to improved outcomes? Are there good practitioner, service user and other stakeholder views? Do others implementing the same or similar practice or strategy changes or interventions report similar findings?

Evidence of what has/has not worked and why. Is there some good guidance here which will be useful to others? What are the golden threads for what works? What barriers and ways of overcoming these have been documented?

> **Actual or potential for replication or transfer** to other contexts and settings. What evidence is there that the practice has already been successfully transferred to different settings, or has the potential for replication? Which elements are especially transferable? What elements are non-negotiable, and which are open to adaptation to suit other contexts? What do people need to put in place to transfer the practice, without substantial loss of effect?

Where two sector specialists assessed an example as being strongly supported by practice experience and evidence, or as describing promising practice along with a good rationale for the intervention and some evidence of success and potential to be replicated, the Theme Lead reviews the assessment. Only examples which are endorsed by the Theme Lead are validated.

This review has drawn on five validated practice examples.

The local practice validation form is supplied below.

Local Practice Validation Form

Panel/Theme/s *(if more than one theme, add details under 'Other notes'*		**Date of panel**	
		Date example submitted to C4EO	
ID		**LA/Organisation**	
Submission title/description			
Theme priorities *(please tick)*	P1	P2	P3
	Fits theme but no priority	Special call	Fits another theme
Other notes			

Guidelines – please read carefully

1. The completed and signed validation form will be returned to the submitter. Every section of the validation form <u>must</u> be completed in order to provide evidence that <u>all five criteria</u> have been considered. Please complete all sections with constructive comments and feedback (in full sentence format) which will be useful to the submitter. All validation forms will be evaluated at some stage and this information is essential.

2. Where further information or support is needed: please ensure that you specify <u>exactly what is required</u> and present your comments in as positive a way as possible to enable the C4EO team at NFER to relay this precisely to the submitter.

3. The outcome section in this form is for completion by the Validation Panel and must be completed, signed and dated by the panel members.

Validation criteria *(please complete all sections)*

CRITERION	JUDGEMENT
1. Adequacy of the information supplied (Ref. all sections of submission form but particularly sections 1 and 2) *Checklist* Is there enough information to apply the validation process? Background/context? Goal/purpose of practice? Clear and measurable aims and intended outcomes?	
2. Strength of the rationale (Ref. sections 1 and 2 of submission form) *Checklist* Is the intervention/practice fit for purpose and based upon a clear and sound rationale? Is the rationale related to an evidence base? Is it based on prior and good quality evidence of need and what works in similar contexts?	
3. Sufficiency of impact and outcome evidence and evaluation (Ref. sections 3 and 4 of submission form) *Checklist* Is there sufficient external and/or internal evaluation evidence that the practice/intervention has made a difference and led to improved outcomes? Does it mention the number of children's/young people's and families' lives that have been improved? Are there good practitioner, service user and other stakeholder views? Do others implementing the same or similar practice, strategy, changes, or interventions report similar findings?	

4. Evidence of what has/has not worked and why linked to evaluation and transferability (Ref. section 4 of submission form primarily plus section 3 possibly) *Checklist* Is there guidance here which will be useful to others? What are the golden threads for what works? What barriers and ways of overcoming these have been documented?	
5. Actual or potential for replication or transfer and sustainability (Ref. all sections of submission form) *Checklist* *Potential for replication/transferability* Is the practice transferable to other contexts and settings? What evidence is there that the practice has already been successfully transferred to different settings, or has the potential for replication? Has evaluation evidence been included on, for example, external evaluation reports, internal reviews, children, youth or parent feedback surveys, other surveys/data, anecdotal evidence, budgetary and/or statistical information, plans and/or timelines? Which elements are especially transferable? What elements are non-negotiable, and which are open to adaptation to suit other contexts? What do people need to put in place to transfer the practice, without substantial loss of effect? *Sustainability* Is there any evidence this example is/has potential to be sustainable? Check for funding, resource, lack of evidence of continued impact.	

Other comments *e.g. please provide any specific comments relating to copyedit, order of text, or layout requirements before publication*

134

OUTCOME OF VALIDATION PANEL – *to be completed, signed and dated by panel members*

1. Validated *(published on C4EO website plus considered for knowledge reviews)* Good evidence of systems change plus evidence of impact on population of children, young people and their families presented.	*Panel feedback to submitter*	
2. Promising Practice *(published on C4EO website)* Some merit and evidence of change in systems and services and some evidence of impact presented.	*Panel feedback to submitter*	
3. Further support recommended *(please tick appropriate column)*	Writer *(clarity of text/layout/presentation)*	Sector Specialist
4. Other outcome *(please advise C4EO VLP Team)*	Early Days (some merit)	No further action
Signed and endorsed by:	***Print name and date***	
Panel member/Sector Specialist Signed:	Name Date	
Panel member/Sector Specialist/Theme Lead Signed:	Name Date	

Overall Theme Lead/Coordinator *(3 signatures are needed for validation)* Signed:	Name Date

Appendix 6: Stakeholder data

Children and young people

The National Children's Bureau held consultation events with young people that contributed their opinions and shared their experiences. These included:

- 50 Youth4U young inspectors from the following areas (Thurrock, Southampton, Bromley, Sutton, Nottinghamshire)
- Nine Young NCB members (YNCB)
- 12 members of the Skills Development Programme
- Seven young people in Tyneside who were part of the Pathways entry to employment programme.

These groups were asked the following questions:

1. Who do you think offers the best sources of help for children and young people facing difficulties?

2. Which person(s) are you most likely to confide in if your parents were having problems?

3. What would encourage young people to talk openly about how they are feeling about their home environment?

4. What would stop young people from openly talking to anyone/how easy do you find it to ask for help when you are worried about things to do with your family?

5. How do young people find out about places to go and people that they can talk to about family problems? What other information would they like to be available?

Parents and carers

The Family and Parenting Institute consulted parents at C4EO's Parent Panel who shared their experiences and opinions. The Panel were asked the following questions

1. Where would you go if you had any health concerns?

2. How, at the moment, do you find out what health services might be available to help you?

3. How would you like to be able to find out what health services might be available to help you?

4. What support would you find most helpful regarding your health and wellbeing? If you could design a system to help people with health in every area of their lives, what would it look like?

Service providers

Evidence was gathered from service providers and managers during discussion groups at C4EO training events (events at which the authors presented findings from the families, parents and carers research reviews). These were held in London, Birmingham, Manchester and Bristol during October 2010. Thirty-five service providers took part in facilitated groups, focusing on the following questions for discussion:

1. How do you ensure locally that agencies work together, including managing the children's and adult services interface, to support parents and carers with health related issues?

2. The research suggests that there are some cross-cutting themes in relation to this theme: overcoming stigma; building resilience and developing workforce. What effective local practice can you share that contributes to these cross-cutting themes?

3. What do you do to ensure that parents and carers are involved in the design/ commissioning/promotion/evaluation of programmes? What factors prohibit this locally?