EARLY INTERVENTIONS TO IMPROVE THE HEALTH & WELLBEING OF CHILDREN & YOUNG PEOPLE OF BIRMINGHAM

Findings of a Search for the Evidence of Effectiveness and the Analysis of Local Descriptive Epidemiological Data

1. INTRODUCTION

The Birmingham Health & Wellbeing Board established its first set of priorities in March 2013 which included improving the health and wellbeing of children & young people in the City. In particular the Board set a challenge to intervene earlier in both service responsiveness and a structured programme approach.

A Task & Finish group has drawn together the evidence of effectiveness for service based approaches, Early Intervention programmes, and the current pattern of need for service. The output is to be used to direct initial investment from the Public Health allocation. It is then intended to support the operationalisation of the Early Help offer and the Birmingham Safeguarding Children Board's *Right Service, Right Time* responsive model for concerns which will include a network of specialist and programme interventions.

This document draws together the findings of the group.

2. THE EVIDENCE OF EFFECTIVENESS

The initial literature search identified research/intervention evaluation and national guidance documents for this review. The quality and validity of these were assessed and 34 papers were reviewed in detail.

Early preventative interventions and programmes can be classified in a number of ways. The National Institute of Clinical and Health Care Excellence have adopted the framework developed by the Institute of Medicine (Mrazek et al; 1994)[1] and this is used here. It is described in the context of these papers and reports in Table 2.1 and structures this part of the document.

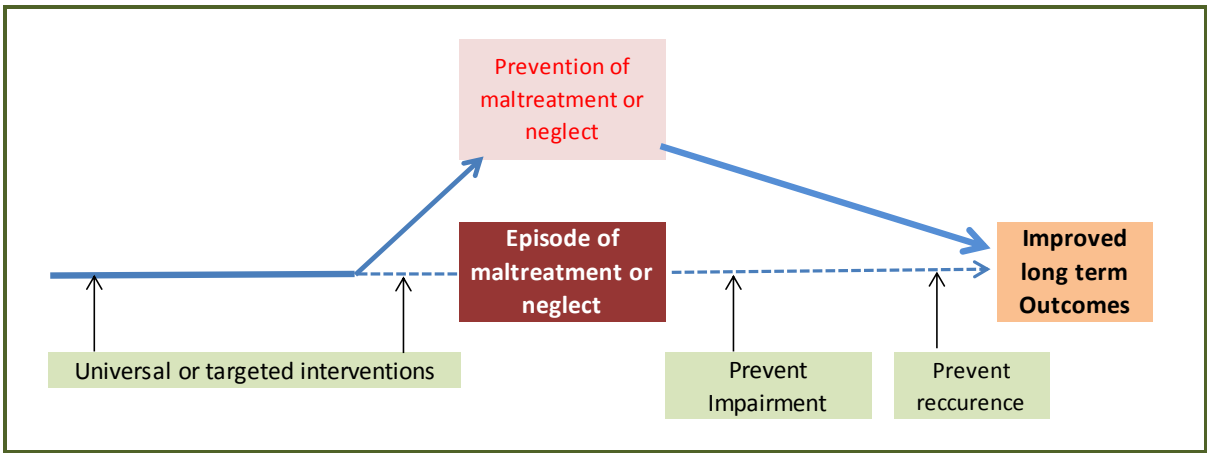
Table 2.1: Framework for reviewing Evidence of Benefit

MAKING SENSE OF EARLY INTERVENTION	
1 Making the Case for Early Intervention	*Benefits , social and financial, of working with parents and families early*
2 Universal Preventive Early Intervention	*Targetted at populations of higher risk*
3 Selective Preventive Early Interventions	*Targetted at children and/or families identified as higher risk.*
4 Indicated Preventative Interventions	*Targetted at children and families signs of difficulty or behaviours not requiring specialsit interventions and best delivered soon after identification*
4a Children & Young People	*Treating young peoples behaviour using Family Intervention programmes* *Working with Young people on the cusp of care or already in care or Youth Justice* *Multidimensional Treatment Foster Care for Adolescents (MTFC-A)* *Using recreational approaches to prevent behavioural problems*
4b Parents	*Identifying and treating parents with depression/substance misuse* *Early Parental Intervention Pilot* *Parenting programmes* *Using other socially based (housing) approaches*
4c Family	*Family Intervention programmes* *Intensive Family Support* *Whole Family and Team Around the Family* *Evaluating outcomes from working with families*

2.1. MAKING THE CASE FOR EARLY INTERVENTION

In a report reviewing the state of Safeguarding Children Services, Munroe [2]described reactive early intervention as a preventative process. She also recognised the importance of responses to improve the long term outcomes should abuse occur (Figure 2.1).

Figure 2.1: Reactive Early Intervention Munroe Framework



An evaluation of Intensive Family Support Projects (*The longer-term outcomes associated with families who had worked with Intensive Family Support Projects*: 2008)[3] concluded that in many families the behaviour of children/young people appeared to be symptomatic of structural disadvantage combined with long-standing cognitive and psychological problems, which had not been addressed by welfare and educational agencies at an earlier stage. The findings from this early study highlight the importance of timely intervention.

In 2010 a report by the Centre for Excellence in Outcomes (C4EO), *Grasping the Nettle: early intervention for children, families and communities,*[4] opened with the following observation.

> *The growing interest in early intervention as a policy issue reflects the widespread recognition that it is better to identify problems early and intervene effectively to prevent their escalation than to respond only when the difficulty has become so acute as to demand action. It is better for the individual, their families, and society more broadly; it avoids a lot of personal suffering; reduces social problems; and generally costs less than remedial action – so early intervention is nothing new.*
>
> *What has changed is that our knowledge and understanding of human development, especially in childhood, has grown to the point where we can identify more problems earlier; some we can even anticipate or identify clear risk factors.*

The report reviewed the effectiveness and cost-effectiveness research and identified five golden threads which can be woven into a coherent strategy for systemic change.

a) **The Best Start in Life:** A child's early development, including before birth, lays the foundation for their future life. Unfortunately little of the knowledge about that development is applied systematically to ensure that all children get off to the best start. Too much is still left to what is often referred to as the 'accident of birth'.

   Traditional, cross-generational support networks are often weaker than they were as a result of changes in society. So universal services, such as children's centres and schools, are more important in transmitting the knowledge and information to ensure a good early start – but many of the most vulnerable don't even make it to children's centres without

significant encouragement. Children's centres should be strongly encouraged to develop effective outreach strategies to draw in isolated and 'hard to reach' families.

Despite the significant benefits of breastfeeding having been clearly illustrated, breastfeeding rates in England are among the lowest in Europe. Effective local initiatives are needed to achieve and sustain significant improvements. More needs to be done to promote the use of peer support: volunteers from the community (including local parents) who are trained to work alongside professionals, but whose similar life experiences bridge the 'approachability gap'.

b) Language for Life: The ability to communicate is an essential life skill which underpins a child's future development, but more children struggle than is commonly recognised. Awareness of the importance of language and communication skills and the creation of language rich environments for young children remains generally inadequate. It is encouraging that a high proportion of language difficulties can be remedied with the right support – though for some it appears that this needs to be done by the age of 5½.

The scale of children affected is considerable: up to 10% of children have a long-term, persistent communication disability, and approximately 50% in socially disadvantaged areas have significant language delay on entry to school. There is a strong correlation between communication difficulties and low attainment, mental health issues, poor employment or training prospects and youth crime.

A skilled and confident workforce is critical, with the ability to identify communication problems at an early age and distinguish between transient and persistent difficulties so that appropriate interventions can be put in place. Many Early Years staff feel inadequately equipped to help these children and over 60% of primary teachers lack confidence in their ability to meet children's language needs.

Effective local practice to address this was characterised by a large scale training programme and dissemination of information to equip staff and parents.

c) Engaging Parents: The national approach to parenting support is far from systematic, with the inevitable consequence that many children and young people experience problems that are largely avoidable, and which blight their lives – and those of their parents and families – often escalating into more serious situations that may require expensive intervention. Effective intervention with children depends not only on the *fact* of involving their parents, and sometimes wider family, but also on the *way* of doing so.

Parents are the most significant influence on children, and parenting has profound consequences for their future lives, so it is important to persuade parents that engaging in their child's development can make a difference, to build positively on their existing strengths, and actively involve them in decisions. Disadvantage is not a block to good parenting but low levels of literacy and numeracy and confidence are obstacles, and self-perception contributes to parents' motivation to change – so it is particularly important to persuade such parents to engage with support services by convincing them that they can bring real and lasting benefits to their children.

A key feature of several examples is the use of peer support: volunteers from the community who are trained to work alongside professionals, but whose similar life experiences bridge the 'approachability gap' that often prevents the take up of support. To some extent, this is also a way of addressing an issue identified previously that many professionals still lack confidence in working with parents, and receive inadequate training to help them. Most parents need support of some kind at some time, and 'normalising' parenting support would greatly widen the reach of the benefits it brings.

d) Smarter Working, Better Services: Effective commissioning starts with a strategic understanding of how the whole system works and how the total resource is being used. A key to success is to understand that early intervention requires a reorientation of the system at all levels.

The importance of agencies working in partnership to meet the needs of children and families lies at the heart of recent changes in approach to service development and delivery. This requires a move from contracting based on providers and shifting to pathway commissioning leading to procurement of suitable providers. Staff in all settings need to have an increased understanding of the principles of early intervention, of how they can identify early difficulties, of how they should respond, and of the role of others.

The problems experienced by some children and families will respond to a single intervention, others will require longer term support; some will be complex and may even cross generations. It is, therefore, essential that a continuum of support is available with the capacity to meet specific needs at a particular time. Creating and sustaining such provision requires a high level of interagency collaboration, as well as good communication with families.

To overcome the inconsistencies and confusion that exist in many places, the Common Assessment Framework **process** should be developed into a standardised tool for conducting assessments for children's additional needs, and for developing and agreeing on a process through which agencies work together to meet those needs. The work of the NCB Early Support tool (MAPIT) is commended.

e) Knowledge is Power: An Ofsted review of Special Education Needs and Disability observed that; "*What consistently worked well was rigorous monitoring of the progress of individual children and young people, with quick intervention and thorough evaluation of its impact*".

It is the progress, or lack of it, being made by a child that often signifies the existence of a problem with service responsiveness. The recording of these individual assessments aggregated up to population level are often powerful ways of shaping and reshaping the service responses needed and then available.

Evidence suggests that the use of data is a systemic weakness. In short, if we cannot provide evidence to show that an intervention is having a positive impact, how can we justify funding it? Evidence should be used as an integral part of the process and as an aid to innovation. We can learn much from international experience in this area.

The report then went on to pose the core question:

Where is it best to invest?: The powerful body of research (home and abroad) showing that what a child experiences during the early years (starting in the womb) lays the foundation for the whole of their life, makes a compelling case for prioritising investment in this area.

In general, targeted approaches tend to be judged more cost effective than universal approaches. Yet there is little comparative evidence to determine which approach might be most 'cost effective'. The evidence suggests that it is unlikely to be a question of one or the other. What is needed is a range of interventions able to provide support at different levels of need.

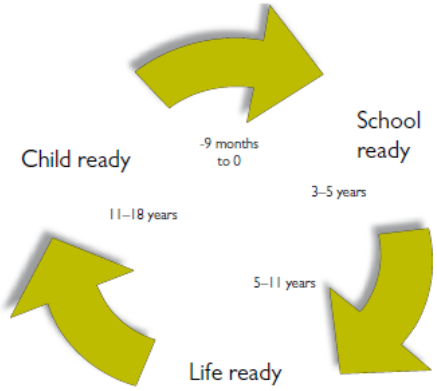
Spending should be prioritised on children's centres and early years (in particular breastfeeding initiatives and the Nurse Family Partnership); speech, language and communication needs; parenting programmes; targeted family support; and young people on the edge of care.

Early Interventions: The Next Steps (Allen; 2011)[5]added further support to the introduction of Early Intervention, exploring the recent neuro-biological research which underpins the argument and the social-economic benefits of doing so. He argues for the introduction of systematic universal and selective preventive programmes based upon their proven cost effective benefits. He looks to establishing a virtuous circle that spirals upwards by preparing each generation of adults to be ready to parent children differently from the way they were.

Figure 2.2: A Virtuous Circle That Spirals

CHILD READY

- **understanding what it is like to build and sustain a relationship,**
- **to have a family and look after a small child,**
- **understanding how babies grow and develop, and**
- **how parents can best promote this development**



SCHOOL READY

- **Having the social and emotional foundation skills to progress in speech, perception, ability to understand numbers and quantities, motor skills, attitude to work, concentration, memory, and social conduct;**
- **Having the ability to engage positively and without aggression with other children;**
- **Having the ability to respond appropriately to requests from teachers.**

LIFE READY

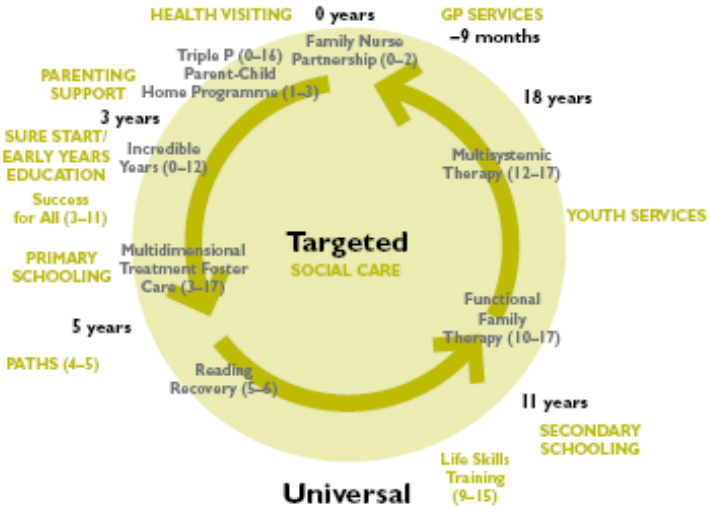
- **Having the social and emotional capability to enter the labour market,**
- **Understanding the importance of social, health, and emotional benefits of entering work,**
- **Understanding the impacts of drug and alcohol misuse, crime, and domestic and other violence**

Allen also advocates for a series of evidenced programmes along the life course of children and their families (Figure 2.3). In Annexe B of his report he lists and describes these programmes without attempting to identify their relative cost –benefits. 72 Early Intervention programmes met the defined criteria, with 19 of them at the highest, Level 1. Eight programmes are currently considered as having the most robust evidence base, although for many programmes the evidence base is small with many studies involving randomised control trials (the highest level of evidence) being limited in value by small study size. These will be reviewed in sections 2.2-2.4.

Michael Little of the Social Research Institute (*Proof Positive*; 2010)[6] explores the challenges to systematising these evidence based practice programmes to improve the outcomes for children. We deliver services within systems, which he argues are organic but output process based rather than children's health & wellbeing outcome focussed. In addition innovation is constrained because public services are funded in a revenue neutral manner, i.e. under and over spending is penalised and there is no incentive for cost-effectiveness to be attractive. The NHS QIPP programme was conceived to overcome this but there is little data to support a benefit. In public services there are stakeholders rather than shareholders. Social Enterprises and Community Interest Companies attempt to bridge this divide.

Little describes Birmingham's attempt at Business Transformation where savings (inefficiencies or redundant services) are realised as cash to reinvest in more effective endeavours (benefit realisation). These are often tested on a small scale before "scaling up" which is a process that mainstreams the programme rather than adding it at the margin. Where programmes are designed for targeted groups there may be tensions with the more universal component of

Figure 2.3: Effective Interventions by age (Allen Report)



service, e.g. Health Visitors and Family Nurse Partnerships. There should be a leaching of learning between the two which strengthens the effect of each. Fidelity to the manual of these evidenced based programmes appears to be an important feature. If this is true than scaling up the programme requires a scaling up of support and training (and cannot be achieved if the feature required is the physical presence of the originator of the programme!). It may be that not all programmes can/should be scaled up. Some programmes could be adapted and/or absorbed into professional practice without loss of effectiveness. It could be that system reform might be more effective in improving outcomes than the introduction of evidence based programmes.

Little certainly challenges all the sacred cows of systems delivery and professional territorialism but not in a pessimistic attitude. He clearly sees that:

- Systems do change but change always needs driving, e.g. the introduction of Children's Centres did not happen spontaneously;
- The way that people engage/enter the systems needs to change; earlier in the development of 'disorder' or different doors into the common system;
- The system response should change; caseloads, practitioner status, measuring outcomes rather than outputs.

Reviewing *Prevention and Early Intervention in Children's Services* [7]Michael Little and Sonia Sodha (The Social Research Unit) reported a number of approaches to measuring the value, cost, and resources required for Early Intervention Programmes. The principal approaches are:

a) Cost-Effectiveness;

b) Social Return on Investment; and

c) Cost Benefit.

They then point towards three reliable sources of information concerning Early Intervention programmes, namely:

a) Clearing Houses: databases of evaluated programmes indicating the likely benefit to be realised;

b) The Cochrane and Campbell Collaboratives: Collections of healthcare (Cochrane) and Social Scientists (Campbell) producing systematic reviews of published evidence to answer specific and important service effectiveness questions; and

c) The Social Research Unit Investing in Children: A series of cost –benefit analyses of early intervention programmes particularly in the settings of Early Years & Education, Child protection, and Youth Justice.

The clearing houses list many programmes with whatever measure of effectiveness the original programme builders or sponsors used. There is no attempt to add cost or comparable benefits. This limits the usefulness of this approach in trying to identify which programmes may be beneficial for a local population's need. It is useful if you have identified the needs and are comparing a small number of programmes for inclusion in a locally commissioned system.

The systematic review collaborations are useful if you have a particular strategic question to answer while building a pathway of care/response for family's needs. It is less helpful in comparing programme effectiveness and outcomes.

The additional value of defining cost-benefit, used in the Social Research Unit approach, is that it helps to support the resource allocation and return likely to accrue from implementing the programme. They identify five cost –beneficial programmes, all targeted towards groups at higher risk (Selective Preventive: Family Nurse Partnership, Triple P) or those with established difficulties (Targeted Preventative: SafeCare, Functional Family Therapy, Multisystemic Therapy). Their cost-benefit scores suggest that for every £1 funding the programme will deliver:

PROGRAMME	PURPOSE	COST-BENEFIT
Family Nurse Partnership	Young first time mothers before 16 weeks gestation	1.87
Triple P	Positive Parenting Programme offered in disadvantaged communities	4.84
Safe Care	Home based Parent training programme to reduce risk of child mistreatment	2.07
Functional Family Therapy	Family based programme to reduce adolescent behavioural problems	12.35
MultSystemic Therapy	Family based Programme to reduce Youth Offending behaviours	1.58
PATHS	Whole school based programme to improve pupil behaviours	N/A
Incredible Years	Targeted Family programme to reduce risk of conduct disorder	N/A

The OECD suggests that expenditure on children should be regarded as if it were an *investment portfolio*, and be subjected to a continuous iterative process of evaluation, reallocation and further evaluation to ensure child well-being is actually improved, poses a formidable but necessary challenge to this nation.

2.2. UNIVERSAL PREVENTIVE EARLY INTERVENTIONS

Activities in this group are directed at whole populations and often targeted at populations of greater risk. In the context of children's development and achievement this is often areas with higher child poverty and social disadvantage. They are universal because they are available to all families in that population.

Midwives, Health Visitors, and school nurses are probably the earliest examples of universal preventive Early Intervention programmes, introduced by Local Authorities in areas of greatest need but later generalised.

The development of Sure Start and the subsequent roll out of Children Centres probably provides the most recent large scale intervention delivered early in children's lives. In Birmingham the Children's Trust Brighter Futures Strategy was based on conducting trials of four evidence based Early Intervention programmes. An evaluation of the benefits and impacts of the investment in three of these four programmes in Birmingham[8] was equivocal about the effectiveness of the programmes as implemented. Despite this it is clear that the provision of and commitment to these programmes resulted in a significant improvement in the attainment of Early Learning Goals in Birmingham from 42% (Lowest quintile nationally) rising to 56% (highest quintile) in 2012.

The Impact of Sure Start Local Programmes on seven year olds and their families (2013)[9] reports in the final summary:

> After taking into consideration pre-existing family, area and school characteristics four positive effects of Sure Start Local Programmes emerged from 15 outcomes at age 7, two of which applied to the whole population and two of which applied to sub-populations. For the whole population, mothers in Sure Start Local Programme areas, relative to counterparts not living in Sure Start Local Programme areas reported:
>
> a) Engaging in less harsh discipline;
>
> b) Providing a more stimulating home learning environment for their children;
>
> Additionally for sub-populations, mothers in Sure Start Local Programme areas reported:
>
> c) Providing a less chaotic home environment for boys (not significant for girls);
>
> d) Having better life satisfaction (lone parent and workless households only).
>
> There were only beneficial effects and no negative effects discerned in any of the analyses. Results for sub-populations can be as important as those for the total population, and knowing about sub-population differences can inform the targeting of services. This is important as children's centre services are increasingly targeted at the most vulnerable, and also service delivery may be targeted differently for specific sub-populations.
>
> The effects of Sure Start Local Programmes appeared to be the same in the most deprived Sure Start Local Programme areas relative to those somewhat less deprived (but still deprived) areas. Hence it is concluded that the evidence is compatible with the view that Sure Start Local Programmes had similar effects across the demographic spectrum of children and families served by Sure Start Local Programmes. This together with the Sure Start Local Programme effects discerned for lone parent and workless families indicates that Sure Start Local Programmes are likely to be reaching all sections of the populations served.

In addition, the authors noted that when developing community-based programmes, it is important to ensure that there is the correct balance between professional and community involvement and that the best use is made of available evidence and expertise.

In particular, language development in the early years underpins both cognitive and social development. Hence if children's centres are to have an observable impact upon school readiness greater emphasis needs to be given to improving children's language development.

A report by Action for Children and New Economics Foundation (*Backing the Future: why investing in children is good for us all*; 2009)[10] found that as well as economic returns, any investment in early intervention would improve children's psychological and social well-being. For every £1 invested in Action for Children's targeted services designed to catch problems early and prevent them from reoccurring, society benefits by between £7.60 and £9.20.

They also described five key pathways that promote children's wellbeing:

a) services that build relationships based on stability and trust and link children into their wider community and 'core economy';

b) services that improve the wellbeing of those in closest contact with children and provide guidance and support - promotion of positive emotions and experiences;

c) children and young people are viewed as providers of services as well as recipients;

d) services provide opportunities for play, enjoyment and fun; and

e) Services are aware of the interplay between children's external circumstances and their wellbeing.

The preliminary findings from the *Helping Children Achieve Study* (2012[11]) sought to discern how is parenting style related to child antisocial behaviour? It found that a negative parenting style, characterised by more harsh, inconsistent discipline, was clearly associated with more severe child antisocial behaviour. Maternal wellbeing (depression and stress) and partner violence were also associated with child antisocial behaviour over and above the effect of negative parenting. The implications of this are that it is appropriate to offer parents parenting programmes that promote positive parenting and it is appropriate to offer interventions that reduce depression and anxiety and improve couple relationships.

Incredible Years[12]

This is the other parenting intervention identified by the National Institute for Health and Clinical Excellence as cost-effective in reducing conduct disorder. The large lifetime costs associated with conduct disorder, estimated to average £75,000 in milder cases to £225,000 in extreme ones, suggest that even a low success rate would constitute good value for money. Evaluation outcomes include:

- Significantly reduced antisocial and hyperactive behaviour in children;
- Reduction in parenting stress and improvement in parenting competences; and
- Positive effects on child behaviour and parenting.

The results from a recent Birmingham based RCT of Incredible Years (Little et.al 2012) [13]indicate significant benefits when offered as part of children's centre provision (universal early years). There were reductions in reported negative parenting behaviours among the parents attending Incredible Years groups compared to controls. There are strong reductions in child behaviour problems and improvements in relationship for children receiving the intervention.

In common with other evaluations of Incredible Years, the Social Research Unit's evaluation[14] concluded that there was some improvement in behaviours and this was related to the length of the intervention and increased with intensity. Training and supervision arrangements for Incredible Years facilitators, which boost fidelity of programme delivery, were also implicated in better outcomes.

Promoting Alternative Thinking Strategies (PATHS)

Promoting Alternative Thinking Strategies is a relatively low-cost programme offered as a whole school programme. Evaluations of Promoting Alternative Thinking Strategies have found positive impacts in terms of:

- reducing sadness and depression;
- lowering peer aggression and disruptive behaviour; and
- improving classroom atmosphere

The Birmingham evaluation[15] concluded that Promoting Alternative Thinking Strategies produced mixed results with some improvement in the first 12 months compared to a cohort of control schools, which was lost by 24 months. There is however a confounding influence on this comparison. Promoting Alternative Thinking Strategies is a whole school programme which aims to improve all pupils' behaviour. In the control group of schools there were other whole school programmes which became available and were used. From this evidence it would seem that

PATHS proves to be no better than other whole school programmes at producing beneficial change in pupils' behaviours but all do have a beneficial effect.

Triple P[16]

Positive Parenting Programme is one of two parenting interventions identified by the National Institute for Health and Clinical Excellence (NICE) as cost-effective in reducing conduct disorder. The large lifetime costs associated with conduct disorder, estimated to average £75,000 in milder cases to £225,000 in extreme ones, suggest that even a low success rate would constitute good value for money.

It is a tiered structure which makes it an adaptable programme to offer across the whole range of preventive early interventions. Level 1 is an awareness campaign, level 2 is to strengthen parenting behaviours in general, level 5 is for use with

Measured outcomes from Triple P include:

- significantly lower levels of conduct problems; and
- noted clinical changes on behaviour scale (33% vs 13% of children with problems).

However a systematic review conducted in Scotland (2012)[17] found no convincing evidence that Triple P interventions work across the whole population or that any benefits are long-term. This may have implications for a universal approach which might reflect the proportion of a population participating rather than an insignificant benefit at individual family level, which is where most of the programme evaluations are focussed.

The Birmingham evaluation[18] of the 'Triple P' parenting course showed similar rates of improvement in behaviours as the families on a waiting list, a control group really using a 'wait & see' approach. The published results of Triple P programmes, where the developer is involved, are much better. Is this the result of his enthusiasm and can he be everywhere at once? This may therefore be a serious flaw in the programme.

Solihull Approach[19]

This programme was developed in the late 1990s and uses the research from behavioural psychology and child development to enhance parental-child containment and reciprocity to enhance bonding and manage emerging child behaviours. Courses are run by trained practitioners with mothers and/or fathers, and expectant parents. It has been repeatedly evaluated[20] [21] [22] over the years and parental feedback remains high[23].

It is one of 13 providers offered to parents who live, work, or study or who have children attending nurseries in Camden (London), Middlesbrough, or High Peak (Derbyshire) through the CANparent[24] network (classes& advice network). The scheme funds £100 vouchers for families to use at any time from birth to the end of Year One at school.

2.3 SELECTIVE PREVENTIVE EARLY INTERVENTIONS

These interventions are targeted towards individuals or groups of individuals that are at greater risk or showing early signs of developing difficulties.

The case for early intervention in this group is made in a report by the Cabinet Office Social Exclusion Task Force (*Reaching out: Think Family – analysis and themes from the Families at Risk Review*: 2009). [25]The research identifies opportunities to improve outcomes for families at risk by:

- extending the logic of the reforms in Every Child Matters to support the whole family, applying key principles such as a common vision, clear accountability, multi-agency

working, information sharing, core processes and assessments and adults' and children's services working better together;

- building on promising approaches that tailor services to the diverse and different needs of the whole family, with support from a lead professional who builds trust and empowers families to take responsibility for their own outcomes; and
- Capitalising on the reach and expertise of the public sector to provide families with joined-up support and joined-up multiple entry points.
- Identifying and responding to families experiencing multiple difficulties e.g. mental health, disability, young carers, child welfare, drugs and alcohol, crime and anti-social behaviour, domestic violence

NICE (*National Clinical Guidance 158: Antisocial Behaviours and Conduct Disorders in Children and Young People*)[26] reviews the impact of selective preventive interventions in small populations at higher risk of developing conduct disorders. It identified limited moderate-to-high quality evidence to show that for younger children (< 11 years old) at risk of a conduct disorder, classroom-based interventions involving teachers may be effective in reducing antisocial behaviour.

The evidence suggests that the classroom-based emotional learning and problem-solving programmes for children, aged typically between 3 and 7 years in schools, are delivered where classroom populations have a high proportion of children identified to be at risk of developing oppositional defiant disorder or conduct disorder as a result of the following factors:

- low socio-economic status
- low school achievement
- child abuse or parental conflict
- separated or divorced parents
- parental mental health or substance misuse problems
- Parental contact with the criminal justice system.

These classroom-based emotional learning and problem-solving programmes should be provided in a positive atmosphere and consist of interventions intended to:

- increase children's awareness of their own and others' emotions
- teach self-control of arousal and behaviour
- promote a positive self-concept and good peer relations
- Develop children's problem solving skills.

Typically the programmes should consist of up to 30 classroom-based sessions over the course of 1 school year.

The review also identified moderate quality evidence suggesting that a parent-focused intervention involving prenatal and infancy home visitation by nurses (known in the UK as Family Nurse Partnership) may reduce the risk of serious offending behaviour over the long-term.

Family Nurse Partnership/ Nurse Family Partnership[27]

Family Nurse Partnership has been consistent in delivering positive economic returns over 30 years of research. Benefits to cost ratios of studies examined fall in the range of around 3:1 to 5:1. Some example impacts from the US evaluation include:

Age 2 – nurse-visited children seen in emergency departments 32% less often than the control group;

Age 4 – this effect on emergency treatment endured (on average 1 visit per child to emergency room vs 1.5 for the control group);

Age 15 – greater effects on reports of child abuse than at age 4 (Risk Ratio 0.29 verified reports vs 0.54 for the control group);

– fewer subsequent pregnancies (1.5 vs 2.2 for the control group); – fewer months on welfare (average of 60 months per child vs 90 months for the control group);

– fewer arrests (average of 0.16 per child vs 0.9 for the control group) as well as a reduction of illicit drug use, smoking and alcohol usage.

Family Nurse Partnership has one of the best evidence bases for preventive early childhood programmes, being identified by many rigorous evidence reviews as having the highest quality of evidence and best evidence of effectiveness (see for example The Coalition for Evidence Based Policy, Blueprints for Violence Prevention, and Society for Prevention Research[28]).

It has also been shown to result in significant economic savings to the Government and to society more generally. A recent review of home visiting programmes by the US Government[29] identified Family Nurse Partnership as having 64 positive effects across 7 different domains, many of which were long lasting, making it the most effective preventative home visiting programme.

In England, the Parenting Programme Commissioning Toolkit[30] has recently evaluated Family Nurse Partnership and rated it as having the highest quality of evidence, one of only a few programmes rated at this level.

A large randomised control trial of Family Nurse Partnership is currently on-going across 18 health organisation areas in England, known as the "Building Blocks" trial and overseen by Cardiff University. This study involves delivering Family Nurse Partnership under control trial conditions to some 1600 participants and results are expected late 2013/2014.

2.4 Indicated Preventative Interventions

Interventions in this group are directed towards individuals or families with the earliest signs of a developing disorder, particularly the behavioural and conduct disorders but could also include specific learning difficulties. This is intervention at the earliest signs of dysfunction.

2.4a Indicated Preventative Interventions for Children & Young People

Understanding the needs of vulnerable young people is a pre-requisite to strategically planning services. Researched carried out by Matt Barnes, Rosie Green and Andy Ross, (NatCen: 2011[31]) for the Department for Education used analysis from the Longitudinal Study of Young People in England to try and clarify needs. The research identified six forms of disadvantage among young people aged 16 / 17 years:

- Low attainment – 19%;
- Not in employment, education or training – 8% ;
- Teenage parenthood – 1% ;
- Emotional health concerns – 22% ;
- Criminal activity – 9%; and
- Substance misuse – 15%.

45% of young people experienced at least one of these disadvantages and 15% experienced two or more. This means that 40% had none of these factors.

The research characterises young people with multiple disadvantages as:

- 'Risky behaviours group': This was 8 per cent of all young people. This group takes part in criminal activity with a tendency for substance misuse, low attainment and emotional health concerns. The group at the age of 14 are boys, persistently truant and being suspended and/or bullied at school
- 'Socially excluded group': This was 6 per cent of all young people. This group are not in employment, education or training, have a 50/50 chance of low attainment with some risk of substance misuse and emotional health concerns. The group at the age of 16 are part of a single parent family, parents are in poor health, aspiring to leave school and work at the age of 16 and/or truant from school.

Both of these groups are likely to experience the poorest outcomes at the age of 18 with a high proportion not in employment, education or training and on benefit.

The report argues that early intervention could make significant impacts on these young people's lives and substantial savings to society.

A report for the Department for Education by the National Centre for Social Research (*Monitoring and evaluation of Intensive Intervention Projects for young people*: 2011)[32] applied the intensive family support model (i.e. Family Intervention Project model) to address the behaviour and other problems of the young people. The primary focus was on the young person rather than the whole family. However, other family members were involved were there was a need to address the inter-connectedness between the young person and other family members' problems.

They found that 49% of young people who had left an Intensive Intervention Projects were reported by Intensive Intervention Projects staff as having successfully completed their intervention and achieved a positive outcome. A further 21% left because their circumstances had changed and they were no longer eligible. 30% either refused to continue working with an Intensive Intervention Project or their carer refused to allow them to continue.

Results for the 790 young people who had exited an Intensive Intervention Project or been working with an Intensive Intervention Project for at least 8 months were as follows:

- 60% had fewer crime and Anti-Social Behaviour issues;
- 65% were reported to have improved the way their family functioned;
- 63% had reduced the number of their health risks; and
- 46% had reduced their education and employment issues.

The survey used in Ofsted research *(Edging away from care – how services successfully prevent young people entering care*: 2011[33]) found that all 11 local authorities were taking steps to reduce their number of looked after children and to manage the risk associated with maintaining young people within their families and communities. The provision varied but some consistent themes emerged: The quality of the professionals involved, especially the key professional, was the crucial factor in helping to achieve success. These key professionals had a range of backgrounds and qualifications including social work, youth offending, nursing or psychology. They persevered with families who often did not want to engage with them. They were described as persistent, reliable, open and honest, which included being absolutely straight about what needed to change. They enabled the families to see that they had strengths and that change was possible. These were professionals who had the time to respond quickly, often outside normal working hours, and work intensively with families. They were able to understand, and work from, the families' starting point. They also recognised that, while the young person's needs were the priority, the needs of parents, including fathers, had to be addressed and they successfully achieved this balance; the most successful services were those which incorporated explicit and clearly stated models and methods of intervention, including a repertoire of tools for professionals to use.

A clear intervention model framework supported these professionals to be more confident and informed and led to better and clearer outcomes with young people and families. It was the clarity of the model framework, rather than the model framework itself, which seemed to support this success and this in turn enabled young people and families to understand more clearly the overall direction, plan and timescale of the intervention.

Other key factors were:

- strong multi-agency working both operationally and strategically; this involved strategic analysis and understanding of the needs of this cohort of young people and investment in services to address these needs;
- clear and consistent referral pathways to services; clearly understood and consistent decision-making processes based on thorough assessment of risks and strengths within the family network;
- a prompt, persistent and flexible approach, which was based on listening to the views of the young person and the family and building on their strengths; and
- a clear plan of work based on thorough assessment and mutually agreed goals; regular review of progress and risk factors; robust and understood arrangements between agencies in respect of risk management; and clear planning for case closure and for sustainability of good outcomes.

All of the young people who took part in the survey were able to identify benefits from the support they had received and none had entered care. But there were inconsistencies within and across local authorities in the methods they used to identify and capture outcome and success criteria. None of the areas visited could demonstrate an overall reduction in care numbers but there were early signs of a reduction in the number of over 10s entering care in at least 3 areas.

Annual surveys of 15 to 18 year olds in prison[34] suggest that between a quarter and a half have been in care at some point previously. A census of every child imprisoned over a 6 month period in 2008 found that: 76% had an absent father; 47% had run away or absconded; 39% had been subject to a child protection plan and / or experienced abuse or neglect; 27% had been or were looked after; and 13% had experienced the death of a parent or sibling. Some children had offended before entering the care system – most commonly as a result of peer pressure. Difficulties controlling anger, lack of money, being bored and living in a high crime area were also cited as reasons for offending. Children's pre-care experiences were significant in shaping their offending behaviour.

Research carried out by the National Children's Bureau for the Prison Reform Trust (*Care – a stepping stone to custody?* 2011)[35] sought the views of children in care on the links between care, offending and custody. Children's views on whether being in care might contribute to the likelihood of offending were diverse and often complex or contradictory. The features of the care system identified as risk factors were:

- Loss of, or infrequent contact with, family / friends ;
- Poor relationships with carers and social workers;
- Peer pressure, including being brought into contact with children already offending ; and
- Type and number of placements – frequent placement change, being in a children's home, few diversionary activities on offer, lack of money.

Other risk factors, not directly related to the care system, which appear to be relevant include:

- The quality of relationships with professionals;

- Community sentences – but this did not necessarily have a lasting impact;
- Activities undertaken as part of custodial sentences; and
- A desire to re-engage with education and gain qualifications and / or employment.

The report makes 7 recommendations for local authorities:

i. Proactive care planning;
ii. Getting the placement right;
iii. Recognising the importance of relationships with adults;
iv. Being aware of family influences;
v. Nurturing children's aspirations;
vi. Working across agencies; and
vii. Being a good parent.

The Home Office reviewed the effectiveness of various types of intervention to tackle anti-social behaviour used by local areas[36], including acceptable behaviour contracts, anti-social behaviour orders, housing injunctions, parenting contracts, parenting orders, crack house closure orders and individual support orders. The majority of people in the sample who received an anti-social behaviour intervention did not re-engage in anti-social behaviour. But there was a hard core of perpetrators for whom interventions had limited impact.

International research suggests preventive programmes, including education, counselling and training, are cost-effective methods of addressing anti-social behaviour.

Acceptable Behaviour Contracts are the most frequently used intervention for which data is available. 65% of people who received an Acceptable Behaviour Contract did not re-engage in anti-social behaviour. Contracts were less effective with under 18s with just over 60% displaying further anti-social behaviour. 63% of people who received a warning letter desisted from anti-social behaviour. Just under a quarter of the sample received an Anti-social Behaviour Order and just over half breached it, with a third of this group doing so on five or more occasions.

Preventing anti-social activities in young people should involve a variety of approaches. Research carried out by the Audit Commission (*Tired of hanging around: using sport and leisure activities to prevent anti-social behaviour by young people*: 2009[37]) explores an alternative approach. Sport and leisure can engage young people, attracting those at highest risk of anti-social behaviour into more intensive developmental projects. This approach must therefore, target deprived areas where perceptions of anti-social behaviour are highest. It concludes that preventive projects are cost-effective. A young person in the criminal justice system costs the taxpayer over £200,000 by the age of 16, but one given support to stay out costs less than £50,000.

Life Skills Training[38]

A US economic appraisal of Life Skills Training estimated the benefit to cost ratio at 25:1. A review of alcohol interventions by NICE noted the impact Life Skills Training had on long-term drinking behaviour and reductions in the use of drugs and alcohol.

2.4b Indicated Preventative Interventions for parents

Working solely with parents in order to improve the wellbeing of children and young people is less common.

A report by York Consulting on behalf of Action for Children (*Effective relationships with vulnerable parents to improve outcomes for children and young people: final study report*: 2011[39]) looked to develop a skills framework that would define the key aspects of effective professional relationships

for staff working with vulnerable parents. The case studies included a service to support children aged 8 to 13 who are vulnerable to offending, two family intervention projects for families with complex needs, a children's centre and an early intervention service. They found that human relationships are core to the delivery of effective services but are often overlooked. The qualities and skills that were identified as being fundamental included:

- Maintaining a child-focused approach;
- Achieving an effective balance of support and challenge;
- Being open, clear and direct ;
- Building trust and mutual respect;
- Empowering and enabling families ;
- Action-focused practice;
- Being able to interact well with children and young people; and
- Presenting information in ways that parents can understand.

2.4c Indicated Preventative Interventions for families

The case for early intervention in socially excluded families is made in the context of the Think Family approach in a report commissioned by the Cabinet Office Social Exclusion Task Force and carried out by researchers from the University of Birmingham, University of Nottingham and University of Vermont USA.

The report, *Think Family: a literature review of whole family approaches*,[40] reviews whole family approaches in families experiencing multiple difficulties e.g. mental health, disability, young carers, child welfare, drugs and alcohol, crime and anti-social behaviour, domestic violence. Whole family approaches to the consequences of social exclusion present tensions and opportunities. The right to private family life and the public interest in family intervention is a core tension. Evidence in the review indicates that it cannot be assumed that whole family approaches are appropriate or useful for all families or for all needs. But for some needs and some problems, the evidence shows whole family approaches may be well supported and enables good outcomes.

Marginalised families may face specific barriers in accessing appropriate services – family members' own perspectives as well as professional perspectives are required to inform an understanding of this experience. It is important to recognise that some of the difficulties faced by 'at-risk' families will also be shared with less marginalised groups of families. There is evidence that existing service provision finds 'thinking family' both challenging and controversial and this has implications for professional knowledge and frameworks, training and ultimately the arrival of shared objectives. The evidence indicates there is a problem in arriving at full engagement with families either by focusing on the presenting problem or particular functions of one family member or failing to engage with all families experiencing particular difficulties.

The components of the working relationship between families and professionals (trust, openness, respect, responsivity) are crucial regardless of the actual service type (e.g. whether 'specialist' or 'mainstream')

Westminster City Council decided in 2008 that a new approach to tackling entrenched social problems was required. It calculated that around 40 families were responsible for the vast majority of extreme anti-social behaviour and displayed strong criminal tendencies. The council introduced a 'whole family' approach which aimed to deal with the causes of these problems rather than the symptoms. A Team Around the Family (TAF) was assigned to each family to develop a bespoke care plan. The families are required to sign a 'contract with consequences' to formalise their involvement with the programme. Voluntary organisations were involved in the provision of some

types of support such as preparation for work, debt advice, drug assessments and interventions and dealing with the perpetrators of domestic violence.

The report on the achievements of its Family Recovery Programme, *Repairing broken families and rescuing fractured communities: Lessons from the frontline*: 2010)[41] recorded that 50 families that have been through the programme and identifies the following benefits:

- 69% reduction in 'accused offences';
- 83% reduction in 'suspected offences' per month;
- 48% of neighbours reporting Anti-Social Behaviour reduction since families registered with the programme; and
- 9% of participants were not registered with a GP compared with 30% at the start.

The average cost per family of their involvement in the Family Recovery Programme is £19,500. This compares with the average estimated cost avoidance per family of £41,000. The estimated annual cost of supporting 50 families is £650,000 compared with £2 million estimated costs avoided.

Monitoring and evaluation of family intervention services and projects between February 2007 and March 2011,[42] a report by researchers from the National Centre for Social Research and the Bryson Purdon Social Research for the Department for Education, reviewed 3,675 families who exited a Family Intervention Programme. They found that there were eight core features of the family intervention model that are viewed as critical to its success:

i. recruitment and retention of high quality staff;
ii. small caseloads;
iii. having a dedicated key worker who works intensively with each family;
iv. a 'whole-family' approach;
v. staying involved with a family for as long as necessary;
vi. having the scope to use resources creatively;
vii. using sanctions alongside support for families; and
viii. effective multi-agency relationships.

The report concludes that there is now compelling evidence endorsing the role and value of family interventions and show a consistent reduction in all important Health & social care domains but suggests the family intervention approach had the biggest impact in relation to crime and anti-social behaviour. The results should be treated with caution due to the small sample size of the control group and lack of follow-up data for many families who would have been in the control group.

Evaluating whole family approaches or Family Intervention Projects is not easy as demonstrated in a paper by David Gregg of the Centre for Crime and Justice Studies (*Family intervention projects: a classic case of policy-based evidence*: 2010)[43]. The research reviewed evaluation reports covering a total of around 60 Family Intervention Projects.

Family Intervention Projects target socially inadequate families, around 80 per cent of whom have significant mental and physical health problems and learning disabilities. Most families were targeted for exhibiting 'statistical risk factors' which include: being a poor lone mother, living in bad social housing, having mental health problems, having a child with schooling problems, learning disabilities or a statement of special educational needs. Despite high levels of mental health problems, only 11% of families received professional psychiatric treatment or counselling.

The report identifies weaknesses in evaluation methodology and database quality. It finds that conclusions about 'success' are often based on qualitative measures on very small family samples which evaluators concede can be biased.

The report concludes that the Family Intervention Project initiative was an interesting social experiment which had the potential to help poor, very vulnerable families who failed to fit in to their communities. Professional medical support was not provided in most cases and sustained reductions in anti-social behaviour in the wider community have not been delivered.

The Family Pathfinder programme launched in 2007 aimed to develop local responses to the needs of families who face multiple and complex social, economic, health and child problems. Fifteen councils received funding to test intensive family focused models of support (referred to as 'Family Pathfinders') while 6 of these councils and a further 12 councils received funding to support young carers (referred to as 'Young Carer Pathfinders').

An evaluation of this programme by York Consulting for the Department for Education (*Turning around the lives of families with multiple problems – an evaluation of the Family and Young Carer Pathfinders Programme*: 2011)[44] reported a significant improvement in outcomes for 46% of families supported by the Family Pathfinders and 31% of families supported by the Young Carers Pathfinders. A further 41% of Family Pathfinder families and 56% of Young Carer families experienced a reduction in the range and severity of risk factors experienced. However, these families were assessed as having the same overall level of service need on entry to, and exit from, the programme. Around 13% of families experienced an increase in their assessed level of need across the two types of Pathfinder. This was either because additional, previously undiagnosed needs were identified (e.g. child protection) or because families did not engage with the support provided.

Success was dependent on the use of a key worker responsible for providing and coordinating effective support for families. 3 critical components of delivery are:

i. A persistent and assertive key worker role – a highly skilled, credible and experienced professional who could both deliver intensive support to the family and broker specialist support;

ii. A robust framework of support – including a comprehensive assessment of the needs of all family members and a multi-disciplinary Team Around the Family (TAF) approach; and

iii. An intensive and flexible, family focused response where the effectiveness of support was measured by outcomes for the family. Clear support plans need to be in place for families on exit to ensure that positive outcomes are maintained.

Average cost of support was £19,233 for Family Pathfinder programmes and £4,331 for Young Carer Pathfinder programmes. A conservative assessment of the return on investment indicates that for every £1 spent, the Family Pathfinders generated a financial return of £1.90. The comparable figure for the Young Carer Pathfinders was £1.89.

If evaluating the tangible benefits is hazardous then evaluating the cost benefits can be more so. This does not stop researchers trying. A paper by Sheffield Hallam University and Centre for Regional Economic and Social Research (*Evaluation of Rochdale Families Project – Briefing Paper on Economic Cost-Benefits of Family Interventions*: 2011)[45] attempts this for the Rochdale programme of family interventions. The researchers recognise that calculating the economic cost benefits of family interventions is complex and methodologically challenging. Previous research evidence indicates that they provide good value for money and often achieve significant cost savings for public agencies. The costs associated with a range of risk factors linked to vulnerable families were calculated and are substantial. The limited evidence from the evaluation of the Rochdale Families

Project suggests that significant direct and short term savings for agencies will have been achieved and that these savings are likely to have, at the least, offset a substantial element of the direct costs of the project. There are also likely to be longer term financial savings in addition to other non-economic positive outcomes.

An evaluation of the Northamptonshire Family Intervention Project, *The economic and social return of Action for Children's Family Intervention Project, Northamptonshire*: 2011,[46] describes a project which worked with 29 of the most vulnerable families (including 73 children) for an average of 40 hours a month. The families face multiple issues including: drug and alcohol abuse; anti-social behaviour; domestic violence; being at risk of losing their home; and children at risk of being taken into care. The social benefits documented were:

- less child protection / children being taken into care;
- children feel happier; and
- family life, relationships, behaviour and life prospects improve.

The analysis estimated that, for every £1 invested in the Family Intervention Project, £4.28 of social value is created. If the cost of the initial intervention is deducted the net social return is £3.28 for every £1 invested. Sensitivity analysis suggests that value is likely to be in the range of £3 to £6 for every £1 invested

The Key Elements of Effective Practice (KEEP) guidance notes and source documents (Youth Justice Board 2010) relate [47]mostly to the work of the Youth Justice Board with young offenders. There is some work however that relates to families of those offenders. The most relevant findings, in the context of supporting families with complex needs, are those relating to parenting. Based on the evidence of what works, the guidance identifies key indicators of quality which include:

- A standardised parenting assessment tool should be used; Assessments should serve as the initial basis for collaboratively determining with the family the scope, focus, and intensity of subsequent intervention activities;
- Services should work with parents / carers (mothers and fathers) using a strengths-based approach and parents should be given the opportunity to identify their own needs; The programme materials and mode of delivery should be flexible and address parents' needs in relation to communication, transport, childcare, culture, ethnicity, gender and family structure ;
- Parents should be offered the most appropriate services and interventions should have a clearly articulated delivery plan, a clear theoretical base, detailed aims and measurable objectives; and
- Parents should be supported to access relevant services provided by other agencies and managers should ensure there is effective joined up multiagency working.

A 2012 Cochrane systematic review and meta-analysis (Furlong et.al. 2012)[48] found that behavioural and cognitive-behavioural group based parenting interventions appear to be effective in reducing child conduct problems and in improving parenting skills and parental mental health. There is also some evidence for the cost-effectiveness of these interventions in reducing clinical levels of conduct problems to non-clinical levels. However, there is currently insufficient information to assess the effectiveness of the interventions with respect to child emotional problems and educational and cognitive abilities. However, they suggest that the Incredible Years programme delivered in Sure Start or community-based settings can reduce clinical levels of conduct problems to non-clinical levels for a modest cost

Multi-dimensional treatment foster care [49](MDTFC)

A US economic appraisal of [50]Multi-dimensional treatment foster care found a benefit to cost ratio of around 11:1. The potential savings from rolling out eight adolescent units of Multi-dimensional treatment foster care for five years have been estimated at £213,500,000 after seven years, provided assumptions on take-up and other factors are met.

Annual reports of Multi-dimensional treatment foster care in England[51] found statistically significant differences for:

- offending
- self-harm
- sexual behaviour problems
- absconding
- fire-setting

Functional Family Therapy (FFT)[52]

Functional Family Therapy has been estimated [53]to have a benefit to cost ratio of around 7.5:1 and 13:1. Clinical trials have demonstrated impacts in terms of:

- treating adolescents with conduct disorder; oppositional defiant disorder or disruptive behaviour disorder;
- treating adolescents with alcohol and other drug misuse disorders, and who are delinquent and/or violent;
- reducing crime; and
- reducing likelihood or entry into the care system

Multisystemic therapy (MST)[54]

The benefit-to-cost ratio of MST has been estimated at around 2.5:1. Noted outcomes from evaluations include:

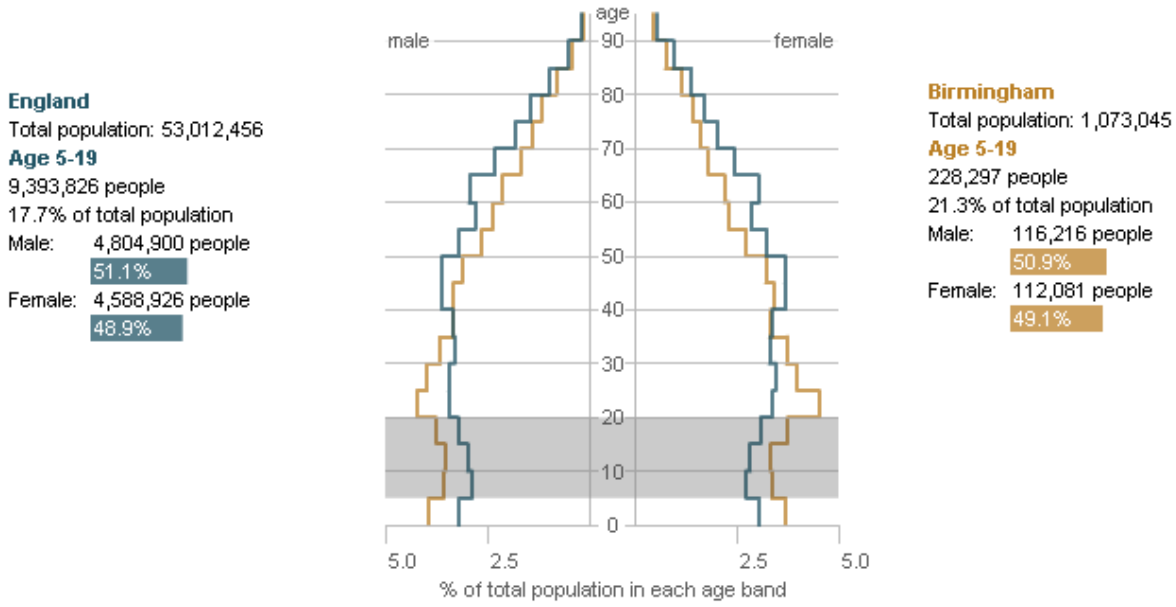
- reductions of 25–70% in long-term rates of re-arrest;
- reductions of 47–64% in out-of-home placements;
- improvements in family functioning; and
- decreased mental health problems for serious juvenile offenders.

3 WHAT DOES CHILDREN'S HEALTH & WELLBEING LOOK LIKE IN BIRMINGHAM?

Birmingham has a population of just over 1 million people and of this around 21% of this is aged 5-19 years. Compared to the population of England as a whole, Birmingham has a larger proportion of children and young persons in this age group (5-19 year olds make up 17.7% of the national population). This difference in population structure is shown in the population pyramid above where the relevant age range is shaded (Figure 3.1).

Birmingham is therefore is a city of young people. It is also an extremely ethnically diverse city with 62.9% of school children from a black or minority ethnic group. Unfortunately the key measures indicate that the health and well-being of children in Birmingham is generally worse than the England average.

Figure 3.1: The Population Pyramids of England and Birmingham



3.1 The level of **child poverty** is worse than the national average with 33.5% of children aged less than 16 years living in poverty based on accepted indicators. In addition, the rate of family homelessness is far worse than the England average. The Income Deprivation Affecting Children Index (IDACI) by area is shown in Map 3.1. It shows the familiar distribution of poverty affecting those living in the central inner city areas but also smaller pockets on the edge of the City.

Map 3.1: Areas of Child Poverty, Birmingham 2010

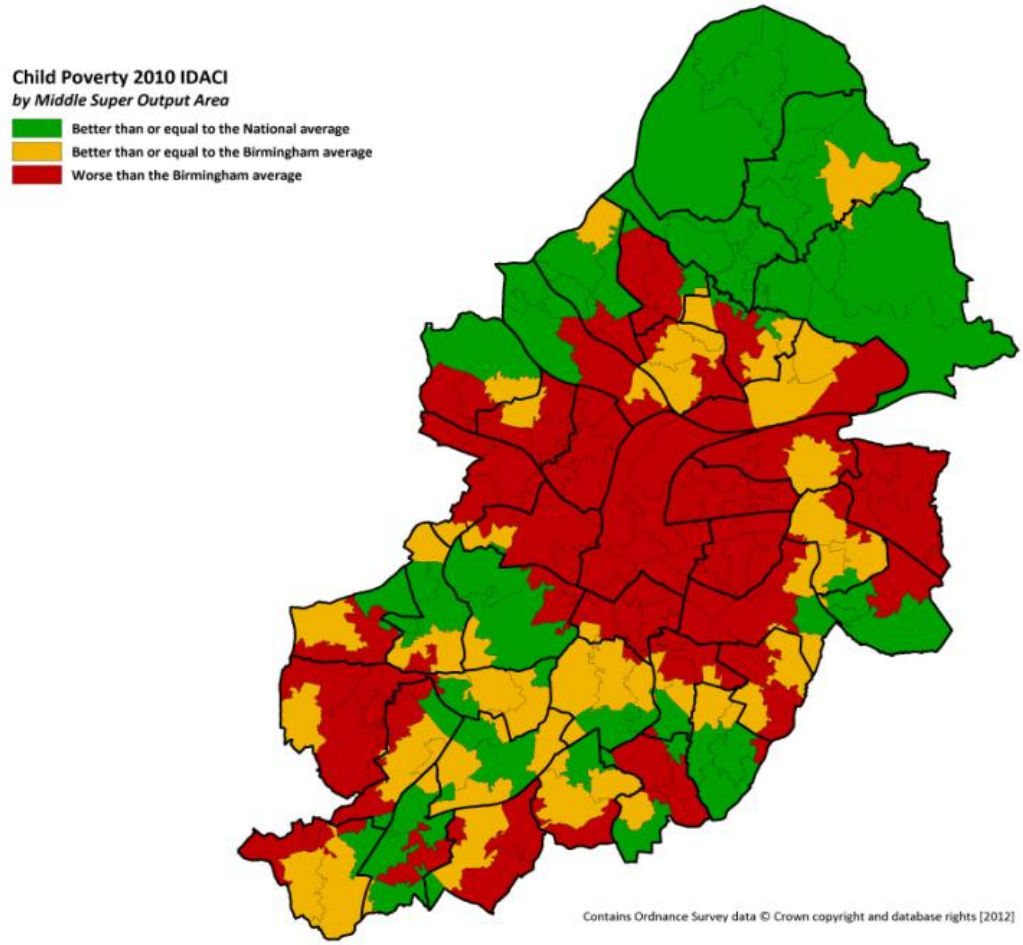
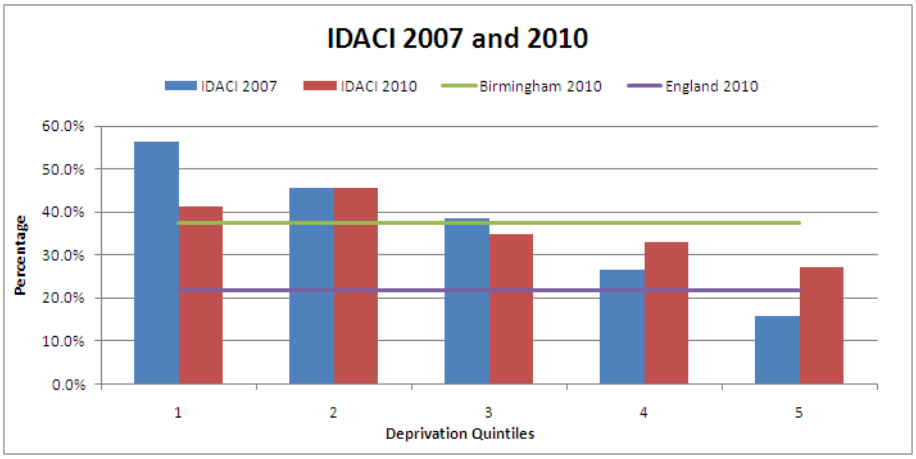


Figure 3.2 compares the Income Deprivation Affecting Children Index with Quintiles of Deprivation. This shows that in addition to the expected gradient of children's deprivation with area deprivation there are also pockets of Child Poverty in more affluent areas. Interestingly these have increased between 2007 and 2010.

This pattern of vulnerability to personal and family distress and dysfunction is seen to persist and strengthen when multiple measures of are combined together, indicating synergies of effect (Map 3.2)

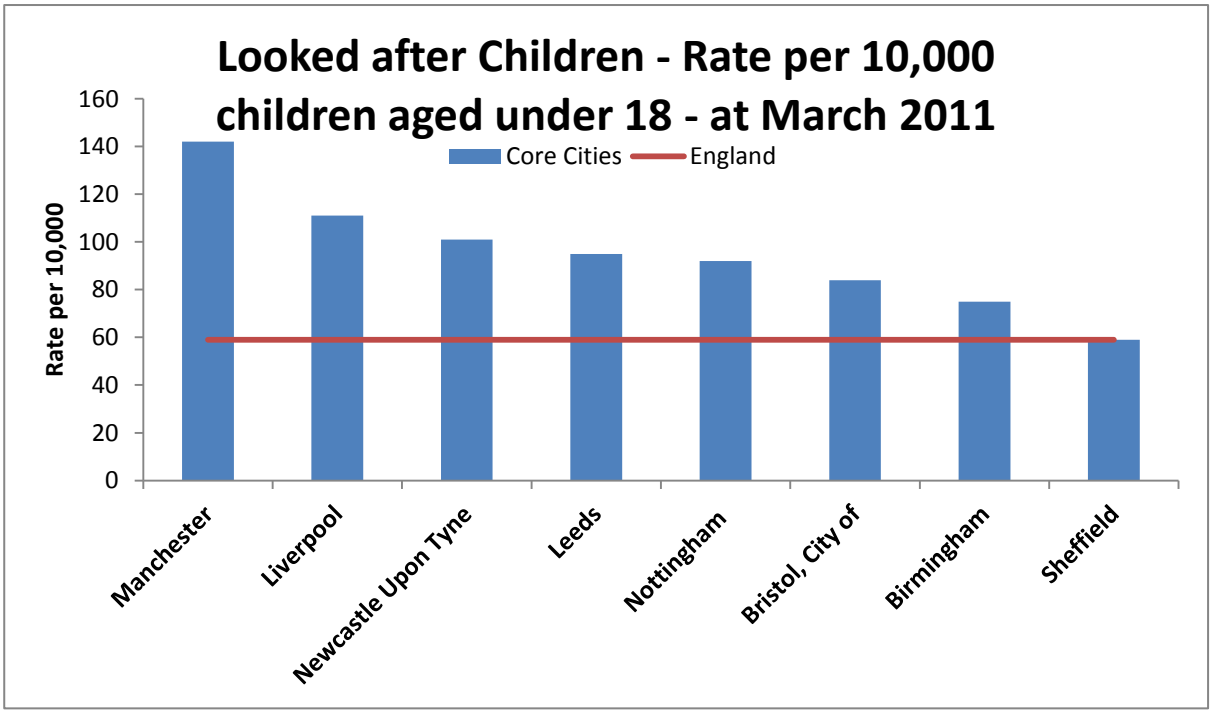
Figure 3.2: Associations of Child and Area Deprivations



Children in care (CIC) / Looked after Children (LAC) are children who have been placed in either foster homes or in residential care homes, away from their parents, who are in the care of the Local Authority.

As at 31st March 2012 there were 1,895 children in care (looked after children) which gives a higher rate (per 10,000 children) when compared to the England average but lower than 6 of the other 7 Core comparator Cities (Figure 3.3).

Figure 3.3: Children in Need and Looked After Children



Map 3.2: Index of Child Vulnerability by Local Area in Birmingham

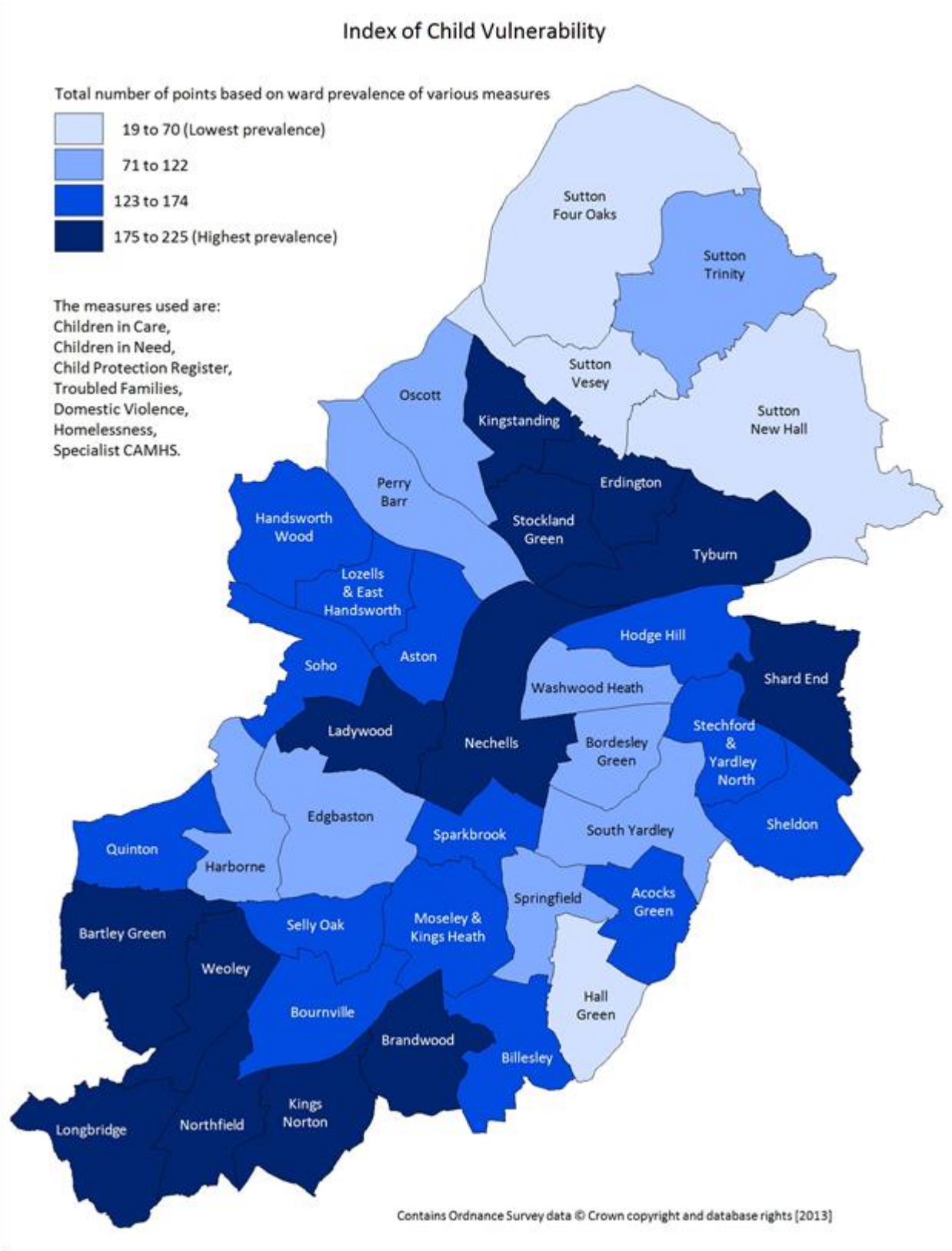
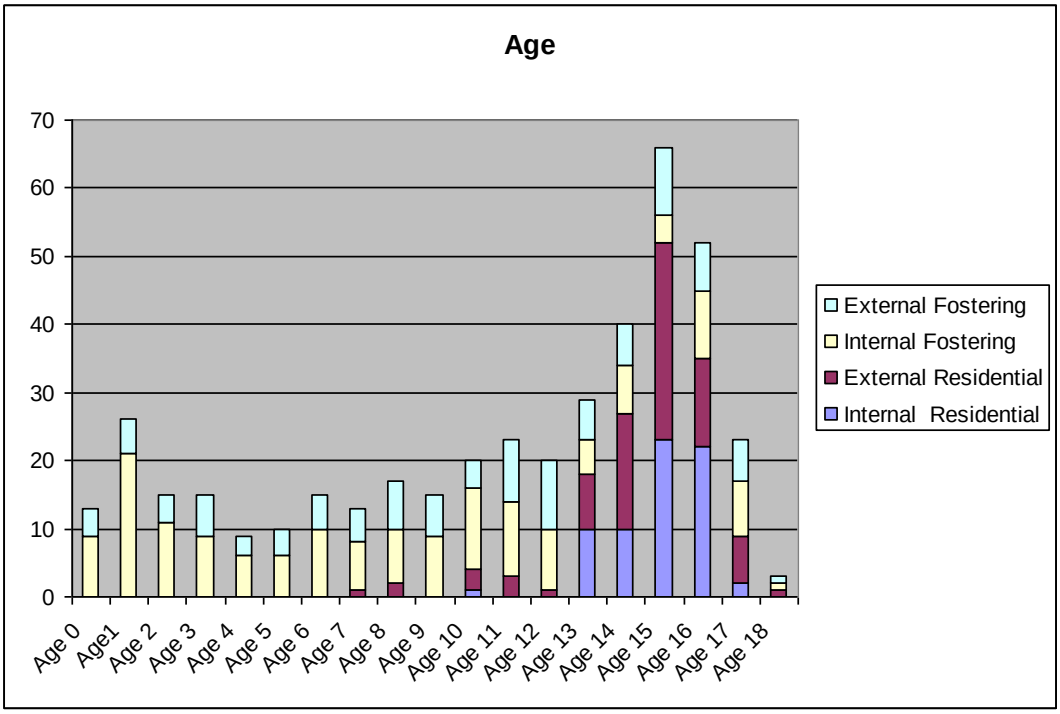


Figure 3.4 reveals that Looked After Children placed in foster care show two age group peaks, 0-3 years and 13-17 years. It is clear from Figure 3.4 that children are more likely to be placed in residential care from the age of 10 and most of the children in residential care are aged 13 – 16 years.

Figure 3.4: Numbers of Looked After Children by Age and Placement in Birmingham 2011



Most looked after children are of White (49.8%), Unknown (19.7%), Black Caribbean (9.2%), or Pakistani (5.9%) backgrounds and are likely to reside in Kingstanding (5.6%), Nechells (5.1%), Lozells and East Handsworth (4.3%), and Weoley (4.1%). 56% of these children are from the 10% most deprived wards in Birmingham.

A lower percentage of looked after children are up-to-date with their vaccinations and immunisations than their peers. However their GCSE achievement is similar to the England average for this group of children but this is significantly lower than their peers. A high proportion of children in residential care *regularly miss school* (60% external, 54% internal).

A cluster analysis of a sample of local looked after children was conducted in 2012 by staff from the City Council Children, Young People, and Family Directorate. A total of 424 case files were analysed using the Matching Needs and Services methodology. The sample comprised of all the residential children (153) and 20% of those being fostered.

The key features identified as being present before becoming a looked after child includes:

- Ill-treatment prior to entering care.
- Family discord (accounts for approximately 50% of all internal residential care and fostering cases, but over 80% of children in external residential and fostering care).
- Carer being over-burdened by parenting – at least 50% of all cases, but accounts for over 80% of cases where the child is placed in external residential care, or external fostering).
- Child's parents having ever been in care: (In approximately a quarter of all cases)
- Family breakdown / Divorce (In at least 38% of cases, but accounts for over 65% of children who are placed in residential care, and in external fostering).

- Domestic violence (at least 50% of all cases. Accounts for over 70% of cases where the child has been placed in external residential care).
- Some children experience a high level of change in placement in residential care, and a high number of episodes in care.
- Behavioural issues - biggest problems are aggressive behaviour at home (155 affected), and school (104), violence at home (111), behaviour problems at home (202), and school (157), and having run away from home (116).
- Psychological issues – mental ill-health (69 affected), conduct disorder (69), learning disability (55), history of self-harm, (60), alcohol misuse (68), drug misuse (72), stress/inability to cope (88), unhappy (82), specific disorder of emotion or conduct (94).
- Sexual exploitation – 46% of those in external care, and 34% of those in internal care are considered at risk.
- Run away from home – 75% of those in external care, and 66% of those in internal care.

3.2 **Children in Need** of support are children aged less than 18 years who require local authority services to help them achieve or maintain a reasonable standard of achievement, prevent significant or further harm to health or development, and those who are disabled. They are predominantly from White (44.1%), Unknown (14.4%), Pakistani (14.2%), and Black Caribbean (7%) backgrounds.

The highest prevalence of Children in Need came from Nechells (4.4%), Acocks Green (3.9%), Shard End (3.8%), and Tyburn (3.7%). 52.4% of children in need live in the most deprived 10% of Birmingham wards.

3.3 **Troubled Families** are defined nationally when they have 3 of the national criteria, having a parent in receipt of DWP benefits, having a member of the family engaged with the Youth Offending Service/Anti-Social Behaviour, and a child who is truanting/excluded from school. If a family only has 2 of the above criteria, they must also fit Birmingham's local criteria of compromised parenting capacity.

Troubled families have been identified with children of all ages, however, most are identified where the children are aged over 5 years, because of the criteria involving the Youth Offending Service/Anti-Social Behaviour and school truanting/exclusions.

30.7% of the troubled families are of White British background, 9% are Pakistani, and 3.8% are White and Black Caribbean.

6.3% of troubled families reside in Washwood Heath, followed by 6% in Kingstanding, 5.2% in Tyburn, 5% in Shard End, and 4.9% in Nechells.

An audit of the features of Troubled Families was conducted in June 2013 by Public Health and Children, Young People, and Family Directorate using the following process.

Troubled Families Audit	
1.	Tool used to input extracted data into was developed by the CYPF department, with input from Public Health.
2.	Data was extracted from the following assessment types: Family Common Assessment Framework (FCAF), ASSETT, and Core
3.	Forms on 381 individual children who were known to be within the Troubled Families cohort were used. Of these, 281 had a known LAC status; ie, whether or not the family had at least 1 LAC. Factors affecting these 281 families were used in the analysis.
4.	The raw data was coded, so that only indicators with a confirmed yes or no were taken into account in the calculations for each

Caveats:	
1.	TF audit case notes are based on 1 client only. Notes about other family members are only included if deemed relevant by the social worker filling the form in.
2.	As the notes are in written text, the judgement of each person who went through the notes had to be used at times, to determine if one of the factors looked at was present. Therefore, there may be differences in opinion where there is subjective matter, unless it
3.	The analysis may show true significance, or it could show potential bias of the person who has filled the form in. The social worker who has filled the form in may be more aware of the family having problems, especially if the child has been taken into care or given a
4.	Apparently, all social workers have a set number of areas to ask questions about. However, judging by the number of "Unknowns" in the data, this does not appear to be the case.

Table 3.1 indicates whether variables of socio-economic experience were statistically significantly recorded in the assessment forms of families with looked after children identified (Yes) compared to the assessment forms of families where there was a record of no looked after children in the family (No). However some of the assessment forms (100/381: 26%) did not record the status of children in the family. The analysis can only compare the prevalence of the socio-economic experience in the 281 families where the looked after status is recorded. This circumstance does not undermine the conclusions we can draw on these variables for inclusion in any driving forces.

Table 3.1: Audit of Assessment Forms for Troubled Families

Factor affects	Variable	Yes/No	Prevalence	LCL	UCL
Adult	Alcohol misuse	No	14.2%	9.7%	20.3%
		Yes	39.1%	22.2%	59.2%
	Depression	No	26.2%	20.2%	33.2%
		Yes	64.0%	44.5%	79.8%
	Self-harm	No	2.5%	1.0%	6.2%
		Yes	23.8%	10.6%	45.1%
	Stress / inability to cope	No	54.7%	47.6%	61.6%
		Yes	84.8%	69.1%	93.3%
	Specific conduct/emotional disorders	No	10.5%	7.1%	15.2%
		Yes	42.4%	27.2%	59.2%
	Unhappy	No	44.6%	37.3%	52.2%
		Yes	85.7%	68.5%	94.3%
	Aggressive behaviour in community	No	12.2%	8.2%	17.6%
		Yes	50.0%	32.1%	67.9%
	Violence at home	No	20.2%	15.1%	26.4%
		Yes	45.2%	29.2%	62.2%
	Violence in community	No	12.7%	8.6%	18.3%
		Yes	41.7%	24.5%	61.2%
	Previously in trouble with the police	No	30.1%	23.5%	37.5%
		Yes	65.4%	46.2%	80.6%
	Convicted of minor crime	No	17.6%	12.4%	24.5%
		Yes	52.6%	31.7%	72.7%
Child	Drug misuse	No	23.5%	18.3%	29.6%
		Yes	46.7%	30.2%	63.9%
	Mental health issues	No	16.1%	11.8%	21.4%
		Yes	36.4%	22.2%	53.4%
	ADHD	No	15.5%	11.3%	20.9%
		Yes	43.3%	27.4%	60.8%
	Stress / inability to cope	No	33.6%	27.7%	40.2%
		Yes	60.6%	43.7%	75.3%

	Behaviour problems at home	No	39.8%	33.6%	46.4%
		Yes	69.2%	53.6%	81.4%
	Behaviour problems at school	No	39.8%	33.6%	46.4%
		Yes	71.9%	54.6%	84.4%
	Aggressive at home	No	32.9%	27.0%	39.4%
		Yes	61.1%	44.9%	75.2%
	Violent at home	No	20.7%	15.9%	26.6%
		Yes	48.6%	33.0%	64.4%
	Bullies other	No	5.0%	2.6%	9.2%
		Yes	26.1%	12.5%	46.5%
	Regularly missing school	No	38.2%	31.6%	45.3%
		Yes	68.8%	51.4%	82.0%
	Poor social network	No	25.5%	20.1%	31.7%
		Yes	53.1%	36.4%	69.1%
	Emotional abuse	No	15.8%	11.6%	21.1%
		Yes / At risk of	61.0%	45.7%	74.3%
	Physical abuse	No	12.2%	8.6%	17.1%
		Yes / At risk of	47.5%	32.9%	62.5%
	Child neglect	No	14.0%	10.1%	19.1%
		Yes / At risk of	61.0%	45.7%	74.3%
	Mother: perpetrator of abuse (sexual/emotional/physical /neglect)	No	14.8%	10.8%	19.8%
		Yes	61.4%	46.6%	74.3%
	Father: perpetrator of abuse (sexual/emotional/physical /neglect)	No	13.9%	10.1%	18.9%
		Yes	37.2%	24.4%	52.1%
Family	Accommodation in need of improvement	No	14.5%	10.5%	19.8%
		Yes	30.3%	17.4%	47.3%
	Ever homeless	No	5.9%	3.4%	10.0%
		Yes	36.0%	20.2%	55.5%
	Has money problems	No	44.8%	37.5%	52.2%
		Yes	84.4%	68.2%	93.1%
	Family discord	No	44.9%	38.2%	51.7%
		Yes	83.8%	68.9%	92.3%
	Breakdown / divorce	No	50.0%	43.4%	56.6%
		Yes	84.6%	70.3%	92.8%
	Domestic violence	No	27.2%	21.1%	34.2%
		Yes	69.0%	50.8%	82.7%
Agency involvement	Adult mental health	No	9.4%	6.2%	14.1%
		Yes	32.1%	17.9%	50.7%
	Child Mental health	No	22.7%	17.7%	28.7%
		Yes	57.1%	40.9%	72.0%
	Police	No	33.8%	27.9%	40.2%
		Yes	73.7%	58.0%	85.0%

	Probation services	No	8.2%	5.2%	12.6%
		Yes	32.1%	17.9%	50.7%
	Social services	No	27.6%	22.2%	33.8%
		Yes	81.0%	66.7%	90.0%
	Special education	No	17.0%	12.6%	22.4%
		Yes	38.2%	23.9%	55.0%
	Targeted Family Support	No	8.9%	5.8%	13.4%
		Yes	30.8%	16.5%	50.0%

The four components of the family, namely Adults, Children, family circumstances, and Public Agencies involved with the family, provide an opportunity to identify the stronger drivers and likely opportunities to have intervened earlier in the course of the family's journey. Caution is needed in assuming that the 'mental health issues' identified in the assessment forms are amenable to generalist or specialist treatment or that involvement of an Agency is delivering a specialist treatment.

The Adults in the family have two broad groups of factors identified which were significantly present in these families:

i. **'Mental health issues':** These were described as Alcohol misuse, Depression, formal conduct/emotional disorder. A history of Self Harm has less than 25% of case status recorded and the significance of the contribution is therefore unreliable.

ii. **Behaviour at home and in the community:** Identified aggressive or violent behaviours at home and/or in the community, 'trouble' with the police or minor convictions.

The children and young people themselves have four broad groups of factors identified which were significantly present in these families:

I. **'Mental health issues':** A history of substance misuse and 'mental health issues' are weakly significant along with difficulty in coping or stressed and a diagnosis of ADHD.

II. **Behaviour at home and in the community:** Identified aggressive or violent behaviours at home and/or in the community were all significantly present in these families. A history of 'those who bully others' is only 31% of case status recorded and the significance of the contribution is therefore unreliable.

III. **Poor social and/or educational attainment:** This was specifically identified as regularly missing school and poor social networks.

IV. **A past history of personal abuse:** Physical and emotional abuse and neglect was identified as significantly present in these families. Sexual abuse, pregnancy, or risk of sexual exploitation was not significantly present in these families. Where there was data on parental perpetration of such abuse, both parents were significantly likely to be involved but mothers were more strongly associated than fathers from the assessment forms.

The family issues described fell into three broad groups which were significantly present in these families:

I. **Adult relationships:** Family discord and adult relationship breakdown or divorce were all over recorded but very significantly present.

II. **Money problems:** This was clearly identified as a significant issue.

III. **Housing issues:** This group was less powerful in their significance. A need for accommodation improvement and a history of ever being homeless were under reported (45% and 42% of families) which weakens the significance of its presence in these families.

The recorded involvement of a Public Agency was strongly significant when these were Social Services, Police, and/or Children & Adolescent Mental Health Services. The involvement of Probation, Special Education, and Adult Mental Health services were less strongly significant.

This exercise suggests that the FCAF/ASSETT/Core Assessment forms should all have a checklist of which factors must be asked about (eg. alcohol use). This will ensure better collection of information and understanding of the issues the client and their family face.

An exercise undertaken in 2012 where 45 Family Common Assessment Frameworks from Shard End, which included 131 children, were analysed to establish the types of needs a family had at the time of the audit. The exercise was part of a trial of the adaptation of the previous Common Assessment Form to a wider family intervention approach.

The following factors were identified in these families and are presented according to the family member involved. Once again the identification of the physical and mental health issues are self-reported and give no indication of the benefits likely or derived from specialist treatment. It is difficult to gauge the strength of the presence of the described output but there is some concordance of themes.

Table 3.2: Audit of Family Common Assessment Forms, Shard End Birmingham 2012

ISSUES	In the adult females:	In the adult males (only 7 males were questioned):	In the Children:
Environment	36 families affected: Bereavement; Communications; Debts; Drugs and alcohol; Housing Issues; Isolated/no social life; Poor Housekeeping; Unemployed; External family issues : non specific.	Debts; Drugs and alcohol; Housing Issues; Isolated/no social life; Poor Housekeeping; Unemployed.	31 families affected: Bereavement; Drugs and Alcohol; Isolated; NEET; Negative impact on others (non family); Negative impact on siblings; No contact with father; Parental relationship issues – negative; Parental relationship issues – over-attached; Pregnancy; Unsuitable peers.

Mental Health	29 families affected: Anxiety; Behaviour; Depression; Lacks confidence/low self esteem; Low mood; Mental health issues – personal; Mental health issues – extended family; Mood Swings; Self harm; Stress.	Depression/low mood; Self harm; Stress.	33 families affected: ADHD, ASD, Autism, ASD, Aspergers; Anxiety; Depression; Emotional well being; Low self esteem; Mental health issues – non specified; Risk of self harm; Self harm; Suicidal thoughts; Suicide attempts.
Parenting problems	25 families affected: Child relationship issues; Struggles to enforce rules/boundaries; Struggling to parent.	Struggling to parent.	
Domestic Violence	18 families affected: DV Victim – partner perpetrated; DV Victim – extended family perpetrated; DV Perpetrator.	DV Victim – partner perpetrated; DV Perpetrator.	5 families affected: DV Victim; DV Witness.
Physical health	7 families affected: Physical health issues, Sleep deprivation.	Physical health issues; Sleep deprivation	34 families affected: Hygiene; Sleeping difficulties; Toileting issues; Weight issues; Eating issues; Physical health – non specific.
Abuse – sexual/other	Yes: less than 5 families affected		Yes: less than 5 families affected
Offending	Yes: less than 5 families affected		8 families affected: Arson; ASB; Inappropriate sexual behaviour/language; Offending – non specific; Risk of offending.
Abuse – racial		Yes: less than 5 families affected	
Aggression	Yes: less than 5 families affected	Yes: less than 5 families affected	28 families affected: Aggression – non specific; Aggression – physical; Aggression – verbal.
Deceased		Yes: less than 5 families affected	

Behaviour			36 families affected: Bullying; Low concentration; Poor emotional/anger control; Poor safety awareness; Risk of harm; Struggles with rules and boundaries; Trusting and vulnerable.
Educational			28 families affected: Attainment; Attendance; Exclusion; Truancy.
Development			15 families affected: Development; Learning difficulties; Motor issues; Poor communications/speech and language.
In Care			Yes: less than 5 families affected
Race Issues			Yes: less than 5 families affected

3.4 Local providers of treatment services for **Children and Young People with Alcohol/Substance misuse problems** report that clients are aged between 14 and 18.

Those clients who access Lifeline were identified to be from a White British (57%), White and Black Caribbean (11%), or Pakistani background (7%). They accessed Lifeline from the Youth Offending team (48%), and Children and Family Services (7%). Interestingly only 10% of clients are self-referrals.

The largest drug group are clients who smoke cannabis (79.2%), and on average they spend about 11.5 weeks in treatment. A smaller proportion of clients abuse alcohol (19%), and on average they spend about 12 weeks in treatment. A large proportion of all clients smoke cannabis and also abuse alcohol (44.6%).

There is a range of in-service therapies used but in addition, 35.8% are referred into YP Harm Reduction Service, and 26.8% are referred into YP Psychosocial Motivational Interviewing treatment.

The key features associated with these clients are:

- Young people Not in Education Employment or Training;
- Youth offenders and those at risk of offending;
- Truants and persistent absentees;
- Excluded pupils;
- Those in care and care leavers;
- Exposure to substance misuse amongst family members/carers;

- homelessness;
- Teenage pregnancy / teenage parents;
- Sexually exploited young people;
- Mental health problems.

3.5 Domestic violence

In 2012/13 Women's Aid dealt with families seeking assistance due to domestic violence in which 3,821 children were affected. Almost 85% of these are aged under 11 years, 42.2% are under 5 and 42.6% are 5 – 11. There is no significant difference between the number of boys and girls affected. Those of White British (44.3%), Pakistani (16.6%), Caribbean (8.2%), and African (6%) backgrounds were most affected.

Each year there are 12,000 children identified when West Midlands Police respond to an incident of Domestic Violence. These are screened by a multi-agency panel to grade their level of risk of on-going harm.

1. Little evidence of risk of harm; no further action required: 30%
2. Potential for further harm occurring; single or multiagency assessment and support offered: 43%
3. Demonstrable harm or risk of harm; formal social work assessment: 17%
4. Evident serious harm or risk or already known to Social Care with Social Worker allocated and/or Child Protection Plan in place or S47 process commenced at time of incident: 10%

These children are the tip of an Iceberg of children exposed and therefore affected by violence in the home. The implications for improving the health and wellbeing of these children are large and significant and must not be ignored.

4 WHAT NEXT?

There has been a consistent finding in research, particularly well distilled in the Marmot Report[55], that the greatest impact is seen in the context of children living in poverty (Map 3.1) and the greatest improvement in children's health & wellbeing is in the amelioration of that poverty.

The description of the distribution of the Index of Vulnerability (Map 3.2) reminds us that the challenges facing children, young people, and their families are not uniformly spread across the city. Early Intervention, both reactive and programmed responses, is therefore likely to be different in size and scope in different parts of the city.

The audits of Looked After Children, Family Common Assessment Forms in Shard End, and the Troubled Families assessment forms across Birmingham have identified factors that are commonly present in the individuals or family requiring multi-agency specialist/intensive interventions. There is no means of determining from this work whether earlier intervention in these factors had been engaged in or whether, if it had, it would have altered the outcome.

Identifying the factors commonly present however does develop a potential framework for earlier reactive intervention. There are eight factors identified, namely:

I. 'Mental Health Issues' in particular:
    a. Substance and/or alcohol misuse (adults and children);
    b. Depression/anxiety (adults and children); and
    c. Attention Deficit Hyperactive Disorder.
II. Violence in the home

III. Violence in the community;

IV. Past personal physical, emotional, and/or sexual abuse;

V. Poor educational engagement and/or attainment ;

VI. Breakdown of the relationship between the adults of the family resulting in dysfunction, separation , and/or divorce;

VII. Family financial difficulties; and

VIII. Poor quality unsustainable family accommodation.

4.1 **How should we respond?**

The families studied are already in 'crisis' or difficulty. Key workers need to be able to introduce the members of the family, individually and collectively depending on the problem being addressed, to a qualified provider of advice/assistance. The network of providers addressing the above areas should be commissioned under the Early Intervention banner.

Key workers of Health, Social Care, or Youth Justice working with families who are showing signs of impending crisis/increasing difficulties could still use these providers in an attempt to avert crisis. This falls into the **Indicated Preventative Interventions** of section 2.4 and we should heed the messages about interagency work and the qualities of key workers. This co-ordinated approach fits well with the 'whole family' and Family Intervention approaches.

The proposal is to commission services that strengthen family functioning and build resilience through evidence-based interventions such as **Functional Family Therapy, Family Group Conferencing** and **Solution Focussed Therapy.** The approaches aim to change family interaction and family relationships, and through this, individual problem behaviour. These interventions support the CYPF operating model which aims to move social work practice from an assessment focus to enabling family change using a systematic model. The Public Health investment currently supports three Intensive Family Support projects and it is proposed that these are re-tendered against a specification that shifts the focus to those at the edge of care using a system model of family change.

Established challenging behaviours or conduct disorders in young people also require attention. The proposal is to commission evidence-based interventions that tackle challenging behaviour in children such as specific **Cognitive Behaviour Therapy Programmes** related to **Aggression Reduction Therapy** and **Multi-Systemic Therapy.** These programmes combine elements of direct work with young people, parenting support and practical assistance with the aim of rebuilding relationships between the young person, the family and the networks around them. The approach equips the family with the tools to solve problems in the future, thereby effecting sustainable change such as reducing anti-social behaviour and enabling children to live safely at home.

In response to the mental health needs of young people, it is proposed that the three existing projects that support the emotional well-being of young people are re-specified and targeted at children with more complex and challenging needs and that the systematic use of **Cognitive Behaviour Therapy** by health professionals is increased and available early at the point of identified need, for teenagers with anxiety, depression or psychological issues

Selective Preventive Early Interventions will still require key workers to introduce clients or families to these providers but the interventions are likely to be shorter and/or less intense. This is the rationale of the *Right Service, Right Time* framework adopted in Birmingham. Key workers will need to be kept aware of the providers and access points.

In addition there are also programmes which have been shown to have a positive impact upon children and families before entrenched problems have arisen, namely Family Nurse Partnership, Triple P, Safe Care, Incredible Years and Promoting Alternative Thinking Strategies. Serious consideration about commissioning these approaches needs to be undertaken.

Universal Preventive Interventions contribute opportunities for reducing the progression of individual difficulties to family difficulties and improving the nurturing of the children's health & wellbeing, the virtuous circle that spirals. This should be seen in the

- collaboration of health, early years & social care expertise and opportunities to enhance the language and emotional development of children;
- availability to all parents of opportunities to shape their parenting approach using Triple P and/or Solihull Approach;
- adoption of a Birmingham Healthy Child Framework that is based on principles of socio-emotional opportunities for growth rather than a deficit physical health model. This may change the skill mix of providers of complementary approaches and opportunities.

These proposals should be seen as the first step. There are other components of the picture described above, particularly domestic violence, financial difficulties, and accommodation issues, which have opportunities to be addressed through other partnerships or programmes.

Dr Dennis Wilkes
Public Health Children's Health & Wellbeing Lead
On behalf of the Early Intervention Task & Finish group (Appendix One)
06 August 2013

Appendix One:

The members of the Early Intervention Task & Finish Group, all of whom contributed significantly to the Summary Report:

Adrian Phillips
Chris Glynn
Narinder Saggu
Seeta Wakefield
Hashum Mahmood
Allan Reid
Susan Keung
Tony Bunker
Penny Arcantinis
Steven Rose
Chris Baggott
Maria Kidd
Jak Lynch
John Lees
Charlene Mulhern

Infatigueable Project Support: Clare Reardon

REFERENCES

[1] Mrazek and Haggerty, 1994: Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research
[2] E Munro, 2010: The Munro review of child protection interim report: The child's journey; www.dera.ioe.ac.uk
[3] Nixon, 2008: The longer-term outcomes associated with families who had worked with Intensive Family Support Projects; J Nixon - 2008 - dera.ioe.ac.uk
[4] Grasping The Nettle: Early intervention for children, families and communities; Centre for Excellence and Outcomes (2010)
[5] Allen G. 2011; Early Intervention: The Next Steps, www.dwp.gov.uk/docs/early-intervention-next-steps.pdf
[6] Little M. 2010; Proof Positive, Social Research Unit at Dartington, Demos 2010, available at: http://dartington.org.uk/proof-positive/
[7] Little, M and Sohda, S. 2012: Reviewing Prevention and Early Intervention in Children's Services, Nesta 2012
[8] Little, M., Berry, V., Morpeth, L., Blower, S., Axford, N., Taylor, R., Bywater, T., Lehtonen, M. & Tobin, K. (2012) 'The impact of three evidence-based programmes delivered in public systems in Birmingham, UK', International Journal of Conflict and Violence
[9] Melhuish, E., Belsky, J., and Leyland, A.H. (2012) *The Impact of Sure Start Local Programmes on Seven Year Olds and* Their Families. Other. Department of Education, London, UK.
[10] Backing the Future: why investing in children is good for us all, 2009, published by nef (the new economics foundation).
[11] Beckett, Celia and Kallitsoglou, Angeliki and Doolan, Moira and Ford, Tamsin and Scott, Stephen, Department for Education (DFE), corp creator. (2012) *Helping Children Achieve : summary of the study 2007-2010 : interim report*
[12] Incredible Years programme developed by Carolyn Webster-Stratton at the Washington University Parenting clinic for parents and teachers.
[13] Morpeth, L., Berry, V., Blower, S., Tobin, K., Taylor, R., Edwards, R. T., Linck, P., Bywater, T., Axford, N. and Lehtonen, M. (2012) The Effectiveness of the Incredible Years Pre-school Parenting Programme in Birmingham, UK: a Randomised Controlled Trial, Dartington, Social Research Unit.
[14] Little, M., Berry, V., Morpeth, L., Blower, S., Axford, N., Taylor, R., Bywater, T., Lehtonen, M. & Tobin, K. (2012) 'The impact of three evidence-based programmes delivered in public systems in Birmingham, UK', International Journal of Conflict and Violence
[15] Little, M., Berry, V., Morpeth, L., Blower, S., Axford, N., Taylor, R., Bywater, T., Lehtonen, M. & Tobin, K. (2012) 'The impact of three evidence-based programmes delivered in public systems in Birmingham, UK', International Journal of Conflict and Violence
[16] Sanders, M. R. 2008. Triple P-Positive Parenting Program as a public health approach to strengthening parenting Journal of Family Psychology 22 (3): 506–517.
[17] Wilson P, Rush R, Hussey S, Puckering C, Sim F, Allely CS, Doku P, McConnachie A, Gillberg C., 2012; How evidence-based is an 'evidence-based parenting program'? A PRISMA systematic review and meta-analysis of Triple P. BMC Med. 2012 Nov 2;10:130. doi: 10.1186/1741-7015-10-130.
[18] Little, M., Berry, V., Morpeth, L., Blower, S., Axford, N., Taylor, R., Bywater, T., Lehtonen, M. & Tobin, K. (2012) 'The impact of three evidence-based programmes delivered in public systems in Birmingham, UK', International Journal of Conflict and Violence
[19] Milford, R., Kleve, L., Lea, J., Greenwood, R. 2006 A pilot evaluation study of the Solihull Approach. Community Practitioner, 79: 11, 358-362
[20)] for families with infants and young children. International Journal of Infant Observation, 7: 1, 89-107
[21] Milford, R., Kleve, L., Lea, J., Greenwood, R. 2006 A pilot evaluation study of the Solihull Approach. Community Practitioner, 79: 11, 358-362
[22] Bateson, K., Delaney, J., Phybus, R. 2008 Meeting expectations: the pilot evaluation of the Solihull Approach parenting group. Community Practitioner, 81: 5, 28-31
[23] Johnson, R., Wilson, H. 2012 Parents' evaluation of understanding your child's behaviour, a parenting group based on the Solihull Approach. Community Practitioner, 85: 5, 29-33.
[24] http://www.canparent.org.uk/about.html
[25] *Reaching out: Think Family – analysis and themes from the Families at Risk Review*: 2009 Cabinet Office, Social Exclusion Task Force
[26] National Institute for Health and Clinical Excellence June 2013, *National Clinical Guidance 158: Antisocial Behaviours and Conduct Disorders in Children and Young People*
[27] http://www.nursefamilypartnership.org/about
[28] Coalition for Evidence Based Policy (2009) Early Childhood Home Visitation Models: An Objective Summary of the Evidence About which are Effective http://toptierevidence.org/wordpress/

[29] Paulsell, D.A, Avellar, S., Sama Martin, E., and Del Grosso, P. (2010) Home Visiting Evidence of Effectiveness Review: Executive Summary. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Washington DC.
[30] http://www.education.gov.uk/commissioning-toolkit/Programme/Detail/7
[31] Barnes, Green, Ross 2011, Understanding Vulnerable Young People: Analysis from the Longitudinal Study of Young People in England
[32] Department of Education 2011, Monitoring and evaluation of intensive intervention projects for young people
[33] Ofted, 2012; Edging away from care - how services successfully prevent young people entering care
[34] Prison Reform Trust 2012, Out of Trouble
[35] Blades, Hart, Lea, Willmott; Prison Reform Trust 2011, Care-A stepping stone to custody?
[36] National Audit Office, 2006; The Home Office, Tackling anti-social behviour
[37] Audit Commission 2009, *Tired of hanging around: using sport and leisure activities to prevent anti-social behaviour by young people*:
[38] http://www.lifeskillstraining.com/index.php
[39] Crowther and Cowan 2011, Effective relationships with vulnerable parents to improve outcomes for children and young people: final study report, Action for Children research, York Consultancy
[40] Morris, 2008. Think Family: a literature review of whole family approaches, Cabinet Office, Social Exclusion Task Force
[41] Repairing broken families and rescuing fractured communities: Lessons from the frontline: 2010 Local Government Leadership and City of Westminster
[42] Department of Education 2011; Monitoring and evaluation of family intervention services and projects between February 2007 and March 2011
[43] Gregg 2010; Family intervention projects: a classic case of policy-based evidence; Centre for Crime and Justice Studies
[44] Department of Education 2011; Turning around the lives of families with multiple problems – an evaluation of the Family and Young Carer Pathfinders Program. York consultancy
[45] Flint 2011, *Evaluation of Rochdale Families Project – Briefing Paper on Economic Cost-Benefits of Family Intervention.* Sheffield Hallam University and Centre for Regional Economic and Social Research
[46] Action for Children 2010, *The* economic and social return *of Action for Children's Family Intervention Project, Northamptonshire*:
[47] The Key Elements of Effective Practice (KEEP) guidance notes and source documents ,Youth Justice Board 2010
[48] Furlong M, McGilloway S, Bywater T, Hutchings J, Smith SM, and Donnelly M, 2012; Behavioural/cognitve-behavioural group-based parenting interventions for children age 3-12 with early onset conduct problems
[49] http://www.mtfc.com/
[50] . National Collaborating Centre for Mental Health (UK). 2010; Antisocial Personality Disorder: Treatment, Management and Prevention. NICE Clinical Guidelines, No. 77
[51] Biehal, Dixon, Parry, Sinclair, Green, 2012; The Care Placements Evaluation (CaPE) Evaluation of Multidimensional Treatment Foster Care for Adolescents (MTFC-A), Department for Education, London
[52] http://www.fftinc.com/
[53] Little, M and Sohda, S. 2012: Reviewing Prevention and Early Intervention in Children's Services, Nesta 201
[54] Cary M, Butler S, Baruch G, Hickey N, Byford S (2013) Economic Evaluation of Multisystemic Therapy for Young People at Risk for Continuing Criminal Activity in the UK. PLoS ONE 8(4): e61070. doi:10.1371/journal.pone.006107
[55] Marmot review report; Fair Society, Healthy Lives 2010