# The Effectiveness of Adolescent Support Teams

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Submitted for the degree of PhD

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March 2004

# Abstract

This study evaluates the effectiveness of adolescent support teams in achieving positive outcomes for young people at risk of care or accommodation. It reports on a prospective, comparative study carried out in eight English local authorities. Both quantitative and qualitative methods were used to compare services and outcomes for young people referred to specialist family support teams working with adolescents with those for a group receiving mainstream social work services. A sample of 209 young people was recruited to the study. Interviews with young people, parents and workers were carried out shortly after referral and again at six month follow-up.

The study describes the characteristics, circumstances and histories of the young people referred to both types of service, providing evidence of their high levels of need. Interventions by specialist and mainstream services are described and outcomes on a range of dimensions are compared, namely in terms of child and family functioning, child perceptions of well-being, severity of child difficulties, parental mental health and placement. The question of how, why and in what circumstances the interventions were likely to be more or less successful is also explored.

The study found that for the majority of the young people circumstances improved on a range of measures. However, there was no evidence that the specialist teams were more successful in improving child and family functioning than mainstream services, although there was some indication that they were more successful in preventing placement.

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# Acknowledgements

This study was funded by the Department of Health and involved data collection across eight local authorities, so many other people were involved in bringing it to fruition. Although I designed the study, analysed the data and wrote it up myself, I am grateful to the many colleagues who assisted me in other ways. In the earlier stages of the study Suzy Alcock and Sarah Ellison played a vital role, each undertaking the task of co-ordinating the fieldwork at different times. They trained and supported a large team of interviewers who also played an essential role in the study and to whom I am very grateful.

I would particularly like to thank Professor Ian Sinclair and Dr Ian Gibbs. As my supervisor, Ian Sinclair gave advice on statistical analysis, commented on draft chapters and generally gave moral support. Ian Gibbs also gave invaluable advice on statistical analysis. Thanks too to Jim Wade, who helpfully commented on draft chapters, to Claire Baker, Jo Dixon, Fiona Mitchell and Emilie Smeaton for help with the fieldwork and to Helen Jacobs and Dawn Rowley for secretarial support.

I would like to thank the Department of Health for sponsoring this project and thanks are especially due to Dr Carolyn Davies and Dr Caroline Thomas for their support throughout. I also benefited from the advice of our Advisory Group throughout the course of the study. Thanks then to Professor David Berridge, Dr Jeni Beecham, Dr John Coleman, Janet Grauberg, Tessa Ing and John Rowlands and Kevin Woods.

I also owe a major debt to everyone in our participating local authorities who helped and advised me during the course of this study, in particular to the staff of the support teams and the social workers and managers who helped with the study. Many support workers and social workers generously gave their time to complete our interviews and postal questionnaires, despite being extremely busy, and for this we are very grateful.

Above all, I am extremely grateful to the many young people and parents who agreed to take part in the study. Without their willingness to talk about what were often very difficult experiences, this thesis could not have been written.

# 1 Introduction

## Preventive services for teenagers

This thesis is about services which aim to prevent family breakdown and the placement of young people in residential or foster care. Placement rates are known to be high for older children and adolescents. Two large surveys in the 1980s found that children aged 14-15 were particularly vulnerable to admission to care and one observed that the proportion of children admitted at the age of 14 or over had increased from 3% in 1962 to 25% in 1987 (Bebbington and Miles 1989; Rowe *et al.* 1989). This increase was to some extent due to legislative changes. The Children and Young Persons Act 1969 had abolished the system of approved schools, with the result that many teenage young offenders were brought into the care system. Although the Children Act 1989 removed offending, truancy and moral danger as specific grounds for a care order, the proportion of teenagers among new admissions to substitute care has remained high. Recent government statistics have shown that 42% of children starting to be looked are aged 10-15, and that there has recently been a slight increase in the proportion of children in this age range looked after at any one time (Department of Health 2003a).

Concerns about high rates of admission to substitute care or accommodation for older children and young people, as well as the high cost of accommodating them, has led to the establishment of the specialist support teams that are the subject of this study. Support teams for adolescents have developed rapidly since the late 1980s and it was estimated that by the late 1990s there were over 80 such teams in England alone (Brown 1998). Typically, they offer an intensive, short-term preventive service aimed at diverting adolescents from the care system[1]. Most of these teams have been set up in tandem with a reduction in residential provision and many of their staff have been re-deployed from residential units. A survey of community support teams around the country found that *all* had been created in order to reduce the rate of admission to local authority accommodation, although some had additional aims (Brown 1998).

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[1] Since the majority of young people referred to support teams for adolescents display behaviour problems at referral, this thesis focuses to a large extent on young people with these kinds of problems. However, it is important to bear in mind that most adolescents receiving help of various kinds from social services do not have behaviour problems.

country found that *all* had been created in order to reduce the rate of admission to local authority accommodation, although some had additional aims (Brown 1998).

## Outline of the study

The study builds on an earlier exploratory study of a single adolescent support team (Biehal *et al.* 2000). It employs a quasi-experimental design to consider the effectiveness of specialist support teams in comparison with mainstream social work services. Outcomes for the young people referred to six specialist support teams are compared to those for a similar group receiving a 'service as usual' in three authorities. The study concentrates on three main issues:

*Service users*

- What are the characteristics of young people and families who receive a family support service?
- In what circumstances do they request, or are they referred to, this service?

*The nature of the service*

- In what ways does the service provided by specialist support teams differ from that provided by mainstream social workers to young people in similar circumstances?

*Outcomes*

- Are specialist support teams for adolescents more successful in achieving positive outcomes for young people at risk of family breakdown than mainstream social work services?
- Are these specialist support teams effective in improving service outcomes through reducing the number and duration of placements, in comparison with mainstream services?

## Outline of the thesis

The first section of this thesis aims to situate the study within a policy and research framework. Accordingly, Chapter 2 focuses on the policy and conceptual frameworks underpinning the current provision of family support services to teenagers and their families and Chapter 3 reviews the relevant research literature. Since this study was

funded under the Department of Health's research initiative on the Costs and Effectiveness of Services to Children, Chapter 4 considers the debates on the feasibility, and indeed the desirability, of measuring effectiveness and the vexed question of whether it is possible to discover 'what works.'

The remainder of the thesis focuses on the study itself. Discussion of the methodology used in Chapter 5 is followed by a description of the authorities and teams which took part in the study in Chapter 6. Chapters 7, 8 and 9 describe the young people's histories and their difficulties at referral, as well as outlining their parents' difficulties and the families' expectations of the service. Chapter 10 considers the strategies used to manage the demand for family support services and describes the interventions by the support teams and by social workers. The three chapters which follow are concerned with outcomes. Chapter 11 analyses changes in child and family functioning while Chapters 12 and 13 focus on the prevention of placement. Finally, Chapter 14 tries to tease out how and in what circumstances the interventions appeared to help and the barriers to positive outcomes.

# 2 Prevention: policy and concepts

## From prevention to family support

Since the Children Act 1948 there has been a continuing tension between state paternalism and the defence of the birth family. In some periods policy has favoured a legalistic, protectionist approach to children while in others there has been a stronger focus on providing support to families with a view to preventing entry to care wherever possible (Packman and Jordan 1991; Packman 1993). This has been characterised as an ongoing conflict between protagonists of the 'state as parent' and the 'kinship defenders', with the latter arguing for greater support to families in order to prevent admission to substitute care (Fox-Harding 1991). Although the pendulum swings in state policies towards children are said to have commenced as far back as the Poor Law Amendment Act of 1834,[2] they appear to have intensified since the early 1970s (Parker 1990).

The concept of prevention was not explicit in the Children Act 1948, although some have argued that it was implicit (Marsh and Triseliotis 1993). Certainly, questions were raised in parliament as early as 1949 regarding the wisdom of removing neglected children from their families rather than supporting families to prevent cruelty and neglect. In 1950 the Home Secretary issued a circular (jointly with the Ministries of Health and Education) which was the first government statement explicitly to link the prevention of neglect and ill-treatment with the prevention of removal of children from their homes (Heywood 1978). As the 1950s progressed, a number of factors converged to focus attention on the need prevent unnecessary admission to care: the increase in the number of children entering care, mainly for reasons of neglect; the rising costs associated with this increase and the influence of Bowlby's work on the psychological consequences for children of separation from their parents (Bowlby 1951; Packman 1975). There was increasing recognition of the

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[2] This was the first legislation to require parishes to provide some rudimentary education for the destitute children looked after in workhouses (Heywood 1978).

link between material deprivation and neglect and increasing pressure from children's officers, appointed by the local Children's Committees, for wider powers to undertake preventive work (Heywood 1978). As Parker has observed, what changed in the years after the 1948 Children Act were views about what it was necessary to prevent 'namely the disruption or breakdown of families that led to children having to be looked after by a corporate body' (Parker 1990, p.98). These concerns led the government to set up a Committee of Inquiry chaired by Lord Ingleby in 1956 to enquire into, among other things, the working of the law in respect of children brought before the courts as being in need of care or protection or as delinquents.

The conclusions of the Ingleby Report in 1960 informed the Children and Young Persons Act (1963). This marked a new departure in that it was the first legislation to set out a statutory duty to provide assistance to families 'to promote the welfare of children by diminishing the need to receive children into or keep them in care'. It marked a new attitude on the part of government: 'moving away from the paternalistic, protective, child-centred attitude to positive and skilled family work.'(Heywood 1978:191). The concept of prevention embodied in the 1963 Act encompassed not only the prevention of admission to care but also the restoration of children to their families, the prevention of neglect and cruelty in the home and the prevention of juvenile offending. The aim was to promote the welfare of children, particularly those experiencing neglect, by helping the family as a whole and it resulted in a reduction in the number of children with less serious problems entering substitute care (Packman 1993). The focus on preventing admission to care was reinforced by studies of the foster care service, which identified a number of problems, including high breakdown rates (Trasler 1960; Parker 1966; George 1970). Preventive work was also broadened by the introduction of Intermediate Treatment by the Children and Young Persons Act 1969, which led to a great deal of preventive activity with teenagers until criticism of its labelling and net-widening effects led to its decline (Thorpe *et al.* 1980).

During the 1970s, researchers identified the problem of children who 'drifted' in care due to a lack of proper planning and concern was expressed about the possible consequences of long term care for the psycho-social development of children

(Fanshel and Shinn 1978; Goldstein *et al.* 1973; Rowe and Lambert 1973;). In the same period, these concerns led to the emergence of the permanency planning movement in both the UK and the USA. The permanency planning approach encouraged a focus on ensuring continuity of care for children, preferably within their own families but, if this was not possible, through adoption or long-term foster care (Maluccio and Fein 1983). In the UK, the emphasis of permanency planning was primarily on planning for children in care rather than on keeping them with, or returning them to, their birth families. The work of Goldstein and colleagues (1973) was influential during this period. This promoted the idea that state intervention in family life should be minimal but, once parenting was found to be severely impaired, decisive action should be taken by the state. This action might include the severance of ties with the biological family and encouragement of the development of new psychological ties to substitute parents. Hence, preventive and rehabilitative work came to be viewed as less important. In the UK, though, perhaps the major factor which contributed to concern over child care policy and practice during this period was a series of chid abuse inquiries, in particular the Maria Colwell Inquiry which reported in 1974 (Parton 1991; Secretary of State 1974). The combined impact of the permanence movement and of panics over child abuse led to a decline in preventive activity as the 1970s progressed (Holman 1988; Parton 1991).

However, by the early 1980s renewed interest in prevention was evident in the Barclay Report. This argued for the development of community social work, which would tap into local networks of formal and informal support to families (Barclay Working Party 1982). Shortly afterwards the House of Commons Social Services Committee report, known as the Short Report, complained of a lack of commitment to preventive work and a lack of understanding of where preventive effort should be targeted (House of Commons Social Services Committee 1984). This was followed by the Review of Child Care Law, which questioned the distinction between the needs of the child and the needs of the family (Department of Health and Social Security 1985a). In the same period, a number of studies argued for greater attention to supporting families in order to prevent family breakdown and the collection of pressure groups which constituted the parents' rights lobby, such as the Family Rights Group, campaigned to re-establish a commitment to preventive work (Parker 1980;

Fisher *et al.* 1986; Holman 1988). This renewed concern with preventing admission to care was reinforced by a series of research studies in the mid-1980s which identified a lack of planning for children in care and poor outcomes for young people leaving care (Department of Health and Social Security 1985b; Stein and Carey 1986).

These developments helped to shape the Children Act 1989, which placed a duty on local authorities, under Section 17 (in Part 111 of the Act), to safeguard and promote the welfare of 'children in need' and to promote their upbringing by their families. The Act represents a shift in emphasis from the old negative conception of prevention to a more positive, pro-active duty of family support with the broader aim of promoting the welfare of children. Parents of 'children in need' were encouraged to look to local authorities for non-stigmatising support services, without fear of a loss of parental responsibility. Indeed, the continuity of parental responsibility was emphasised by the Children Act, thus satisfying both conservative and liberal commentators. The focus on supporting families and the promotion of parental responsibility reflected the contemporary Conservative anti-collectivist policies aimed at reducing the role of the welfare state and a concomitant reassertion of the role of the family in taking responsibility for its members. In line with this philosophy, the emphasis was on reducing state intervention in the private sphere of family life (Jack and Stepney 1995). At the same time this policy satisfied those with more liberal views regarding the need for support to disadvantaged families to enable them to care adequately for their children. Thus for different reasons, the policy of family support appealed to 'kinship defenders' across a wide political spectrum.

The Act sought to integrate the duty to protect children from harm and the duty to support families, so that the aims of preventive services would no longer be focused on the narrow goal of preventing children being looked after, but on preventing harm, or the need for compulsory intervention, or offending. The Children Act 1989 also abolished the use of Care Orders in criminal proceedings and in response to truancy, thus increasing the pool of young people who might potentially require family support services instead. However, within a few years of the Children Act's implementation, concern was being expressed at the continuing prioritisation of child protection work

and the marginalisation of family support services (Audit Commission 1994; Rose 1994). A review of a series of Department of Health-funded studies into the operation of the child protection system found that too many families were drawn into the child protection net without receiving any services to meet their needs. It called for a rebalancing of services to shift the focus of attention from investigation to support to families with children in need. The intention was to lower the threshold for the provision of services from the identification of significant harm to the identification of the needs of children (Department of Health 1995). The aim was that a refocusing of services would ensure that family support became the context within which child protection interventions might take place, rather than an alternative to them.

Despite these intentions, a subsequent inspection report found that that social services continued to give little attention to supporting the families of children in need and suggested that to some extent that this was due to pressures on public expenditure and reduced local authority spending on personal social services (Social Services Inspectorate 1997). It has also been argued that the increase in numbers of children looked after during the late 1990s demonstrated that there was still little evidence of a shift in social work policy and practice from investigation and protection to prevention and support (House of Commons Health Committee 1998; Walby and Colton 1999).

## Prevention and the concept of need

Attempts to conceptualise prevention have centred on the concept of need and the question of where interventions should be targeted. Although an apparently simple notion, prevention can be a slippery concept which can have a variety of meanings, depending on who is using it. As Hardiker and colleagues have noted, a key question is 'preventing what?' and the answers to this question are likely both to reflect a variety of value positions and require a variety of practice strategies (Hardiker *et al.* 1991; Tunstill 1996). As we have seen, in the early years after the 1963 Children and Young Person Act, prevention came to refer not only to the prevention of admission to care but also the prevention of abuse, neglect and delinquency. While official views of prevention tend to be fairly narrowly focused in this way, others have taken a

broader view of the needs of children and hence of what should be prevented. For example, Holman addressed the question 'preventing what?' with a seven point typology. This included not only preventing admission to care, preventing children being abused and neglected and preventing young people appearing before the courts but also the prevention of poor parenting, the prevention of lengthy episodes in care, the prevention of the isolation of children in care from their families and preventing children suffering the effects of severe socio-economic disadvantage (Holman 1988). He also argued that prevention may be either a reactive activity, for example to prevent children being unnecessarily separated from their parents when problems arise, or a positive support to promote the well-being of children in their families and so forestall the development of severe problems. Like Packman, he argued for a wider perspective on prevention, one that is broader than a solely problem-focused approach (Packman 1986; Holman 1988).

Drawing on the classifications of preventive medicine, Parker highlighted the need to view preventive activity as a continuum of provision ranging from universal services to those targeted at children in greatest need (Parker 1980). Accordingly, prevention has been categorised in terms of three levels of need, each of which requires a particular model of service characterised as primary, secondary or tertiary prevention (Parker 1980; Hardiker *et al.* 1991; Gardner 1992; Sinclair *et al.* 1997). Primary interventions are intended to prevent the emergence of problems and normally involve provision of universal services on an open access basis, such as nursery education. Secondary preventive services address problems in their early stages, for example neighbourhood services located in areas of social disadvantage whose users are self-selected. Tertiary prevention aims to limit the damaging effects of a problem already established and normally involves provision targeted at particular individuals who are referred to specialist services (Sinclair *et al.* 1997).

This conceptualisation of prevention has led to debates about the most effective levels at which to intervene and, associated with this, to discussion of the right balance between universal and targeted services. For example, Holman has argued that universalist provision would reduce the need for coercive intervention in family life and make state intervention unnecessary in all but extreme cases (Holman 1988).

Similarly, Gibbons advocated a strategy of neighbourhood based family support services delivered by independently run voluntary and informal groups, with local authority intervention only in situations where serious problems are identified (Gibbons 1990). Within local authorities, different family support services may intervene at different levels of prevention, for example some family centres may target families at high risk of losing their children while others may be concerned with community initiatives reaching out to a broader spectrum of families (Packman and Hall 1998).

With the passing of the Children Act 1989, the debate shifted from a discussion of levels of prevention to an examination of the concept of 'children in need', but at the heart of this new debate lie the same concerns about the merits of universal or targeted services, of early intervention or later reaction to problems which have become more serious. Although the Children Act 1989 has expanded the duties and powers of local authorities to provide services, it has at the same time stipulated that these services are to be available only to children 'in need'. The concept of family support could conceivably imply that a wide range of children might be entitled to universal services, which potentially has enormous resource implications for local authorities. The concept of children in need serves to narrow the focus of service provision, so that services are targeted at those 'in need,' as defined in Section 17 of the 1989 Children Act. A child is considered to be 'in need' if:

- he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services:
- his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or
- he is disabled.

Implicit in the Act, therefore, is the notion of targeting, the precise nature of which is to be determined through local discretion.

Concern has been expressed about the way the deliberately wide definition of need in the 1989 Children Act is translated into operational definitions at local level. Some have argued that Children Act's aim of developing a positive and proactive family

support service – whose purpose would be to identify and meet a wide range of needs rather than simply prevent a narrow range of negative outcomes – is not being fulfilled. For example a study of the implementation of Section 17 of the Children Act found that, instead of attempting to ascertain the particular needs of children in their local areas, most local authority policy statements went little further than the definitions provided in the Children Act and its Guidance (Aldgate and Tunstill 1995). This study of 82 English local authorities found that many had established a hierarchy of access to services for children in need, with the highest priority given to children at risk of abuse or neglect and children 'looked after'. Similarly, Colton and his colleagues' study of English and Welsh authorities found that social workers continued to think in terms of protection rather than prevention (Colton *et al.* 1995a). They were also reluctant to identify needs which could not be met and so tended to define children as being 'in need' only if resources were available to meet that need (Colton *et al.* 1995b). Several commentators have argued that local authority discretion in this matter has led to the category 'children in need' being interpreted too narrowly and to insufficient resources being allocated to family support work (Gibbons 1991; Tunstill 1992; Colton *et al.* 1995; Tunstill 1996). The concern is that the targeting of family support at 'children in need' is likely to be sensitive to financial pressures and will therefore serve as a means of rationing services.

Underlying these debates are broader value positions. Government and local authority definitions of need tend to frame the concept in terms of individualised social and health related difficulties, whereas proponents of more comprehensive definitions of need and of greater provision of universal services are generally working with a concept of need framed in terms of social justice (Gardner and Manby 1993). The latter have argued that concepts of need should include attention to the impact of economic disadvantage on children and families as well as to health, development and disability, pointing to research evidence showing that poverty is a major factor associated with family stress and with the separation of children from their families (Packman and Randall 1986; Holman 1988; Bebbington and Miles 1989; Rowe *et al.* 1989). As the Short Report put it, 'children in care are the children of the poor' (House of Commons Social Services Committee 1984). Accordingly the Children Act 1989 has been criticised for not locating its discussion of need within a

wider social, political and economic analysis of the circumstances of children and families under stress (Parton 1997). The implications of the social justice model are that areas of high social need should have an infrastructure of enhanced universal services (Gardner and Manby 1993).

If the category of 'children in need' is narrowly defined, local authorities are unlikely to provide a wide range of universal, open-access services to ensure children's needs are met and to avoid stigmatisation. In these circumstances family support becomes a residual service targeted at those deemed to be in the greatest need. Yet needs are not attributes of individuals, waiting to be discovered by policy makers and professionals. Instead, policy makers bring to their construction of local definitions of 'children in need' concepts derived from the legal framework of the Children Act 1989 together with concern about the management of limited resources and hence the management of demand. These national and local political concerns are also articulated with an assessment of the specific needs of local children and with professional social work theories about child welfare, to produce definitions of children in need which underpin both service development and assessments of eligibility for family support services. In this way, definitions of need are socially constructed within politically negotiated boundaries (Smith 1980; Webb and Wistow 1987). In a context of limited resources it is likely that thresholds for service provision will be high and that definitions of children in sufficient need to meet those thresholds will be narrow. These issues of need, resources and demand management were very much in evidence in this study and will be discussed in the chapters which follow.

## Changing policy under the Labour government

Following the election of the Labour government in 1997 new policy initiatives took centre stage and the language changed, with a shift from debates about the relative merits of investigative or family support approaches to a focus on performance indicators to ensure quality in service delivery. The *Quality Protects* initiative abandoned the issue of refocusing in favour of setting specific targets for the support, protection and care of children (Department of Health 1998a). There is little direct attention to family support services in the *Quality Protects* framework, with

objectives relating to family support integrated within broader objectives on referral and the care of children. The initiative contains requirements for local authorities to identify children in need, assess different levels of need and produce a timely response, which has direct implications for access to family support services. It also requires authorities to ensure that children living with their families, as well as those who are looked after, are provided with safe and effective care for the duration of their childhood. The requirements pertinent to family support services are pitched at a greater level of generality than the far more precise targets set for services for children at risk of significant harm, looked after children and care leavers.

However, the *Assessment Framework* demonstrates a sharper emphasis on support to families and reiterates the central principle of the refocusing debate that safeguarding children should not be seen as a separate activity from promoting their welfare (Department of Health 2000a). It also emphasises the importance of a whole family, rather than child-focused, approach, reminding readers that Section 17 of the Children Act 1989 makes provision for services to be 'provided to any members of the family in order to assist a child in need' (Department of Health 2000a:). The ecological approach underpinning the *Assessment Framework* is also conducive to a broadly-based vision of family support work, with its emphasis on the need to focus not only on child development but also on work which aims to enhance parenting capacity and which takes account of the impact of environmental factors. These three dimensions of the *Assessment Framework* have since been incorporated into the *Integrated Children's System* in an attempt to underpin work with children both in and out of the care system with a common conceptual framework and develop a more coherent approach to ensuring good outcomes for children (Department of Health 2003b).

Other key policy developments have focused primarily on issues related to the care system, notably the Children (Leaving Care) Act (2000), the Adoption and Children Act (2002) and the *Choice Protects* initiative and, in the Children Act (2004), on child protection. Emerging, as it has, from the government's response to Lord Laming's inquiry into the failure of a number of agencies to prevent the murder of Victoria Climbie, the principal concern of the Children Act (2004) is on arrangements for the better protection of children. Although there is a nod to the value of universal

services to promote the physical and mental health, education and training, social and economic well-being and contribution to society made by all children, a framework informed by the recent work of the government's Children and Young Person's Unit, the emphasis throughout the Act is on organisational change to ensure the better protection of children. The question of family support is notable by its absence.

The Children Act (2004) provides the legislative basis for the wider programme of reform in children's services (including social care, health and education services) set out in the *Every Child Matters: Change for Children* programme and the *National Service Framework for Children's, Young People's and Maternity Services* (Department for Education and Skills 2004; Department for Education and Skills/Department of Health 2004). Much of the emphasis in the *Every Child Matters* programme, the *National Service Framework* and the Children Act (2004) is on organisational arrangements. Together they aim to promote the greater integration of services in order to meet clearly-specified service standards and achieve positive outcomes for children, for example through the development of the *Common Assessment Framework* and the development of local Children's Trusts arrangements for commissioning and delivering services.

The *National Service Framework* sets out a number of core standards, which should underpin all services for children. The first five of these might, in theory, contribute to improvements in family support services. They address issues of prevention through identifying needs at an early stage in their development and intervening early; offering age-appropriate services to children and young people that are child and family–centred; safeguarding and promoting the welfare of children and supporting parenting. The *Every Child Matters: Change for Children* programme sets out the five outcomes for children which represent the components of well-being for children and the purpose of co-operation between agencies. These are intended to serve as a basis for policy development and for agreeing local service priorities. A core aim of this programme is to secure a shift from intervention to prevention, but the focus appears to be primarily on child protection, offending and early years services, rather than on adolescents at risk of family breakdown. The forthcoming Green Paper on youth, to be published in 2005, will primarily address education, training, youth work

and leisure services for young people but it is possible that it may have a wider remit which would support the provision of social work services to young people and families in crisis.

These policy and legislative developments could provide a rationale for developing family support services for young people as well as for younger children, just as Section 17 of the Children Act (1989) did, but as always in the context of limited resources for public services, actual provision is likely to be determined by decisions about which areas of service should be prioritised. In the context of a quite proper concern with child protection evident in the Children Act (2004) and an equally important emphasis on improving services for children who are looked after, evident in the *Choice Protects* programme, it seems likely that services to prevent the breakdown of families with adolescents may remain the poor relation of children's services.

Since 1997 there has also been a shift in the thinking of policy-makers from the concept of children 'in need' towards the increasingly dominant concept of parenting. Policies on parenting have had a somewhat different focus in relation to families with younger or older children. As the question of parenting has moved up the policy agenda, there has at the same time been renewed attention to the perennial question of troublesome youth. The two are connected by political concerns over the link between perceived failures in parenting and anti-social behaviour by young people. The current political discourse on parenting has two strands: the need for support to parents and the need for parental accountability. When these political concerns are translated into policy, however, the strands begin to separate, with policies concerning *support* principally targeted at families with younger children and policies grounded in concerns about parental *accountability* principally directed at parents of older children and teenagers.

For example, Goldson has pointed to the conceptual shift over the last decade which has resulted in children in trouble increasingly being viewed, and treated, as 'offenders' first and 'children in need' second, if at all (Goldson 2000). Yet while older discourses of parental responsibility and of young people's threat to the moral

and social order have acquired a renewed emphasis, for example in the Crime and Disorder Act 1998, there is still relatively little parenting support available to families with teenagers (Brannen 1996).

Although group-based parenting programmes have become more widely available in recent years, most are targeted at parents of younger children. However, although there are few parenting programmes available to parents of teenagers who may want them, some parents may be *obliged* to attend such programmes under the terms of a Parenting Order (one of the provisions of the Crime and Disorder Act 1998) if their children are at risk of, or known to be engaged in, offending, in order to ensure more effective parental control over troublesome young people. Although these programmes are compulsory, many parents who attend have been anxious to receive help in managing difficult behaviour by their children (Ghate and Ramella 2002). Tellingly, perhaps, the only reference to parenting support in the Children Bill (2004) is in Section 48, which amends the Crime and Disorder Act 1998, allowing courts additional powers to make a (compulsory) parenting order where a child has failed to comply with the requirements of a child safety order under that Act. This power to make a parenting order replaces the power to make a care order in these circumstances and so represents an emphasis on parental, rather than state, responsibility for anti-social behaviour by children and young people.

Apart from this compulsory provision, there are few support services of any kind for teenagers and their parents. A study of services for children in need in seven local authorities commented on the dearth of age-relevant family support services and community facilities for children in middle childhood and adolescence, which meant that few received early intervention with emerging mental health or substance abuse problems (Tunstill and Aldgate 2000). Apart from telephone helplines such as Parentline, there are few open-access services to support parents of teenagers, although in setting up the Parenting Fund in 2003, which offers funding for voluntary and community organisations to provide parenting support, the Government has encouraged an expansion of services to those groups who currently have little access to such support, including the parents of adolescents (Department for Education and

Skills 2003b). It remains to be seen whether services will indeed develop to serve this group.

The residual nature of most family support services for teenagers and their families also results from the more wide-ranging restructuring of the welfare state since 1979, which has involved a greater centralisation of state control alongside a decentralization and dispersal of service provision (Clarke *et al.* 2000). In the field of social care for children, greater central control has been exercised in recent years not only through the Best Value requirements for all public services but, specifically, through the Quality Protects objectives mentioned above and the Performance Assessment Framework Indicators (Department of the Environment, Transport and the Regions, 1998; Department of Health 1998a; Department of Health 2002a). While tightening its central control on public services, the Government has at the same time dispersed the provision of secondary preventive services through promoting and supporting local private and voluntary sector partnerships in areas of high social need. A mixed economy of welfare had already been envisaged by the Children Act 1989 in its commitment to a corporate approach to service provision and this vision had been further developed by the Audit Commission some years later (Audit Commission 1994). In this development of a mixed economy of children's services, however, the scope of public sector services has been reduced. Although the Children Act 1989 set out a broad vision of the family support services to be commissioned or provided by social services, in practice there has been a retrenchment in statutory preventive services and an expansion of voluntary sector services (Walker 2002).

The encouragement of community partnerships to provide support services for parents and children forms part of a wider Government strategy to promote community development through supporting local partnership and regeneration. As such, these local networks of private and voluntary provision constitute a key strand in the Government's wider strategy to prevent child poverty and social exclusion. Its cross-cutting approach to social exclusion has resulted in a broad preventive strategy aimed at children at risk of abuse, neglect, school failure, disaffection and offending. In relation to family support other policy has become more important than the Children

Act 1989 and the role of social services in delivering family support has become more narrowly defined. While a plethora of area-based initiatives offer open-access support services to a broad group of children living in areas of high socio-economic deprivation, for those children in greatest need social services provide a narrowly-targeted residual service as their resources continue to be directed primarily at services for children at risk of harm or those in substitute care.

## Policy on support for families with teenagers

In its social exclusion policy the Government has chosen to focus on initiatives which provide services principally to families with younger children, such as Sure Start and the Children's Fund. Although the Connexions initiative is aimed at teenagers, it is qualitatively different from the other two initiatives, as its principal focus is on education and the prevention of school failure and disaffection rather than a broader concern with the welfare of children within their families. Thus the unprecedented expansion of voluntary sector services to support families during recent years has, for the most part, been evident in the development of services for families with younger children (Henricson *et al.* 2002). Families with troubled or troublesome adolescents, who turn to social services for support because there is little other support available, are therefore unlikely to be eligible for a service unless their children are considered to fall within a fairly narrow conceptualisation of children 'in need'.

There is perhaps an assumption that as a result of initiatives aimed at younger children, fewer problems will occur during adolescence. It is too soon to tell, however, whether the Sure Start and Children's Fund initiatives will indeed have a longer-term impact, but it is undoubtedly the case that some teenagers and their families will continue to need support. As they grow older children may continue to display emotional and behavioural problems or, alternatively, these may emerge during adolescence. In addition to the continuing impact of family problems, which may bring distress, separation or loss, with the onset of adolescence peer groups begin to exert a greater influence on behaviour, and this may be a negative influence for some young people (Rutter *et al.* 1998). There is also an increased risk of involvement in drug and alcohol abuse, offending and running away (Graham and Bowling, 1995).

Mental health problems, which are uncommon among younger children, are more likely to emerge during adolescence (Coleman and Hendry 1999; Meltzer *et al.* 2001). Running away and the problem of youth homelessness are also indicators of family problems for young people, as they are often associated with abuse, neglect and unresolved conflicts between teenagers and their parents (Biehal and Wade 2000; Pleace and Quilgars 1999; Safe on the Streets Research Team 1999). Furthermore, the research evidence suggests that the need for support to families with teenagers may have grown, since over the past 50 years there has been a rise, in real terms, in the prevalence of psychosocial disorders among young people (Rutter and Smith 1995). Rutter and Smith's comprehensive review of the research shows that increasing numbers of young people have conduct disorders, eating disorders, depression, suicidal behaviours or misuse drugs and alcohol.

Despite this research evidence, the Government's broader preventive strategy appears to have paid little attention to early intervention with older children and teenagers in difficulty. There is therefore a gap in provision, with young people and families receiving little help before they reach crisis point and become eligible for help from social services. It is the services that social services departments provide at this point which are the subject of this study.

# 3 Background to the study

The young people in this study displayed a variety of behavioural and emotional problems which were often quite severe. Accordingly, this chapter first considers evidence from studies in developmental psychology on risk and protective factors for emotional and behavioural difficulties in children. Second, the services described in this study all had the aim of preventing placement, so the British research evidence on preventive social work with teenagers is outlined. Third, preventive services of this kind are located within a wider range of family support services in this country. The body of research on family support is therefore also of relevance to this study and is briefly reviewed. Fourth, many of the debates about family preservation services in the USA have much in common with issues raised in this study and have been helpful in shaping its design. These too are reviewed, with particular attention to the small number of evaluations of family preservation services for older children and adolescents. Finally, there is a brief discussion of a number of psychological interventions with teenagers that have been developed in the USA. The review of studies below focuses principally on delineating research findings on the outcomes for children associated with different interventions.

## Risk and protective factors

Research in the field of developmental psychology has been highly influential in its identification of the stresses associated with the development of emotional and behavioural problems in children. A number of longitudinal studies investigating the developmental outcomes of children have, despite their frequent preoccupation with juvenile delinquency, provided more widely–relevant evidence on the correlates of social and emotional difficulties in children and young people. The key studies in the UK have been the National Child Development Study, the Newcastle study and the Cambridge study, all of which followed up cohorts of children into adulthood (Fogelman 1983; Kolvin 1990; West and Farrington 1973). Cumulative evidence from these studies has indicated that risk and protective factors for developmental problems may be located in the individual child, the family, the school and the local

neighbourhood. Studies of this kind in the UK and elsewhere have informed the ecological model of child development, which suggests that outcomes for children are influenced by the interaction between factors in the individual child, the family context, the child's peer group, the school and the wider community. Individuals are nested in this set of inter-connected domains, so that any difficulties they experience are likely to be due to the interaction of multiple factors (Bronfenbrenner 1979).

In each of these domains both risk and protective factors for children's well-being may be identified. Both Buchanan and Little and Mount have helpfully summarised the key risk and protective factors identified by a range of longitudinal studies (Buchanan 1999; Little and Mount 1999). Risk factors in the individual child include temperament, impulsiveness, physical illness, physical or learning disabilities and genetic factors. Good health and development, a continuous engagement with school, high IQ and a resilient temperament, manifest in a positive outlook on life, have all been identified as protective.

There has been much debate about the impact of genetic factors on developmental outcomes but it is now widely thought that, although genetic factors may have moderate effects on both internalising and externalising behaviour, environmental factors create the conditions whereby these effects either do or do not become manifest (Rutter *et al.* 1998; Buchanan 1999). The implications of this are positive, since it may be possible to intervene in a child's environment to prevent the emergence of problems or to assist recovery from difficulties which have emerged.

The principal risk factors for emotional and behavioural problems located in the domain of the family are family adversity, mental illness, alcoholism and criminality in parents, marital conflict, weak and inconsistent discipline or harsh and erratic discipline. A lack of domestic tensions, good relationships with parents, support from grandparents and family involvement in activities have all been identified as protective for children. At the level of the school and the neighbourhood, bullying at school, schools with low rates of achievement and disadvantaged communities with high levels of crime appear to be risk factors (Buchanan 1999). Furthermore, as mentioned earlier, peer groups become increasingly influential during adolescence, so

peer group affiliation may have either positive or negative effects depending on the nature of the peer group (Rutter *et al.*1998).

It is important to bear in mind that the influence of risk and protective factors on the child is not always one way, as qualities in the child, such as their temperament or behaviour, may have an impact on parenting style as well as *vice versa*. Also, risk factors do not usually operate singly. Instead, it is the cumulative interaction between them that can produce the most harmful effects (Rutter 1979). Little and colleagues highlight the importance of both mediator and moderator variables (Little *et al.* 2004). Mediator variables transform the risk factor in such a way as to lead to a particular outcome. For example, poverty may be a risk factor for anti-social behaviour but only insofar as it operates as an indirect, or distal, process through making parenting more difficult. On the other hand, moderator variables may change the strength or direction of risk factors. For example, a pro-social peer group or a supportive environment at school may moderate the negative effects of poor parenting on children's behaviour, while anti-social peers and school failure may intensify these effects. However, other factors may be protective. Variables such as intelligence, good problem-solving skills, a supportive school environment, consistency in parenting or pro-social peers may moderate the potentially harmful effects of accumulated risk factors (Rutter *et al,* 1998).

In recent years, an appreciation of risk and protective factors has begun to inform approaches to child welfare. The concept of resilience is important here, defined as the capacity of children to develop positively despite experiencing adversity (Rutter 1987). Resilience should not be seen as a trait since it involves environmental factors as well as qualities such as temperament or IQ which are intrinsic to the child (Little *et al*. 2004). Accordingly, there is scope for professional intervention in children's social environments to enhance children's strengths and supports and promote their resilience. There has been increasing recognition of the importance of promoting resilience in children, through attempting to reduce the number of risk factors and increase compensatory protective factors (Flynn *et.al.* 2004; Gilligan 2001; Newman and Blackburn 2002; Sinclair and Burton 1998). Either explicitly or implicitly, an understanding of risk and protective factors has informed a number of the

interventions discussed below, particularly those in the USA that are explicitly based on ecological approaches, as well as some of the work undertaken by support workers and social workers in this study.

## Preventive work with older children and adolescents in the UK

Since the 1980s a variety of researchers have questioned the necessity of 'looking after' so many children and have called for improved preventive services. In the mid-1980s a series of studies funded by the DHSS and the ESRC highlighted the lack of emphasis on services to prevent admission. *Who Needs Care?* found few sharply identifiable differences between those who were admitted to care and those who were not, although those admitted tended to have somewhat more severe relationship and behaviour problems, or problems in their parents' behaviour were more extreme (Packman *et al.* 1986). Admission to care was frequently unplanned and traumatic, with care often used as a last resort rather than as a planned service to support families in difficulty. 'Prevention' was often little more than the refusal to admit a child, which was experienced as neglectful and unhelpful by families. *In and Out of Care* reported that preventive services were rarely offered unless families were in crisis, so that families had to plead desperation or imminent abuse in order to receive a service (Fisher *et al.* 1986). *In care: a study of social work decision-making* similarly found that social workers admitted children to care with great reluctance and often only after sustained pressure from families or other agencies (Vernon and Fruin 1985). An overview of these and other contemporary studies commented that, while none of them were specifically concerned with prevention, their findings directly or indirectly highlighted the importance of preventive services (Department of Health and Social Security1985b).

Other studies conducted at around the same time considered the consequences of admission to care and raised questions about the value of admission. *Trials and Tribulations*, a study of young people returned 'home on trial' to their families after a period in substitute care, found that removal had done little to change their troublesome behaviour and that any changes were not sustained once they returned home, so admission to care had brought few lasting changes. Paradoxically,

behaviour that had originally led to admission to substitute care was not considered sufficient grounds for removing children a second time. Admission to care of troublesome young people had achieved little more than to exacerbate the disruption in their lives (Farmer and Parker 1991). Furthermore, research on young people leaving care at the age of 16 and over highlighted the poor outcomes for care leavers (Stein and Carey 1986). The cumulative findings from these studies of the care system, several of them government-funded, undoubtedly contributed to strengthening the emphasis on family support in the Children Act 1989.

Since the Children Act 1989 there have been few studies which have focused specifically on support services to prevent the placement of older children and teenagers. However, in the mid-1990s three studies of social work with teenagers were funded by the Department of Health and later summarised in a useful overview report, two of which are pertinent to the concerns of this chapter (Biehal, Clayden, Stein and Wade, 1995; Department of Health 1996; Sinclair *et al.* 1995; Triseliotis *et al.*1995). There have also been a few modest evaluations of specialist teams working to prevent the accommodation of young people.

*Teenagers and the Social Work Services* (Triseliotis *et al.* 1995) was a follow-up study of 116 young people aged 13-17 years referred to social work services in Scotland. Just over half of the sample had just been admitted to care at start of study, so this was a rather mixed group. *Social Work and Assessment with Adolescents* was a critical case study of a specialist adolescent assessment service in one London local authority (Sinclair *et al.* 1995). The 75 young people in this study had all experienced a 'transitional event' namely, consideration of admission to care, admission to care or placement breakdown, so again the focus was wider than simply the prevention of placement. Both studies followed up the young people one year later. Only the London study included a comparison group of young people (who received a 'routine' service from area social workers) but in this study outcomes were assessed solely by social workers. Although the Scottish study had no comparison group, outcomes were assessed one year later by means of interviews with young people and parents as well as social workers and, unlike the London study, standardised measures of behaviour and self-esteem were used.

It is difficult to draw firm conclusions about the effectiveness of different interventions from these studies since neither was designed with the evaluation of effectiveness as its principal aim. However, both are valuable since they consider social work with teenagers in considerable depth and provide many useful insights into the objectives and the process of social work with teenagers at risk of entry to long-term care.

These studies found that preventive work with teenagers was afforded only low priority by social work teams. The service these teenagers received was variable and inconsistent, and it was often difficult for families to get help at an early stage, before a major crisis occurred, by which time it was often too late for social workers to deploy preventive strategies which might avert admission. One of these studies noted that part of the problem was the misapprehension that 'children in need' were non-statutory cases (Sinclair *et al.* 1995). Due to the lack of consistent work prior to admission, this study found that most admissions of adolescents to substitute care or accommodation were emergency admissions and took place shortly after referral. Those teenagers offered preventive work by mainstream services were likely to be dealt with by less experienced staff with less knowledge of community resources and less experience of working with families in ways which are appropriate to teenagers (Sinclair *et al.* 1995; Triseliotis *et al.* 1995).

There have been only five UK studies of specialist support teams working with teenagers to prevent family breakdown, similar to those in this study, and most of these have been small-scale qualitative studies of single teams. The earliest was an evaluation of the MARS project, a preventive social work team managed by the charity Barnardos. This study attempted to develop a methodology for evaluating preventive work based on the intensive analysis of twelve cases (Fuller 1989). Few details of the intervention were provided, other than that the team worked intensively with children age ten and over who were at imminent risk of a breakdown in their living or schooling arrangements. The interventions had multiple objectives and the team's staff were asked to rate their success in meeting these. However, the author acknowledged that the lack of any independent assessment of outcomes plus the lack

of a control group made it difficult to set much store by the finding that the team were effective in 75% of cases.

Shortly afterwards, a more broadly based study of the closure of children's homes in the English county of Warwickshire included some discussion of specialist teams set up to offer direct work to (mainly) older children to prevent admission to care (Cliffe with Berridge 1991). Again, the principal focus of the discussion of this service was on process rather than effectiveness, so it is difficult to draw clear conclusions about outcomes.

Towards the end of the 1990s two further small-scale studies of specialist support teams were published. Frost's study of a specialist family support team in the North of England working predominantly with older children and teenagers considered at risk of placement gathered some descriptive data on 327 families and then examined a sub-sample of 30 cases (Frost 1997). Another small evaluation, with a sample of sixteen cases, examined the Adolescent Community Support Team in Stockport. This provided outreach support for children aged 11-15 years and their parents in order to prevent family breakdown (Brodie *at al.* 1998). The team was based in a small residential unit, which also offered emergency and planned respite care. Again, this was a modest study with a single group design, whose strength lies in its qualitative analysis of process.

In an earlier exploratory study I monitored preventive work undertaken by an adolescent support team with 56 young people and also undertook an intensive study of twenty cases (Biehal *et al.*2000). The focus of this evaluation was on how, why and in what circumstances positive change in child and family functioning occurred rather than on effectiveness in preventing placement. It found that positive change was less likely to occur in families with chronic and severe difficulties and that the adolescent support team was more successful in its work with families where difficulties were of more recent onset. These three studies concluded that the specialist teams were helpful in supporting young people at home and so preventing placement, but again the lack of a comparison group meant that it was unclear what

proportion of these young people might actually have been placed in the absence of this service.

## Studies of family support and family preservation

Although not specifically concerned with older children and teenagers, the UK literature on family support and the North American literature on family preservation services is concerned with the description and evaluation of services to support families and prevent family breakdown and so is pertinent to this study.

### *Studies of family support services in the UK*

The UK research on family support has principally been concerned with the description of different types of services and few studies have attempted to evaluate outcomes for children. Although a number of such studies have been published since the late 1980s, the literature on family support has paid little attention to social work with older children and adolescents, reflecting the paucity of family support services for this age group identified the last chapter.

In the UK, research on family support has tended to take two forms: studies of individual family support organisations (for example, Frost *et al.* 1996 and McAuley 1999 on *Home-Start;* Oakley *et al.* 1995 on *Newpin*) or studies describing particular types of provision (for example, Aldgate and Bradley 1999 on respite care; Oakley *et al.* 1990 on home visiting; Sloper 1999 on services for disabled children and Statham *et al.* 2000 on day care). The descriptive nature of most UK studies of family support is understandable, since these are often formative evaluations of relatively new services. Also, evaluating the impact of *preventive* services is particularly difficult. As Parker acknowledged over twenty years ago, it is hard to show that something has *not* happened as the direct result of an intervention (Parker 1980).

For example, Gibbons and her colleagues pointed to the difficulty of demonstrating the impact of neighbourhood family centres on the prevention of specific problems (Gibbons *et al.* 1990). They found that problems showed greater improvement among the families using family centres compared to those who were not, but found no association between these improvements and the provision of family centre services.

They attributed the improvements to the use of day care and the development of better informal support networks. A later review of family support services found little evidence for the effectiveness of open-access family support centres, but this may in part be due to the fact that few of these studies directly addressed the question of the impact of such services (Statham 2000). Gibbons and Sinclair and their colleagues also questioned whether primary preventive services, such as open-access family centres, succeed in promoting the introduction of families with more severe problems to secondary or tertiary preventive services (Gibbons *et al.* 1990; Sinclair *et al.* 1997). Research reviews in both the UK and the USA have, however, found some evidence to support the case for providing intensive, targeted support within a framework of universal provision (Danziger and Waldfogel 2000; Statham 2003).

Another strand of research in this area has focused on parenting education and support. Parenting programmes are either behavioural in their approach, drawing on social learning theory, or are relationship-focused and draw on a variety of theories for example, humanistic, psychodynamic, Adlerian and family systems theory (Barlow 1999). There is evidence that for younger children, behaviourally-based training programmes can improve children's behaviour and that positive effects can persist over time, whereas programmes which emphasise relationships and communication have been found to have less impact on child behaviour (Statham 2000). Barlow and Parsons' systematic review of parenting programmes found evidence of their effectiveness, particularly when programmes were group-based and helped parents develop strategies for positive reinforcement of desirable behaviour in their children, but the programmes reviewed were all designed for families with very young children (Barlow and Parsons 2002). Although most such studies have been conducted in the USA, a recent experimental study of the SPOKES project in London, a school-based programme for five to eight year olds with behavioural difficulties which combined a parenting course with support for child literacy, found strong evidence of effectiveness (Scott and Sylva 2002, cited in Statham 2003).

Some reviewers have concluded that parenting programmes are more effective with younger children, for example Scott suggests that they are most effective in families with children age 10 years or under (Henricson and Roker 2000; Scott 1998). One

study of a group-based parenting programme for parents of adolescents, in this case young offenders, found a reduction in reconviction rates at one year follow-up but, without a comparison group, it was unable to assess how far outcomes could be attributed to the programme (Ghate and Ramella 2002). The authors considered that the parenting programme may have contributed to these outcomes but that it was unlikely to have been solely responsible for them, since it was targeted only at parents while other professionals worked with the young people. They concluded that brief parenting programmes are unlikely to offer a 'quick fix' for entrenched antisocial behaviour by young people.

A common theme in the family support literature has been the link between family stress and social disadvantage. For example, both Gibbons and Gardner have argued that for families who come to social services, interpersonal and health problems are combined with stresses arising from socio-economic problems (Gardner1992; Gibbons 1991). Initiatives offering early education and day care services aim to improve the life chances of children from disadvantaged families. It is too early to assess the impact of the Sure Start initiative in this respect, but evidence of the long-term impact of the similar Headstart initiative in the USA suggests that, while early intervention of this kind with families and children in areas of high social need can bring real improvements to children's lives, they cannot overcome the impact of poverty on children's development (Statham 2003).

Another theme has been the importance of an inclusive, empowering approach. Services working in partnership with parents, using a strengths-based approach and including a social support component, have been found to be more effective than services that do not have these characteristics (Aldgate and Bradley 1999; Cleaver 2000). Attention to the *process* of helping has been found to be an important element of successful family support services such as parenting programmes (Statham 2003). However, one study of family support services commented that workers often considered empowerment as an end in itself and focused on this exclusively instead of tackling the substantive issues that were troubling families (Macdonald and Williamson 2002). This focus on process is evident in many UK studies of family support. Studies of family centres, for example, have paid less attention to their

impact on outcomes for children and have instead assessed them principally in terms of their popularity with parents (Holman 1988; Smith 1996). Holman, for example, used family centres' ability to engage hard to reach families as a measure of their success. He concluded that that successful family centres were characterised by open door policies, the involvement of users in running the centres and an informal atmosphere, and aimed to draw out families' strengths rather than label them as problems (Holman 1988).

There is also some evidence that an integrated approach offering both child-focused and parent-focused interventions may help to improve outcomes for children. The SPOKES project cited above is one example of an integrated approach of this kind. Another is the Matrix project targeted at vulnerable 8-11 year olds, which adopted a whole family approach and co-ordinated services from a range of agencies. This study reported improved parenting skills and some improvement in children's behaviour, but these promising findings must be treated with some caution as the sample was small (17) and there was no comparison group (McIvor and Moodie 2002). Cox's review of home visiting services argues that in successful projects practitioners visit often enough to develop an alliance with families and that these projects are based on an ecological framework which takes factors in multiple areas of children's lives into account (Cox 1997).

Few studies have evaluated the impact of social worker support on outcomes for children. A review of studies of social work effectiveness has found that there is a dearth of empirical data about this area of social work activity (Macdonald 1999). One of the problems in evaluating the impact of social worker support to children is the difficulty of separating the personal qualities of social workers from the activities they undertake, since the relationships they develop with children and parents are intrinsic to much of what they do (Statham 2000).

Three recent British studies of mainstream family support services, delivered principally by social workers, are particularly relevant to this study. All three had single group designs and assessed outcomes for children and parents either at six month follow-up (Carpenter and Dutton 2003; Tunstill and Aldgate 2000) or when the

case was closed (Macdonald and Williamson 2002). Both Tunstill and Aldgate and Macdonald and Williamson examined Social Services support for children in need. The former had a sample of 93 families with children aged 0-16 years while the latter examined computer records on 249 children, the case records of 152 children and interviewed 72 families. Carpenter and Dutton's study evaluated therapeutic family support services provided either by Social Services or the voluntary sector to 79 'high risk' families with children in need aged 12 years and under.

All three studies reported that the principal problems at referral were emotional and behavioural problems in the children, stress and low self-esteem in the carers, difficulties in parenting and family relationships and domestic violence. Tunstill and Aldgate observed that behavioural problems were often the result of emotional disturbance and inadequate parenting and were both a cause and effect of family stress. Past events such as domestic violence had a continuing resonance within families and there was a clear association between children's behavioural problems and parents' emotional problems.

These studies all found that the service provided was much appreciated by both parents and children. Around three quarters of the parents in Tunstill and Aldgate's study felt that social work support had relieved family stress and helped with child development and 41% felt it had brought about an improvement in family relationships. MacDonald and Williamson conducted follow-up interviews with 30 families, of whom 42% felt that their circumstances had improved to some extent, although only 25% attributed this improvement to the social work intervention.

Carpenter and Dutton used a number of standardised measures to assess outcomes and found some improvement in children's pro-social behaviour and peer relationships but no overall change in emotional symptoms and behaviour problems. They also found little change on measures of family functioning, although a more supportive informal support network for carers was associated with improvement in pro-social behaviour for children. The strongest predictor of all outcomes was the severity of difficulties at referral but, once this was adjusted for, the study also found that older children were less likely to show improvement in their behaviour at six month follow-up. When the

three studies are considered together, evidence of the effectiveness of family support services is therefore somewhat mixed, although families clearly appreciate the process of receiving these services. Differences in methods used by each of the studies to assess the impact of services makes it difficult to draw together their findings and arrive at firm conclusions about the impact that mainstream family support services have on children.

Although the majority of UK studies do not offer robust evaluations of services, the recurrence of similar messages gives some weight to their cumulative findings (Statham 2003). Many studies have drawn attention to the impact of child poverty, the importance of informal support networks, the value of an empowering, strengths-based approach, the need for integrated whole family interventions and the importance of a co-ordinated inter-agency response. Yet, while the above studies of family support carry individual implications they do not amount to a coherent set of research findings (Tunstill 1996). Part of the problem in drawing firm conclusions from this body of literature may lie in the diffuse nature of the family support services themselves, which range from voluntary sector community-based interventions and self-help initiatives to specialist therapeutic interventions. Such a wide, inclusive definition may result in family support, as a concept, losing any useful meaning (Katz and Pinkerton 2003).

A further limit to the usefulness of this literature in informing the current study is that the majority of the family support interventions discussed have been aimed at younger children. This is the reason why many of these studies have examined services targeted principally at parents, which aim to improve parenting skills and parent-child relationships with a view to improving outcomes for children. In work with older children and adolescents, however, there is a need to balance attention to the needs and wishes of parents with attention to those of children, whose views may conflict with those of their parents.

### *Family preservation services in North America*

In the United States, family preservation services (FPS) originated in the 1950s and have been extensively developed since the 1980s. The defining characteristics of FPS

are that they are family-centred and delivered in the home. They focus on family strengths and empowerment, are community- oriented and use a case management approach to co-ordinate services (Schuerman *et al.* 1994). Intensive family preservation services (IFPS) offer, as might be expected, a more intensive and short-term service. IFPS originated in the development of the *Homebuilders* model by two psychologists in Washington State in 1974, in order to prevent the placement of emotionally troubled children (Kinney *et al.* 1977). Many basic components of IFPS have been adopted from crisis intervention theory, including a response within 24 hours and time-limited services (Staudt and Drake 2002). Insofar as they provide short-term, intensive services which are crisis-oriented and targeted at children thought to be at imminent risk of placement, IFPS are in some respects similar to the specialist support teams in this study.

However, unlike these support teams, the majority of IFPS have focused on preventive work with younger children and they are also far better resourced, since social workers typically have caseloads of only two to four families. They also offer a more intensive service than British support teams. For example the *Homebuilders* model, which draws on crisis-intervention and social learning theories, provides an average of twenty hours input into families each week, with staff available 24 hours a day, seven days a week for four to six weeks (Fraser *et al.* 1991). The *Family First* model, which draws on systems theory and an ecological approach, offers a similarly intensive service but over a period of three months (Schuerman *et al.* 1994).

The ascendance of family preservation as an approach in the later 1980s was the product of similar shifts in policy to those in the UK in the post-war years, that is, between a concern with supporting families to care for their children and an emphasis on child rescue/protection (Lindsey 1994; Berry 1997). During the 1980s this tension between family-strengthening and child-saving was resolved in favour of an emphasis on maintaining the integrity of families, a policy development influenced not only by politically popular notions of 'family values' and by concern about the cost of rising numbers of children in care but also by a backlash by child welfare professionals against the concentration on child protection and the lack of support to families (Lindsey *et al.* 2002). Service development was influenced by the permanency

planning movement and also by a number of theoretical approaches notably ecological theories, social learning theory, family systems theory and brief-treatment models (Bronfenbrenner 1979; Maluccio and Fein, 1983; Minuchin, 1974; Reid and Epstein 1972).

Many studies of these services have been undertaken, but the evidence on their effectiveness in placement prevention is mixed. Numerous studies have found no evidence that IFPS were more effective than mainstream services in preventing the placement of children. For example, a meta-analysis of 27 studies of IFPS found that children receiving IFPS were placed almost as often as those in the control groups (Dagenais *et al.* 2004). Another review included 36 studies and found that, of the only four studies identified which used randomised experimental designs, three reported that placement rates were slightly higher for those using IFPS than for those receiving routine social work services (Meezan and McCroskey 1996; Schuerman *et al.,* 1994; Yuan *et al.* 1990; reviewed in Lindsey *et al.* 2002). The findings of the fourth study indicated a positive effect but the credence that can be given to these findings is questionable due to a number of design problems which are discussed below (Feldman 1991). Lindsey and colleagues concluded that the only studies which claimed that IFPS were effective in placement prevention were those which used single group designs and were purely descriptive in nature. Even where IFPS were apparently effective, the available evidence suggests that any positive effects dissipated over time. They surmised that this failure in meeting the goal of placement prevention was due to a combination of factors including a reliance on casework intervention which, they argue, has repeatedly been shown to be ineffective in producing positive outcomes; an approach that implies that 'one size fits all' interventions can be effective with all families; a limited intervention period and a failure to address the severe problem of poverty.

Despite the lack of conclusive evidence on effectiveness in placement prevention, evaluators have not come to the conclusion that these services are perhaps ineffective in meeting their expressed objectives. Instead, they have suggested that because of difficulties in identifying who may be at imminent risk of placement, services have not been properly targeted at those most in need. If risk of placement is low for all

groups in these studies, then placement rates are unlikely to be significantly lower for children receiving IFPS. The logic of this argument is that it is meaningless to seek to prevent an event that was unlikely to happen anyway.

There has also been much debate as to the validity of placement prevention as a measure of effectiveness, as this may indicate system-based changes as well as, or indeed instead of, family-based changes. The adequacy of the concept of 'imminence of risk of placement' has also been questioned as it begs a number of questions. How soon is imminent? How can risk of placement be predicted? What constitutes a placement? Is placement always undesirable? These questions have been addressed in different ways by different studies, so that some, for example, include kinship care or short-term placements under the rubric of out of home placement while others do not. For example, Fraser and colleagues have argued that placement taken out of context is a poor indicator of the effects of IFPS since placement may or may not reflect changes in child and family functioning (Fraser *et al.* 1997). In some cases planned short term placements may reflect understanding of a family's need for respite and support.

These problems led some later studies to turn their attention to other outcomes. There is some evidence that IFPS may bring improvement in some aspects of child functioning (Meezan and McCroskey 1993; Pecora *et al.*1991; Schuerman *et al.* 1994). Modest improvements in family functioning have also been found by some studies (Pecora *et al.* 1991; Schuerman *et al.* 1994) but not by others (Feldman 1991; Meezan and McCroskey 1993). However, these improvements were usually short-lived. From the limited evidence available on outcomes other than placement, it appears that IFPS may produce modest changes in child and family functioning but that these effects rapidly disappear.

There has also been some attention to the impact of IFPS on different groups. For example, Szykula and Fleischman (1985) found that family preservation services were moderately effective where the presenting problem was child conduct, but this did not hold true for multi-problem families– a serious drawback, since the majority of families who meet thresholds for receiving services tend to have multiple problems. They also found that IFPS were ineffective with families where problems were

chronic and severe. Some studies have reported that older children referred for oppositional behaviour were more likely to be placed (Bath *et al.* 1992; Fraser *et al.* 1991). Others have indicated that children referred for reasons of neglect are more likely to be placed than those referred due to physical abuse (Bath and Haapala 1993; Yuan and Struckman-Johnson 1991). The review of 27 studies of IFPS mentioned earlier found that three programmes targeted at young people referred for oppositional behaviour or delinquency were more effective at preventing placement (Dagenais *et al.* 2004, referring to Henggeler et al 1992; Pecora et al 1991: Schwartz et al 1991)[3]. However, a more recent analysis of data on 6,522 families in the Illinois randomised experimental study of *Family First* has indicated that case characteristics accounted for less than 8% of the variance in outcomes and that the same was true for service characteristics (Littell and Schuerman 2002). The evidence on the effectiveness of IFPS therefore remains inconclusive.

### *Family preservation services for adolescents*

Just as there have been few studies of family support services for adolescents in the UK, in the USA there have been relatively few studies of family preservation services for this age group. Most of these studies have focused either on projects based on the *Homebuilders* model or on interventions with specific populations, either young people with severe emotional and behavioural problems or young offenders. Indeed, the *Homebuilders* model was initially developed for work with emotionally disturbed, angry adolescents before being more widely applied.

Evaluations of IFPS using the Homebuilders model with older children and teenagers have assessed the impact of these services on young people with a variety of difficulties who were, in many respects, similar to the young people in this study. Feldman's study of the Homebuilders model used with 117 young people aged 12-17 years and at risk of first time placement included those referred for a wide range of reasons including emotional and behavioural problems, abuse, neglect and substance abuse (Feldman 1991). The majority (71%) of the 678 young people in Haapala and Kinney's sample were aged 13-17 years and were referred for behaviour problems,

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[3] These three studies are discussed later in this chapter.

family conflict, school-related problems, parenting problems , physical violence, running away and substance abuse (Haapala and Kinney 1988). Pecora and colleagues studied outcomes of the FIT project, a Homebuilders service in Washington state and in Utah. The children in their sample of 446 families, referred to the project because their children were considered to be at risk of placement, were similar to those in the other two studies in terms of their reasons for referral but were somewhat younger, with the majority either pre-adolescent or in early adolescence (Pecora *et al.* 1991).

Although these studies produced some interesting results, the value of these findings is compromised by methodological flaws in all of them. Feldman and colleagues' randomized control trial found that initial differences in placement rates between the experimental and control group had dissipated after one year, so the programme appeared to be more successful in delaying placement than preventing it. Furthermore, the study's findings are undermined by problems in sampling, since 33 families were excluded from the experimental group because the children entered care or the family refused to participate. Within this group of young people who were 'turned back', almost twice as many had previous placements, which are known to be a powerful predictor of further placement, so selection bias is likely to have had an impact on the observed differences in placement rates (Fraser *et al.* 1997). Both groups improved on standardized measures of child and family functioning but there were few significant differences between them. Haapalá and Kinney's study found that 87% of the sample avoided placement, but since there was no control group it is difficult to know how far they had been at risk of placement at the outset. Pecora and colleagues' study concluded that the intervention was effective in changing behaviours. In Utah, more than twice as many children in the comparison group were placed. However, kinship care placements were not included in the figures for those placed in substitute care and the sample was largely composed of a specific population - Mormons, which limits the generalisability of these findings. Furthermore, this study is compromised by the fact the comparison group included only 26 families (who were compared to an experimental group of 446), and one third of these had been lost by follow-up.

The Hennepin County study evaluated an IFPS intervention with seriously emotionally disturbed adolescents (age 12-17 years) which used a structural family therapy model (Schwartz *et al.* 1991). A group of 58 young people using the specialist service delivered by specially trained social workers were compared to a case overflow sample of the same size. Both groups had multiple and serious behavioural, family, school, health and substance abuse problems. Interestingly, only 28% of the young people had a negative attitude to placement. The comparison group were significantly less likely to be placed and the difference in placement rates between the two groups was very large, with 91% of the control group placed compared to 56% of the experimental group, possibly because the comparison group received no service at all rather than an alternative service. However, the fact that over half of the experimental group was nevertheless placed in substitute care led Fraser and colleagues to comment that this model may not be appropriate for many emotionally-disturbed young people (Fraser *et al.* 1997). It might equally be true that placement may have been the optimal outcome for some of these young people.

Many of the family preservation services developed in the USA that have been more directly aimed at teenagers have been targeted at specific subgroups, such as young offenders or young people with serious mental health problems. For example Wraparound services (sometimes referred to as individualized services), are principally aimed at young people with serious emotional and behavioural problems. The best known wraparound services are Project Wraparound, in Vermont, and the Alaska Youth Initiative (Burchard and Clarke 1990; Van Den Berg 1993). Both serve children under eighteen years old with severe emotional and behavioural problems who are at high risk of residential placement.

These services have been designed to offer greater flexibility in responding to young people's needs and represent an attempt to address problems of poor inter-agency co-ordination. Wraparound services are grounded in an ecological approach to service provision, arguing that adolescent behaviour must be understood in terms of the social contexts in which it occurs: the family, the peer group, the school and the neighbourhood (Scholte 1992). Inter-disciplinary services offer an individualized response to young people's needs in each of these areas, with a view to preventing

placement through 'wrapping' tailored services around a child and family (Burchard and Clarke 1990). The emphasis is on the social context in which young people's behaviour occurs, not solely on the behaviour itself.

One study has found that children receiving wraparound services improved over a one-year period on parent-rated measures of behavioural adjustment, but failed to improve over two years on teacher-rated measures of behaviour (Clarke *et al.*, 1992, cited in Bates *et al.*). However, this study used a very small sample and had no comparison group, so its value is limited. Overall, there has been little published evaluation of wraparound services and the studies that exist have been criticised as lacking in methodological rigour, so it is difficult to judge the effectiveness of this potentially promising service approach (Bates *et al.* 1997).

There is no compelling evidence that the key features of IFPS, such as brevity and intensity of services, are necessarily associated with positive outcomes for families. It is also unclear which aspects of services are associated with positive outcomes for particular sub-groups. To sum up, evidence on the effectiveness of these intensive family support services remains inconclusive. However, although few IFPS have been specifically targeted at adolescents, one review of the research evidence in the United States concluded that they may be moderately effective with older children and those in early adolescence, where child behaviour is identified as a major problem (Fraser *et al.* 1997). The authors suggest that the apparently greater effectiveness of these programmes with older children may in part be due to differences in reasons for referral since neglect, often a feature in referrals of younger children, appears particularly intractable. It may be that behaviour problems in adolescents, often a core reason for referral for this age group, may be more likely to respond to this type of service than abusive or neglectful behaviour by parents.

## Psychological interventions with young people

There is also a substantial body of North American research on psychological interventions with adolescents with serious behaviour problems. Many studies identified have focused on interventions with children and adolescents who have a

clinical diagnosis of conduct disorder. The characteristics of the young people in this study and their difficulties at referral, described in Chapters 7 and 8 below, reveal that the majority had quite serious behaviour problems. Although none were known to have clinical diagnoses of conduct disorder, a consideration of effective strategies for working with children with serious conduct problems is nevertheless clearly relevant to this study.

However, most of the studies identified have focused predominantly on persistent young offenders. A systematic review of family and parenting interventions with 10-17 year olds with conduct disorder or delinquency assessed the findings of the eight randomised control trials which met the review's stringent inclusion criteria (Woolfenden *et al.* 2003). In seven of these studies the participants were young offenders and only one study was concerned with children/adolescents with conduct disorder who had not had contact with the juvenile justice system. The young people in these studies are, for the most part, likely to have more severe behaviour problems than those of the young people in this study, of whom a relatively small proportion had come into contact with the juvenile justice system. The principal psychological interventions that have been evaluated are multi-systemic therapy, cognitive behavioural therapy, behavioural parent training and functional family therapy.

*Multi-systemic therapy* (MST) draws on family systems theory, considering that child behaviour problems typically reflect dysfunctional family relations. However, it differs from standard family systems therapy in that it is also explicitly grounded in a social-ecological model of development. MST intervenes directly in all systems in which young people are located, for example in parental discipline, family relationships, the school and peer systems (Borduin 1999).

Henggeler and colleagues studied of a group of 84 seriously emotionally disturbed young people who were serious offenders and were at imminent risk of out of home placement (Henggeler *et al.* 1992). The mean age of the young people was 15 years and all came from families with multiple problems. A pre-test post-test design with random assignment was used to compare the effectiveness of MST with 'usual services'. The MST group received interventions which included cognitive-

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period of six months or more (Joughin 2003). Joughin's brief review of the evidence on CBT suggests that it may have a positive effect in decreasing anti-social behaviour, particularly for older children and adolescents. She also highlights some evidence that CBT works best when administered in intense one-to-one programmes conducted by trained staff and that CBT administered to adolescents in groups may actually make matters worse (Rutter *et al.* 2002).

Although there is strong research evidence as to the efficacy of CBT in improving child behaviour for children with conduct disorder, this does not mean that other interventions are necessarily ineffective. The fact that alternatives have not been systematically evaluated using experimental methods may result in a bias towards evaluated approaches such as CBT. Also, evaluations of CBT have been criticised for focusing predominantly on demonstration projects rather than routine practice (Joughin 2003).

*Behavioural parent training* for parents of adolescents teaches parents to use specific behavioural skills based on social learning theory by identifying positive and negative behaviours and observing the situations in which they occur and the typical reactions they elicit. The aim is to systematically reinforce positive behaviours, often through use of the concrete privileges (Brosnan and Carr 2000).

A review of two experimental studies of parent training interventions with repeat adolescent offenders (Bank *et al.* 1991; Dishion and Andrews 1995) found that intensive behavioural parent training of at least 45 hours over one year reduced recidivism during active treatment (Brosnan and Carr 2000). For adolescents with significant conduct problems who were at risk of offending, less intensive treatment of twelve sessions over three months improved parent-child interaction in the short-term but had little impact on conduct at home or at school. One of the studies reviewed, in which outcomes of highly structured parent training for families of chronically offending delinquents were compared to outcomes of either systemic family therapy (with a behavioural element) or group therapy (with drug counselling), found a similar reduction in offending rates for both groups at follow-up (Bank *et al.* 1991). However, the authors commented that while parental behaviour had changed

in relation to managing the conduct of their children, there were no detectable changes in general family functioning. These remained severely distressed families with multiple problems. This study concluded that the value of the parent training model in work with persistent delinquents was doubtful and suggested that preventive efforts beginning much earlier in the young people's lives were likely to be more effective.

*Functional family therapy*, a behavioural-systems approach to family therapy with a strong emphasis on behavioural and social learning theories, focuses on communication within families and on parental supervision. Therapists work with families to identify patterns of communication and beliefs about problems and solutions within families and then facilitate the development of improved communication, negotiation and problem-solving skills and the reinforcement of positive interaction patterns. Reframing and relabelling are used to encourage parents to recognise that deviant behaviour is maintained by situational factors (Alexander and Parsons 1982; Gordon *et al.* 1988).

Studies of these interventions did not focus on groups similar to the sample in this study, being mainly concerned with young offenders whose behaviour was likely to have been more anti-social. A review of four experimental studies of the impact of behavioural or functional family therapy on adolescent conduct problems found that it was effective in reducing conduct problems and improving family communication and these improvements were maintained eighteen months to three and a half years later (Brosnan and Carr 2000). An important finding was that the therapist's ability to maintain warm, collaborative relationships with families was one of the key ingredients in the success of these interventions.

## Conclusion

Few studies in either the UK and or the USA have focused on the issue of support services for adolescents considered to be on the brink of admission to substitute care. Most studies of family support or family preservation have been concerned with prevention of the abuse and neglect of younger children and have aimed to support families to enable them to care safely for these children. In contrast, in work with

adolescents the principal focus is on behavioural and emotional problems rather than abuse and neglect, although there is certainly evidence both from this study and others that adolescents may also be at risk of these (Rees and Stein 1997; Safe on the Streets Research Team 1999). For younger children at risk of abuse and neglect, parents are seen as the locus of problem, whereas for older children it is often the child's behaviour that is seen as the central problem. To use the terminology of an earlier study, younger children may be viewed as 'victims', while older children may be viewed as 'villains' and may, as a result, be 'volunteered' to the care system by their parents (Packman *et al.* 1986). Yet the family circumstances and histories of adolescent 'villains' may be little different to those of younger 'victims.'

Although British studies of the care system and of social work with teenagers have raised the question of preventive work, few studies have taken this issue as their central concern. The few small-scale studies that have done so have largely been descriptive and have provided little evidence on outcomes. This is also true for many of the UK studies of family support services for younger children. While American studies of family preservation studies *have* focused on outcomes for children, the evidence is inconclusive and, in any case, many of these studies have had serious methodological flaws. In contrast, evidence from a variety of intensive and highly-structured psychological interventions, mainly targeted at young offenders, has shown positive effects on young people's behaviour, at least in the short-term, although effects on parenting and on family functioning were either weaker or non-existent. However, disagreement as to the nature of the outcomes that should be measured, inconsistency in the measurement of common outcomes (for example, regarding the inclusion of brief placements or kinship care under the rubric of 'placement') and the real difficulty of proving that something has *not* occurred as a direct result of a service, makes it difficult to arrive at clear conclusions as to the effectiveness of services which aim to prevent placement.

Despite the lack of conclusive evidence on the outcomes of services, these studies raise a number of key themes. In both the UK and the USA, researchers have drawn attention to the impact of poverty on child developmental outcomes, the value of informal support networks, the importance of the *process* of service delivery and

families' appreciation of a strengths-based approach. Evidence from developmental psychology on risks and protective factors and on the potential of compensatory interventions in different domains of children's lives has underpinned some service developments. There is some evidence that an integrated, well-co-ordinated approach that intervenes both with the child and parent, and in some cases in the child's wider social networks such as the school or peer group, can be effective. Many of these issues will recur during the course of this study.

# 4 Situating the study

This chapter aims to situate this study within the broader developments in research and policy that have informed its methodology. The study was funded under a government research programme on the costs and effectiveness of services for children. The principal aim of this initiative was to discover 'what works', and at what cost, in order to inform policy development. The nature of this research question is very much a product of its social and historical context and both the question and the context guided the choice of methodology for this study.

## Developments in social research

The changing nature of research questions and, associated with these, the methodologies employed to investigate them, are linked to wider intellectual and social-historical developments. Quantitative methods, such as surveys and experiments, are founded on the positivist approach to scientific enquiry. Positivism as an intellectual approach is closely associated with Enlightenment thinking, with its belief in rationality, detachment and the possibility of establishing universal truths about both the natural and the social world. Within social science, positivist approaches typically include the assumption that methods employed for investigating the natural world can be applied to the investigation of the social world, which is viewed as essentially measurable and knowable. The belief that only phenomena which are observable can constitute knowledge – sometimes referred to as empiricism – is also characteristic of most positivist approaches, as is the view that scientific knowledge is arrived at through an accumulation of verified facts.

Researchers in the positivist tradition typically use quantitative methods to measure concepts and to map the associations between them in a search for causal links (Bryman 1988). Positivist approaches to research have often laid claims to scientific objectivity and have not been especially concerned with issues of subjective meaning or with the possibility that the values of researchers are of relevance to scientific

enquiry. Yet, as Bauman suggests, unlike natural phenomena, social phenomena are always already imbued with meaning:

> The object of sociological commentary is an already experienced experience coming in the shape of a pre-formed narrative rather than a set of raw unnamed sensuous data waiting for a meaning to be offered by the subsequent commentary (Bauman 1992: 73).

Qualitative approaches also have a reasonably long history. Bryman suggests that the use of qualitative methodology first appears in social anthropology, in Malinowski's use of participant observation at the turn of the twentieth century. Its intellectual antecedents include a number of overlapping strands which developed in the early decades of the twentieth century. Influences include the phenomenology of Husserl, later developed by Schutz, which was concerned with individuals' subjective apprehension of the world. Weber's concept of *verstehen* (understanding meaning), and the work of the early symbolic interactionist thinkers W.I. Thomas and G.H. Mead, were also highly influential in their focus on the importance of subjective meaning and interpretation (Bryman 1988). A concern with human agency and human understanding was central to the work of all of these thinkers and has remained central to qualitative approaches to understanding the social world. As the twentieth century progressed, both quantitative and qualitative methods have been used, with one or other approach often being more or less in favour at different times. Researchers of different persuasions have argued about the relative merits of the measurement of social phenomena (using quantitative methods) and the in-depth description of these phenomena and an exploration of subjective meanings (through the use of qualitative methods), but in the last decade or so there has been increasing acceptance of the possibility that these methodological approaches might be complementary.

In mapping the ascendance of the constructivist approach to social research, Denzin and Lincoln have outlined a succession of historical 'moments' in social research in the twentieth century. They describe the 'traditional period' from the beginning of the century until the Second World War, which saw the emergence of the 'lone

ethnographer' and the sociologists of the Chicago school, who used observational methods to study the culture of everyday life and had a particular interest in 'outsider' individuals and communities (Denzin and Lincoln 1994; Gould 2000). Social work research in this period was notable for the case study approach, for example *Social Diagnosis* by Mary Richmond, which has been described as a form of applied qualitative research, (Richmond 1917; Sherman and Reid 1994). However, this is a somewhat US-centric view of the centrality of qualitative methods in the early days of social research, ignoring as it does the poverty surveys conducted by Rowntree and Booth. These proponents of social reform sought quantifiable evidence in their attempts to understand the causes of poverty (Booth 1892; Rowntree 1901).

During the 1950s and 1960s major social programmes were implemented in the United States as part of the drive towards post-war reconstruction and were accompanied, in that country, by the rise of evaluation research. Then, as now, there was a focus on establishing the effectiveness of different social initiatives and to this end experimental methodologies were largely employed. Two of the most famous examples of this were the evaluation of the Headstart and the High/Scope Perry Pre-School programmes (McKey *et al.* 1985; Schweinhart and Weikart 1993). However, as Gould has pointed out, this 'golden age' of experimental evaluation of social programmes coincided with the consolidation of social contructionism in American sociology, which focused on the ways in which individuals actively constructed their social reality (Gould 2000). Thus, there was a parallel 'golden age' of qualitative research in the field of sociology which included the observational studies of Whyte and Becker on, respectively, working patterns in Chicago restaurants and becoming a marijuana user, and Goffman's famous study of institutional life, *Asylums* (Becker 1953; Goffman 1961; Whyte 1943). These approaches were later to be outlined in the influential text *The Social Construction of Reality,* which set out the tenets of symbolic interactionism (Berger and Luckmann 1967).

Although experimental models of evaluation were dominant in social research in the early post-war years, at least in the United States, these studies often failed to find conclusive evidence that interventions worked, leading to the disappointing conclusion that 'nothing works' (Martinson 1974). However, others have argued that

this conclusion was probably overly pessimistic, deriving from the setting up of impossibly stringent criteria for success, that is, that interventions should always produce positive changes for experimental groups in all contexts (Pawson and Tilley 1997).

By the end of the 1960s direct challenges to experimental approaches employing quantitative methodologies became stronger. The 1970s saw the development of what has been referred to as 'the paradigm wars,' generated by the critique of experimental methods from perspectives variously termed 'interpretivist,' 'social constructionist,' or 'naturalist' – and which I shall refer to collectively as *contructivist*. Proponents of these approaches viewed qualitative methods as more appropriate to the study of the social world. Constructivists pointed to the plurality of factors that might be associated with an intervention and its outcomes and criticised experimental evaluations for their lack of any explanation as to how and why social interventions worked. They argued that social initiatives should no longer be conceptualised in terms drawn from traditional *scientific* models, such as 'independent variables' or 'treatments' and instead should be viewed as complex *social* processes of human understanding and interaction. This led to a greater emphasis on process as opposed to outcomes and greater interest in the views of service users as to why (if at all) they had been influenced by an initiative.

However, constructivism has not been without its problems. Pawson and Tilley have criticised constructivist approaches for their preoccupation with understanding meaning and hence understanding the variety of perspectives of the different actors involved in any intervention. Constructivism is grounded in a markedly different epistemology to positivism, starting from the assumption that 'truth claims' about an objective, knowable, external reality are simply not possible and all that can be known are individual narratives of social reality. Whereas experimentalists have been accused of over-optimism about the possibility of discovering 'truth' through empirical research, constructivists have been accused of going to the opposite extreme in focusing principally on the negotiation of perspectives between different stakeholders. As Pawson and Tilley put it succinctly in their critique of Guba and

Lincoln, this can amount to a 'throwing out of the objectivist baby with the relativist bathwater' (Guba and Lincoln 1981; Pawson and Tilley 1997: 21).

Parallel developments in the UK in the post-war years took a different form. Social work research in the UK has, until recently, been to a large extent characterised by a concern with needs and process. While research in clinical medicine has typically employed experimental methods to evaluate outcomes, for example randomised control trials (RCTs), experimental studies have been rare in research on social work in this country. The majority of British studies in the post war period have been informed by the constructivist perspectives that became popular in the 1970s and have largely, although not exclusively, adopted the qualitative methodologies associated with them. Indeed, within research on social care in the UK, quantification and experimentation have often been viewed with deep suspicion, sometimes bordering on hostility (Davies *et al.* 2000; Smith 1987).

To some extent, this was influenced by differences in the nature of post-war reconstruction between the UK and the United States. In the UK a key development was the introduction of the welfare state and within this, the children's departments, which were subsumed into the new social services departments in 1970. Although the Children Act 1948 and the further child welfare legislation which followed it produced important policy developments in the post-war period, these national changes in policy were locally implemented in a variety of ways rather than in the form of large-scale initiatives amenable to large-scale experimental evaluation. British research was typically smaller in scale and most researchers focused on exploring issues of need and process in different areas of practice, such as fostering, residential care, intermediate treatment, or on organisational dynamics, rather than undertaking major experimental evaluations.

Very little child care research was undertaken at all in the UK between the 1940s and early 1970s, as university departments did not become significant producers of research until the mid-1970s (Gould 2000). Thus, the setting up of the new social services departments in 1970, the development of professional training for those who were to work in these departments and the expansion of the British university sector

from the later 1960s together meant that academic social work research began to develop significantly just at the time when constructivist approaches, such as symbolic interactionism, were in the ascendant.

## The changing context for research

Although the roots of the experimental approaches to child welfare research in the United States in the 1950s-1960s lay in the social programmes initiated in the post-war years, these programmes were themselves located in the overarching social/historical context which has been characterised as modernity, albeit taking place towards the end of the modern period. Thus, they were associated with ideas of rational scientific progress towards a brighter future, with discourses of freedom and happiness which were to be achieved through social progress and with the over-arching discourse of society's overall progress towards future 'goodness.' These discourses had evolved from the Enlightenment thinking in which the 'grand narratives' of liberal democracy, Marxism and psychoanalysis were grounded (Bauman 1992).

The historical/social/cultural shift from modernity to postmodernity in the later post-war years has commonly been characterised as the collapse of these grand narratives. No longer is the rationale for public (and private) life framed in terms of 'goodness' or social progress (Bauman 1991). Instead, the grand narratives of modernity, with their 'big ideas' of progress towards a future good have been replaced by a plurality of mini-narratives focused on the present. By the later 1960s the reaction against state-imposed structures and values imposed from above was evidence of the shift from the over-arching grand narrative of liberal democracy (whose principal critics drew their class analysis from the competing grand narrative of Marxism), towards a proliferation of mini-narratives. These mini-narratives included discourses of generation, gender, 'race' and sexuality, so that the social world came to be seen as multiply stratified. As a plurality of fragmented discourses focusing on single issues emerged, sometimes embodied in new social movements which were concerned, for example, with feminism or racism, social processes came to be seen as more heterogeneous.

From the 1960s, political and philosophical theories associated with postmodernity began to be manifest in, for example, the ascendance of 'identity politics' and the work of deconstructionist thinkers. Such theories were characterised by a challenge to universalising discourses which represented themselves as objective truths and the emergence of the deconstructionist view that 'truths' were not objective but were maintained by regimes of power (Foucault 1972). In the field of welfare, new social movements based on the politics of identity developed, challenging the 'false universalism' of service provision with their particularist demands for recognition of the specific needs of different groups, such as people with disabilities or mental health problems (Williams and Popay 1999).

How, then, did these shifts manifest themselves in the field of social work research? Lorenz has suggested that in social research 'the intellectual hiatus in the immediate post-Second World War years was filled with the seeming reassurance of positivism's objectivity.' (Lorenz 2000). As the early post–war years progressed, the waning Enlightenment consensus of modernity, with its belief in the possibility of establishing universal objective truths about human behaviour, coexisted with the ascendant post-Enlightenment questioning of universalism in all its forms. We therefore find the experimental evaluation characteristic of the declining years of the modern period coexisting with the growing acceptance of social constructionism, which was characteristic of the early postmodern period. Thus, the focus on the way in which social systems could change the social world gave way, to some extent, to an interest in the way in which the social world was actively constructed through human agency.

Both approaches are apparent within social work research in the 1950s and 1960s, but the scientific project of establishing objective truths about human behaviour was dominant, for example in the emerging body of research on child abuse in the USA (Lorenz 2000). By the 1970s the relativism characteristic of post-modern theory, grounded in a rejection of 'truth claims' and a privileging of the notion of a plurality of competing discourses, is evident in the constructivist approaches to social work research in the UK. For example, the influence of symbolic interactionist approaches

and the popularity of associated theories such labelling theory during the 1970s can be clearly seen in the work of a key producer of research on child welfare, the Dartington Social Research Unit, during that period (see Millham *et al.* 1977 and 1978). Both universalising and pluralist discourses can be discerned in the phenomenon of radical social work which developed in the 1970s and whose concerns were expressed in the magazine *Case Con*. The grand narrative embodied in Marxist historical materialism underpinned the radical social work view that the problems faced by service users were to a large extent produced by the structural relations of economics, class and state power, but this view was nuanced by social constructionist approaches to deviance and emerging analyses of sexuality (see, for example, Bailey and Brake 1975). The social constructionist approach has remained an important strand in social work research in the UK, still clearly evident in the 1990s in the collection of studies on child protection summarised in the overview *Child Protection. Messages from the Research*, although these studies were concerned not only with process but also with outcomes for children (Department of Health, 1995; Parton 1996a).

This greater awareness of the complexity of both the human 'subject' and of social processes informed the increasing interest in qualitative methods of interpreting the social world, which had long been used to explore issues of context and process. During the 1970s and 1980s, the focus on micro-power relations within a multiply stratified society and the growing attention to questions of empowerment led to an increased questioning of the researcher's privileged knowledge of social reality and, in the field of social work, a developing interest in 'client studies' and in participative practice and research methodologies (Biehal and Sainsbury 1991; Fisher 1983; Mayer and Timms 1970; Reason 1994; Rees 1979) As Beresford and Evans have suggested, participatory research attempts to define a new relationship between researchers and research participants (Beresford and Evans 1999).

## Effectiveness and the question of 'what works?'

The transition from the modern to the postmodern world has been associated with developments in the organisation of public services, as well as private spheres of life. Alongside the mini-narratives of diversity outlined earlier there developed others that

were less ideologically charged, for example narratives concerned with business models of public life and, in the private sphere, health and lifestyle (Lyotard 1979). These are characterised by a concern with what gives the best results. Instead of over-arching grand narratives underpinning social and cultural phenomena therefore, we now have a plurality of mini-narratives which share a concern with short-term functional goals rather than ideals, articulated with other discourses of social plurality ('race', gender, disability), consumerism and its *alter ego* empowerment.

In Britain, the value of the business model in the public sphere has become a powerful mini-narrative, and its emergence over the last 30-40 years in the field of social services can be clearly traced. In the early post-war years, social work as an activity was fragmented across a number of voluntary sector organisations and a range of local and central government departments. Howe has argued that social work's high water mark of modernity came (late) in the early 1970s as services were organisationally structured into large local government departments following the Seebohm Report in 1968, and attempts were made to synthesize various social work theories (Howe 1994). However, within a decade a shift could be discerned from mid-twentieth century models of welfarism, with their notions of expert professional decision-making and the centralised delivery of services, to flatter, more decentralised organisations in which budgets and decision-making were devolved, 'clients' were redefined as consumers and private and voluntary sector providers were increasingly drawn in to contribute to a mixed economy of welfare (Parton 1996b). The shift from mass production and consumption to greater segmentation, diversity and niche marketing in the economic sphere was mirrored by a shift from predominantly monolithic provision managed by large local state bureaucracies to organisational fragmentation, welfare pluralism, quasi-markets and consumer sovereignty (Clarke 1996).

The increasing emphasis on business models in the provision of public services has been associated with the rise of managerialism as 'social work has been transformed from a self-regulating professional activity into a managed and increasingly externally regulated set of tasks' (Jones 1999:38). The New Public Management approach, with its interest in accountability, value for money, performance monitoring and evidence–

based practice, has been widely adopted across the public sector and there has been an increasing emphasis on quality assurance in public policy (Dunleavy and Hood 1994; Pfeffer and Coote 1991; Newburn 2001). Drawing on the 'excellence' approach in management theory, policy-makers have foregrounded concerns with effectiveness in service delivery. The drive to replicate business approaches in the public sphere brings with it the assumption that services can be specified and evaluated according to measurable criteria (Watson 2002). The shift from large state bureaucracies to more consumer-oriented organisations has also entailed an appropriation of the concepts of participation and empowerment, more usually associated with debates on human rights and citizenship. 'Participation' has been redefined in terms of consumer choice within quasi-markets of welfare and viewed as a means for enhancing effectiveness in service delivery, while 'empowerment' has become a crucial feature of the Total Quality Management approach to quality assurance (Pfeffer and Coote 1991; Biehal 1993; Watson 2002).

The adoption of business models in public life has brought with it increasing regulation of professional activity. Within child and family social work, the *Quality Protects* objectives specified measurable performance targets and shortly afterwards the White Paper *Modernising Social Services* set out proposals for a new performance assessment system for social services within the Best Value regime for all public services, paving the way for the introduction of the Performance Assessment Framework indicators (Department of Health 1998a, 1998b and 2002a). Since 1999 all local authorities have been required to produce annual Management Action Plans to report on their performance in relation to the *Quality Protects* indicators. Thus at one and the same time there has been a process of decentralization, with the fragmentation of services into a mixed economy of welfare and an increasing centralization of control, with minimum performance targets set for the implementation of policy accompanied by monitoring and inspection to ensure that these targets are met (Watson 2002).

Associated with these concerns with effectiveness and with the increasing regulation of professional social work activity, there has been growing interest both within and outside government in building an evidence base to guide policy and practice. The

government's intention to use evidence to guide policy making can be found in a number of policy documents, for example the White Paper *Modernising Government* and the report of the Performance and Innovation Unit *Adding it Up* (Cabinet Office 1999 and 2000). In contrast to the early decades of the welfare state, social work currently operates within a context of concern about containing public sector spending and emphasis on value for money, as epitomised by the Best Value requirements for local authorities (Department for the Environment, Transport and the Regions 1998). It is within this context that the current concern with social work effectiveness has come into sharper focus. As Lishman argues:

> Social work operates in an ideological and political context which currently promotes market forces, consumerism and managerialism in the public sector, remains critical of post-war welfarism and the ensuing 'dependency culture' and emphasises the necessity for regulation, audit, performance monitoring and inspection (Lishman 2000).

The political context does not directly determine the nature of practice and research in a simple way, but it creates the conditions in which certain priorities and solutions become dominant. The shift in the nature of the political world, including the retreat from ideology, the growing pragmatism in public policy and the focus on welfare consumerism, has given a new twist to older debates about knowledge and power, democracy and technocracy (Solesbury 2002). With the transformation of the old monolithic welfare state into the current market-based mixed economy of welfare over the last few decades and the accompanying redefinition of the role of social workers as case managers and co-ordinators of resources, answers come to be sought to particular research questions, such as 'what works?' Although this same question was originally asked in relation to the major post-war social programmes in the United States, today it interrogates a multiplicity of service developments tailored to diverse sub-groups, such as care leavers, children in rural areas, children with disabilities and so on. This is not only qualitatively different from the earlier large-scale experimental evaluations in the United States. It also represents a departure for social work research in the UK, which has rarely addressed such questions in the past. The focus has shifted from exploratory and process-oriented studies to outcome or ends-based research (Gibbs 2001).

This interest in extending evidence-based policy making and practice beyond the field of medicine, where it has been more commonly found, has to some extent been driven by funders of social policy research. Government departments and research charities, such as the Joseph Rowntree Foundation and the Nuffield Foundation, have increasingly adopted an instrumental view of research, requiring studies that are a means to social development rather than with the furthering of knowledge as an end in itself (Solesbury 2002). Researchers in need of funding are obliged to respond, some willingly, some less so and, as Solebury also observes, have adopted an increasingly pragmatic approach to questions of theory and method. The focus on evidence-for-policy is manifest in institutional forms such as the Social Care Institute for Excellence (SCIE), the Centre for Evidence-Based Social Services (CEBSS) at the University of Exeter and the Evidence for Policy, and Practice Information and Co-ordinating Centre (EPPI) at the Institute of Education, all of which receive at least part of their funding from the Government, and in the ESRC – sponsored Evidence Network, a network of social policy researchers across a number of universities. The child care charity Barnardos, with its series of publications on 'what works' in different areas of child welfare, is yet another institution at the forefront of the promotion of evidence-based practice (Alderson *et al.* 1996). The view that research should be useable has led to a new emphasis on dissemination and hence the development of initiatives such as *Research in Practice* and *Making Research Count* designed for this purpose.

Within the field of social care, some of the foremost proponents of evidence-based practice have argued that only experimental studies can properly answer the question of what works and have therefore advocated a greater use of the randomised control trial [RCT] (for example, Macdonald and Roberts 1995; Newman and Roberts 1997; Sheldon 1986 and 2001). This methodological approach has been the principal target of criticism by those opposed to the 'what works' approach to research in this field. Opponents have not only questioned whether such methods are ethical but have also argued that the (predominantly positivist) approaches commonly used in the disciplines of psychology and medicine cannot be uncritically imported into social care. Apart from raising epistemological questions about whether it is possible to

know incontrovertible truths about what works, critics of the 'what works?' agenda have rejected the notion that it is merely a set of innocent technical questions, a value-free approach to measuring social problems and the effects of responses to them. It has been argued that such technicist approaches bracket out the fact that the ways in which such problems come to be defined and the debates about how they should resolved are inherently social and political questions, rooted in particular historical and social contexts (Frost 2002; Gibbs 2001; Trinder 1996).

Proponents of evidence-based practice have often been keen to promote practice strategies such as cognitive-behavioural therapy, which lend themselves more easily to measurement since their aim is to change observable behaviours rather than, for example, relationships or patterns of attachment. As Trinder has argued, the focus is predominantly on 'narrowly focused answers to narrowly focused questions.' (Trinder 1996: 235). The promotion of the current 'what works' agenda and the ascendance of task-centred and cognitive behavioural approaches in social work (which, as we shall see, were favoured by the adolescent support teams in this study) are closely intertwined and the investigation of these issues often entails some use of quantitative research methods. The same is true for the principal opposing strand in current social work theory, practice and research, where a concern with 'depth' rather than 'surface' interventions, for example in the use of attachment theory, tends to be associated with qualitative research which focuses on narrative histories rather than behavioural change in the here-and-now (Howe 1996).

However, as the proponents of evidence-based practice have argued, from the perspective of service users, 'what works?' is an eminently sensible question. How a system is working and what outcomes it produces for children and families are clearly pertinent questions for those on the receiving end. Without evidence that the interventions attempted are actually helpful, professionals should be cautious about intruding into children's lives. Well-intentioned interventions may have no effect at all or, worse still, may even be harmful (Alderson *et al.* 1996). While it is true that the ascendance of the evidence-based approach has been accompanied by a diminution of professional discretion, it cannot be seen as a direct cause of the assault on professionalism: both have been consequences of much wider shifts in public life

and the associated rise of managerialism in public services, as outlined above. So although concerns with effectiveness are undoubtedly associated with other developments in public services which may be questionable, depending on one's point of view, questions of effectiveness are not, in themselves, inherently unsavoury. In some ways this is similar to the appropriation of the concept of participation and its redefinition in terms of welfare consumerism, discussed earlier: concepts take on different meanings according to the historical moment and the particular discourses in which they are located. The fact that the concept of effectiveness is articulated with discourses of managerialism may make us view it with suspicion, but this does not mean that it is not worthy of attention. Viewed in terms of the welfare and rights of children, a concern with the outcomes of the services they receive makes sense. There is a role for research that not only aims to improve our understanding of how society works but also tries to provide guidance on how to make it better. However, as various commentators have pointed out, what works is not the only thing that matters. There is *also* a continuing need to consider wider questions such as 'what is the problem?' 'what is going on?' and 'what causes it?' (Parton 1996a; Solesbury 2002).

A central issue is, what do we mean by 'effective' and what do we count as evidence of effectiveness? If, as we have argued, neither the way in which social problems are defined nor the way in which the limits to knowledge are explained are value-free, then what counts as evidence cannot be seen as a neutral question. Equally, 'what works' for children may not be the same as 'what works' for parents or, indeed, for society (Glass 2001). A further problem is that, in a complex and rapidly shifting social world, evidence is likely to be situational and contextual, which makes the application of evidence a complex process (Frost 2002). To complicate matters further, in the contemporary mixed economy of welfare, children in need are likely to receive help from several agencies so it is difficult to discover which service, or combination of services, have produced positive outcomes for a group of children. As Bullock and colleagues have argued, this service environment makes the 'black box' model of 'pre-test, intervention and post-test' difficult to apply to children in need (Bullock *et al.* 2000).

It remains doubtful whether it is possible to establish precise causal links between interventions and outcomes, which will hold true whenever the intervention is implemented. The culture of performance management may set precise questions as to the effectiveness of services, but whether it is possible or even desirable to arrive at an unequivocal answer to these questions is another matter altogether. Policy-makers and managers may have 'over-certain' views of what evidence might consist of and how it should be interpreted, in contrast to the more modest, nuanced claims that researchers may feel entitled to make (Smith 2000). Smith suggests that, while empirical social science should not be used to make law-like generalisations about the social world, in the manner of the natural sciences, nonetheless useful generalisations can be drawn from it as long as they acknowledge the unpredictability of the social world and the effects of different contexts on social phenomena. He argues that a decontextualised preoccupation with outcomes may lead to results that are non-significant, masking the real value of certain interventions under certain conditions (Smith 2000). Thus, findings may be qualified, rather than providing straightforward yes/no answers to simple questions regarding effectiveness.

One response to the problem of evaluating effectiveness has been to change (or rather, modify), the question. Proponents of realistic evaluation have suggested that instead of asking 'what works? ' evaluators should investigate what works for which subjects in which situations and seek to understand *how* these interventions work (Pawson and Tilley 1997). Instead of over-simplistic answers to crudely-formulated questions on effectiveness, policy-makers and practitioners need to know what works for whom, and in what circumstances. In the USA, the 'theories of change' approach to the evaluation of community-based initiatives also seeks strategies to understand the processes whereby interventions bring about change (Connell and Kubisch 1998). These approaches involve evaluators in attempting to answer two related questions: 'what happened?' and 'why did it happen?'

It is perhaps best to maintain a healthy scepticism towards any claims to unequivocally establishing 'what works' and, given that both what is knowable and what is known are contested, as researchers we should be somewhat less grandiose in our aspirations. In a shifting social, political and service context, the aim should be to

address the question: which strategies appear most likely to be helpful to *these* children in *these* circumstances and which are unlikely to have any effect or even to be harmful to them. Of course, the terms in which even this more nuanced version of the question 'what works' is framed are open to question. What we mean by 'helpful' will be related to our views as to the 'good' that the intervention seeks to bring about and this in turn will inform decisions about the outcomes that should be measured and the methods we might use to measure them. Like practice, research is essentially a social act and, as such, can never be value-free.

It is not solely the answers to questions about what works that should concern us, but how such answers are used to inform policy and practice. Given the variety of factors which may affect outcomes for children, pronouncements on 'what works' *in general* may be helpful in informing work with individual children, but practice decisions at the level of the individual must also take account of the complexity of factors in any individual child's life. Knowing that a particular intervention tends to work best overall, in relation to another type of intervention with which it has been compared in a particular study, does not necessarily mean that it will work best with any *particular* child. In other words, research on effectiveness is likely to be helpful in informing professional decision-making, but as an aid to the exercise of professional discretion at the level of individual cases, rather than as a substitute for it. There is a danger that, when particular methods are judged to be effective (for example, anger management techniques) they are uncritically applied to all cases, a one-size-fits-all approach that loses sight of individual complexity. They may also come to be seen as technical 'fixes', to be administered by (cheaper) staff without professional social work qualifications. The focus on changing surface behaviours and the question of the deprofessionalisation of social work activity are key issues which emerged in this study and are addressed later in the chapter *The Interventions*.

### *Methodological pluralism in social work research*

In order to answer the key research questions 'what happened?' and 'why did it happen?' researchers in social care increasingly draw on both quantitative and qualitative approaches as the use of mixed methodologies becomes increasingly popular (Lishman 2000; Lorenz 2000; Newburn 2001). Since the 'paradigm wars' of

the 1970s, there has been a greater rapprochement between qualitative and quantitative approaches, so that they are often seen as complementary rather than opposing strategies. Whereas modernity brought with it notions of evaluation (which method is best?), discernment and hierarchy, 'postmodernity, on the contrary, is about flattening hierarchies' (Bauman 1992: 34). The hierarchies of evidence associated with universalising discourses are replaced by the acceptance of a plurality of approaches, in social research as in other arenas.

The pragmatic adoption of different methodologies for different purposes, rather than the espousal of a single epistemological/political, and hence methodological, approach has been rather disdainfully dismissed by some (Trinder 1996). However methodological pluralism has been common in social work research during the last ten years or so and may be particularly appropriate to it. Difficulties in evaluating social work practice are to some extent due to the complex and ambiguous nature of social work activity itself (Lishman 2000; Parton 2000a). As Jordan pointed out long ago, the practice of social work is influenced by a variety of complex forces, which makes the precise scientific measurement of the effects of specific interventions extremely problematic (Jordan 1978). The complexity inherent in social work requires policy-makers, practitioners (and hence researchers) to pay attention to questions of ethics, legal accountability, individual rights and responsibilities, and structural inequalities. At one and the same time social work must assess risk, provide care, protection and control, ration resources and work in partnership with service users (Lishman 2000). The ensuing ambiguity and uncertainty about the nature of the social work task add to the difficulty of assessing its effectiveness. Furthermore, many of the problems that social work addresses cannot be definitively 'solved' in any clearly measurable way (Jordan 1978). In this context, defining and measuring a 'good' outcome is no simple task – an issue which is discussed in the next chapter.

Thus, reflecting the complex nature of social work as an activity, 'hard' indicators of effectiveness may need to be nuanced by explanation and in-depth analysis derived from qualitative data. As both Thoburn and Parton have argued, detailed description of social work practice is necessary to capture both the complexity of social work

interventions and their outcomes (Parton 1996a; Thoburn 2000). For example, probabilities regarding the circumstances in which placement occurs and its impact on changes in child functioning and quality of life can be explored using statistical techniques. These can also be used to control for key variables, such as the severity of child conduct problems or the experience of abuse, to indicate both *what happened* and *what factors* were associated with this event/outcome. Alongside this, a qualitative exploration of the process of intervention is helpful in explaining *how* outcomes occurred and *how* they were influenced by a variety of factors. To this end, the reasons for the placement beginning (and ending), how it was used as part of a multi-faceted package of family support and whether children (and parents) felt their circumstances had improved as a result of placement can be explored through qualitative analysis. The effectiveness of professional practice is not, therefore, judged according to whether or not placement has been avoided but in terms of *why* and *how* an intervention has (or has not) helped to improve children's quality of life.

In this study quantitative and qualitative methods have been used in a complementary fashion to explore how, and in what circumstances, interventions are effective – not in overly-simplistic and potentially misleading terms such as 'preventing placement', but in improving the well-being of children who receive them. The aim is not to provide a simple affirmative or negative answer as to whether support teams for adolescents 'work', but to tease out what it is that these particular interventions address, what it is that they appear to change, the circumstances in which positive changes tend to occur and how these changes seem to operate. The methodology used to address these questions is presented in the chapter which follows

# 5 Methodology

## Guiding ideas of the research

In order to assess the effectiveness of a service, it is helpful to have some idea of what might happen in the absence of that service. The clearest answer to the question of whether specialist support teams are effective would be obtained if young people using them could be compared to a similar group receiving no service at all, but this approach was rejected on both ethical and practical grounds. Instead, this study compares the outcomes for young people involved with specialist support teams with those for a similar group receiving a mainstream social work service from area social workers, which may be conceptualised as 'treatment as usual.' However, that when a service is compared to another type of service, the *degree* of change that may occur in the lives of young people is likely to appear more limited than it would if compared to a 'no service' alternative.

In comparing the effectiveness of two types of service, some clarity is needed about what constitutes a 'good' outcome. Lessons from the North American studies outlined in Chapter 3 suggest that the prevention of accommodation should not be the sole, or principal, indicator of positive outcomes. As well as considering placement patterns, which may be conceptualised as *service outcomes*, this study also focuses on *outcomes for the young people*, examining changes in child and family functioning and in young people's own perceptions of their well-being. Several outcome measures are used in an attempt to capture change in different aspects of young people's lives.

Outcomes for young people are likely to be influenced not only by the services they receive but also by a number of other intervening variables. Some interplay between young person, family and service variables was likely to be influential, so I therefore explored the following questions:

- What are the characteristics and histories of the young people using these two services?
- What difficulties have their parents experienced?
- What is the nature and severity of young people's problems at referral?
- What is the nature of the interventions by the specialist teams and mainstream social work services?
- What actions by other agencies affect these young people's lives?

As we have seen, attempts in the United States to conduct rigorous experimental evaluations of preventive services have proved inconclusive. Either the services studied there were ineffective, or the methods used were not sufficiently sensitive to issues of process and how these may be related to outcomes (Maluccio 1998). In other words, in order to understand how preventive services work, we need to improve our understanding of how they are delivered, how they are perceived by users and crucially, *how* and *in what circumstances* positive change occurs

## Design of the study

For the reasons outlined above, the study employed a prospective, quasi–experimental design. Young people referred to specialist support teams were compared to those receiving a service from mainstream social workers. Young people, parents and support workers from the specialist teams were interviewed as soon as practicably possible after the families' first contact with social services. In most cases, the first interviews took place within two weeks of referral but some were a little later. At the same time, postal questionnaires were sent to social workers. Where young people had social workers as well as specialist support team workers (this was the case for all but one of the specialist teams) questionnaires were completed by both workers. Follow-up interviews were conducted approximately six months later with as many of the original respondents as possible, although in some cases the workers had changed. Careful attention was given to research ethics, including questions of informed consent, confidentiality and anonymity.

Semi-structured interviews were undertaken at both stages of the study. These included a mixture of pre-coded and open-ended questions and some self-completion

checklists. The answers to the open-ended questions were, where possible, recorded verbatim by interviewers (with direct quotes enclosed in quotation marks when recorded on the questionnaires) and provided one source of qualitative data for the study. Questionnaires at Time 1 collected data on the characteristics and histories of the young people and details of the referral. Young person, parent and worker assessments of the nature of problems at referral were all obtained. At follow-up, data were collected on events in the intervening period, on how these were viewed by the respondents, on the interventions by workers and other agencies and on outcomes on a range of dimensions. The fieldwork took place between September 2000 and July 2002.

Some standardised instruments were incorporated into the questionnaires for young people and parents at both stages for use as measures of outcome. The standardised instruments used were:

- the Strengths and Difficulties Questionnaire, a measure of emotional and behavioural difficulties in children designed for use with children up to 16 years [used with young people and parents] (Goodman 1997);
- the General Health Questionnaire (GHQ-12), a measure of psychological distress/mental well-being [used with parents] (Goldberg and Williams 1988);
- the Family Assessment Device (FAD), a measure of family functioning [used with young people and parents] (Epstein *et al.* 1983);
- the general well-being section of the Lancashire Quality of Life Profile, a self-reported measure of subjective well-being [used with young people] (Huxley *et al.* 2001).

A Severity of Difficulties measure was also designed for the study in order to measure change in the specific problems presented at referral. Further details of these outcome measures are given below.

At follow-up, in-depth interviews were conducted with a sub-sample of 50 families. Young people and parents were selected for the qualitative component of the study if, at referral, a social worker or support worker had assessed them as being at high risk

of accommodation. The first 50 cases to meet this criterion were included in the qualitative sample and in-depth interviews were undertaken with young people, parents and their workers too wherever possible. Those included in the qualitative sub-sample completed the same checklists as the other respondents at follow-up and factual information on events was recorded on pre-coded questionnaires at the start of the interview so that this could be included in the quantitative analysis.

## Sampling

Young people referred to specialist teams in six local authorities were compared to others receiving a service from mainstream area social workers in three authorities. A total of eight authorities took part in the study as in one authority, City, a sample of young people using the services of three specialist teams was compared to a sample of others receiving mainstream social work services. This within-authority comparison was possible because City was a very large authority and the specialist teams were unable to offer a service to all young people who might be referred, particularly in the early stages of the research when only one team was in operation. The authorities that agreed to take part in the study included three counties, a large city, two metropolitan borough councils, a metropolitan district and a unitary authority and are described in the next chapter. The distribution of the sample between the eight authorities is shown in Table 5.1.

**Table 5.1 Sample at referral by case status and local authority (n=209)**

| Local authority | Specialist teams *n* | Mainstream teams *n* | Per cent of total sample |
|---|---|---|---|
| Eastshire | 19 | - | 9 |
| Met East | 28 | - | 13 |
| City | 22 | 33 | 26 |
| Midshire | - | 16 | 8 |
| Met West | 35 | - | 17 |
| Borough | - | 16 | 8 |
| Northshire | 28 | - | 13 |
| Met North | 12 | - | 6 |
| **Total** | **144** | **65** | 100 |

Since the intention was to compare outcomes for young people in similar circumstances, an attempt was made to identify comparable groups of authorities through analysis of DETR socio-economic indicators for the authorities (Department of Health, 2000b). In terms of social and economic need, Northshire and Met East appeared to be comparable to Borough. Although Northshire was a county authority, levels of deprivation were similar to those in the other two authorities. Government comparator groups, selected for the purpose of the Audit Commission/Department of Health Joint Reviews, have been selected by matching councils that are closest in terms of deprivation levels and demography. According to this scheme, the authorities whose mainstream social work service was studied were matched with authorities with specialist support teams as follows:

- City with Borough and Met North (plus within-authority comparison for City)
- Midshire with Eastshire
- Borough with Met West and Met North

The principal objective of the specialist teams was to provide family support in such a way as to prevent placement so, in order to compare like with like, it was necessary for the samples recruited both from specialist teams and mainstream services to be

equally at risk of placement. However, as we have seen in studies in the United States, imminent risk of placement is hard to define with any accuracy. Inclusion in the study was therefore based on a concrete set of criteria regarding risk of placement. Young people were included in the study if:

- They were 11-16 years old
- They had just been referred (or re-referred) for a service
- *Either* the parent or the young person had requested accommodation at referral
- *Or* the social worker who first saw them considered the young person was at risk of being accommodated within four weeks of the referral.

Recruitment was difficult because of the prospective nature of the study and because inclusion did not depend on a clear case event (such as placement or child protection registration) that could be identified from agency records. Instead, we had to rely on busy social work staff to inform us of relevant new referrals. Also, as we could not approach families directly, we asked staff to invite families who met the criteria for the study if they would like to take part. The intention was for staff to recruit *every* family who fitted the criteria, until an agreed number per authority had been reached. In practice, there were considerable difficulties in implementing this, particularly in respect of recruiting young people using mainstream services. This accounts for the smaller sample of young people in the comparison group. Only a few families who were invited refused to take part, but on the information available from social workers about reasons for referral and circumstances at referral these did not appear to be dissimilar to those recruited in terms of the nature or severity of their problems. However, it is possible that our difficulties in recruiting a comparison group via field social workers resulted in an element of selection bias, since not all social workers were equally willing to assist with the study. Although it was hoped to include both young people and parents in the sample, a few cases were included in the study in which only one of them agreed to take part.

Only five per cent of the young people recruited to the study were known to come from minority ethnic groups. This was disappointing, as four of the local authorities contained relatively large black and Asian communities and had been expressly

selected in order to ensure the inclusion of a reasonable proportion of young people from minority ethnic groups in the study. It was not possible to over-sample young people from ethnic minorities due to the considerable problems experienced in obtaining *any* referrals to the study.

At follow-up, 195 cases were included in the sample. The total number of questionnaires received at referral and at follow-up is shown in Table 5.2.

**Table 5.2 Questionnaires received at referral and at follow-up**

| | **Number at referral** | **Number at follow-up** |
|---|---|---|
| Young people | 177 | 106 |
| Parents | 203 | 140 |
| Support workers | 143 | 132 |
| Social workers | 152 | 94 |
| **Total** | **675** | **472** |

The distribution of cases at follow-up in terms of the nature of the service and by local authority is shown in Table 5.3.

**Table 5.3 Total sample at follow-up by case status and local authority (n=195)**

| **Local authority** | **Specialist teams** | | **Mainstream teams** | |
|---|---|---|---|---|
| | **n** | **%** | **n** | **%** |
| Eastshire | 17 | 13 | - | - |
| Met East | 28 | 20 | - | - |
| City | 21 | 15 | 31 | 54 |
| Midshire | - | - | 16 | 28 |
| Met West | 31 | 23 | - | - |
| Borough | - | - | 11 | 19 |
| Northshire | 28 | 20 | - | - |
| Met North | 12 | 9 | - | - |
| **Total** | **137** | 100 | **58** | 100 |

It was not possible to obtain full interview sets for all cases at follow-up as sometimes family members or workers could not be contacted. Outcomes in respect of the five outcome measures mentioned above, and data on young people and parent views of the service and of outcomes, could only be gathered where at least one family member was interviewed. Where no family member could be contacted at follow-up, a decision was taken to include worker interviews so that data on case events could at least be collected on issues that workers could be expected to have knowledge of, for example on placement and on child protection enquiries, registration and contact with the juvenile justice system. In this way, information on interventions and some data on outcomes were collected for 93% of the sample.

At follow-up a full interview set, including at least one family and one worker interview, was obtained for 62 per cent of the original sample (129 cases), as shown in Table 5.4.

**Table 5.4 Questionnaires received per case at Time 2 (n=472)**

| Questionnaires obtained per case | Number of cases | Per cent of original sample |
|---|---|---|
| Family member(s) and worker(s) | 129 | 62 |
| Family member(s) only | 16 | 8 |
| Support worker only | 22 | 11 |
| Social worker only | 28 | 13 |

When sample attrition was examined it was found that there were no significant differences between the samples at referral and at follow-up in terms of age, sex or the severity of problems (as measured on the Severity of Difficulties scale and the Strengths and Difficulties Questionnaire).

The qualitative sub-sample of 50 cases included 38 families in contact with support teams and 12 families in contact with mainstream social work teams only, as shown in Table 5.5.

**Table 5.5 Qualitative sample at follow-up by case status and local authority (n=50)**

| Local authority | Specialist teams *n* | Mainstream teams *n* |
|---|---|---|
| Eastshire | 8 | - |
| Met East | 8 | - |
| City | 7 | 6 |
| Midshire | - | 5 |
| Met West | 6 | - |
| Borough | - | 1 |
| Northshire | 5 | - |
| Met North | 4 | - |
| **Total** | **38** | **12** |

### *The timing of follow-up interviews*

Due to difficulties in tracing respondents it was not always possible to carry out follow-up interviews precisely six months after the first interviews, so some were a little later. Average times between interviews are shown in Table 5.6.

**Table 5.6 Months between initial and follow up interviews (n=195)**

| Source | Mean | Mode |
|---|---|---|
| Parents | 7.2 | 6.4 |
| Young people | 7.1 | 6.1 |
| Support workers | 6.1 | 6.1 |
| Social workers | 6.7 | 6.1 |

Since the change measures used in the study were completed by young people and parents, the potential effect of variation in their follow-up times must be considered. However, these clustered closely around a six to seven month period. There was some indication of a significant variation in the duration of the follow–up period

between the two groups being compared, with the mean follow-up period slightly longer for those using mainstream services (who were harder to trace at follow-up).[4] However, there was no significant correlation between the duration of follow-up and change on any of the standardised outcome measures used in the study.[5] Variation in the length of the follow-up period between the two groups did not, therefore, result in a systematic bias in respect of outcomes.

## Measuring outcomes

Before decisions as to *how* outcomes are measured can be made, it is necessary to consider *what* should be measured. First there is the question of whether the unit of analysis for the study should be the child or the family. There are good arguments for taking the family as the unit of analysis, since child and family problems are often intertwined. Positive changes in family functioning may in many cases be accompanied by positive changes for the child. However, other research has shown that there may also be cases where families feel their circumstances are much improved when a child has left the family, even if that child is living in unsatisfactory circumstances as a result (Biehal *et al*. 2000). Also, for adolescents, although the influence of the family remains important the peer group may also be highly influential. The principal unit of analysis for this study is therefore the child, although attention is also paid to changes in family functioning.

### *Selecting standardised measures*

Four standardised measures of child and family functioning, quality of life and mental well-being were chosen following a review of the multitude of measures of available. Existing reviews of standardised instruments were very helpful in this exercise, as well as consultations with fellow researchers (McAuley 1999; Pecora *et al*. 1995;

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[4] The T-Test (independent samples) showed that for cases where young people were interviewed at both Time 1 and Time 2, there was no significant difference in the mean length of follow-up period for those using different types of service: support teams 7 months (SD= 1.80) and mainstream service 7.69 months (SD=1.26), Levene's Test not significant p=.279. However, for parents the difference in mean follow-up period *was* significant: support teams 6.83 months, mainstream service 7.90 months, Levene's Test significant at p=.002. The range was 4.34–10.62 months for those in contact with support teams and 5.92–15.22 months for those using mainstream services.

[5] Pearson correlation showed that there was no significant association between duration of follow-up period and change on any of the standardised outcome measures used.

Weiss and Jacobs 1988). In selecting appropriate measures, the criteria were that they should have proven validity and reliability and, as they were to be incorporated into a longer questionnaire, that they should be reasonably quick to complete. Self-report measures were selected to establish whether both young people and parents themselves felt that change had occurred subsequent to the intervention.

The Goodman Strengths and Difficulties Questionnaire (SDQ) was selected as a measure of the young people's emotional and behavioural difficulties (Goodman, 1997). Its compact format, its focus on strengths as well as difficulties, its coverage of behaviour problems, emotional symptoms and peer relationships and its availability in forms suitable for young people as well as parents all made it appropriate for use in this study. Furthermore, its inclusion of items relating to positive, pro-social behaviour as well as to problem behaviour also made it more likely to be acceptable to young people and more likely to detect positive change. It is reasonably short, easy to complete and to analyse, and is available in versions for both parents and young people up to the age of 16 years. It has been found to be both valid and reliable and is closely correlated with both the Child Behaviour Checklist and the Rutter scales, whose validity and reliability are well-established (Goodman 1997; Elander and Rutter 1996). The question which remained was whether it would be sufficiently sensitive to detect change over a relatively short follow-up period, but no studies could be identified which addressed this issue.

The McMaster Family Assessment Device (FAD) was used as a standardised measure of family functioning (Epstein *et al.* 1983). This measure is based on systems, communication and learning theory and covers problem solving, communication, roles, affective responsiveness, affective involvement, behaviour control and general functioning. The FAD is a well-validated measure in both its long and short (12-item) versions (Byles *et al.* 1988; Weiss and Jacobs 1988; Ridenour *et al.* 1999). It has been used to measure treatment effectiveness in a number of studies, including at least one evaluation of a programme to prevent crisis placement and long-term residential care (Pecora *et al.* 1995; Wells and Whittington 1993; Dore, 1991).

My earlier exploratory study of an adolescent support team had identified a number of parents suffering from depression so it seemed useful to explore this issue further. The General Health Questionnaire was selected to assess the mental well-being of parents included in the study. It is a self-report questionnaire which can identify non-psychotic psychiatric disorder in community settings, as well as the degree of disorder. The shorter version of the GHQ (GHQ-12) was used for ease of administration, but this has been shown to be as good a detector of current mental status as longer versions and just as reliable, valid and sensitive (Goldberg 1992; Goldberg *et al.* 1997; Goldberg and Williams 1988). The GHQ concentrates on detecting symptoms of anxiety and depression and asks about symptoms in the past few weeks. It is intended as a 'case detector', for use in detecting psychological distress rather than conducting a detailed mental health assessment (Goldberg 1978). The GHQ was scored using the dichotomous scoring method (0,0,1,1) recommended for the scale (Goldberg and Williams 1988).

Cantril's Ladder, which has been incorporated into the Lancashire Quality of Life Profile, is a measure of psychosocial functioning which aims to capture a client's current sense of general well-being (Huxley *et al.* 2001). This was incorporated into young people's questionnaires as a self-completion measure. Young people were asked to indicate where they would place themselves at present on a ladder which displayed a number of rungs between 'best possible outcome' and 'worst possible outcome.'

### *Developing the Severity of Difficulties measure*

The Severity of Difficulties measure was a self-completion checklist designed for the study, which aimed to measure change in the severity of a range of difficulties on which social work professionals might reasonably be expected to have some impact. Young people and parents were each invited to complete a version of the checklist when interviewed at referral and again at follow-up. They were asked to indicate the presence and severity of a range of issues: behaviour within and outside the home, staying out late, concerns about peers, parent–child arguments, parent-child communication (two items), and drug and alcohol misuse. The scale was scored from 0 to 27. The choice of items for the scale was informed by the literature on social

work services for teenagers and on admission to care for this age group, as well as by findings from my earlier exploratory study (Biehal *et al.* 2000; Sinclair *et al.* 1995; Sinclair and Gibbs 1998; Triseliotis *et al.* 1995; Packman and Hall 2000*).*

Young people and parents were asked to indicate whether they considered each item on the scale to be *a major problem, a moderate problem* or *not a problem at all* and a simple score was computed. The distribution of the simple scores approximated to a normal distribution for both parent and child versions. Analysis of the means and standard deviations of the total scores for the two scales revealed a satisfactory range, indicating that the items included were significant discriminators between respondents. For the parent version the range was from 14 to 56 with a mean of 38 and the mode at about 40 (SD 7.93), while for the child version the range was from 14 to 46 with both the mean and the mode at around 30 (SD 7.1).

The next task was to reduce this unmanageably large list of nine items to a simple, robust outcome measure through a form of factor analysis known as principal components analysis. This analysis was therefore carried out on the two versions of the Severity of Difficulties measure, using the simple scores for each scale. Three items which did not appear on both scales at both stages of data collection were excluded from the principal component analysis, in order to ensure that the two versions of the scale were comparable.

*Parent version*

The first factor extracted accounted for 32.6% of the total variance, the second factor for 15.3% and the third factor for 9.7%, so that in total these three factors accounted for nearly 58% of the variance. These three factors were examined in some detail to discover whether the items with high loadings on each factor formed meaningful clusters in the light of available knowledge on children and young people referred to social work services.

The first factor was a large general factor, for which all items scored highly. This was not surprising, since the design of the scale was informed by previous research on the difficulties which young people and families typically present to social services and

was particularly influenced by findings from the qualitative study of adolescent support teams that preceded this one (Biehal *et al*. 2000*)*. This general factor was conceptualised as 'severity of difficulties.' In order to refine the conceptualisation of this factor, the SDQ sub-scale scores were entered as additional components. The 'severity of difficulties' factor had very high positive loading on the emotional problems (.792) and conduct problems (0.732) SDQ scores, indicating that those who scored highly on this factor were likely to have more serious emotional and behavioural problems.

The loadings on the second factor were particularly high on the items referring to parent-child arguments, their inability to talk things over with one another and the parents' view that their children did not listen to them. This factor was conceptualised as reflecting parent-child communication problems and conflict, and was labelled accordingly. This 'parent-child communication problems/conflict' factor was found to have a high positive loading on the SDQ peer problems sub-scale (0.506), indicating that young people with high scores on this factor were also likely to experience difficulties in other relationships.

The third factor was more difficult to interpret. The loadings were high for the 'upset about my child's behaviour', 'we can't talk things over' and 'he/she won't listen' and 'school problems' items, and also for the items which referred to problems with drugs or with alcohol. Once the SDQ sub-scale scores were entered into the analysis the picture became clearer, as the factor had a particularly high loading on the SDQ hyperactivity score (0.653). Young people whose behaviour problems were associated with hyperactivity were likely to exhibit difficult behaviour at school and it might well be difficult for parents to get them to focus on listening to them and talking over their difficulties. Although this factor includes the items 'we can't talk' and 'he/she won't listen', unlike the 'parent-child communication problems/conflict' factor discussed above, there is a low loading on 'he/she is argumentative' so this factor reflects a different aspect of parent-child difficulty, which appears to make it difficult for parents to deal with their children's behaviour because their hyperactivity makes it harder for parents to discuss things with them rather than because they are in conflict with one another.

*Young person's version*

The first factor accounted for 27.4% of the variance, the second factor for 14.4% and the third factor for 10.8%, so that in total these three factors accounted for over 51% of the variance. As with the parent version of the scale, all items loaded highly on the first factor, except 'I think there are problems with my behaviour' and, perhaps surprisingly, 'school problems.' When the child-completed SDQ sub-scale scores were added, there was a high loading on the SDQ conduct problems scores (0.509). Also, a Pearson correlation of this first factor with SDQ summary scores indicated a moderate correlation with both the SDQ conduct problems score (r = .334) and the SDQ total difficulties score (r=0.371), both of which were significant at the 0.01 level. As with the parent version, this first factor was taken as a general factor reflecting 'severity of problems', where perhaps part of the problem was that young people did not accept that their own behaviour was problematic.

The second factor loaded highly on the same three items as the second factor on the parent scale, which were those concerning parent-child arguments, their inability to talk things over with one another and the young people's view that their parents did not listen to them. Accordingly, this factor was similarly conceptualised as reflecting 'parent-child communication problems/conflict.' Unlike the parent version, though, once the SDQ scores were added in this factor had a fairly high loading on the SDQ emotional problems score (O.485), suggesting that problems in parent-child relationships were in some way associated with young people's emotional problems.

However, the third factor differed somewhat from the third factor on the parent version of the scale and was more difficult to interpret. Unlike the other two factors, it scored highly on the item 'I think there are problems with my behaviour' and also on 'my parent says I stay out too late', 'I can't talk things over with my mum/dad' and 'I have problems with drugs.' When the SDQ scores were added, the SDQ pro-social score had a particularly high loading (0.685), and there was also a fairly high loading on hyperactivity (0.399). It seemed likely that those scoring highly on this factor recognised that their behaviour was problematic because their pro-social attitudes gave them some awareness of their impact on others. In some cases behaviour difficulties were likely to be associated with their hyperactivity.

To summarise, the three main factors derived from the principal components analysis of the Severity of Difficulties scale were as follows.

| Parent | Young person |
|---|---|
| 1. Severity of problems (general factor) | 1. Severity of problems (general factor) |
| 2.Parent-child communication problems/conflict | 2.Parent-child communication problems/ conflict |
| 3. Behaviour (hyperactivity) | 3. Behaviour plus pro-social attitudes |

*Reliability and validity*

The Severity of Difficulties scale was also tested to establish its reliability and validity. Internal reliability is important in a scale comprising multiple items, to ensure it is internally consistent, in other words, that its items are measuring a single concept (Bryman and Cramer, 1990). Reliability analysis using the Cronbach's alpha test revealed that the alpha coefficient was 0.8839 for the young person version of the scale and 0.7656 for the parent version. These results show that the items comprising each scale are highly inter-correlated, indicating a high degree of internal consistency for both measures.

Reliability was also tested through a comparison of young people and parents' answers to similar questions. First, a Pearson correlation of parent and child factor scores for the *general severity* factor revealed a moderate correlation between the two (.499), suggesting that reliability was acceptable. Nine specific areas of difficulty which appeared on both the parent and the child scales were then compared. A Kappa test was used because, unlike a Pearson correlation, this not only shows the existence of a correlation but also its direction (that is, whether it represents agreement or disagreement). The degree of agreement was rated using Landis and Koch's (1977) benchmarks: <0.00=poor; 0.01-0.20=slight; 0.21-0.40=fair; 0.41-0.60=moderate; 0.61-0.80=near perfect. Some degree of (statistically significant) agreement was evident regarding whether the parents' considered the young people's behaviour at home to be a problem (slight: kappa .056) or were worried about them getting into trouble when they were out (slight: kappa 0.074) or were concerned that they stayed

out too late (fair: kappa 0.261). Correlations were also fairly weak in respect of the young person's problems with school (slight: kappa 0.124), the police (fair: kappa 0.400), drugs (fair: kappa 0.215), alcohol (slight: kappa 0.183) and peers (slight: kappa 0.102). Even the correlation between parent and child views as to whether they could talk things over with one another was only slight (kappa 0.117). All of these correlations were significant at the 0.01 level.

At first sight, the relatively weak association between parent and child views of specific difficulties may be taken to suggest poor reliability. However, two alternative explanations are possible here. First, the matter may be complicated by the fact that the scale measures *both* the nature *and* the perceived severity of the child's difficulties (see Gibbs and Sinclair 1992). As we shall see in Chapter 8 in the majority of cases where parents and young people's ratings differed, they did agree that a problem either did or did not exist, but they disagreed as to its severity. Also, the very fact that there was little agreement between parents and young people as to the severity of the difficulties was perhaps one of the very reasons they had not been able to resolve them and had now approached social services. Thus, although this comparison could not provide evidence of reliability, it does not necessarily show that the scales are *not* reliable.

The validity of the Severity of Difficulties measure was also examined. The face validity of the scales was thought to be good, since the choice of items for the scale was directly informed by existing research on social work with teenagers. Their construct validity was also tested. Construct validity can be tested by postulating the types and degrees of association with other variables and then examining them to see if they confirm expectations (Moser and Kalton, 1971). Construct validity was therefore tested by comparing the scale with an existing validated scale that measures similar, though not identical, phenomena: the SDQ.

While the SDQ does not measure difficulties of the same order as the scales constructed for the study, it is nevertheless a well-validated measure of children's emotional and behavioural difficulties, so at least some degree of correlation might be expected. This proved to be the case. When the parent-completed Severity of

Difficulties measure and SDQ summary scores were compared, the Pearson correlation of the Severity of Difficulties general factor with the SDQ conduct problems score yielded a coefficient of .573, indicating a reasonably strong correlation (which accounted for 32% of the variance). There was also a moderate correlation of this general factor with the SDQ total difficulties score (r=.329)). A similarly moderate correlation was found when the child version of the Severity of Difficulties measure was compared with the child-completed SDQ total difficulties score (r= .371). All of these correlations were significant at p<.001. These comparisons showed that the Severity of Difficulties measure could be compared with scales measuring similar aspects of child and family functioning in a meaningful way, indicating that its construct validity was acceptable.

The reliability, face validity and construct validity of the scale were therefore all found to be acceptable. However, since factors derived from principal components analysis were likely to be difficult for non-researchers to understand, the simple scores derived from the nine item versions of the scale were used to measure change from Time 1 to Time 2, in the knowledge that this scale has acceptable reliability and validity.

*Comparison of simple scores with other measures*

The Mann-Whitney U test showed that there was no significant association between *general severity* scores and case status, so the experimental and control groups did not differ in parent and young person assessments of the severity of child difficulties. Neither was there any significant correlation between *general severity* and age at referral, nor any association with the sex of the young person.

The Pearson r test showed that there was, however, a moderate correlation between parents ratings of the severity of child difficulties and their GHQ scores (r=.330) which was statistically significant at the .01 level. Since the Pearson r test does not tell us the direction of this association, it could have arisen in different ways. Either parents' mental distress may have been caused by the difficulties they were having with their children or, alternatively, parents' psychological problems may have

contributed to these child difficulties. The most likely scenario is that parent and child problems were mutually reinforcing.

## Data analysis

Answers to pre-coded questions and self-completion checklists were analysed using the computer program SPSS-11. All associations between variables that are reported are statistically significant at p= .01 or less unless otherwise stated. As most of the variables were nominal, non-parametric tests were mainly used. Parametric tests were used where the data did not appear to breach the principal assumptions on which parametric tests are based, that is, where data for the dependent variable was normally distributed and was in the form of interval data. Details of the specific tests used in the analysis are given in footnotes.

The fact that there were potentially three (mainstream service) or four (support team service) respondents per case helped us to deal with the problem of sample attrition to some extent. Since the same *factual* information on *events* (such as placement, stays with friends or relatives, formal exclusion from school or contact with the juvenile justice system) was sought from all respondents, there were up to four opportunities to find out whether a particular event had occurred. Composite variables were derived from the source variables on the four questionnaires, so that if any of the respondents indicated that, for example, placement had occurred, I assumed that it had. Where responses appeared contradictory, I scrutinised the paper questionnaires for the entire interview set to establish what had taken place.

One of the difficulties of using quantitative methods to measure change is that, with a relatively small data set, a meaningful effect size is difficult to detect. Our recruitment difficulties resulted in a sample that was smaller than anticipated and, because of the particular problems in obtaining referrals from mainstream social work teams, less than one third of our sample were using a mainstream social work service. This represented a potential limitation to the study. I was concerned that sample size and the imbalance in the size of the groups might have a detrimental effect on

statistical power, potentially making it difficult to detect differences between the two groups being compared.

I therefore analysed the change scores for young people on the three principal standardised outcome measures. Power calculations showed that the likelihood of detecting a difference in outcomes between the two groups (significant at p=.05), where the true difference was half a standard deviation from the mean, was 89% for the FAD and 82% for the SDQ (parent version). In other words, in terms of these measures statistical power was reasonably high. Statistical power was lower for Cantril's Ladder (part of the general well-being section of the Lancashire Quality of Life Profile) and for the child version of the SDQ, at 64% for the former and 62% for the latter.[6]

Where small sample sizes suggest that there are no effects of acceptable size, this can mean one of two things. Either there really is no appreciable difference between outcomes for the two groups being compared, or the design lacks sufficient statistical power due to the small size of the sample. Where the latter is true, then it may be wrongly concluded that an intervention has no effect, when actually it does. Also, it may be difficult for statistical methods to detect the kinds of modest changes in attitude or behaviour that social work typically achieves, as evaluation using such specific criteria produces only small groups for analysis and may not, therefore, produce statistically significant results (Sinclair 2000).

Methodological triangulation helps to address these difficulties, as it allows for a complementary analysis of change using qualitative methods. However, qualitative methods cannot answer precisely the same questions (such as, how likely is one intervention to produce change in comparison with another type of intervention?) as quantitative methods. However, these different methods can be used to answer different types of questions about effectiveness. For example, the problem with focusing *solely* on scale scores is that these cannot capture the reality of a child's life,

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[6] Results of power calculations: FAD 0.8874; SDQ (parent version) 0.8216; Cantril's Ladder 0.6360, SDQ (child version) 0.6176 (all one-tailed).

whereas depth interviews are better able to capture these complexities (Maluccio *et al.* 2000). Also, modest changes in attitude, behaviour or communication patterns, for example, may be experienced as significant by parents or young people, even if the small groups involved mean they are too small to be detected by tests of *statistical* significance. Qualitative analysis of a smaller number of cases may reveal how changes considered positive by service users arise. Intensive case analysis can be also be used to explore how different factors interact to produce particular outcomes.

In this study, in–depth interviews were tape-recorded and transcribed. Qualitative material both from the questionnaires and from the depth interviews was used to illustrate some of the issues uncovered in the quantitative analysis. Analysis of the depth interviews was principally used for individual case studies and to explore themes that emerged across cases. Qualitative data were also used to determine how, why and in what circumstances interventions appeared to be more, or less, successful in producing outcomes that young people and parents considered to be positive.

Using the computer program Atlas-Ti, qualitative data were first coded using both descriptive (e.g. 'social work plans') and conceptual (e.g. 'rationale') categories. Pen pictures of the circumstances and histories of each of the young people in the qualitative sample were also written, based on the data provided by all respondents in each case. One of the problems in analysing qualitative data in applied policy research lies in trying to grasp the complexity of each individual account while carrying out a cross-sectional analysis which can deliver useful insights across a range of subject areas. When data are first coded thematically and then analysed across cases, there is a danger that in the subsequent analysis these themes becomes detached from the context in which the fragments of text were situated. I was anxious not to lose sight of an holistic appreciation of each case while carrying out this cross-sectional analysis. Accordingly, as each theme was explored during the next stage of the analysis, data from particular respondents were always considered in the context of the pen picture describing the young person's circumstances and history and the views of the other respondents in that case. The aim was to build a cross-sectional analysis of the data based on an holistic interpretation of the interview transcripts.

In order to explore the question of how, why and in what circumstances positive outcomes occurred, cases where parents and young people both felt circumstances had improved and those where neither felt that circumstances had improved were selected from the qualitative sample for further analysis. All data (both quantitative and qualitative, from Time 1 and Time 2) relating to each case in each of these two groups were scrutinised to discover what were the ingredients in cases where outcomes were considered to be positive by family members or, alternatively, where they considered outcomes to be poor. Findings on *Outcomes for the young people* based on the statistical analysis, reported in Chapter 11, are therefore complemented by findings from the qualitative analysis in Chapter 14 *How did the interventions help?* Similarly, in respect of the question of placement, findings derived from quantitative analysis are reported in Chapter 12 and are followed in the next chapter by an exploration of the circumstances surrounding placement patterns derived from analysis of qualitative material.

**Table 5.7 Measures used at both baseline and follow-up**

| Measure | Respondent |
|---|---|
| Strengths and Difficulties Questionnaire (Goodman, 1997) | Young person and parent |
| Family Assessment Device (Epstein *et al.* 1983) | Young person and parent |
| Severity of Difficulties Measure | Young person and parent |
| Cantril's Ladder (general well-being section of the Lancashire Quality of Life profile (Huxley *et al.* 2001) | Young person |
| General Health Questionnaire (GHQ-12) (Goldberg and Williams 1988) | Parent |

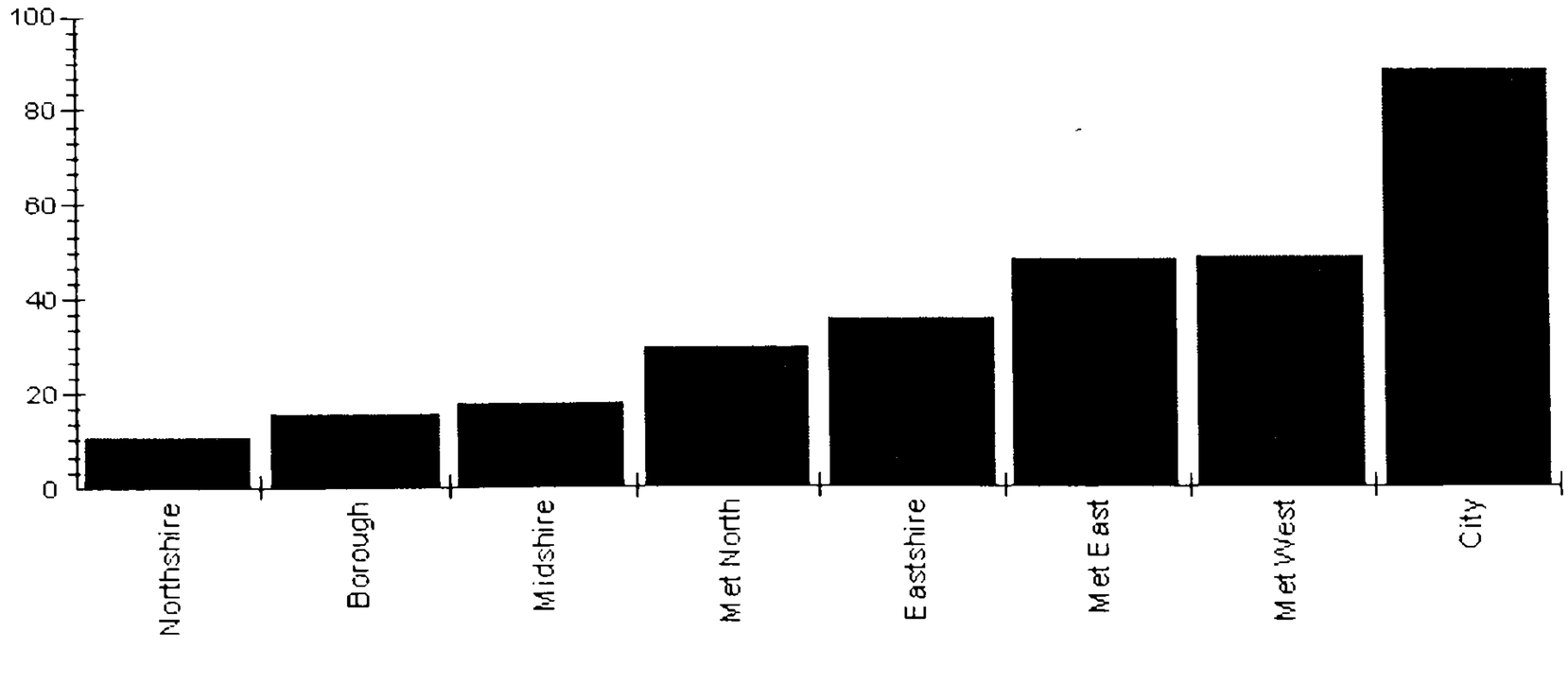
# 6 The local authorities and the support teams

## The local authorities

Eight local authorities took part in the study. These included a major city and three large counties as well as four metropolitan districts with much smaller populations. The authorities are described on the next page.

There was considerable variation across the eight authorities in terms of the proportion of their budgets allocated to family support. Four of them (Met East, City, Eastshire and Met West) devoted a high proportion of their resources for children's services to preventive services. They were ranked by the Department of Health among the top quarter of English authorities in terms of their relative spend on family support. In contrast, Midshire, Borough, Northshire and Met North were among the lowest ranking English authorities in terms of relative spending on family support in 2000/2001 (Department of Health 2002a). Differences between authorities in terms of their spending on family support are shown in Table 6.1.

**Table 6.1 Gross expenditure on family support per capita aged under 18**




In the two local authorities with no specialist support teams, Midshire and Borough, relative spending on family support services was particularly low, but Northshire, which had a thriving specialist support team was, somewhat surprisingly, reported to have the lowest proportionate spending on family support.

*City* (*pop.* 700,000) is one of the largest metropolitan districts in England, comprising a large urban area surrounded by extensive suburban and rural areas, plus some smaller free-standing towns. Its previous manufacturing and engineering industrial base has been largely replaced in the past three decades by thriving financial, retail and service sectors. Although general prosperity has risen steadily in the past two decades City has higher than average levels of deprivation, concentrated in particular areas.

*Midshire* (*pop.* 600,000 ) and *Eastshire* (*pop.* 550,000) are shire counties, both of which cover large geographic areas. Midshire has two main conurbations, several market towns and many smaller rural communities. Although there are some pockets of poverty, overall levels of deprivation are relatively low. This is also true of Eastshire, which comprises five large district councils and where overall unemployment levels are lower than the national average.

*Northshire* (*pop.* 500,000) is less prosperous than the other two counties due to the decline of its traditional heavy industries in the past two decades. It is a mostly rural county with many of its towns and villages suffering high levels of urban and rural deprivation. Unemployment is well above the national average.

*Met East* (*pop.* 200,000) is a metropolitan district largely comprised of a mix of small rural communities and older urban areas. In terms of overall levels of deprivation it is a middle-ranking metropolitan district, but there are sharp contrasts between areas. Unemployment has been a feature of this area for many years.

*Met West* (*pop.* 200,000) comprises nine small towns and is another metropolitan district with a mix of urban and rural communities. It has a number of manufacturing industries but the service industry sector has grown in recent years. Levels of deprivation are average in comparison with similar authorities, but in some areas there are pockets of extreme deprivation.

*Met North* (*pop.* 300,000) is a metropolitan district comprising a small city surrounded by numerous small towns and villages. Following a period of industrial decline, an expansion of the service sector has reduced levels of unemployment.

*Borough* (*pop.* 250, 000) is a metropolitan borough that retains some traditional heavy industries and also serves as a commuter town dormitory for an adjacent large city, with a mix of older housing and more recent urban development. There is a high concentration of deprivation in parts of the borough.

## The support teams

### *The origins of the teams*

Most of the teams were developed in tandem with the closure of children's homes. The Northshire team had been in existence longest. It had been set up in the late1980s when a number of children's homes were closed and their staff redeployed as outreach workers. Similarly, the Met West team was set up in 1994, the Eastshire team in 1997 and the Met East team in 1998 following the closure of local children's homes. Met North was unusual, in that it was developed in 1999 from the merging of a former youth justice team with a former family support team.

### *Staffing*

All but one of the teams was initially staffed by residential workers redeployed to the new community-based service and at the time of the study ex-residential workers continued to predominate among the staff teams. The majority of this group had had many years of experience working in residential care. The remaining staff had backgrounds in youth work, nursery nursing, probation, family centres and education. Met North was an exception, as most of its support workers were former field social workers who held social work qualifications.

Apart from the Met North team, only a minority of staff held a professional social work qualification. Those who were qualified tended to be team managers or deputies. Staff had a range of other qualification including GNVQ certificates in social care, youth work, education or residential childcare and nursery nursing qualifications, but some had no qualifications of any kind.

Two of the teams included workers with a specialist role. In the Met North team one worker specialised in adult mental health while the Northshire team had an education liaison officer. All of the teams employed a pool of sessional staff. Eastshire had a particularly large pool of 40 sessional staff (which supported the work of area teams, residential units and fostering and adoption teams as well as the family support team), but most teams had around eight. Sessional staff worked part-time and were normally paid an hourly rate. Their professional backgrounds included teaching, nursing, youth work and

residential work and some were social work students. The role of sessional staff was primarily to befriend young people and help to engage them in age-appropriate leisure activities in their local communities. It was felt that many needed help in building their confidence and developing their social skills if they were to successfully engage in these positive peer-group activities. Sessional staff also aimed to challenge anti-social ideas and behaviour in a non-judgemental manner. Although they were mostly used to work alongside support team staff in this work with young people, in a few cases they were used to support parents.

### *Aims and target groups*

The six support teams had key features in common. Their principal objective was to prevent accommodation and to this end they all provided an intensive, short-term family support service targeted at young people considered to be at risk of entry to the care system. In their statements of aims and objectives the teams conceptualised placement in negative terms, as a 'risk' to be avoided. Some offered a service only to those considered at high 'risk' of entry while others also aimed to work with those considered at moderate 'risk'. Although the prevention of admission to accommodation was the *raison d'etre* of these teams, some also had additional aims. Three teams aimed to facilitate rehabilitation after family breakdown, two worked to prevent foster placement breakdown and one also worked with children at risk of significant harm. The age groups served varied. However, although only three teams worked exclusively with older children and adolescents, children age 11 and over made up the bulk of the population worked with by the remaining teams. The aims of the teams and the target groups they were working with, as described in their statements of objectives and in initial meetings with teams at the start of the study, are shown in Table 6.2.

**Table 6.2 Aims and target groups of the support teams**

| Team | Aims | Age group | Target groups |
|---|---|---|---|
| **Eastshire** *Family Support Team* | To work with young people at high levels of need and/or risk to reduce the looked after population. | 10-18 | a) Adolescents at high risk of being looked after<br>b) Children at risk of significant harm<br>c) Children needing rehabilitation after family breakdown. |
| **Met East** *Community Support Team* | a) Avoid accommodation<br>b) Prevent foster placement breakdown. | 8-16 (85% age 11+) | Young people at high/moderate risk of accommodation. |
| **City** *Family Resource Centre (3teams)* | a) Prevent accommodation<br>b) Facilitate rehabilitation<br>c) Prevent foster placement breakdown. | 0-16 (61% age 11+) | Children/young people<br>a) At high risk of accommodation or<br>b) Needing rehabilitation. |
| **Met West** *Family Support Team* | To reduce crisis-led admissions to accommodation. | 11-16 | a) Young people at imminent risk of accommodation, or<br>b) Where a high degree of intra-family violence exists. |
| **Northshire** *Community Support Team (1 team on 3 sites)* | To prevent crisis-led breakdown in young people's long-term living situations. | 0-21 (73% age 11+) | Young people whose living situation (at home, in care or after care) is at risk of breakdown. |
| **Met North** *Family Support Team* | a) Prevent accommodation<br>b) Facilitate rehabilitation. | 11-18 | Young people<br>a) At high risk of accommodation or<br>b) Accommodated, but aim is rehabilitation. |

Young people were normally assessed and then referred to the teams by social workers. In Met West, the support workers were the case holders and once a case had been allocated to

them no social workers were involved. In all the other teams, the work of the team was expected to form part of a broader social work case plan. Area social workers were case holders and, to a greater or lesser extent, remained involved with the family alongside the support worker.

### *Methods used by the teams*

All of the teams were offering a short-term, task-centred service. Some ran groups for young people or parents from time to time. The City team provided a daytime service called 'centre support' to give parents and young people a few hours respite from one another and this was offered also to young people who did not have an allocated worker in the team. All aimed to work in partnership with parents and young people and to use a strengths-based approach.

The teams felt that they were not in a position to tackle long-standing problems but instead aimed to work briefly with families in crisis to calm situations and renegotiate ground rules between young people and parents. The emphasis was principally on helping parents to develop more consistent and authoritative parenting skills and encouraging young people to change their behaviour. They also worked with young people on relationships, grief and loss, keeping safe, social skills and on building their self-esteem. They were eclectic in their approaches and used a range of structured materials including:

- Parenting programmes offered individually or in groups, often using workbooks and/or videos (using resources from the Trust for the Study of Adolescence, the Youth Justice Board, NCH and the Family Caring Trust as well as the Webster-Stratton Parenting Plus programme)
- Workbooks on anger management
- Adolescent depression scale or worries checklist
- Videos on life in step-families and on self-harm.

After referral, initial meetings were normally held with parents and young people, at which written agreements were drawn up between support team workers and families. These agreements as to the goals and nature of the work were usually reviewed at four

to six weekly intervals. The account of their work given by the Met West team is briefly summarised below as an illustration of the work that was typical of these specialist support teams. Although each team had its own particular character and emphasis, they had much in common so that, while the work of other teams may not have been identical to the description below, it was similar in many respects.

**Intensive family support work by the Met West team**

- Systemic assessment of family functioning (may use genograms).
- Problems identified, goals set, work planned, clear agreements drawn up.
- Work reviewed every 4-6 weeks.
- Identification of deficits in parenting skills and provision of support to parents in developing coping skills, taking responsibility and regaining control.
- Work with parents: emphasis on appropriate parenting including behaviour management through positive reinforcement, boundary-setting, developing routines.
- Work with young people: exploring views, identifying triggers to conflict and behaviours that are dangerous, being alert to any evidence of abuse.
- Use of sessional staff to befriend young people, build self-esteem and engage them in positive local activities.
- Assessing, repairing and enlarging support networks.
- Providing information and advice e.g. on health or personal safety.
- Partnership work with parents.

### *Staffing levels and service availability*

Staffing levels varied considerably in relation to the size of local populations, even though the proportion of 10-17 year olds in each population was similar, ranging from

10-11 per cent (Department of Health 2000b). Staffing levels may be influenced by assessments as to the extent of need in local populations, which may be affected by socio-economic factors, as well as by local political decisions about resource allocation. Accordingly, caseloads and service availability varied from team to team, as shown in Table 6.3.

**Table 6.3 Staffing and work patterns of the support teams**

| Team | Population | Staffing | Average caseload | Cover |
|---|---|---|---|---|
| **Eastshire** *Family Support Team* | 550,000 | 1 manager, 6 support workers | 11 | Flexible hours Monday-Friday (some weekend work) |
| **Met East** *Community Support Team* | 200,000 | 1 manager 8 support workers | 5 | 7 days a week 9am-9pm |
| **City** *Family Resource Centres (3teams)* | 700,000 | 3 managers 15 support workers | 6 | Monday-Friday Weekend telephone advice line |
| **Met West** *Family Support Team* | 200,000 | 1 manager 11 support workers | 6 | 7 days a week |
| **Northshire** *Community Support Team (1 team on 3 sites)* | 500,000 | 1 manager, 2 team leaders, 18 support workers | 6 | Monday-Friday (some weekend work) |
| **Met North** *Family Support Team* | 300,000 | 1 manager, 6 support workers | 5 | Monday-Friday |

Eastshire had one small team based on a single site, which covered a large county. Northshire, which had a similar population, had a team that was three times larger and staff also had less travelling time to visit families as the county was smaller in size and the team was dispersed across three sites. With its lower staffing ratio, the Eastshire team had higher caseloads than the other teams. Met North also had relatively few staff in relation to

other authorities with smaller populations. Some teams offered a Monday to Friday service only but others had emergency cover at weekends and, in a few cases, occasional planned work took place at weekends when families were in crisis. The average caseload across the six support teams was seven, which was lower than for field social workers, whose average caseload was 17.

## Mainstream social work services in the comparison authorities

### *Borough*

Borough had formerly had a specialist support team for teenagers but this had been disbanded in 1999 in order to target resources on services to prevent younger children being accommodated, as many under-fives were being accommodated due to neglect and remaining looked after long term. Fieldwork teams were organised into four areas, each with an initial assessment team and two long-term teams. Staff at three family centres supported these teams, but their work focused on families with younger children so they were not a resource that could be drawn on in work with teenagers. There appeared to be few local resources to assist social workers in their family support work. Problems were compounded by high staff turnover, the resulting extensive use of agency staff and a local education authority that had been criticised by the Office for Standards in Education for failing to provide effective support to the most vulnerable children.

### *Midshire*

Midshire had just three area teams. Within these areas there were three teams serving children and families: an assessment team, a looked after children team, a family support team and a disabilities team. The assessment teams undertook initial work with families, normally for a period of up to one month and it was these teams, plus the hospital team, which referred cases to the study. Cases assessed as requiring longer-term support were then referred on to the family support team for ongoing work. This team worked with both child protection and family support cases. Although the authority had a number of family centres, their service was principally aimed at younger children, although a few did work with 11-12 year olds.

Social workers working with older children and teenagers in this authority had a few other resources to draw on, however. Families were sometimes referred to the Family Workshop Service (provided by the Child and Adolescent Mental Health Service) for family therapy, or to a 12-week parenting course offered by an independent provider. There was also a youth mentoring scheme, jointly funded by the social services and education departments, and a youth outreach service. This was a small project that recruited sessional staff to work with young people, but waiting lists for this outreach service were long.

### *City*

City was divided into five social work area teams, which were coterminous with five health service primary care groups. Within each of these five areas were a number of social work teams, amounting to a total of 27 children and families teams across the city. Each of the five areas had a Principal Case Worker for Adolescents (as well as a Principal Case Worker for Child Protection). The role of the Principal Case Worker for Adolescents was primarily to advise and assist social workers working with young people referred because they were deemed to be 'beyond control,' and to co-ordinate work on such cases. They also recruited and managed a pool of sessional workers (who were separate from the sessional staff managed by the city's support teams). These were deployed to work alongside area social workers offering a mainstream social work service and were used in the same ways as sessional staff employed by support teams.

These Principal Case Workers worked closely with children's team managers in initially dealing with 'beyond control' cases through the Community Assessment Profiling scheme developed in City. This scheme was aimed at any 10-17 year olds referred by a parent or carer (via the duty system) who was considered to be 'at risk' of becoming looked after if community –based services were not provided. Stage 1 Profiling was an initial meeting of the child and parent with a Principal Case Worker or social worker in order to talk through the issues of concern and, if appropriate, agree on parameters for further work, (which would be undertaken by the social worker, perhaps assisted by a sessional worker). This meeting was similar to the initial family meetings often held by support teams. Stage 2 Profiling was a meeting

of the child and parent with a Principal Case Worker and a social worker or team manager at which work was planned and decisions made regarding referral to other resources such as the support team or youth offending team. If problems were not resolved, a Stage 3 Profiling meeting would be held which would involve staff from other agencies.

Social workers in City were also able to draw on joint social services/health service provision within a multi-agency system of child and adolescent mental health services. The joint social work/mental health service Therapeutic Team offered assessment and therapeutic work for children who have been abused, or display sexually harmful behaviour or mental health problems such as self-harm or eating disorders. Area social workers could consult or co-work with this team or simply refer young people to it.

Within the area social work teams, the Principal Case Workers for adolescents acted as gatekeepers for referrals to the support teams, but in our sample there appeared to be no difference between those referred to the support teams and those who were not in terms of the nature and severity of child and family problems. However, there was some indication that those considered to be at more immediate risk of family breakdown were referred to the more intensive service offered by the support teams.[7] With the Principal Case Workers for Adolescents, sessional staff, Community Assessment profiling scheme and inter-agency Therapeutic Team, social workers working with young people in the comparison group in City appeared to have a more extensive range of resources to support them in their work than social workers in Midshire or Borough. This is consistent with the fact that, as we saw earlier, Borough and Midshire had a relatively low proportion of their budgets for children's services allocated to family support services, whereas City had the highest proportion allocated to family support among all the authorities in the study.

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[7] Details of the comparisons between the two groups within City are given at the end of Chapter 8.

# 7 Profile of the young people and parents

This chapter describes the characteristics and histories of the young people, their histories of contact with social services, and the difficulties experienced by their parents. All of these issues are likely to be relevant to our analysis of outcomes. Equally, this information is needed in order to compare whether the two samples of young people in the study, one group using the specialist service provided by support teams and one using a mainstream social work service, are comparable in key respects.

## Characteristics of the young people

The vast majority (88%) of the young people in the sample were age 12-15 years. Just over half were male (55.5%) and just under half were female (44.5%). Gender was not associated with age.

**Table 7.1 Age of young people in the sample**

| Age | Percentage | Number |
|---|---|---|
| 11 | 8 | 17 |
| 12 | 20 | 42 |
| 13 | 21 | 44 |
| 14 | 23 | 48 |
| 15 | 24 | 50 |
| 16 | 4 | 8 |
| **Total** | **100** | **209** |

The majority of young people who took part in the study were white (80%). Just four per cent defined themselves as being of mixed ethnic origin and only one per cent defined themselves as Black. None of the young people indicated that they were of Asian origin. In total, just 10 young people reported that they were from minority ethnic groups. However, data on ethnic origin were missing for 15 per cent of the

sample. Half of young people from minority ethnic groups came from a single authority, City, and the remainder came from three other authorities.

## Young people with disabilities, health problems and emotional or behavioural difficulties

We asked parents and workers whether young people had physical or sensory impairments, learning disabilities, mental health problems or emotional and behavioural difficulties. These matters can be difficult to define and people do not always agree on definitions. We accepted that young people experienced one of these difficulties if either a parent or a worker reported that they did, but we are aware that this may slightly inflate the figures in each category.

We did not request information on whether hyperactivity was a problem but a substantial minority of respondents reported Attention Deficit Hyperactivity Disorder (ADHD) so it is recorded here. As we did not ask everyone this question, the figure we give may perhaps be an underestimate. On the other hand, it was not clear whether all of the young people reported to have ADHD had a formal diagnosis of this condition, so it is equally possible that the figure for ADHD is a slight overestimate! Almost two fifths of the young people were reported to have an impairment, health problem, mental health problem, emotional or behavioural difficulty as shown in Table 7.2. It should be noted that many had multiple difficulties and therefore appear more than once in this table.

**Table 7.2 Young people with each type of difficulty (n=209)**

| | Percent | Number |
|---|---|---|
| Physical impairment | 3 | 7 |
| Learning disability | 15 | 32 |
| Sensory impairment | 3 | 6 |
| Emotional and behavioural difficulties (with a statement of special educational needs) | 14 | 30 |
| Emotional and behavioural difficulties (but no statement of special educational needs) | 19 | 40 |
| Mental health problems | 14 | 30 |
| Serious health problems | 5 | 11 |
| ADHD | 11 | 22 |
| *None of the above* | *62* | *130* |

One third of the young people were considered by parents or professionals to have emotional and behavioural difficulties (EBD) and 14% had a statement of special educational needs specifically for this reason. Research has shown that whether young people are said to have EBD can sometimes be a function of the attitudes and practices of their mainstream schools rather than an accurate assessment of their real difficulties, but that nevertheless children said to have EBD often have significant mental health difficulties (Cole *et al.* 2002). Where mental health difficulties were specifically mentioned and details were supplied, these usually referred either to depression or self-harm.

The young people with learning disabilities had particularly high levels of need. Half of them were reported also to have emotional or behavioural difficulties, four of them were said to have mental health problems and three had a sensory impairment. Once we take account of those with multiple difficulties, the total proportion of young people who suffered from one or more difficulty is very high, amounting to 38 per cent, as shown in Table 7.3.

**Table 3.3 Young people with one more disability or health problem (n=79)**

| | Percentage | Number |
|---|---|---|
| Physical and/or learning and/or sensory impairment | ***19*** | 40 |
| Emotional and behavioural difficulties (but none of the above) | 8 | 16 |
| *Total with one or more disability and/or emotional or behavioural difficulties* | ***27*** | *56* |
| Mental health problems (only) | 8 | 17 |
| Serious health problem (only) | 3 | 6 |
| *Total with one or more disability/mental health/ health problem* | ***38*** | *79* |

Overall, 19 per cent of the sample had one or more impairments, including physical or sensory impairments and learning disabilities. The OPCS definition of disability is wider than this, encompassing children with emotional or behavioural difficulties too (Bone and Meltzer, 1989). If a fairly tight definition of emotional and behavioural difficulties is employed (embracing only those who *also* had a statement of special educational needs specifically for this reason), and this group is included along with the others already defined as disabled, the proportion reported as disabled rises to 27 per cent.

This is just slightly higher than the estimated figure of 25 per cent for looked after children (Gordon *et al,* 2000).[8] Even if only a narrow definition of disability is employed, encompassing only those with physical, learning or sensory impairments, the proportion reported as disabled is far higher in this sample than among either children in need (13%) or children in the community (3.2%) (Gordon *et al.,* 2000; Department of Health, 2002b). However, some caution is needed in making sense of these comparisons due to the problems of definition raised earlier. Also, bearing in mind our earlier note of caution regarding our figure of 11% reported to have ADHD, it is nevertheless worth noting that in the general population of 11-15 year olds the prevalence of hyperkinetic disorders is under 2% (Meltzer *et al.* 2000).

[8] This estimate was derived from a re-analysis of the OPCS data referred to above, which was reclassified by means of cluster analysis in order to make it consistent with more recent models of disability.

## Special educational needs

As might be expected from the number with impairments or emotional or behavioural difficulties, a substantial minority had been assessed as having special educational needs under the Education Act 1981. Over one fifth (22%) had a statement of special educational needs and a further three per cent were undergoing assessment for this purpose at the time of the referral. This proportion is the same as for the 13-18 year olds in residential or foster care in a recent study of children living away from home (Berridge *et al.* 2002).

The OPCS definition of disability allowed for recognition of the extent to which emotional and behavioural difficulties may co-exist alongside other impairments (Gordon *et al.* 2000). Among the young people in this study, special needs were in most cases associated with difficulties that were behavioural or emotional. Two thirds (30) of those with a statement of special educational needs had emotional or behavioural difficulties and most of this group had other difficulties too. Nearly half of them (14) also had learning disabilities, five were reported also to have mental health problems and five were reported to have ADHD. Very few young people had been assessed as having special educational needs due to a physical disability (1) or sensory impairment (2) and only four due to a learning disability alone. Others who were not reported to have emotional or behavioural difficulties had mental health problems or ADHD.

## Family context at referral

Less than one fifth of the young people were living with both birth parents and nearly half were living with a lone parent, as shown in Table 7.4. In comparison with the wider population of children in England and Wales, they were twice as likely to be living with a lone parent and two and a half times as likely to be living in a stepfamily (National Statistics, 2003). Of the 13 per cent living in other circumstances, five per cent were with adoptive parents, four per cent with grandparents and just over two per cent with other relatives at referral. One young person was living just with a stepparent and two were living away from home, one with a family friend and one in a foster placement (at risk of breakdown).

**Table 7.4 Family composition (n=209)**

| Family type | Percentage | Number |
|---|---|---|
| Single parent | 46 | 95 |
| Parent + step-parent | 25 | 53 |
| Both birth parents | 16 | 34 |
| Other | 13 | 27 |

Where young people were living with only one birth parent, either in a lone parent family or a stepfamily, the vast majority (90%) were with their mothers. Families were far more fragmented than for children in the wider population, where 65 per cent live with both birth parents (National Statistics, 2003). Instead, family composition was similar to that for two recent samples of looked after children, one in residential and one in foster care (Sinclair and Gibbs, 1998; Sinclair *et al.* 2000).

**Table 7.5 Family composition compared to families of looked after children**

| Family type | This sample % *(n=209)* | Residential sample (%)[a] *(n=176)* | Foster care sample %[b] *(n=285)* |
|---|---|---|---|
| Single parent | 46 | 37 | 38 |
| Parent + step-parent | 25 | 35 | 20 |
| Both birth parents | 16 | 16 | 13 |
| Other | 13 | 12 | 28 |

(a) Sinclair and Gibbs, 1998; (b) Sinclair *et al.* 2000

## Duration of young person's difficulties

Parents were asked how long ago they had first become concerned about their children. Less than one quarter (23%) replied that they had first become concerned only in the last year. They indicated that over two-fifths of the young people had caused them concern from the age of nine years or younger, as shown in Table 7.6. For nearly one fifth of the young people, difficulties were said to have emerged when they were under 5 years old and it was clear from other information reported that these parents were principally referring to concerns about the young people's behaviour. We considered that this might be a particularly difficult group to help. A

variety of longitudinal studies have indicated that the origins of persistent youth aggression and violence are to be found in early childhood (Scott, 1998). Where children display behaviour problems at an early age, usually before the age of five, they are more likely to persist in anti-social behaviour into adulthood. This persistence is considered to be related to parent-child relationships, at least to some extent (Rutter *et al.* 1998).

**Table 7.6 Age of young person when parent was first concerned (n=200)**

| Age group (years) | Percentage | Number |
|---|---|---|
| 0-4 | 17 | 35 |
| 5-9 | 23 | 47 |
| 10-12 | 34 | 67 |
| 13-16 | 26 | 51 |
| **All ages** | **100** | **200** |

Consistent with the findings of studies of anti-social behaviour, in this sample boys' behavioural problems were more likely to be of early onset. Nearly a quarter of the boys (24%) were said to have first caused concern when under five years old compared to 10 per cent of the girls. In contrast, parents were more likely to first become concerned about girls during adolescence, as this was the case in relation to 34 per cent of the girls compared to 18 per cent of the boys.[9]

## Past contact with social services

Nearly three-quarters of the young people had been in contact with social services at some time in the past, another indicator that problems were not new for many of them. Over half (56%) had been known for a year or more prior to this referral, and one third had been known for more than three years. The young people using specialist teams were more than twice as likely to have been known to social services for more than three years (44%) in comparison with those receiving a mainstream service (20%). Other research on social work with teenagers has also found that few

[9] Chi-square test, significant at p=.012.

are new entrants to the system (Sinclair *et al.* 1995; Triseliotis *et al,* 1995). In over one third (37%) of cases workers reported that parents had requested the accommodation of this child on a previous occasion. Workers' reports indicated that child behaviour was the most common reason for past social services contact, although this had also been due to relationship breakdown or abuse, as shown in Table 7.7. For some of the young people, past referrals had been made for more than one of these reasons, so they are represented more than once in this table.

**Table 7.7 Reasons for past contact with social services (n=209)**

| Reason | Percent | Number |
|---|---|---|
| Child behaviour | 55 | 114 |
| Relationship breakdown | 39 | 81 |
| Parent unable to care | 16 | 33 |
| Neglect | 12 | 25 |
| Abuse (all) | 33 | 69 |
| • *physical abuse* | *16* | *33* |
| • *sexual abuse* | *7* | *15* |
| • *emotional abuse* | *9* | *19* |

Note: Percentages do not add up to 100 as the items are not mutually exclusive

For a sizeable minority there was evidence that abuse or neglect had occurred at an earlier stage in their lives. Workers reported that 36 per cent (76) of the young people had been the subject of past concern about abuse and/or neglect. For the majority (33%) past concerns had centred on abuse, while for 12 per cent there had been concern about neglect (and for 9% concerns had been about both abuse and neglect).

One tenth (21) of the young people had been placed on the child protection register at some time in the past and a further seven per cent had been the subject of a child protection case conference (but not registered) at some time prior to the current referral. So for half (35) of those for whom there had been past concerns about abuse or neglect, these must have been relatively serious.

### *Care History*

One quarter (53) of the young people been looked after at some time in the past. Indeed, around one tenth (20) of the young people in the study had last been accommodated during the last 6 months.

Information on whether young people had been previously looked after was drawn from questionnaires completed by parents, young people, social workers and support workers. Comparison of these information sources revealed that in nearly half (24) of these cases one or both workers were unaware that young people had previously been accommodated, so their assessment at referral was not informed by a full picture of the young person's past difficulties, which would presumably have been available from agency records (unless the child had moved from another authority). Either agency record keeping was poor or staff were not making sufficient use of agency records.

Around one third (18) of those who had been looked after prior to this referral were known to have been looked after just once, but nearly a quarter of them had been looked after on more than one occasion and indeed for one young person this had occurred five times. This picture is incomplete as data on times looked after, and also on age first looked after, were available only on just over half (30) of the young people who had been looked after. One quarter were reported to have first been looked after before the age of 10 years, but for over half this had happened relatively recently, at age 11 or over.

Data on the total length of time young people had been looked after during the course of their lives were available for only half of those known to have previously been in care, but it is clear from this many had been looked after for considerable periods of time. Just four had been looked after for less than a week, but eleven were placed for 1-12 weeks, eight for 3-12 months, and three for more than a year.

## Parents' difficulties

The parenting of adolescents can be a difficult task, as adolescence brings with it the emotional changes that accompany puberty and the strengthening of peer group influences, which for some may be negative. Yet for parents of adolescents the parenting role is poorly defined and they have few models available to them regarding the appropriate exercise of authority (Coleman 1997). Parents who have additional difficulties of their own are likely to find this task even harder and may be particularly in need of support. To understand the other stresses that might make the parenting task harder to accomplish, we asked parents about other difficulties in their lives in relation to their health, mental health, relationships with partners and material problems, such as financial or and housing problems. We also asked workers for their assessment of the parents' strengths and difficulties in their role as parents.

### *Health and mental health difficulties*

Many parents suffered from health problems. Over a quarter reported serious health problems and 13 per cent reported mental health problems. One in ten indicated that they had a physical disability. Some parents had more than one of these difficulties so that, overall, over a third (36%) indicated that they had serious health or mental health problems and/or a physical disability. One in ten parents said they had problems with alcohol, but only a few (3%) reported a drug problem.

The vast majority of parents (81%) reported that they often felt depressed. The majority of these were mothers, since three quarters of those young people living with either one or both birth parents were living only with their mothers. Workers, perhaps using a tighter definition of depression, considered that only 13 per cent were depressed. However the General Health Questionnaire (GHQ-12) indicated that mental well-being was poor for the majority of the parents (Goldberg *et al.* 1997). The GHQ is a standardised measure designed for use as a screening instrument to detect psychiatric disturbance in community settings. It is normally used to detect breaks in normal functioning rather than lifelong traits and focuses principally on detecting symptoms of depression and anxiety (Goldberg and Williams 1988).

Since a substantial minority of parents in this study suffered from poor health and/or a disability, the cut-off score used to indicate anxiety or depression was increased from three to four in order to control for the influence of physical illness, as recommended by Goldberg and Williams (1988). Using this (relatively high) threshold score, it was evident that nearly three-quarters (72%) of the parents in the study were experiencing high levels of psychological distress. This is far higher than the proportion that would be expected in the wider community, since an international study evaluating the GHQ found that the mean prevalence of mental disorder in the general population was 24 per cent (Goldberg *et al.* 1997). As we have seen, social workers and support workers between them considered that only 13 per cent of parents were suffering from depression. When their assessment is compared to the GHQ scores for this sample, it appears that they seriously under-estimated the levels of psychological distress that parents were experiencing.

Just over a third of all parents said they had begun feeling depressed just in the last year, with around one quarter reporting that they had felt like this for one to three years and just under a quarter indicating that they had felt like this for three or more years. Chronic social difficulties such as poor housing conditions and 'daily hassles' may predispose individuals to a greater risk of depression. As with risk factors for emotional and behavioural problems in children, it is the accumulation of difficulties rather than a single stress factor that creates the highest risk of psychological distress (Goldberg and Huxley 1992).[10]

### *Relationships with partners and others*

Relationships with past and current partners were also very stressful for many of the parents. Many (43%) reported experiencing domestic violence either recently or at some stage in the past. This is higher than estimates for the prevalence of domestic

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[10] Scores on this measure of parents' mental distress were not strongly associated with the severity of current emotional and behavioural problems for the young people. Although statistically significant, Pearson coefficients were weak for correlations between parents' GHQ scores and young people's SDQ total difficulties scores (.235), the SDQ conduct problems score (.221) and emotional problems score (.244). Thus, although the mental well-being of parents was to some extent correlated with young people's emotional and behavioural difficulties, this association was relatively weak.

violence in the wider community. Although it is difficult to assess the prevalence of domestic violence due to victims' reluctance to report it, a number of self-report studies have indicated that it is experienced at some time by around one quarter of the population, almost all of whom are women (Cleaver *et al.* 1999). This suggests that for children whose difficulties brought them to the attention of social services during adolescence, domestic violence past or present was an element of the family stress that a substantial minority of them had experienced. Some young people's accounts illustrated the continuing distress and anxiety they experienced as a result of domestic violence that they were aware of, or witnessed, even several years in the past.

Nearly half (49%) of parents reported that they currently had ' a lot of arguments' with their partners and one third of the young people also reported conflict between their parents (or a parent and stepparent). Parents also indicated that for 22 per cent of them conflict with partners had been a problem just in the past year, but for 27 per cent it had occurred over a longer period. Workers reported that nearly one in ten parents had recently separated from their partners at the time of referral. Not surprisingly, parental difficulties were a source of stress to the young people, as two thirds of them reported that they had often felt worried about their parents.

Friends were the most common source of support, mentioned by 40 per cent of parents, followed by their own parents (33%), siblings (25%) and other relatives (21%). A substantial minority of parents (25%) were socially isolated, however, reporting that they knew no one they could turn to for support. Parents of teenagers who have no strong networks of relatives and friends are likely to find it harder than parents of younger children to find support from other parents at a similar stage in their lives, as they no longer have the opportunity of meeting others at playgroups, nurseries or at the school gates. Other studies have suggested that neurotic symptoms may be a cause, rather than an effect, of a lack of a social network (Goldberg and Huxley 1992). The high proportion of parents scoring above the 'case detection' threshold on the GHQ may therefore help to explain, at least to some extent, the lack of social support for some of these parents.

### *Material problems*

There was evidence of more concrete problems too. Housing problems were mentioned by 18 per cent of the parents, with overcrowding being the most common (13%). Eight families had been evicted and one was in a homeless hostel (a total of 5%). Conflict with neighbours was also mentioned in a few cases.

Over two fifths of parents (42%) mentioned that they had 'serious money worries' largely due to low income (24%), debt (8%) or both (8%). Wages were the principal source of family income for only a third (34%). Two thirds (65%) were clearly living on low incomes (income support, unemployment or other state benefits or claiming family credit to supplement low wages). As might be expected, single parents were significantly more likely to report financial problems as two thirds of them did so, compared to less than one third of those living with partners.[11] Social workers and support staff appeared to be unaware of the stress caused by financial problems for many families, as only nine per cent in total reported these when asked. Alternatively, they may have viewed financial problems as the norm among the families that they worked with, or families may not have shared these concerns with them.

### *Parenting strengths and difficulties*

As we have seen, many parents had considerable difficulties and these strains may well have had an impact on their style of parenting. Numerous studies have found that certain aspects of parenting style are closely associated with long-term anti-social behaviour (Scott 1998; Rutter *et al.* 1998; West and Farrington 1973). We therefore asked workers about those aspects of parenting style known to be associated with better or worse behaviour in children[12]. We asked them for their assessment of whether parents made their expectations clear to the young people, were warm, encouraging and consistent in their responses towards them, were able to set clear boundaries or were harsh towards them. They were asked to assess whether parents

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[11] Chi-square test, significant at p=.016.

[12] The risk and protective factors associated with certain aspects of parenting style were outlined at the beginning of Chapter 3.

behaved in these ways 'most of the time', only some times' or hardly ever' and these items were scored accordingly.[13]

**Table 7.8 Worker assessment of parenting strengths and difficulties (n=178)**

| | Most of the time % | Only sometimes/ hardly ever % |
|---|---|---|
| Makes expectations clear | 52 | 48 |
| Consistent in responses | 34 | 66 |
| Warm towards young person | 56 | 44 |
| Encouraging when young person does something well | 48 | 52 |
| Sets clear boundaries | 28 | 72 |
| Harsh towards young person | 19 | 81 |

Note: the percentages add up to 100 across the rows

Workers considered that difficulty in setting (and presumably enforcing) boundaries was the most common, as this appeared to be an issue for nearly three-quarters of the parents. Possibly linked to this, around two-thirds of parents were considered to be generally inconsistent in their responses to their children. Only 56 per cent were thought to display warmth towards their child most of the time and nearly one fifth were considered to be harsh most of the time. There was a clear association between high scores for parenting difficulties and worker concerns about physical or sexual abuse and emotional abuse at the time of referral.[14]

There was also a significant association between high scores for parenting difficulties and worker assessments that parents were suffering from depression. There is extensive research evidence which indicates that parenting skills may be affected by mental illness, domestic violence and problem drug or alcohol use. Parents who suffer from depression or abuse drugs or alcohol may display apathy and listlessness,

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[13] Both social workers and support workers were asked to make this assessment because questionnaires from both would not be available in respect of all cases. In cases where both workers had completed questionnaires, support worker scores were used where social workers were acting as duty social worker, but social worker scores when they were the allocated worker.

[14] Mann Whitney U test, significant at p=.006 for physical or sexual abuse and p=.038 for emotional abuse.

which may make them inconsistent and ineffective in their parenting. The experience of domestic violence can have a negative impact on parents' ability to look after their children too (Cleaver *et al.* 1999).

Witnessing domestic violence can also have an adverse psychological impact on children (Cleaver *et al.* 1999). A number of studies have found that children who witness domestic violence have significantly more emotional and behavioural problems than those who do not, and those who also experience physical abuse show the highest levels of emotional and behavioural disturbance (Humphreys and Mullender, undated). Serious behaviour problems have been found to be 17 times higher for boys and 10 times higher for girls who have witnessed the abuse of their mother, and some may themselves behave aggressively (Wolfe *et al.* 1985, cited in Cleaver *et al.* 1999).

Domestic violence has been found to be a correlate in a substantial minority of cases of child abuse. A study of nearly 2000 child protection referrals found that domestic violence was an issue in the family in 27 per cent of cases (Gibbons *et al.* 1995), while another study found that 59 per cent of mothers whose children were on the child protection register were themselves the subject of domestic violence (Farmer *et al.* 1995).

It is also known that child perceptions of inter-parental conflict are associated with an increase in negative parent-child interactions and in problems in child adjustment. This effect is particularly strong with regard to mother-son relationships. Children do not have to be directly involved in this conflict for it to affect them in these ways, as already noted (Buchanan and Ten Brinke, 1998). The young people were well aware that parents were experiencing difficulties, as two thirds of them reported feeling worried or upset about their parents. One quarter reported feeling this only in the last year, but 42 per cent had been worried about their parents for longer than this.

## Comparing young people using specialist and mainstream services

There were few significant differences between young people using support teams or mainstream services. The exceptions to this were that past concerns about abuse were

reported more often in relation to those using the specialist service, and the young people using this service were also more likely to have been known to social services for more than three years. On average, parents using the mainstream service had higher scores for psychological distress, as measured by the General Health Questionnaire, than those using the specialist service.[15]

[15] Independent samples T-Test significant at p=.004.

# 8 Young people's difficulties at referral

Young people, parents and professionals reported a range of problems that had led to the referral. In most cases the young people's behaviour within the home was seen as the key issue, but emotional problems, behaviour outside the home and parent-child relationship problems were frequently mentioned too. In particular, problems with school were a major source of stress and many young people were also running away from home. The influence of peers was a key concern, particularly for parents, which is not surprising as peer groups become increasingly influential during adolescence. In addition, many professionals and young people were concerned about abuse.

## Family perspectives

Young people and parents were each asked to complete a Severity of Difficulties checklist to indicate whether a list of potential difficulties constituted 'a major problem', a moderate problem' or 'not a problem at all' in the past few months. The selection of items for this list was informed by an earlier qualitative study of an adolescent support team (Biehal *et al.* 2000) and by the literature on young people and social work services (for example, Sinclair *et al.* 1995; Triseliotis *et al.* 1995; Packman and Hall 1998). There were marked differences between parents and young people in their ratings of the severity of these problems. A far higher proportion of parents considered that the difficulties mentioned constituted 'a major problem' than did young people, as shown in Table 8.1

**Table 8.1 Difficulties rated as 'a major problem' in the past few months (n=209)**

| | Parents (%) | Young people (%) |
|---|---|---|
| Young person's behaviour at home | 85 | 37 |
| Parents upset about behaviour outside home | 64 | 29 |
| Parents' concern about young person's friends | 51 | 26 |
| Stays out late | 36 | 17 |
| Parent/child arguments | 78 | 34 |
| Child/parent 'doesn't listen' | 63 | 22 |
| Child/parent 'can't talk things over' | 54 | 32 |
| School problems | 59 | 34 |
| Drug problems | 12 | 3 |
| Alcohol problems | 10 | 4 |
| Offending | 22 | 12 |

While a higher proportion of parents rated each problem as 'major' overall, when parent and child views were compared on a case-by-case basis there was a fairly strong correlation between their ratings of problem severity.[16] When parents and young people's ratings were collapsed into 'a problem' (moderate or major) or 'no problem' and then compared, it became clear that between approximately two thirds and three quarters of the young people and parents agreed as to the nature of their difficulties, even if they did not always agree as to problem severity, as shown in Table 8.2 Virtually all of them (90%) agreed that the young people's behaviour at home was a problem. Concerns about socially unacceptable behaviour (at home, outside the home, or related to offending) were far higher than for the general population of children in need, for whom the figure is seven per cent (Department of Health, 2002b). This disparity is undoubtedly due to the age of this sample.

[16] Pearson correlation .485, significant at p<.001.

**Table 8.2 Difficulties rated as a problem in the past few months (n=209)**

| | Agreed this was a problem % | Agreed this was not a problem % | Total who agreed with each other[17] % |
|---|---|---|---|
| Young person's behaviour at home | 90 | 0 | 90 |
| Parents upset about behaviour outside home | 68 | 9 | 77 |
| Parents' concern about young person's friends | 50 | 13 | 63 |
| Stays out late | 36 | 31 | 67 |
| Parent/child arguments | 80 | 2 | 82 |
| Child/parent 'doesn't listen' | 55 | 5 | 60 |
| Child/parent 'can't talk things over' | 56 | 8 | 64 |
| School problems | 69 | 8 | 77 |
| Drug problems | 13 | 65 | 78 |
| Alcohol problems | 17 | 57 | 74 |
| Offending | 45 | 32 | 77 |

Parents were also concerned about the young people's violence to themselves and to others. They reported that over one third of the young people had attempted to harm themselves: nearly 20 per cent (40) had self-harmed in the past year and a further 15 per cent had done so prior to this. This represents a very high incidence of self-harm, since the rate of self-harm among 11-15 year olds in the general population who have no mental disorder is negligible (1.2%). The rate in this study is closer to the rate for 11-15 year olds with depression (18.8%) and higher than the rate for those with conduct disorders (12.6%), anxiety disorders (9.4%) and hyperkinetic disorder (8.5%) (Meltzer 2001). The survey from which these comparisons are drawn provides some clues to why so many of these young people may self-harm, since this is more common among adolescents in families with a high degree of family discord or where

[17] Chi-square test of the association between parent and child views significant at $p<.01$ for all items except 'doesn't listen' ($p=.02$); 'can't talk things over' ($p=.014$) and 'behaviour at home' and 'arguments,' which were not statistically significant.

parents have high GHQ scores. As we saw in the previous chapter, both of these were common among our sample.

Over half of the parents (55%) reported that their child had been violent to them in the past six months, and for 29 per cent considered this to be 'a major problem'. Even more young people (69%) were reported to have been violent to others in this period, and for nearly half of these the violence was rated as 'a major problem.' Gender was not significantly associated with the likelihood of aggressive behaviour. Similar proportions of males and females were described as behaving violently, both to their families and to others. Neither was there any great variation in the age of those reported to display violent behaviour. Nearly half of the 12 year olds, over half of the 14-15 year olds and nearly three-quarters of the 13 year olds were violent to parents. Even more were violent to others: around three-quarters of the 11-14 year olds and nearly two thirds of the 15 year olds were said to be violent to others.

Difficulties in relationships between young people and parents were also clear from the fact that only just over a quarter (26%) of the young people saw their parents as a source of help or advice, although grandparents (19%), siblings (14%) and other relatives (15%) were also seen as a source of support. They were more likely to turn to friends (42%) than anyone else, which is not surprising as the peer group is an important source of support and influence for teenagers. Over one tenth (11%) of the young people appeared to be quite isolated, as they said they felt there was no one they could turn to for help or advice.

## Professional perspectives

Social workers and support workers also gave their assessment of the young people's problems at referral. As there were a number of cases where questionnaires were available either from a social worker or from a support worker, but not from both, their replies on this issue were combined. In the discussion that follows, a problem is noted if it was mentioned by *either* worker (or both).

Professionals were concerned about a range of behavioural and emotional problems. They were almost unanimous in their opinion that the young people's behaviour was problematic (98%). Specifically, they reported truancy (66%), petty theft from families (51%) and offending (33%) and drug or alcohol problems (23%).
One fifth of the young people were said to be engaging in sexual behaviour that put themselves or others at risk. This was reported far more frequently in relation to girls, who accounted for three quarters of all such reports. Professionals were concerned about sexual behaviour in respect of 31 per cent of girls compared to just nine per cent of boys.[18]

Professionals reported that nearly half (48%) of the young people were violent to parents and 43 per cent were violent to others. There was a clear association between violence to parents and violence to others, as 76 per cent of those reported to be violent to parents were also violent to others.[19] Violent behaviour outside the home was therefore closely associated with violent behaviour within it.

Alongside these behavioural difficulties, relationship problems between birth parents and children were noted by workers in respect of virtually all the families (98%) and problems in relationships with stepparents were also common (46%). Social workers and support workers also considered that nearly half (48%) of the young people experienced rejection by a parent. Previous research has indicated that the potential effects of parental rejection include aggression, hostility, emotional unresponsiveness, delinquency and, not surprisingly, low self-esteem (Rohner 1986).

Professionals reported that many of these young people were experiencing emotional difficulties as well. Workers were concerned about mental health problems in respect of one quarter and self-harm/suicide attempts by nearly one fifth (19%). Loss was a major issue, as one fifth had experienced a recent bereavement and 28% had experienced recent separation from a parent. Emotional problems often went hand in hand with behavioural problems, since virtually all these young people were also

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[18] Chi-square test, significant at p<.001.
[19] Ch-square test, significant at p=.03.

reported to have behavioural problems. For example, 38 per cent of those thought to have drug or alcohol problems were also reported to suffer emotional abuse.[20]

## Accounts of behavioural and relationship difficulties

### *Difficult behaviour*

Many parents described their difficulty in dealing with the young people's behaviour. They referred to their children's 'attitude' and lack of respect, which in many cases was also a problem at school. These young people were described as defiant, challenging parental authority and refusing to do as they were told. The influence of peers was thought to be an important factor. In many cases parents felt undesirable peers were leading their children astray. Some parents were concerned at their children staying out late or overnight against their wishes, and many described them as 'out of control' or 'uncontrollable'. From their accounts, it seemed that many parents were attempting to set boundaries to the young people's behaviour but were unsuccessful in enforcing them. Some expressed a sense of helplessness and despair about their ability to set limits to their children's behaviour:

> From now on I could see he was going to do what he wanted, not what I or his mother wanted (father of boy, 12 years).
>
> I can't win. I can't ground her, she'll break out and wear me down. She won't let up (mother of girl, 13 years).
>
> If his dad was here he'd be different. I give in a lot for peace and quiet. I feel I can't control him (mother of boy, 14 years).

The accounts of the young people showed that many of them seemed to accept that their behaviour was problematic. In total, nearly half mentioned having behaviour problems either at home or both at home and at school. Around one third said their behaviour at home, their 'attitude' or temper had occasioned the current referral and several mentioned staying out late or overnight as a source of conflict with parents. A number of them referred to being 'angry' or 'in a mood', or admitted to stealing from their families or lying. A few mentioned using drugs or involvement in offending.

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[20] Chi-square test, significant at p=.032.

Eight of the young people blamed themselves for the difficulties they were experiencing, either describing themselves as 'bad' or saying that they felt they needed help with their behaviour. Two felt they could not control their behaviour. One 12 year-old girl explained that she had been 'bad' for the past three years, but that her behaviour had deteriorated recently:

> I hit my mum and shout at my mum, but afterwards when I'm good I can't remember it. My mum has to tell me.

In a few cases, parents and young people ascribed their child's behaviour problems to loss of some kind. The loss of a father through bereavement was thought, by parents and workers, to account for the development of angry, aggressive behaviour in two boys. More commonly, young people experienced loss as a consequence of parental separation. One 15 year-old girl, living with relatives, described her unhappiness since her father had died and her mother had left home and said that she did not want to be separated from her brother and sister. The loss of contact with a father who had left the home was thought to have led to another young person's anger and aggressive behaviour. The parent of yet another explained:

> She was having behavioural problems through being confused emotionally after the separation of myself and her father (girl, 15 years).

Several of the young people gave some account of why they felt their behaviour was poor. Some said they were 'misbehaving' because they were unhappy, or that they felt 'angry inside', but did not explain why. Sometimes they linked problems in their current behaviour to past difficulties, including parental separation and abuse:

> I covered up my upset with anger. I smashed things up and punched friends. It's been going on for quite a lot of years. I know why I get angry – because of my past (boy, 13 years, who previously experienced abuse).

> Mum made me choose between her and my brother and I got messed. I would come in drunk, go out early in the morning and come back at 10.30 pm (girl, 13 years).

My stepfather caused it because he was battering me and winding me up. He left ages ago but it still has an effect (boy, 14 years).

### *Violent behaviour*

Parents described an astonishing catalogue of violent behaviour by the young people, directed both towards members of their families and towards others. Parents' accounts of their children's violence within the family indicated that it was most often directed towards their mothers. In a number of cases siblings were physically attacked; less frequently, attacks on fathers or stepfathers were reported and in two cases, attacks on grandparents. Some young people directed their violence solely at one family member, but in a number of cases they appeared to lash out at everyone around them. Most of the incidents described involved quite serious assaults on family members:

She'll come up behind me and kick me and she chucks things at me (mother of girl, 14 years).

He has hit me a few times, kicked me in the stomach and made me bleed (mother of boy, 14 years).

His violent behaviour towards me....biting, kicking and pushing me around (mother of boy, 12 years).

The main thing was he came home one night in a foul mood and went upstairs and tried to strangle his younger brother (grandparent of boy, 12 years).

Some parents admitted that the violence could be two way, occurring during major arguments:

We actually fight and she punches and kicks me. She's actually told me to get out of the house now (mother of girl, 13 years).

(His stepfather) is now smaller than him and is confrontational with him, which has led to fights and bloodshed between them (mother of boy, 11years).

Violence to others was mostly directed at other children, usually at school, but parents also reported assaults on adults. Attacks on teachers were mentioned in several cases, including an incident where a 12 year-old boy broke a teacher's nose. One parent referred to complaints from neighbours that her 11 year-old daughter was 'torturing

people.' In many cases, violent behaviour was accompanied by general destructiveness. Nearly one in ten parents mentioned their children 'smashing up the house', 'kicking in the door', 'smashing up his room' or generally 'smashing things up.'

Apart from those who were physically violent, many of the young people were verbally aggressive. A number of parents referred to 'temper tantrums,' aggression or general bullying behaviour within the family. Two also mentioned mood swings, with one parent likening her son to Jekyll and Hyde. In a few cases the aggression appeared to be linked to young people's drug or alcohol abuse:

> Drinking, drug abuse, violent temper, he's on a short fuse all the time and extremely volatile. My other daughters are frightened of him....It's like a living bomb, a miniature volcano (mother of boy, 15 years).

Many young people also referred to problems with their temper or to having 'temper tantrums'. A few described their violence or generally aggressive behaviour to siblings as being rooted in their conflicts with parents:

> When my mum used to shout at me I used to go to my brother and beat him up (boy, 12 years).

Others linked it to their experience of abuse:

> I hate it that mum tells everyone that I batter her - she hits me (girl, 14 years).

In a few cases, it was clear that there was a link between domestic violence and the child's own violence:

> There was violence from my partner which she saw and that's when she started being different, when I kicked him out two years ago (mother of girl, 14 years).

A few young people also juxtaposed their descriptions of their own difficult behaviour, sometimes including violence, with accounts of witnessing domestic violence:

> I physically hit my sister and brother (play fight) for no reason. I was getting into trouble with the police and stealing from my mum. Mum argues with my dad. My dad was hitting my mum with a plate and cut her head open and I had to go and get help (boy, 12 years).

### *Family relationships*

Some parents graphically described the breakdown in relationships with their children. Several pointed to difficulties in communicating with their children, complaining that they simply could not talk to them because their child would not listen or arguments would develop. As the parent of one boy, about whom there were current child protection concerns explained:

> We couldn't reach him, he wouldn't listen or respond to us – just one syllable answers, didn't want to interact at all (mother of boy, 14 years).

Some parents expressed despair at this breakdown in relationships and some felt that these parent-child relationship difficulties had a far –reaching impact on the rest of the family. They felt that the child caused arguments between them and their partners and in some cases actively sought to break up their relationships with partners. In one case a mother complained that her child's behaviour had caused her partner to leave home.

Many of the young people also mentioned conflict with parents, sometimes accompanied by serious conflict with siblings. Most of them referred to 'arguing' or 'not getting on' with parents and, just occasionally, stepparents. Few explained why they felt this was happening, although a number set this conflict in the context of other difficulties. Behaviour problems at school or truancy, sometimes provoked by bullying, were mentioned by several young people as one of the reasons for their arguments with parents. Behaviour at home and 'attitude' were also linked to descriptions of arguments and sometimes multiple difficulties were associated with parent-child conflict.

Some parents recognised that their own difficulties had an impact on young people's behaviour. For example, two parents felt that their children were having difficulties because they were upset by their drinking. As one mother put it: 'he seems to be

affected by what goes on at home.' A few parents mentioned that their own difficulties earlier in their lives might be linked to their current difficulties with their children.

### *Family accounts of emotional problems*

Some parents gave graphic accounts of their children's attempts at self-harm or suicide. In around half of these accounts there were complaints about their child's behaviour too, which was most often described as aggressive or out of control. In a few cases self-harm by young people, such as cutting themselves, was accompanied by suicide threats. Two had been diagnosed as suffering from depression and one appeared to be anorexic. A few young people had not actually self-harmed but were described as 'being on self-destruct', for example a 12 year old boy repeatedly 'playing chicken' in the road, on buses and on railway lines. Eight other parents described their children's (sometimes multiple) suicide attempts, which in most cases took the form of overdoses. It was unclear from most parents' accounts why the young people were self-harming or suicidal, although mention was made of sexual abuse, bullying and alcohol abuse in a few cases. One young person felt that her self-harming and other problems were directly linked to past abuse, explaining the reasons for her referral as:

> Because me and mum weren't getting along. Being in trouble with the police, cutting my arms, my behaviour, running away. I was sexually abused for years (girl, 13 years).

A few young people explained that they were unhappy as a result of past parental separation, particularly when this had resulted in their separation from siblings:

> I go to my dad's and when I come home I don't talk to my mum because I feel bad about leaving my brother and sister. I feel upset with my mum (girl, 12 years).

There was some uncertainty among both parents and workers as to whether certain emotional or behavioural difficulties were caused by mental health problems or had some kind of organic component, or alternatively whether the young people were simply badly behaved, as the following comments illustrate:

Basically, the social worker said she needed to go to my doctor so she could assess whether he was mentally ill or just plain naughty (parent of 13 year-old).

With her ADHD it's difficult and she's very hard to parent. She's not like an ordinary teenager and you don't know what's adolescence and what's ADHD, it's hard to determine between the two (parent of 14 year-old).

His parents wonder if he's schizophrenic whereas other professionals have focused on the behavioural and emotional problems. I have to say I'm a bit at my wit's end about it (social worker of 12 year-old).

## Child protection concerns

Twelve (6%) of the children were the subject of a child protection enquiry and 4% (8) were on the Child Protection register when the study began. However, professionals were concerned about child protection issues for a much wider group than those involved in formal child protection procedures, as they reported current concern about abuse or neglect in respect of over half of the young people, as shown in Table 8.3.

**Table 8.3 Professional concerns about abuse or neglect at referral**

| Nature of problem | Percent | Number |
|---|---|---|
| Neglect | 17 | 36 |
| Physical abuse | 11 | 22 |
| Sexual abuse | 3 | 7 |
| Emotional abuse | 34 | 71 |
| Total abuse and/or neglect | 54 | 112 |

Note: Percentages do not add up to 100 as items are not mutually exclusive

Although the percentage involved in formal child protection processes at referral was low, the proportion about whom there were current child protection concerns was much higher and was close to the figure for children looked after whose main need for receiving a service was abuse or neglect (55%) identified in a recent census of children in need (Department of Health, 2002b). For many young people, concerns about abuse or neglect had persisted for some time. There was a clear association between current and past difficulties in this respect. For 46 per cent of those young

people about whom there was current concern about abuse or neglect, there had been similar concern in the past. Where the contemporary concern was with physical or sexual abuse, the likelihood of earlier concern was even greater, as 58 per cent of these young people had experienced abuse or neglect in the past.

In six cases, parents or young people said the referral had been triggered by an incident of physical abuse during a row between a parent and a young person. Some parents described this as 'just a clip', and sought to justify it in terms of the young person's abusive and violent behaviour towards them. In some cases, parents' describe themselves lashing out after years of difficult behaviour. For example, the mother of one 12 year-old boy described the following scenario:

> His step-dad lost his temper with him; he got a mark from him and went to school with it. Teachers saw it and called social services, but there was his behaviour at home and school……going into moods, snarling, screaming. He lights fires, we have to hide all the lighters. He pinches, you name it, he does it. It's been like this for over seven years.

Another mother described the following incident with her 15 year old daughter, who had been looked after in the past:

> She came home drunk, she was abusive to us, my husband loses his temper so he slaps her one….She is swearing, throwing things around the room, pulling pictures down off the wall. She hits me with a baton so my husband phones the police…We asked for her to be accommodated, we didn't want her back.

Her daughter's vivid account of the same incident linked it to her parents' marital problems and indicated that her difficulties were long-term:

> My parents are aggressive to me, but they think I'm aggressive to them too. I'm right cheeky. It's gone on for several years now, it's always about the same thing but I lose my temper. Dad says I'm a tart, a slag, that I've got no friends. He always brings it up. This time mum and dad had been having problems, on the verge of splitting up, and I'd started drinking more. I'd come home drunk, dad started on me, we had a massive row. It all got out of hand, all the street was out looking. My dad hit me and I ended up in hospital.

In these situations, there was an explosive mix of difficult and sometimes violent child behaviour, parental violence, and, in some cases, parental rejection. As one parent explained, because of her 11 year-old son's physical aggression towards her 'I was worried what I might do.' However, in this case the problem was not new, as professionals had had past concerns about the possible abuse of this child and he had been looked after in the past. A few parents and two young people mentioned the continuing repercussions of past abuse, both physical and sexual, as the source of young people's difficulties.

The abuse of adolescents is not always recognised as a serious problem. This may be because adolescents may respond to it differently than younger children. Research on abused adolescents in the United States has shown that, while they are more physically durable than younger children, they tend to display the effects of abuse in other ways, through self-harm, depression, running away or offending (Rees and Stein 1997).

## School problems

One fifth of the sample had not attended mainstream school at all during the six months prior to referral. The four fifths who *had* attended had not necessarily done so continuously, as indicated by the high rates of school exclusion and truancy. The schooling provided for the young people is shown in Table 8.4.

**Table 8.4 Educational provision (n=209) ***

| Educational provision | Percentage | Number |
|---|---|---|
| Mainstream school | 80 | 168 |
| Pupil referral unit | 7 | 15 |
| Home tutor | 2 | 4 |
| No provision | 14 | 29 |

* The total number experiencing each type of provision is greater than the sample size because 7 young people had more than one type of provision during this period.

Some of those who had not attended mainstream school had instead attended pupil referral units (7%) or had a home tutor (2%). However, 14 per cent appeared to be completely detached from school, having received no form of education at all in the preceding six months.

Home and school problems went hand in hand. Between them, social workers and support workers reported that 76 per cent of the young people displayed behaviour problems at school. Data from young people and parent questionnaires revealed that 42 per cent had truanted in the month prior to referral and 60 per cent had truanted in the past year.

Rates of exclusion from school were also extremely high. Parents and young people reported that 42 per cent had been temporarily excluded during the past year and that the majority of these (35%) had, in fact, been temporarily excluded just in the past month. Rates of temporary exclusion may be affected by local policy and practice as well as by the nature of young peoples' behaviour, so they cannot be seen as a straightforward indicator of difficulty. Notwithstanding, the very high proportion of the sample temporarily excluded just in the past month suggests that behaviour at school must have been problematic for many of these young people, even if this was not true for all of them. Permanent exclusion was also an issue. A total of 10 per cent (21) had been permanently excluded from school in the past year, five of them just in the past month.

Around the time of referral, then, there was evidence that a remarkably high proportion of the young people were, to a greater or lesser extent, detached from school. In the past month, over two thirds (67%) of the young people had truanted and/or been either temporarily or permanently excluded from school.

Young people and parents' accounts indicated that getting into trouble for their behaviour at school was the most common issue. Behaviour problems at school included disruptiveness, refusal to go to classes, rudeness to teachers and aggression

to other pupils. For some, problems at school had started following the transition from primary to secondary school or between mainstream and special school.

Some young people mentioned that they truanted from school and two were clearly truanting because they were bullied. Bullying was mentioned in only seven cases, although families were not explicitly asked about this issue so the incidence of bullying may in fact have been higher. Parents described how truancy often went hand in hand with behaviour problems at school, offending or drug or alcohol abuse.

Poor behaviour at school was in many cases linked to behaviour problems at home:

> I just wasn't getting on with my mum and didn't like school and wasn't going (boy, 14 years).

In some cases, trouble at school, or non-attendance, 'ratcheted up' parent-child conflicts. As earlier research has found (Biehal *et al.* 2000), when young people were out of school due to truancy or expulsion, problems at home could be reinforced:

> I was excluded from school, bored, in bad moods. I was getting angry because I wasn't at school and started taking it out on mum and dad (boy, 11 years).

## Offending

Over half of the parents (55%) reported their child's involvement in offending to have been a problem in the past six months and 49% of young people reported this. For 21% of the young people, parents reported that offending was a 'major' problem, but only 11% of the young people indicated that they considered it to be a 'major' issue for them. Surprisingly, professionals appeared to be unaware of the extent of young people's involvement in offending since, in comparison with parents, they reported only half as many young people to have recently been in trouble with the police.

Only half of those recently involved in offending had recently been involved in the criminal justice system (22% of the sample). All of these had been cautioned but none had been charged with offences during the past six months. A study of adolescents

who are accommodated found that 22 per cent were persistent offenders while a larger proportion had occasional brushes with the law, but it is difficult to make direct comparisons as the category 'persistent offenders' is not directly comparable to our categories of cautioned/charged (Packman and Hall 1998).

## Running away

Running away was a major issue for this group of young people and was a clear indicator of their unhappiness at home or at school. Seventy one per cent (149) had run away in the past year, according to young people or their parents or both. Well over a quarter of parents (29%) reported that running away had been a major problem in the past six months and eight per cent said it had been a moderate problem.

Just two thirds of the reported runaways (83) indicated how many times they had run away in the past year. Of these, nearly one quarter (23%) had run away only once but over one third (36%) reported that they had run away three or more times in the last six months. Thirteen per cent had run away more than three times during this period, a proportion similar to that found among the wider population of young runaways, of whom 12% have reported (ever) running away more than three times, (Safe on the Streets Research Team 1999).

In twelve cases, parents or young people mentioned running away or being thrown out as a reason for referral. Two 15 year-old boys had been thrown out by their parents. In one case, a grandparent took the boy in after his mother and stepfather threw him out and refused to have him back. In the other case, other relatives said they were the only people willing to have him, as he would otherwise be 'out on the street.' Although they had asked for help from social services, they said they had difficulty in obtaining a response.

Although most runaways were missing for only short periods, some seemed quite determined to stay away. One parent reported that her 14 year old daughter had been missing for five weeks while another girl of the same age had spent some time living rough and had also taken several overdoses. Yet another 14 year old, about whom there were current concerns regarding abuse, was truanting and was reportedly

involved with drugs, alcohol and 'bad company'. He was staying away for days at a time and, according to his mother, had said that 'he didn't want to be here. Anywhere else would be better, even dossing.' Most of the young people who mentioned running away did not explain why they had done so, but two said they had run because of trouble at school and two explicitly linked it to problems in their relationships with parents:

> I kept falling out with mum, kept going away to get away from it all, so I was never at home (boy, 15 years).
>
> I'd been on the streets for one week….I wanted help, I couldn't face another night out. I couldn't stay at home, my mum can't cope. She says I have a bad attitude (girl, 14 years).

Two young people mentioned threats of violence that had led them to run away and others described these threats as a response to their own behaviour:

> I ran away from home. My mum's boyfriend threatened to beat me up. I was back chatting to my mum and hanging around with older people (girl, 13 years).

A number of studies have shown that running away may be an attempt to escape abuse, and given the high level of professional concern about abuse in respect of the young people in this study, this may have been a motivating factor for some of those who ran away (Stiffman 1989; Cohen *et al.* 1991; Widom and Ames 1994; Safe on the Streets Research Team 1999). This highlights the importance of taking running away seriously and carefully assessing the difficulties that may prompt young people to run away (Biehal and Wade 2002).

## Drug and alcohol misuse

Young people and parents were asked whether the young person had a problem with drug or alcohol use. This question is fraught with problems of definition – the extent of substance use that has to occur before it is considered 'a problem' will vary from person to person. It is also more than likely that this issue will be under-reported. Young people may not wish to admit to substance misuse, or may consider their usage of drugs and alcohol to be normal, and parents may not be aware of it.

Problems with drugs or alcohol misuse (or both) were reported in respect of just over one fifth of the young people, as shown in Table 8.5.

**Table 8.5 Reported substance misuse by young people (n=44)**

| Nature of substance use | Percentage | Number |
|---|---|---|
| Alcohol | 13 | 28 |
| Drugs | 17 | 35 |
| Both drugs and alcohol | *9* | *19* |
| Total substance misuse | 21 | 44 |

In most cases, details of the types of drugs used were not supplied. There was a strong association between recent involvement in offending and both drug and alcohol misuse. These were both significantly associated with truancy too, although not with any form of exclusion from school. Sexual behaviour 'putting self or others at risk', as reported by workers, was also closely associated with alcohol and drug misuse. In all cases where drug or alcohol abuse was reported, parents were also concerned about the friends that their children were associating with.

Substance misuse appeared to be more closely linked to the young people's peer group and to other behaviour problems outside the family home rather than to problems within the family, as no associations were found with parental depression, marital conflict, domestic violence or parent alcohol misuse. Neither was there any association with young people's past experience of abuse or neglect.

## Number of difficulties at referral

The number of child problems reported at referral was also counted. To those aspects of child behaviour and parent-child relationships mentioned in Table 8.1 were added temporary and permanent exclusion, running away, self-harm, violence to parents and violence to others. The number of problems reported is shown in Table 8.6.

**Table 8.6 Number of problems reported by parents at referral (n=203)**

| Number of problems | Per cent | Number of young people |
|---|---|---|
| 1-5 | 7 | 15 |
| 6-10 | 51 | 104 |
| 11-15 | 42 | 84 |

Most parents reported multiple difficulties in respect of their children. It is clear that it was an accumulation of stresses that had brought the family to crisis point, rather than a single stressor.

## When young people's problems emerged

Table 8.7 sets out parents' response to the question that asked how recently some of their children's current problems had emerged.

**Table 8.7 When young people's problems emerged (n=200)**

| | In last year | 1-3 years | 3+ years | *Total* |
|---|---|---|---|---|
| Behaviour problems | 29% | 23% | 42% | *94%* |
| School problems | 24% | 26% | 32% | *82%* |
| Self-harm | 19% | 10% | 4% | *33%* |

For a sizeable minority, behaviour problems and problems at school had emerged three or more years earlier. Self-harming behaviour, on the other hand, had in most cases begun more recently. This is not surprising since internalising behaviour of this kind is more likely to emerge during adolescence than in earlier childhood (Coleman and Hendry, 1999).

## Young people's emotional and behavioural strengths and difficulties

An objective measure of the extent of the young people's emotional and behavioural difficulties was sought through use of the Strengths and Difficulties Questionnaire (SDQ) (Goodman 1997). Versions of the SDQ were completed by both parents and

young people and their scores indicated that levels of need were extremely high. This is clear when total parent and child scores (excluding the pro-social sub-scale) are compared to the scores anticipated for a community sample to indicate the range for low need (0-15), some need (16-19) and high need (20-40) (Goodman 1997).

**Table 8.8 Comparison of SDQ Total Difficulties scores with community sample**

| | Low need % | Some need% | High need % |
|---|---|---|---|
| **Community sample** | *80* | *10* | *10* |
| Parent ratings | 9 | 15 | 76 |
| Young person ratings | 26 | 24 | 42 |

Consistent with their self-rating on the Severity of Difficulties measure discussed above, as a group the young people clearly viewed themselves as having less severe problems than their parents' ratings would suggest. Nevertheless, even if their considerably more positive views of themselves are taken rather than their parents', the proportion with a high level of need is still considerably higher than would be anticipated among children in the community as a whole.

The recommended cut off points for the individual sub-scales, as for the total scores, have been selected so that roughly 80 per cent of children in the community do not have needs in these areas, 10 per cent have some needs and 10 per cent have high needs (Goodman 1997). These sub-scale scores are given in Table 8.9.

**Table 8.9 SDQ sub-scale scores ***

| | **Parent rating** | | | **Young person rating** | | |
|---|---|---|---|---|---|---|
| **Sub scale** | ***Low need*** | ***Some need*** | ***High need*** | ***Low need*** | ***Some need*** | ***High need*** |
| Conduct problems | 7 | 13 | 80 | 18 | 14 | 68 |
| Hyperactivity | 17 | 12 | 71 | 32 | 20 | 48 |
| Emotional symptoms | 59 | 15 | 26 | 76 | 12 | 12 |
| Peer problems | 40 | 29 | 31 | 58 | 27 | 15 |
| Prosocial | 50 | 10 | 40 | 66 | 16 | 18 |

* *Where percentages do not add up to 100 this is due to rounding*

Both parent and young person ratings indicated that the proportion of young people in the sample with conduct problems and hyperactivity was far higher than would be likely among children in the wider community. Parents also indicated that the proportion of young people with high scores for emotional problems and peer problems and low scores for pro-social behaviour was also higher than among children in the community.

Domestic violence clearly had a major impact on the young people. Those young people whose parents had reported experiencing domestic violence had higher average scores on the SDQ emotional problems sub-scale than the other young people.[21] Young people reported by parents to have witnessed this domestic violence scored highly on the conduct problems sub-scale too.[22]

Young people's violence to their parents was also closely associated with their emotional problems. Young people reported to display violence to their parents also scored highly on the emotional problems sub-scale.[23] However current or past experience of abuse or neglect was not significantly associated with higher scores for emotional or conduct problems.

We saw in the previous chapter that nearly one fifth of parents had been concerned about their children since they were under five years old. These young people scored significantly higher on the SDQ hyperactivity and peer problems sub-scales than those whose difficulties apparently emerged later and they were clearly a group with a long history of considerable difficulties.[24]

## Gender

There were some gender differences in respect of the difficulties reported. Analysis of both versions of the SDQ revealed that boys had higher scores for hyperactivity

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[21] Kruskal-Wallis test significant at p=.009.
[22] Kruskal-Wallis test significant at p=.048.
[23] Kruskal-Wallis test significant at p<.001.
[24] One-way anova: p=.014 for hyperactivity; p=.004 for peer problems.

then girls. Analysis of the child questionnaires indicated that girls had higher scores for emotional problems and also for pro-social behaviour.[25] However, girls were no more likely to self-harm than boys. They were, however, more likely to have a problem with alcohol abuse than boys, although there was no gender difference in the pattern of drug abuse.[26] Alcohol problems were reported for twice as many girls (19%) as boys (9%). We have also seen earlier that concerns about sexual behaviour were more than three times as common in relation to girls.

Parental reports on the age when difficulties started suggested that onset was earlier for boys. Boys also accounted for around three quarters of those temporarily excluded from school (72%) and those with a statement of special educational needs (76%). As might be expected from national patterns of offending, boys were also more likely to be involved in offending (43%) than girls (24%).[27]

## Comparing the groups using specialist and mainstream services

There were no significant differences between the group referred to specialist support teams and the comparison group using the mainstream service in terms of age, gender, disability, family composition or whether the child had a statement of special educational needs, as we saw in the previous chapter. Neither were there any significant differences between them in relation to truancy, school exclusion, offending, running away, the number and severity of problems reported at referral, nor in the ages at which parents considered the child's difficulties to have started. There was also no difference in whether young people had ever been accommodated in the past or, specifically, during the six months prior to this referral. This was important for the purpose of comparison, since studies in the USA have found that those previously placed were at higher risk of further placement.

However, the young people using specialist teams were more than twice as likely to have been known to social services for more than three years (44%) as those receiving

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[25] One-way anova. Hyperactivity: child version,p=.036; parent version p=.002. Pro-social and emotional problems p<.001.
[26] Chi-square test significant at p=.024.
[27] Chi-square test significant at p=.009.

a mainstream service (20%), an indicator that their difficulties were more likely to have been long term.[28] Past concerns about abuse (though not neglect) were more likely in relation to those in contact with specialist teams, as these concerns had been raised in the past in respect of 40 per cent of those in the experimental group but only 17 per cent of those in the control group[29]. Chronic difficulties therefore appeared to be more common among those referred to support teams, and this might potentially have an effect on outcomes for this group.

In addition, young people's mean scores for total difficulty on the SDQ (young person questionnaire only) were significantly higher for the group using specialist teams.[30] On their own assessment, this group's emotional and behavioural difficulties appeared to be more severe. However, there was no significant difference between groups on the *parents'* SDQ ratings. As we saw in the previous chapter, there was also some difference between parents in the two groups. Mean scores for mental distress, as measured by the General Health Questionnaire, were significantly higher for parents using the mainstream service.

Scores on the two other standardised outcome measures used in the study and on the Severity of Difficulties measure were also compared. Across the sample as a whole, no significant differences in scores were found between the two groups in terms of family functioning (using the Family Assessment Device) or young people's ratings of their well-being (using Cantril's Ladder from the Lancashire Quality of Life Profile). Scores for young people using either specialist or mainstream services are shown in Table 8.10. Differences between the groups which were statistically significant at the 5% level are shown in bold.

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[28] Type of service by whether there had been contact with social services for less than 3 years or for three years or more was tested using the chi-square test: significant at p=.009.
[29] Chi-square tests: duration of problem by type of service significant at p=.001;. past abuse by type of service significant at p=.002.
[30] One way anova significant at p=.032.

**Table 8.10 Scores on outcome measures at referral**

| Outcome measure *(n)* | Perspective | Support team group Mean (SD) | Mainstream Group Mean (SD) | Mean difference (95% CI) | p-value[2] |
|---|---|---|---|---|---|
| Well-being[1] *(175)* | Young person | 54.68 (25.68) | 51.89 (21.69) | -2.79 (-10.50 – 4.92) | 0.476 |
| GHQ-12 *(202)* | Parent | 6.47 (3.72) | 8.14 (3.79) | -1.67 (-2.81 - - 5.26) | **0.004** |
| FAD *(209)* | Combined | 2.38 (0.50) | 2.35 (0.50) | 0.03 (-0.18 – 0.13) | 0.740 |
| Severity of difficulties *(176)* | Young person | 10.02 (5.08) | 11.33 (5.43) | -1.32 (-2.99 – 0.36) | 0.122 |
| Severity of difficulties *(203)* | Parent | 16.97 (5.20) | 17.80 (5.50) | -0.83 (-2.44 – 0.78) | 0.311 |
| SDQ *(177)* | Young person | 19.44 (5.08) | 17.67 (4.92) | 1.77 (0.16 – 3.38) | **0.032** |
| SDQ *(202)* | Parent | 23.64 (5.77) | 23.79 (6.11) | -0.15 (-1.95 – 1.65) | 0.866 |

[1] Based on the Lancashire Quality of Life Profile (Huxley et al, 1996)

Taken together, the differences in young people's scores for emotional and behavioural difficulties, in their histories of past contact with social service and past abuse, their recent use of mental health services and contact with psychologists suggest that, as a group, the difficulties of young people using support teams were both more long-standing and more severe. However, the picture is somewhat mixed, as measures of the number and severity of problems at referral, family functioning, young people's sense of well-being (quality of life) and parents' mental well-being did not indicate greater difficulty for this group.

However when City was excluded from the analysis, it was found that young people in the two other authorities where mainstream services were studied had significantly worse scores for quality of life compared to those using support teams.[31] They also had worse scores, on their own ratings, on the Severity of Difficulties measure

[31] As over half of the comparison group using mainstream services came from City, City was sometimes considered separately or excluded from the analysis in order to test whether particular effects in a single authority were skewing the overall analysis.

designed for this study, the components of which are included in Table 4.1 at the start of this chapter. This suggests that the young people using mainstream services in Borough and Midshire may have been a generally unhappier group at the time of referral even though, as we have seen, their scores for emotional and behavioural difficulties (as measured on the SDQ) were lower than scores for those using support teams.

Although *past* concerns about abuse were more likely to be reported in relation to the group using the specialist teams, there was no difference between them in terms of workers' *current* concerns about abuse or neglect. However, those currently on the child protection register were significantly more likely to be in the group using mainstream teams than those using the specialist service.[32] All but one of the five young people using the mainstream service who were registered came from a single authority (Midshire) and it is possible that this result may be influenced by local policy and practice on registration. Alternatively, it may be that thresholds for receiving a service are particularly high in this authority, since a quarter of our sample in this authority were on the child protection register.

The pattern was similar within City, as there were no differences on any of the measures mentioned above when young people using the support team were compared with others using mainstream services. In contrast to the sample as a whole, however, young people's ratings of total difficulty on the SDQ were no higher for those using support teams in City than for those using mainstream services. It was anticipated that policy and resources in respect of the placement of young people were likely to influence placement rates. Since local policy and resources were the same for both groups within City, care history and social worker ratings of the risk of accommodation at referral were compared. Young people using the support teams were five times as likely to have been in care at some time in the past compared to those receiving mainstream services. Workers were also twice as likely to indicate that those using the specialist teams were at high risk of accommodation than those

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[32] Chi-square test significant at p=.049.

using the mainstream service. [33] It is possible that this assessment was influenced by the fact that many of the former group had been looked after in the past.

## Conclusion

Multiple difficulties were reported by parents and young people at referral and reports of violence were common. This included violence by young people towards parents, other family members or others outside the home and, as we saw in the previous chapter, in 43% of the families there was known to be a history of domestic violence. Social workers and support workers also reported concern about abuse or neglect in relation to over half of the young people, with concerns about emotional abuse particularly common although physical abuse was reported in relation to over one in ten.

The majority of the young people had high levels of need, which were shown by an objective measure of behavioural and emotional difficulties (the SDQ scale) to be far more extensive among this group than in the wider community. For example, parents' ratings on the SDQ indicated that 76% had high levels of need, whereas scores at this level would be anticipated among only 10% of children in the community. SDQ scores were particularly high in relation to conduct problems and hyperactivity, but many were clearly troubled as well as troubling since over one quarter had high scores for emotional problems on the SDQ and one fifth had recently attempted to harm themselves. At least one fifth were known to be misusing drugs or alcohol.

Problems within the home went hand in hand with problems outside it, as three-quarters of the sample displayed behaviour problems at school. Rates of exclusion

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[33] Chi-square test showed that 46% of those referred to the specialist teams had been in care in the past compared to 9% of those referred to the mainstream service (p=.002).
The proportion rated as at high risk of accommodation was 25% of those using the support team compared to 13% of those using mainstream services; the proportion rated as at low risk of accommodation was 38% of those using the support team compared to 78% of those using mainstream services. Chi-square test significant at p=.016).

from school were high and truancy was a serious problem. Worryingly, only 80% attended mainstream school and 14% had no school provision at all. Offending was reported by one fifth of parents, but social workers and support workers were not always aware of this.

Both social workers and support workers were therefore working with a group of young people with serious and multiple difficulties whose parents, as we saw in the previous chapter, had serious problems of their own. There was some indication that, as a group, those young people in contact with support teams were more likely to have severe emotional and behavioural problems than those using mainstream services. They were also more likely to have long-term difficulties. In other key respects, however, the two groups were similar.

# 9 Expectations of service and agency contact

This chapter describes families' expectations of the service and also outlines their contact with other agencies. In around two thirds (67%) of all cases parents had initiated contacted with social services on this occasion. In a further 16 per cent of cases, the approach had been made jointly by young people and parents and in six per cent of cases the approach had been made just by the young person. Only a very small proportion of referrals had been made by other agencies, including schools (3%) and the police (2%).

## Help wanted from social services

### *Help wanted by parents*

One quarter of parents responded to questions about the type of help they would like from social workers and support workers. Numerous parents said that they felt unable to cope with their children any more and that they desperately needed help. A few said they found it hard to cope because they were depressed or lacked confidence. Several were consumed with anxiety about their children's behaviour but felt at a loss to change it. In particular, the parents of five young people with Attention Deficit Hyperactivity Disorder (ADHD) were clearly at their wits end.[34] One was being treated for depression and two said they felt suicidal, such was their despair about their children:

> I was having serious thoughts of suicide, both for myself and harming him. I decided if I took my own life I couldn't leave him behind as he isn't capable of looking after himself. No one else for that matter is capable of looking after him (mother of 14 year-old boy).

When asked what help they had wanted from social workers, sixteen of the parents who responded mentioned the removal of their child. However, in most of these cases they said they had requested only respite care, typically 'to give me a break.' Some

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[34] As mentioned in Chapter 3, we do not know if all of these young people had a clinical diagnosis of ADHD. Young people are here classified as having ADHD is a parent or worker mentioned that they had this condition.

mentioned that they would like some respite together with support to help their child live at home.

Some parents said they simply wanted 'support' in coping with their child: 'to be there as a back up for me and him.' Many hoped for specific advice, to give them greater confidence in their parenting and make them 'a better parent' or, as one put it: 'We want to know what we should do as parents to help.'

A number of them specifically mentioned wanting advice on 'strategies' for dealing with their child, saying that they wanted a positive, structured approach that would give 'clear goals, strategies to work on' and 'identify problems and the way forward'.

> I want help to identify when I need to take action about her behaviour and when I need to stand back, as at the moment I react to everything (mother of girl, 12 years).
>
> How to deal with his aggression. How to defuse a situation when he gets out of hand (mother of boy, 14 years).
>
> I need help when he goes into one of his rages or when he gets so low that I know he is going to harm himself. (mother of boy, 15 years, with ADHD)

As might be expected, many of the parents wanted help from workers in controlling their children's behaviour: 'to get her to do as she is told.' They wanted guidance on how to deal with their children's behaviour at home and, in some instances, how to ensure that they went to school. Some specifically asked for their children to be given help in managing their anger. For many, though, it was back-up in setting boundaries and enforcing them that they felt they needed. They hoped that workers might help their children understand why limits had to be set and why they should accept them. They wanted workers to:

> Help me put in place discipline. My children don't listen to me (mother of boy, 14 years).
>
> Help me to get her to understand that there has to be discipline in her life and that when I tell her not to do things, it's for her own good (girl, 12 years).

Parents also wanted help to improve family relationships, particularly their relationship with the young person who had been referred, but also his/her

relationship with siblings. Some were clearly hoping for mediation between family members, to help them understand one another better and improve communication between them.

A number of parents also said that they hoped that workers would offer support, understanding and guidance to their children, and in some cases they specifically asked for counselling for the child. There was a strong sense that many parents felt their children needed help in understanding why they were behaving as they were. Some parents felt that they too wanted help in understanding this. They wanted both social workers and support workers:

> To sort out what is going on inside his head.
>
> To help her get to the bottom of her problems that she couldn't deal with me.

Some parents hoped that support workers would be able to offer their children a positive relationship, someone they could talk to. They hoped the young people might open up to someone outside the family and begin to work on their difficulties, and a few anticipated that through this relationship workers might help to build up their confidence and self esteem. A few specifically asked for young people to be helped to develop their social skills and their ability to relate to their peers, and some wanted support workers to help their children to get involved in social activities.

Nearly half of the parents had requested accommodation at referral and many parents described the state of sheer desperation they had reached when they had made this request. For example, one mother explained:

> When I phoned them I told them what I wanted, I know they wouldn't do it, but what I really wanted them to do was to say 'Right, things have got so volatile we will come and remove him from the home'. Even if it was just for a couple of hours, because I couldn't protect the other children from him.

Only four mentioned material help with housing or benefits as one of their priorities. The overwhelming focus was on support and advice regarding their children and on rebuilding relationships with them. Finally, many of the parents expressed the wish that social workers or support workers might get their children back into school. In

some cases, they wanted help in dealing with truancy, while in others they requested help in finding a school that would accept their child following exclusion.

### *Help wanted by young people*

When young people were asked about what help they would like the most common response was a wish that they would 'help me with my behaviour.' Many of the young people who replied appeared to accept that their behaviour was problematic and said they wanted the worker to help them find strategies to change it. A number specifically hoped for help to control their anger and several said they hoped that the worker would 'calm me down.' This group were clearly motivated to accept social work help and to try to change, and some said they wanted to understand why they behaved as they did:

> Calm me down – stop me being angry (boy, 14 years).
>
> Helping me with my behaviour – telling me different ways to react (girl, 12 years).
>
> Help me to understand and change my aggressive behaviour, anger and bad language (boy, 13 years).

They clearly wanted some kind of mediation with their parents too, and in some cases with their siblings, to help them get along better. They wanted workers to 'stop us arguing,' 'calm us both down' or 'help to make family life happier.' Most felt that their own 'attitude' was part of the problem and wanted help to change that, but a few felt that it was principally a parent who needed to change. For example, one young person wanted the support worker to:

> Try and stop me and my mum arguing more, by having a word with my mum. Tell her not to shout at me.

Many of the young people clearly hoped for help to improve their relationships with parents and siblings. A number of them mentioned that they wanted all the arguments at home to stop, to make them all 'happier.' Several specifically said they wanted workers to 'stop us arguing and fighting.' Some wanted more general support, someone who would listen to them and understand them, someone they could talk to

about their problems. A few mentioned wanting counselling, or help to understand themselves and change:

> I wanted them to help me and to see what was wrong with me (girl, 12 years).
>
> Help me stop taking overdoses (girl, 15 years).

Several of the young people wanted help with school problems, principally to get them back to school. At least some accepted that they had to go to school and felt they needed help to make this happen. This meant help in finding a school for them to go to because they had been excluded, or help in stopping their truancy, or help in changing to a school where they felt they would be happier. Three had asked for help in stopping the bullying they were experiencing at school.

## Expectations of the service

Surprisingly few said they felt clear about the work that social workers and support workers planned to do with them. Two thirds (67%) of parents said they felt clear about how support workers planned to help them, but only 47 per cent of those who replied were clear about what social workers intended. The pattern was similar for young people, as just 60 per cent of those who answered felt clear about support workers' plans and 45 per cent were clear about social workers' intentions.

Parents indicated that they expected social workers to provide general support and advice regarding parenting and a few expected them to work directly with young people to help them change their behaviour. They also expected social workers to mobilise support from other agencies to provide counselling, work on drugs or, most commonly, help to resolve school-related problems. Some expected support to ensure that their child could stay at home with them, while others wanted social workers to remove their child, either as a brief respite or in the longer term.

Some young people also expected social workers to move them, mentioning that social workers were either going to find care placements for them or work to rehabilitate them with a parent or other relative. Several mentioned that social

workers would support them through 'talking' to them and references to social worker plans to help them 'behave' or 'change my behaviour and attitude' were also fairly common. A number also mentioned social worker plans to get them to go to school and seemed quite positive about this. As one 14 year old girl summed up her social workers' plans:

> Trying to keep me in school and out of care.

As for support workers, many parents who responded expected that support workers would also give them advice on parenting. Some expected specific help in coping with difficult situations, preventing conflicts getting out of hand, setting boundaries and being more consistent. Others anticipated more generalised support that would back-up their attempts to deal with their children. Both parents and young people anticipated that support workers would act as mediators and would intervene to improve family communication and relationships. They also expected that they would provide individual support to young people through talking to them and, in some cases, through getting them involved in activities outside the home - something that young people spoke quite enthusiastically about.

Earlier research has shown that an informal, participative approach by workers is generally welcomed by older children and teenagers and may be more successful in engaging them (Biehal *et al.* 2000). Shortly after referral, young people were asked to indicate how far they felt that workers understood them and involved them in decision-making.

**Table 9.1 Young people's views of workers *(n=106)***

| | Social worker % | Support worker % |
|---|---|---|
| Understands how s/he sees things | 58 | 88 |
| Involves her/him in decisions | 80 | 92 |

At this early stage in the work, although over half of the young people who replied felt that social workers understood how they felt, a far higher proportion felt that support workers did so. Similarly, a somewhat higher proportion of the young people felt that support workers involved them in decision-making in comparison with social workers. These somewhat higher positive ratings for support workers may have been to some extent due to the fact that direct work with young people was an integral part of their work so they had more opportunity to build relationships and engage them.

## Other professional support to young people and parents

### *Support from other agencies at referral*

Parents, young people and professionals were asked about current or recent (during the past six months) support to the child from other agencies. Their answers revealed that the majority of the young people were already receiving support from other agencies, as shown in Table 9.2

**Table 9.2 Recent support to young people from other agencies (n=209)**

| Type of professional/agency | Percentage |
|---|---|
| Education welfare officer | 61 |
| Educational psychologist | 30 |
| Psychiatrist or psychologist | 35 |
| Youth offending team | 13 |
| Young carers group | 3 |
| Youth worker | 9 |
| Drug or alcohol project | 3 |
| No professional support | 13 |

In total, 87 per cent were receiving, or had recently received, some form of professional support apart from their contacts with social workers and support workers. The agency most likely to be in contact with these young people was the education service. Young people were most frequently found to be in contact with education welfare officers, which is not surprising given the high rates of truancy and school exclusion in the sample.

The seriousness of the emotional and behavioural problems of many in the sample is reflected in the fact that 30 per cent had recently seen an educational psychologist and 35 per cent had seen a psychiatrist or psychologist. A relatively small proportion of those involved in offending were in contact with youth offending teams and just a few were in touch with youth workers.

Parents and professionals were also asked about other current or recent support to parents. It was clear from their responses that parents were less likely to be in contact with other professionals than young people. The health service was the agency most likely to be in contact with parents. In particular, mental health services were used by nearly one fifth of the parents, as shown in Table 9.3.

**Table 9.3 Support to parents from other agencies (n=203)**

| Type of professional/support | Percentage |
|---|---|
| Psychiatrist or psychologist | 10 |
| Community psychiatric nurse | 6 |
| Counsellor/therapist | 3 |
| Other health professional | 8 |
| Family centre | 14 |
| Family aide | 2 |
| Social worker from adult services team | 13 |
| Probation officer | 1 |
| Community group | 2 |
| Police | 2 |

### *Support from other agencies between referral and follow-up*

Between referral and follow-up young people remained in contact with, or were referred to, various other agencies as well as with social work staff. Table 9.4 shows that fewer young people were in contact with education welfare officers, educational psychologists and youth workers at this stage, but the proportion in contact with child psychiatrists or psychologists had changed very little.

**Table 9.4 Professionals in contact with young people between referral and follow-up**

| Type of professional | Young people receiving service | |
|---|---|---|
| | % | Number |
| Education welfare officer | 47 | 91 |
| Educational psychologist | 9 | 18 |
| Child psychiatrist/psychologist | 34 | 67 |
| Youth Offending team | 16 | 31 |
| Family centre | 10 | 20 |
| Drug/alcohol project | 7 | 13 |
| Young carers group | 4 | 7 |
| Youth worker | 3 | 6 |

No young people had been in touch with family centres prior to referral and it is probable that the 10 per cent who were by follow-up had been referred by social workers or support workers in the course of their work.

Help, or alternatively a lack of support from schools and education authorities, could have a major impact on young people. Nearly one quarter (24%) of them reported that they had received help from school staff and many were particularly appreciative of this. However, some education authorities could be less than helpful, and this often exacerbated family stress. This was particularly the case where young people had been permanently excluded for lengthy periods of time with inadequate, or no, alternative provision for their education.

### *Comparing service use by the two groups*

During the six months prior to referral, young people using support teams were almost twice as likely to have seen an educational psychologist (35%) than those using mainstream services (19%). They were also more than twice as likely to have seen a child psychiatrist or psychologist during this period (44%) than those using mainstream services (17%), which suggests that their emotional or mental health problems may perhaps have been more severe.[35]

Between referral and follow-up, those involved with specialist support teams were significantly more likely to have received a service from an educational welfare officer, a child psychiatrist or psychologist or a drug or alcohol project in the past six months, as shown in Table 9.5.[36]

**Table 9.5 Agencies involved with young person between referral and follow-up by service type (n=195)**

| Type of professional | Mainstream social work % *(n)* | Specialist support team % *(n)* |
|---|---|---|
| Education welfare officer | 26 *(15)* | 56 *(76)* |
| Psychiatrist/psychologist | 16 *(9)* | 42 *(58)* |
| Drug/alcohol project | 0 *(0)* | 10 *(13)* |

During this period young people receiving the specialist service were generally more likely to receive a service from another agency. They were also likely to receive services from *more* agencies, as shown in Table 9.6.[37]

**Table 9.6 Number of agencies involved between referral and follow-up (n=195)**

| Nature of service | No other agencies % | 1-2 agencies % | 3 or more agencies % |
|---|---|---|---|
| Mainstream social work (n=58) | 33 | 57 | 10 |
| Specialist support team(n=137) | 17 | 56 | 27 |

[35] Chi-square tests significant at p=.017 for educational psychologists and p=<.001 for child psychiatrists or psychologists.
[36] Chi-square test - education welfare p<.001; psychiatrist/psychologist p=<.001; drug/alcohol project p=.015.
[37] Chi-square test: p=.007.

Those referred to support teams were therefore likely to be in contact with a greater number of other agencies, and were more likely to have contact with agencies dealing with mental health, school or substance abuse problems. They received services that were both more intensive (on the part of social services, as families had more intensive contact with support workers than with social workers) and more extensive (in terms of other agency involvement). Those with the highest levels of need may attract a wider range of services but this may be an indication that this group might be the most difficult to help, which could have implications for the outcomes that might be achieved in work with them.

The multi-agency context in which both the specialist support team service and the mainstream social worker service took place also has other important implications for attempts to measure the outcomes of these services, as it is difficult to disentangle the relative effects of specific types of service being offered at the same time. For example, a social worker may have a considerable, but indirect, impact on outcomes for a family through assessing them and then referring them to a family therapy service or mental health practitioner, or by lobbying the child's school or education authority to improve the support offered to the child. At the same time, they may or may not undertake direct therapeutic work with families themselves, or may commission their local support team to undertake this. Equally, while support teams normally undertook direct work with families, they too tried to link them to other resources or intervened with other agencies, such as schools.

The multi-agency environment in which children's services are delivered, and the complex ways in which services may interact to produce a particular effect, make it difficult to tease out the relative impact of each separate service. It follows that, in teasing out the relative effectiveness of a support team or a mainstream social work service in this context of concurrent interventions by other agencies, caution is needed to avoid making over–certain claims about causal links between any single intervention and the outcomes with which it is associated.

# 10 The interventions

The description of young people's characteristics, histories and difficulties at referral given earlier revealed that these young people had extremely high levels of need and that the majority had serious emotional and behavioural difficulties. It is clear from this that thresholds for receiving a preventive service were very high. Some parents complained that they had asked for help on one or more occasions in the past, before the current crisis, but social services had not responded. It often appeared to be the case that it was only when families reached crisis point that social services intervened. In three-quarters of all cases, a particular event or crisis had led to the referral. This was true in respect of referral both to specialist teams and mainstream services. A number of parents described how they had approached social services for help in the past, to no avail:

> And I'm like in tears on the phone....(*the social worker*) basically didn't want to know. And this is what I'm like saying to Social Services 'Please could somebody help me here, I've got an abusive violent child, I've got two little ones,' but nobody wanted to do anything (lone mother of boy, 13 years).

> I was having a lot of trouble with her and I also suffer from depression...I'd hit her and then I ended up taking an overdose and my doctor wrote to them and then they thought they would get involved ....I had a meeting with Social Services, we went to the meeting and I had a letter back saying they didn't want to know (mother of girl, 14 years).

> They were not interested when we wanted help. Then they would call when one of our little ones had fallen off his bike (mother of boy, 12 years).

> I ring them up, they don't take me seriously. I feel you have to physically damage your children before they do anything (mother of boy, 13 years).

> When we've rung and asked for help they've said there's no-one available. When we adopted the children we were told support would be available (adoptive father of boy, 13 years).

It was particularly difficult for area social work teams to offer family support work. Many of the area teams in the study explained that they were understaffed, to some extent due to the national social worker shortage. Many social workers mentioned that, in these circumstances, most of their time was taken up by work on child

protection or with looked after children, leaving little scope for preventive work. Several social workers and team managers spoke of the gate keeping strategies employed to manage demand. Unless there were serious child protection concerns, many families referred initially received only a letter or phone call rather than a visit, on the assumption that if they were in serious need of a service they would make contact again. One team manager spoke of holding new referrals in his in-tray for a number of weeks and then closing them without assessment if the family made no further contact. Area social workers and team managers were very concerned about the amount of unallocated preventive work, often involving young people at serious risk although not necessarily in crisis at that point in time. Some social workers appeared to be quite honest with families about the financial reasons for their inability to offer a service, as parents in two authorities explained:

> I think the facilities that they say they offer should be improved because it is always the thing that they have run out of funding. They can't afford to do this and they can't afford to send nobody out and I'm sick of hearing it, I've heard it all my life (mother of boy, 13 years).

> Instead of saying 'I am sorry, there is nothing we can do, we haven't got no money' (*social workers*) should actually listen to us, as in support us (father of girl, 12 years, with severe mental health problems).

Another strategy for managing demand appeared to be the downplaying of parents' concerns. A few parents complained that they had not had their concerns taken seriously on this or on previous occasions. Social workers, and occasionally support workers, had portrayed behaviour that parents considered serious as being little different from normal adolescent behaviour. In some cases, this may have been entirely justified if workers considered that parents were unduly critical of their children and that the problem lay principally with the parent rather than the child. On the other hand, we have seen that the majority of the young people were displaying some serious behavioural and emotional problems, so this response may well have been a form of 'counselling out', with a view to reducing the demand for a service which was in short supply.

Another reason for this 'normalising' of the young people's behaviour may have been that both social workers and support workers were so used to working with families

with high levels of need that some became inured to the severity of their difficulties even though parents, and often young people, were expressing considerable distress. Some workers came to see young people's problems as normal for the population they worked with, and therefore not requiring intervention, as these comments indicate:

> In this case it's about troubles with behaviour, stealing, staying out late, drinking, boyfriends, school exclusion, they are pretty run of the mill stuff, aren't they (social worker of girl, 14 years).

> My daughter had been sexually abused, she had taken an overdose. I needed that help but I didn't get it.... They are very patronising and say there are children much worse off than my child (mother of girl, 15 years).

> They seemed to think a 15 year old staying out and experimenting with drugs was normal behaviour, they actually said that (mother of girl, 15 years).

Evidence from this study is supported by a government inspection report on one of the authorities from which our comparison group was drawn, which was published during the course of the fieldwork. This Joint Review report commented that access to social work services was inconsistent and that thresholds for receiving a service were very high. Children's cases often reached crisis point before help was offered and only a small proportion of initial referrals were transferred on for longer-term work. This inspection recommended that targeted provision was needed for families of children of all ages who were struggling to cope and that, in particular, more resources were needed to divert older children from the care system.

The gate keeping strategies employed by authorities in this study meant that, in effect, agency needs were prioritised over young people's needs. Such strategies were also likely to be effective (for the agency) as a short-term means of reducing rates of accommodation, through a privileging of service outcomes over outcomes for young people. Levels of resourcing for children's services, together with the effects of the national social worker shortage, clearly have a profound impact not only on the level of family support services available but also on workforce psychology. In the struggle to manage demand, managers and workers develop strategies that in themselves serve as a further barrier for families seeking much-needed help from hard-pressed services.

While rationing and demand management are inevitable in the provision of any publicly funded service, it is clear that there are particular pressures on social services to manage the demand for family support services. In the context of the performance targets for social services, discussed in Chapter 2, and of wider public pressure to manage the risks associated with abuse, there may be a perverse incentive for managers and social workers to prioritise child protection services and services for looked after children at the expense of family support services.

## Duration and intensity of interventions

Support workers typically worked with families for a shorter period of time than did social workers, as shown in Table 10.1.

**Table 10.1 Duration of contact with families by social workers and support workers**

| | **Social workers** *Percent (n=71)* | **Support workers** *Percent (n=126)* |
|---|---|---|
| Under 6 weeks | 11 | 6 |
| 6 weeks to under 3 months | 6 | 28 |
| 3 months to under 6 months | 20 | 43 |
| 6 months and over | 63 | 24 |
| *Mean (weeks)* | *36* | *19* |

One third of support team cases were closed within three months and over three-quarters (77%) within six months, whereas just 17 per cent of social workers had closed cases within three months and just over a third (37%) within six months. The duration of social worker involvement was not associated with whether or not a support team was also working with the family. Social workers worked with families around twice as long as support teams, for an average of nine months in comparison with an average of just under five months for support teams.

The total duration of contact with families was similar for social workers across all authorities. However, there was more variation between support teams. For example,

whereas MetEast support workers were involved with families for just over 14 weeks on average, their colleagues in City were involved for just over 25 weeks.[38]

During the (approximately) six months between referral and follow-up, support workers typically had more face to face contact with families than did social workers – a mean of nearly 33 hours compared to 11 hours for social workers.[39] Families receiving the specialist service (who saw both social workers and support workers) had on average over 45 hours contact with social services over the six-month period compared to less than nine hours for those receiving mainstream services (who saw only social workers).[40] The number of face-to-face contacts by both types of worker and the intensity of this contact in total hours varied by local authority, as shown in Table 10.2.

**Table 10.2 Amount of face-to face worker contact by local authority**

| | **Social workers** *(n=93)* | | **Support workers** *(n=131)* | |
|---|---|---|---|---|
| | **Mean number face to face contacts** *(p=.008)* | **Total face to face contact (hours)*** *(p=.410)* | **Mean number Face to face contacts** *(p=.004)* | **Total face to face contact (hours)** *(p=.001)* |
| Eastshire | 6.7 | 7.5 | 11.2 | 16.1 |
| Met East | 9.9 | 10.2 | 16.3 | 24.8 |
| City | 8.2 | 10.5 | 16.6 | 42.7 |
| Midshire | 11.3 | 12.0 | - | - |
| Met West | - | - | 23.7 | 36.8 |
| Borough | 8.9 | 9.5 | - | - |
| Northshire | 18.7 | 16.8 | 22.7 | 44.3 |
| Met North | 10.9 | 11.9 | 16.0 | 25.3 |
| *Mean* | 10.1 | 11.0 | 18.6 | 32.9 |

* *Variation between authorities in this column was not statistically significant.*

[38] Kruskal Wallis test, significant at p=.027.
[39] Independent samples T-test, significant at p=.014. As we saw in Chapter 1, in most cases follow-up time was in the range 6-7 months and variations in follow-up time did not result in any systematic bias (see Table 1.6).
[40] One way anova, p=<.001.

There was considerable variation between authorities in the number of face-face contacts by social workers. Social workers offering only a mainstream social work service had less direct contact with families (a mean of 8.5 hours) than they did with families who also received the specialist service (a mean of 12.5 hours face-to-face contact). Within City, where both a specialist and a mainstream service was studied, the mean number of face to face contacts with families was 12.8 for social workers working alongside specialist teams and 7.6 for those offering a mainstream service only.[41]

As for support workers, there was significant variation between local authorities both in the number of face-to-contacts undertaken and in the total duration of those contacts. Support workers in Eastshire, who were based in a single office but covered a very large county, and had higher caseloads than the other teams, had significantly fewer contact hours and fewer total hours of face-to-face contact time than other support workers. Total face-to-face contact time was highest in Northshire and City, followed by Met West.

## The nature of the interventions

It would be misleading to consider support team interventions in isolation from work by social workers since (except in Met West), they were often delivered in tandem with continuing social worker support. The extent of this support varied from case to case. In some cases social workers more or less withdrew from direct involvement with families for the duration of support team involvement, retaining only an overall case management role. In others, social workers worked alongside support workers, so that each delivered different aspects of the intervention. For this reason, the specialist support team service is here conceptualised as a service involving some combination of both support worker and social worker interventions, whereas the mainstream service involved only social worker interventions.

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[41] These differences were not statistically significant, perhaps due to the small numbers involved, p=.08.

At follow-up, workers were asked to tick a list of possible areas of work that they had undertaken with families (and could indicate any other interventions not included in the list if necessary). Although both social workers and support workers worked on the same issues, there were differences in the balance between different types of work undertaken as shown in Table 10.3.

**Table 6.3 Interventions delivered to families receiving different types of service[42]**

| Focus of help | Elements of the intervention | Percent of users of mainstream service *(n=44)* | Percent of users of specialist service *(n=132)* |
|---|---|---|---|
| *Practical help* | Practical help/services | 30 | 35 |
| | Financial/material help | 25 | 22 |
| | Help with housing problems | 18 | 13 |
| | Advice about benefits | 41 | 57 |
| | Advocacy with other agencies | 39 | 54 |
| *Young person's behaviour* | Strategies for parent | 55 | 87 |
| | Strategies for young person | 50 | 79 |
| | Work on drug or alcohol problems | 0 | 27 |
| | Young person's social skills | 34 | 59 |
| | Sexual behaviour puts self/others at risk | 18 | 24 |
| *Emotional problems (child)* | Emotional problems | 46 | 79 |
| | Mental health problems | 5 | 16 |
| *Family relationships* | Mediation | 57 | 82 |
| | Improving communication | 64 | 89 |
| | Focus on underlying causes of problems | 57 | 83 |
| *Parenting capacity* | Work on marital difficulties | 16 | 30 |
| | Support to improve parental care | 9 | 44 |
| | Mental health problems | 7 | 13 |
| | Work on drug or alcohol problems | 5 | 8 |
| | Mobilising informal social support | 30 | 37 |

[42] Chi-square tests showed that the differences between services highlighted above were statistically significant at p=.01 or less.

The principal differences between the two types of service lay in the extent of direct work undertaken with families. Where support teams were involved, families were twice as likely to receive interventions that offered strategies to young people, parents, or both, in respect of changing the young person's behaviour and addressing their emotional problems. Workers delivering the specialist service were also roughly twice as likely to offer direct work on improving family relationships, including working on reframing parent-child communication and mediating between them. The specialist service also appeared to offer a greater emphasis on exploring underlying problems within families, although this was somewhat surprising as most teams said that they were principally concerned with a focus on change in the here-and-now. They were also more likely to offer support to improve parental care. However, there were no significant differences in the provision of other interventions to improve parenting capacity. Neither were there any significant differences between the two types of service in the provision of practical, financial or other material help.

Support workers typically engaged in *more* direct work both with young people and parents than did the social workers of families receiving this specialist service, and this is borne out by the fact that they had more face-to-face contact time with them as already shown.[43] While social workers offering a mainstream service did undertake direct work with young people and parents it is clear that this was less common. Their case management role involved the co-ordination of services from other professionals within or outside social services. However, apart from some social workers in City who were able to draw on a pool of sessional staff, in the absence of a specialist family support team they generally had fewer resources available to them to allow for the provision of very much direct work by others and, as we have already seen, in most cases they themselves had fewer opportunities for face-to-face contact with families referred for family support. This was due to the prioritisation of other types of work.

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[43] Analysis of qualitative data and scrutiny of the paper questionnaires to compare interventions ticked with later descriptions (in answer to open-ended questions) of what social workers and support workers were each doing indicated that this was this case.

Analysis of qualitative material from the interviews showed that support workers, who had more opportunities for direct work, were able to develop their specialist skills in working with older children and teenagers. This helped them to successfully engage many of those referred to them. Since their contact was more intensive this also helped them to rapidly build relationships, as they could spend time listening to young people and demonstrating their understanding and concern. Contact time was needed to build trust, which was often a prerequisite to engaging young people and so working with them successfully. Social workers, on the other hand, rarely had the time to build relationships with young people due to other demands on them. The support teams' participative approach centred on building strengths rather than focusing on deficits, and this too may have helped workers to engage both young people and parents.

In most cases, support workers focused both on helping parents to develop more effective parenting strategies and helping young people to manage their own behaviour. Although the intention was usually to focus on the present situation and how it might be changed, there was sometimes some exploration of underlying causes of problems as well.

*We used the parenting group to reinforce her parenting, support her parenting and support her in setting some boundaries, and allowing her to talk to him about the reasons for his angry outlook as well. ...In his past there's quite a lot of issues so it was to give him the chance to explore those to see if they were causing his behaviour and also we talked about how he could manage his anger* (support worker of boy, 13 years, previously abused by his father and currently involved in offending).

*(The support worker) was brilliant. With Emma it was about her boundaries, what she should be looking for in the home, what she should be looking for out of the home. With me it was about things like, when she does start, help her step back, things like that. It was really helpful...A lot of good things she told us, like confronting her, and because we were predicting what she was going to do, she wouldn't do it....If we do have a grievance with her, instead of using 'you' we've got to use 'I' statements. Like when she's late in, instead of saying 'You are late, you're supposed to be home' I've got to say 'I'm not very happy and I'm worried because you're not home.' And that seems to work as well* (mother of girl, 13 years, violent to her parents and to others).

Although workers paid a lot of attention to helping young people change their behaviour, they were aware that the development of behaviour problems was often linked to their experience of emotional or other kinds of abuse, or severe conflict between their parents, or inconsistent parenting. The two-pronged focus both on parenting and on young people's behaviour was therefore likely to be helpful. However, workers sometimes felt it was a little unfair to expect young people to change in cases where the underlying problems were clearly rooted in a parent's negative attitude towards them. Nevertheless, in the context of such difficult practice dilemmas they were usually pragmatic about what they felt needed to be done in the child's best interests, as one explained:

> I mean, the social worker is very much coming from the point of view that the mother has got to change before we can do any work with this child, but that isn't to me realistic. Yes, I wanted to avoid the trap, I did not want to put pressure on him to come up to his mum's expectations to get mum off his back, but at the same time I knew that this is a real, ongoing, deeply entrenched thing, so we had to move a little way towards it (support worker, explaining reasons for work on behaviour problems with 11 year old).

While the focus was principally on enhancing parenting skills and changing the young people's behaviour, workers were also concerned to build the young people's self-esteem and develop their social skills, sometimes through involving them in groups or encouraging them to take part in youth clubs and local sports or other leisure activities. The intensive work undertaken by support workers was usually multi-faceted, addressing difficulties in different domains of the young people's lives: in their families, at school, in their peer groups. The following case example illustrates the wide-ranging nature of the work typically undertaken by support workers.

Heather, age 11, lived with her mother, who suffered from depression and had recently separated from Heather's stepfather. The social worker felt her mother was emotionally abusive, neglectful and unable to demonstrate affection, due her own institutionalisation during a lengthy episode in care as a child. Heather was deeply unhappy at home, did not like her stepfather and had run away repeatedly, explaining: *'I was scared coming home all the time.'* She stole from her family, was violent, was sniffing gas and had made several recent attempts to hang herself. Her support worker described the wide-ranging nature of her intervention:

*'With mum, I've tried to talk to her about strategies that are likely to work and strategies that aren't and tried to help her improve her understanding of why Heather behaves the way she does and talking to her about the way she copies mum's coping strategies. Mum will go on and on and then throw her hands up and say "I'm going to take all my tablets" as a means of controlling Heather. I've tried to say to mum "you need to be clear with her what you want." What she tended to do was not give her any guidance, not give her any boundaries and then when she overstepped them you know, go up like a bottle of pop. I see a lot of the difficulties coming from the past. I didn't do many in-depth discussions but I've tried to encourage her to look at them, to think about it.*

*I did some work (with Heather) around the dangers of gas. We have got some cards, you know, all about gas and dope and that sort of stuff. I tried to introduce her to youth clubs and things that wouldn't cost a lot of money, that her mum would continue doing after the service was withdrawn….She has been introduced to a counsellor…….She has done the anger management course and that had a double purpose as well. It is done in a group so it is with other young people, to try to improve co-operation and that kind of thing between young people.*

*She had several episodes of weekend respite with her paternal grandma. …I have tried to engage with mum's partner but that's not been very successful because he just comes and goes. I've tried to help her link up with her birth father but that's proving difficult because his new wife doesn't know anything about her so it's not possible, which is a shame.'*

Heather was positive about the help she received:

*'We watch TV and then I talk to her about how school's been, how the past has been, if I had had any bad feelings or anything, iron the anger out ….I tell her everything and then I don't have the problem again. It's just like, when I release them, I don't have them again, the problems. Feels like….a cream part of my heart's been put in, instead of the bad side of it.'*

### *The role of social workers*

As mentioned earlier, for young people referred to support teams in all authorities except Met West area social workers retained case responsibility and had varying levels of direct involvement with them. In most cases their role was principally one of case management and co-ordination. They often liaised with other agencies to obtain services for the family and sometimes worked more closely with other agencies on the young person's behalf, particularly with schools. They were also responsible for dealing with any child protection concerns that arose. In some cases, they would work with a parent while the support worker worked with the young person, or vice versa, or they would visit the family from time to time to discuss how the work with the support team was going. In most cases, however, responsibility for direct work with the family was handed over to the support team for the duration of their involvement. Most social workers had little time to work directly with families, but could commission this work from support teams, as this support worker explained:

> What you do is, you work with families, you work with them to empower them to sort out their problems……If the social workers haven't got the time to do it then at least somebody's doing it…...I haven't got case holder responsibility, so that means I can concentrate on the work that needs doing.

For those young people who were using a mainstream social work service, the extent of social worker intervention was also variable. In some cases social workers focused predominantly on obtaining services for the family from other agencies, such as family therapy or adolescent mental health services or, for example, battling with an education authority to provide schooling for a child permanently excluded from school. Some also tried to involve young people in local leisure activities, such as youth clubs or sports activities. A few social workers went further than this and worked directly with parents on parenting and communication, took young people out to talk to them about their difficulties, or mediated between parents and young people and addressed problems in communication between them. However, a more limited role was more common. As we have seen earlier, social workers offering a mainstream social work service generally had fewer direct contact hours with families

than those who commissioned the specialist service. A greater proportion of their time was spent on the co-ordination of resources and liaison with other agencies.

### *The use of sessional workers*

In around one quarter of the cases (26%), a sessional worker also worked with the family, in most cases with the young person. In two cases in City where these sessional workers were deployed, the mainstream social work service was not dissimilar to the service offered by the city's support team. The support teams in City had their own separate pools of sessional workers. The Eastshire and Northshire support teams also made considerable use of sessional staff. Their extensive use of sessional staff helped the Eastshire support team to compensate to some extent for the fact that they themselves were unable to offer as many contact hours as other teams due to the wide geographical dispersion of their service users. Young people in touch with support teams were twice as likely to see sessional workers, as 31 per cent did so, compared to 14 per cent of those using mainstream services only. As mentioned earlier, sessional workers were mainly used to befriend young people and, through this, to give them an opportunity to discuss their difficulties and to involve them in positive activities. As one social worker explained:

> He's a very quiet person, he hasn't got any friends or anything, he hasn't had any relationships with any sort of grown up, so the reason (*for having a sessional worker*) was for him to have somebody he could form a relationship with, to explore activities in the local area (social worker of 14 year old boy, living with relative while parent was in prison).

## Theories and methods

At the beginning of the study support team managers and team members were asked about the methods they normally used. Most teams did not draw on an explicit theoretical base. The Met West team was an exception to this, as it had produced a document outlining its approach that indicated that their work drew on family systems theory, attachment theory and social learning theory. The Met East team said their work was informed by family systems theory too and that they also used cognitive-behavioural methods. Although the other teams did not indicate that they were using any particular theoretical models, the work on anger management that was common to

all teams clearly drew on cognitive-behavioural theory and much of the structured work on parenting skills appeared to be informed by social learning theory. The teams also spoke in more general terms of undertaking general 'family work', 'direct work' with young people or having a 'therapeutic approach', as well as providing practical and emotional support.

At follow-up both support workers and social workers were asked whether they had drawn on any specific theories or methods in their work with this family. Less mention was made of theories than of methods, but just a few mentioned drawing on attachment theory or family systems theory and one support worker mentioned concepts drawn from psychodynamic approaches. A few social workers mentioned using task-centred methods and support workers from most of the support teams said they used Solution Focused Brief Therapy.

This approach, which was mentioned more than any other, has its roots in Strategic Family Therapy and has often been used by services which have the aim of preventing family breakdown (Lethem 2002). It was developed in the early 1980s mainly by de Shazer and his colleagues at the Milwaukee Brief Family Therapy Centre (Parton and O'Byrne 2000). Employing the notion of 'problem-free talk', it focuses on finding exceptions to reported problems and on negotiating concrete strategies to bring about change. It therefore 'concentrates on the how, when, what and where of solutions' and rarely asks 'why' questions (Lethem 2002: 191). The approach encourages practitioners to adopt a collaborative therapeutic style, which focuses on developing family strengths. Apart from this, a small number of support workers reported using behaviour modification techniques and a few social workers said they had used counselling techniques or crisis intervention. Support workers and social workers were often eclectic, drawing on more than one of the above approaches, and some said they were unsure as to what theories informed their work.

## The nature of work with young people

Support workers who, for the most part, held vocational rather than professional qualifications, often used structured programmes and resources, while professionally qualified social workers acted as case managers and had a largely administrative role. Of course this pattern varied, with some social workers engaging more directly in work with families, but the general pattern was for them to oversee work undertaken by others. Taken together with the extensive use of sessional staff, this represents evidence of a degree of de-professionalisation in work with young people. This is part of a more widespread trend towards de-professionalisation in public sector services, as evidenced by the use of learning mentors in schools and the shift towards increasing use of unqualified sessional workers and volunteers to carry out face-to-face work in youth justice (Pitts 2001). De-professionalisation results in a cheaper, more flexible workforce, making it easier for overstretched services to respond to demand.

Professionally qualified social workers were assessing families and then passing on much of the work with them to support teams largely composed of staff without professional qualifications, to carry out task-focused work (often using structured programmes, worksheets and similar resources). These staff had considerable skills and experience, in most cases developed over many years of looking after children in residential care. However, the shrinkage of the children's residential sector will mean that in future years such a pool of staff with long experience in work with young people will no longer be available and more attention will be needed to ensuring that staff are suitably qualified.

The goals of the largely task-focused work undertaken by support teams were, principally, helping parents to develop skills that were more effective in managing young people's behaviour, a reduction in problematic behaviour by young people and parents and a reduction in parent-child conflict. Of course, such goals were agreed with families at the start of the work and, as we saw in the previous chapter, this was the kind of help that they wanted. Parents and young people were therefore helped to change their behaviours, and as we shall see in the chapters that follow, many felt that

this was helpful. There was little time, however, to address broader questions of motivation and need, underlying issues that might have longer-term consequences both for young people's well-being and their behaviour. In work on anger management, for example, people are not asked to consider why they feel a loss of control or reflect on the roots of their impulsive behaviour, but are instead taught to 'manage' their anger, to work out what actions to take if they feel aggressive (Howe 1996). This may indeed be very helpful, but underlying conflicts may continue to manifest themselves in other ways.

Given the tight time scales and demands of other work, social workers and support workers were obliged to focus largely on changing behavioural performance rather than consider in depth such issues as poor attachment, emotional abuse, rejection, or the continuing effects on young people's emotional health of domestic violence or other parental problems. Non- professional staff were not trained for work of this kind and in any case it would have been difficult for them to undertake it in the context of providing a short-term service. As for social workers, they had little opportunity to do it, given the demands of their case management role and the prioritisation of other areas of work. Where they did not have local support teams or sessional staff to assist them, as in two of the comparison authorities, little face-to-face work could be undertaken with families.

This concentration on changing surface actions and behavioural performance, with little time to focus in any depth on the messy, complex problems that might underlie them, has been identified as a more widespread phenomenon within social work, one that is not confined to preventive work with young people (Howe 1996). This is not to say that underlying problems were ignored, as both support workers and social workers clearly recognised their impact and some indicated that they had addressed these issues. However, this was not a central strand in their work.

The task-oriented practice which has become increasingly common in contemporary social work, with its focus on the development of concrete skills and performance-related changes in child and family functioning, allows staff without a professional grounding in psychologically- and sociologically-based social work theories to

undertake work with families. These strategies allow for the de-professionalisation of work with young people, which may help to reduce service costs and facilitate the provision of help to families who might not otherwise receive a service. It has been argued elsewhere, however, that the shift in focus from a concentration on the actor to a concentration on the act, requires workers to perform as technicians following a handbook rather than as skilled, autonomous professionals (Howe 1994). The 'here and now' focus on what people do rather than why they do it, in the context of brief, time-limited interventions, means that each time a case is re-opened a fresh set of negotiations leads to a fresh set of goals for the behaviour of service users, which may be unrelated to past events and past interventions (Howe 1996).

To sum up, families' expectations of the service that they wanted, described in the previous chapter, appear to have been met by the service that was provided to them. They had wanted advice on parenting strategies, help to change undesirable behaviours, help in understanding young people's problems and support for both young people and parents. On the whole, this appears to be what they got. Their views on whether they found this service helpful are discussed in the next chapter.

# 11 Outcomes for the young people

In the last chapter, we saw that the specialist teams worked more intensively with families, and over a shorter period of time, than social workers. Overall, they also had more face-to-face contact time than social workers and carried out more direct work with young people and parents. The principal areas on which they were more likely to work, in comparison with social workers, were in offering advice on parenting strategies, teaching young people new patterns of behaviour, helping with emotional problems, working on parent-child communication and mediation. The question is, was this different emphasis in work with families *more* likely to contribute to positive outcomes for young people than the work of mainstream social workers?

This chapter will address three issues through the analysis of quantitative data. First, it will outline the changes that took place between referral and follow up. Second, it will explore whether the characteristics of the young people or the characteristics of the different types of service were associated with any differences in outcomes. Finally, it will report on family satisfaction with these changes and on young people's and parent's views of the effectiveness of the services they received.

## Comparing levels of need in the two groups

In order to compare outcomes for young people using either support teams or a mainstream social work service it is important to understand to what extent the two groups were similar, so it may be helpful to reprise the comparisons that have already been made. Although the two groups were comparable in many ways, they differed in some key respects. Table 11.1 summarises the similarities and differences between the groups using the two types of service at the point of referral.[44]

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[44] Scores on these measures at referral have been given in Chapter 8.

**Table 11.1 Similarities and differences between the groups at referral** (n=209)

| Differences | Support team service | Mainstream service |
|---|---|---|
| Chronic difficulties | 44% | 20% |
| Past abuse | 40% | 17% |
| Recent contact with child psychiatrist/psychologist | 44% | 17% |
| Recent contact with educational psychologist | 35% | 19% |
| SDQ score for emotional/ behavioural difficulties (on young people's rating, but not parents' rating) | Worse | Better |
| Score for parents' mental well-being (on GHQ) | Better | Worse |
| **No difference between groups** | | |
| Child characteristics, family composition, school exclusion, truancy, offending, running away, drug and alcohol misuse, number and severity of difficulties reported, past placement in care and initial scores for family functioning and child quality of life. | | |

## Change between referral and follow-up

### *Scores on outcome measures at follow-up*

Differences between the groups on the child-completed version of the SDQ and on the GHQ had vanished by follow-up. At this stage there were no longer any statistically significant differences in scores for the two groups on any of the outcome measures used, as shown in Table 11.2.[45]

[45] Scores for the two groups were compared using the independent samples T-Test.

**Table 11.2 Scores on outcome measures at follow-up**

| Outcome measure *(n)* | Perspective | Support team group Mean (SD) | Mainstream Group Mean (SD) | Mean difference (95% CI) | p-value |
|---|---|---|---|---|---|
| Well-being *(104)* | Young person | 65.87 (24.82) | 68.84 (16.08) | -2.97 (-11.48 – 5.54) | 0.489 |
| GHQ12 *(136)* | Parent | 3.73 (4.03) | 4.13 (3.81) | -0.40 (-1.87 – 1.08) | 0.597 |
| FAD *(141)* | Combined | 2.23 (0.49) | 2.23 (0.49) | -0.001 (-0.18 – 0.18) | 0.992 |
| Severity of difficulties *(103)* | Young person | 7.79 (5.44) | 6.20 (5.21) | 1.59 (-0.86 – 4.05) | 0.200 |
| Severity of difficulties *(136)* | Parent | 12.30 (7.73) | 13.10 (7.70) | -0.80 (-3.70 – 2.09) | 0.584 |
| SDQ *(105)* | Young person | 17.14 (5.65) | 15.08 (5.34) | 2.06 (-0.48 – 4.59) | 0.111 |
| SDQ *(134))* | Parent | 20.721 (6.80) | 19.97 (7.26) | 0.74 (-1.87 – 3.35) | 0.575 |

### *Changes in the number and severity of problems*

Almost the entire sample had multiple difficulties at referral and there had been no significant differences in this respect between those receiving the two types of service. At follow-up the number of problems reported had decreased, as shown in Table 11.3.

**Table 11.3 Change in number of problems reported by parents**

| Number of problems | At referral % (n =203) | At follow up % (n=134) |
|---|---|---|
| 1-5 | 7 | 34 |
| 6-10 | 51 | 37 |
| 11-15 | 42 | 29 |

Over half (55%) reported one to five fewer problems at follow-up and 16 per cent reported six to eleven fewer. The mean number of problems reported fell from 9.73 to 7.62.[46] While there was improvement for many in the sample, there was no significant difference in the extent of change between those receiving specialist or mainstream services.

Ratings of specific problems at referral and at follow up (as being either major, moderate or not a problem) were also compared. There was positive change in respect of most of the main issues that parents and young people had reported at referral, as shown in Table 11.4[47].

[46] T-test significant at p<.001.
[47] Scores for the two groups were compared using the paired samples t-test.

**Table 11.4 Parents' view of changes in child behaviour**[48]

| | Better % | Same % | Worse % | *Number** |
|---|---|---|---|---|
| Young person's behaviour at home | 58 | 40 | 2 | *135* |
| Behaviour outside the home | 37 | 53 | 10 | *132* |
| Parent's concern about friends | 35 | 48 | 16 | *122* |
| Stays out late | 58 | 24 | 18 | *101* |
| Parent/child arguments | 47 | 47 | 6 | *132* |
| Child 'doesn't listen' | 39 | 50 | 11 | *131* |
| Child/parent 'can't talk things over' | 45 | 43 | 12 | *127* |
| Alcohol problems | 38 | 32 | 30 | *66* |
| Drug problems | 35 | 28 | 37 | *60* |
| Violence to parent | 63 | 24 | 13 | *83* |
| Violence to others | 44 | 36 | 20 | *101* |

**The number given is the number of young people for whom data on this measure were available both at referral and at follow-up.*

Positive change appeared more likely to take place in behaviour within the home than outside it. In particular, there was a considerable decrease in young people's violence towards parents. Parents and young people appeared to be able to negotiate with one another more successfully, as 45 per cent of those who had previously had difficulty in resolving their problems were now better able to talk things over. Similarly, arguments were now less of a problem for 47 per cent of those who had previously complained of arguments. Staying out late, which was often a source of parent-child conflict, had also become less of a problem to 58 per cent of those parents who had previously complained about it.

[48] *Better* = issues rated as a moderate or major problem at referral which were subsequently given a lower rating. *Worse* = issues rated as no problem or a moderate problem at referral which were subsequently given a higher rating. *Same* = issues rated as a moderate or major problem at referral where the rating did not change.

Problems in behaviour outside the home also appeared to have improved, but to a lesser extent. Nevertheless, over one third of parents who had previously reported problems in behaviour outside the home, peer-related difficulties and violence to others felt that matters had improved by follow-up. For those with problems of drug or alcohol misuse, improvement was reported in over one third of cases. However, positive change in any of the above problems was not significantly associated with whether young people received the specialist support team service or the mainstream service.

Where young people had been rated by themselves or by parents as having a 'major' problem with alcohol at referral, they were significantly more likely to show improvement on the Severity of Difficulties measure (on both the parent and young person versions). Presumably for the 38 per cent whose alcohol problems were reported to have improved, a decrease in alcohol use was accompanied by a general reduction in difficulties at home, although it is unclear which influenced which. There was also a greater degree of positive change on the Severity of Difficulties measure for those young people whose behaviour in the home parents rated as a moderate problem, in comparison with those whose behaviour they considered to be a major problem. In other words, general improvement on this measure appeared more likely among those whose behaviour had been considered somewhat less problematic at referral.

At referral running away was reported to be a major issue for many of the young people, but by follow-up there was a big reduction in this behaviour. The majority- of the young people who had run away during the six months prior to referral had not continued to do so, as shown in Table 11.5.

**Table 11.5 Changes in running away between referral and follow-up (n=195)**

| Change | Running away | Percent | Number |
|---|---|---|---|
| ***Improved*** | At referral but not at follow-up | 51 | 99 |
| ***Same*** | At referral and again by follow-up | 20 | 39 |
| ***Worse*** | At follow-up but not at referral | 2 | 5 |
| | Did not run away at all | 27 | 52 |

Since running away is often an indicator of parent-child conflict or abuse, this finding adds substance to the emerging picture of positive change in family relationships for many of the young people (Safe on the Streets Research Team 1999).

Some improvement was also reported in respect of young people's problems at school. At referral, 60 per cent of the young people were reported to have recently truanted (42% in the month just prior to referral), whereas at follow-up, just 34 per cent were reported to have truanted in the past six months. One-fifth (21%) were reported to have truanted often and one eighth (12%) to have truanted only occasionally.

However, there was little change in rates of temporary exclusion, as 35 per cent had been temporarily excluded in the month prior to referral (and 42% in the preceding year), while at follow-up 34 per cent were reported to have been temporarily excluded in the preceding six months. Furthermore, permanent exclusion had become a greater problem, as 14 per cent were reported to have been permanently excluded at follow-up, compared to 10 per cent in the year prior to referral.

There was also little improvement in offending behaviour, as shown in Table 11.6.

**Table 11.6 Involvement in offending between referral and follow-up (n=195)**

| Change | Reprimanded or charged | Percent | Number |
|---|---|---|---|
| ***Improved*** | At referral but not at follow-up | 9 | 18 |
| ***Same*** | At referral and again by follow-up | 13 | 26 |
| | No reprimand or charge at either time | 54 | 105 |
| ***Worse*** | At follow-up but not at referral | 24 | 46 |

Just over one fifth of the young people (22%) had been reprimanded during the six months prior to referral, and more than half of these been either reprimanded or charged by the time of the follow-up interview. Furthermore, nearly a quarter who had not been in the juvenile justice system in the six months prior to referral had been reprimanded or charged in the subsequent six months. In total, 14% were charged between referral and follow-up and 34% (72) were reprimanded and/or charged.

Neither did there appear to be any substantial improvement in patterns of self-harm. At referral, parents had reported that 20 per cent of the young people had attempted to harm themselves in the past year. There appeared to be only a slight reduction in self-harm by follow-up, as 18 per cent were said to have harmed themselves in the preceding six months, although for six per cent this was rated by parents as a 'mild' problem.

Overall, then, there appeared to be a greater degree of change in behaviour at home and in patterns of parent-child communication and negotiation, that is, in precisely those areas where social work interventions might potentially have an impact. Behaviour at school and in the community showed less improvement. It seems unlikely that social work intervention might change patterns of school exclusion since this is a product of the interaction between child and school. Social work staff may intervene with both children and schools, but ultimately exclusion is determined by local education policy and practice. Similarly, youth offending teams and the probation service might be expected to have a greater impact on patterns of offending than either mainstream social workers or the support teams.

### *Child protection concerns*

Between referral and follow-up the number of young people involved in formal child protection processes doubled, so that in total one fifth were either the subject of child protection enquiries or placed on the child protection register. During the six-month study period new child protection enquiries and registrations occurred in respect of a further 22 young people. The total proportion involved in the formal child protection process during the study is shown in Table 11.7 (numbers in each group are given in brackets).

**Table 11.7 Involved in the formal child protection process**

| | **At referral** *% (n=207)* | **At follow up** *% (n=179)* | **At any time** *% (n=209)* |
|---|---|---|---|
| New enquiry | 6% (12) | 7% (14) | 12% (26) |
| Newly registered | 4% (8) | 4% (8) | 8% (16) |
| Total young people | 10% (20) | 14% (22) | 20% (42) |

This increase in formal enquiries and registration as time progressed suggests that family support interventions may serve a case-finding function. A similar phenomenon was found in a large North American study of family preservation cases, where there was a significantly larger increase in the percentage of child abuse cases in the group receiving intensive services, in comparison to the control group (Schuerman *et al.* 1994). This study concluded that more intensive contact with families brought with it greater surveillance, so that more abuse was detected. It is likely to be the case here, too, that contact with social services in itself made it more likely that possible abuse or neglect would be identified.

Again, at referral there had been no difference between the groups receiving both types of service in terms of workers' concerns about abuse or neglect, or in the proportion subject to a formal child protection enquiry, although those on the child protection register at that time were less likely to be in contact with support teams. By follow-up, there was still no difference between the groups in respect of the proportion of child protection enquiries or registration. The case-finding effect of contact with social work services was presumably similar for both groups.

## Comparing scores on measures of outcome

At follow-up, approximately six months after referral, scores on all of the outcome measures had improved considerably but there were no statistically significant differences in the extent of change between the two groups on any of the measures used, as shown in Table 11.8.[49]

**Table 11.8 Change in outcomes between referral and follow-up**

| Outcome measure *(n)* | Perspective | Support team group Mean (SD) | Mainstream group Mean (SD) | Mean difference (95% CI) | p-value |
|---|---|---|---|---|---|
| Well-being*(99)* | Young person | 13.74 (26.28) | 12.60 (21.11) | 0.12 (-11.52 – 11.76) | 0.983 |
| GHQ-12 *(135)* | Parent | -2.99 (4.77) | -3.68 (3.79) | 0.69 (-0.849 – 2.22) | 0.377 |
| FAD *(141)* | Combined | -0.19 (0.47) | -0.05 (0.57) | -0.14 (-0.32 – 0.04) | 0.137 |
| Severity of problems *(99)* | Young person | -2.88 (5.10) | -3.33 (5.51) | 0.45 (-1.97 – 2.87) | 0.711 |
| Severity of problems *(136)* | Parent | -5.06 (6.92) | -4.95 (8.06) | -0.11 (-3.05 – 2.83) | 0.939 |
| SDQ *(101)* | Young person | -3.46 (6.29) | -2.56 (4.64) | -0.90 (-3.62 – 1.81) | 0.512 |
| SDQ *(134)* | Parent | -3.05 (5.34) | -2.38 (5.10) | -0.67 (-2.65 – 1.32) | 0.507 |

[49] Scores for the two groups were compared using the t-test for paired samples.

### *Changes in child and family functioning*

Consistent with the positive changes in respect of specific difficulties reported at referral, scores on the Severity of Difficulties measure indicated that matters had improved. For the sample as a whole, the mean score on the young person's version of this measure fell from 10.42 at referral to 7.41 at follow-up while the change was even greater on the parent version, which fell from a mean of 17.21 to 12.53.[50] Many parents and young people therefore felt that a range of problems were less severe at follow-up than they had been at referral. However, there was no difference in the degree of change between those using specialist and mainstream services.

Scores on the SDQ, our measure of emotional and behavioural difficulties, also showed a striking degree of improvement overall.[51]

**Table 11.9 SDQ Total Difficulties scores at referral and at follow-up ***

| **Source** *(number at follow-up)* | **Low need %** | **Some need %** | **High need %** |
|---|---|---|---|
| *Goodman community sample* | *80* | *10* | *10* |
| Parent ratings *(n=134)* | 25 *(9)* | 20 *(15)* | 55 (*76*) |
| Young person ratings *(n=105)* | 42*(26)* | 29 *(24)* | 28 *(42)* |

* *Percentages at referral are given in brackets.*

A substantial minority of young people with high levels of difficulty therefore showed positive change. This is remarkable, as one would not expect change in the deep-rooted traits measured by the SDQ to be associated with a short-term social work intervention. Although those with very high scores for difficulty at referral may have

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[50] T-tests significant at p<.001 for both. On the young person's version of this measure, sample attrition was 50% overall, but there was little difference in attrition between those with low scores at referral (56%) and those with high scores (50%). On the parent version attrition was 38% both overall and for those with low scores, but was only 24% for those with high scores. Therefore the difference in means noted above was *not* due to the fact that only the less difficult children were contacted at follow-up.

[51] T-tests showed that parent scores decreased significantly from a mean of 23.68 at referral to 20.50 at follow-up. For young people scores decreased from a mean of 18.89 to 16.65, significant at p<.001 for both. This and subsequent t-tests comparing scores at T1 and T2 are for paired samples.

shown some natural improvement over time, this is unlikely to account for the full extent of change that occurred across the sample and it is therefore possible that the services provided did indeed have a beneficial impact. Overall levels of need for the sample remained high though, in comparison with scores for a community sample (Goodman 1997).

I compared the extent of improvement on the SDQ in our two groups. At referral the young people receiving the specialist service had, on their own ratings, a significantly higher mean total difficulty score. The difference on this score was not significant at follow-up. The reduction in this difference does suggest that the specialist service was indeed making a difference.[52] However, the extent of the change did not differ significantly between the groups.[53]

Young people reported (by parents or workers) to suffer from ADHD had considerably worse scores on the SDQ (on parent rating) at referral than those not reported to have ADHD. Positive change appeared to be harder to achieve with this group since, although their mean SDQ scores had improved by follow-up, there was significantly less change than among other young people.

As for family functioning, measured by the FAD, this too showed significant improvement for the sample as a whole. This indicates that for many families positive change occurred on those dimensions measured by the FAD, namely family problem-solving, communication, behaviour control, affective involvement and responsiveness and general functioning. However, again there was no significant difference in the degree of change between the groups receiving each type of service.[54]

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[52] Without a 'no-service' alternative, we cannot be confident that change was produced by this service.

[53] For all the change measures used, differences in the mean scores between Time 1 and Time 2 were tested using a one-way anova, with the initial score as covariate to adjust for differences in initial state.

[54] T-test showed statistically significant improvement in overall family mean scores: reduced from a mean of 2.38 to 2.23, significant at p=.001.

Since the FAD and the SDQ were both validated measures, I explored whether other factors relating to child and family characteristics or history might predict change in relation to these. In order to do this I needed to take account of the initial score, which in the case of both variables was strongly correlated with improvement ($p<.001$ in both cases). In other words, young people who scored 'worse' at referral showed a greater degree of change for the better. After doing this, I found that no child or family characteristics were associated with a greater degree of improvement on either of these measures. I also considered whether areas of difference between the two groups at referral, namely recent contact with a psychiatrist, child psychologist or educational psychologist and the presence of chronic problems, were associated with the degree of change at follow-up. Again I found that no variables were associated with change on either the FAD or the SDQ.

### *Young people's general well-being*

The change in scores on Cantril's Ladder between referral and follow-up suggested a considerable improvement in sense of well-being for the majority of the young people, as 71 per cent of scores improved and indeed 53 per cent improved considerably (by 10 points or more).[55] However, for a minority (13%) scores were much worse at follow-up (decreased by 10 points or more). Again, there were no significant differences regarding changes on this measure between young people receiving a specialist or a mainstream service.

### *Parents' mental health status*

At referral, high levels of psychological distress were found for 72 per cent of the parents, as measured by the General Health Questionnaire (GHQ-12). By follow-up, mental well-being had improved as only 38 per cent scored above the threshold. [56] Although initial scores had indicated slightly higher levels of mental distress among those in the comparison group, this difference had disappeared at follow-up. Yet again, there were no significant differences in the degree of change between parents receiving each type of service.

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[55] T-test shows mean score rose from 53.81 at T1 to 66.59 at T2, a mean overall change of 12.78 points, significant at $p<.001$.
[56] The t-test showed a mean score at referral of 6.96, while at follow-up it was 3.85, $p<.001$.

Taken together, these measures therefore showed general improvement in child and family functioning, child behaviour, child quality of life and parents' mental well-being but no significant differences in the degree of change between those receiving either the specialist or the mainstream service. Neither was there any variation in change scores on any of these measures in relation to the age or the sex of the young people and few in relation to the specific nature of child difficulties at referral. For all of these measures, the key predictor of the extent of change that occurred was the severity of difficulties at referral. Those whose scores indicated the most severe difficulties at referral improved to the greatest extent.[57] This may be due to regression to the mean, since for those experiencing a particularly severe crisis at referral there is little scope for matters to get even worse and after any crisis there is likely to be some (relative) improvement.

## Comparing specialist and mainstream services

We have seen that, although there was considerable improvement across the sample as a whole, there were no significant differences between the groups receiving specialist or mainstream services in the extent to which the number of reported problems decreased or in the proportion reporting improvement in respect of a range of specific problems. Neither were there any significant differences between the two groups in scores on our measures of change in emotional and behavioural difficulties, child perceptions of well-being, family functioning, the severity of child difficulties and parental mental health. Since the specialist teams offered a more intensive service, we might have expected better outcomes in comparison with mainstream services, but this was not the case. There are various possible explanations for this rather disappointing result. First, the young people receiving the specialist service may have been more difficult, but in ways that we were not able to take into account. Second, the services provided by the mainstream teams may have been adequate to the problem. Third, the difficulties presented by some young people may have been too severe to allow for more than a temporary improvement.

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[57] Linear regression showed that for all measures except the SDQ, scores at referral were the only significant predictors of change.

We saw earlier that, although the nature and severity of specific problems was similar for young people receiving both types of service, for the sample as a whole those with high scores for total difficulty (on the child-completed version of the SDQ) were more likely to be found in the group receiving the specialist service. Further analysis showed that those young people who had high scores for emotional and behavioural difficulties at referral were also more likely to have high scores for problems in family functioning and to have given lower ratings for well-being on Cantril's Ladder.[58] Also, as we saw in Chapter 8, young people known to social services long-term were more than twice as likely to be in contact with specialist support teams than with mainstream social work services. Several studies of interventions with children have found that positive outcomes are harder to achieve with families with multiple, longer-term problems (Cleaver and Freeman, 1995; Biehal *et al.* 2000; Thoburn *et al.* 2000). Similarly, a study of social work with families found that longer-standing social problems and poor coping abilities were associated with poor outcomes for parents at 12 month follow-up, whereas short-term acute crises were associated with prompt restitution (Goldberg and Huxley, 1992).

These differences suggest that the young people receiving the specialist service were indeed more difficult. However, the differences in difficulty that we detected were not sufficiently great to account for the lack of difference between groups in the extent of improvement. However it is possible that, with more sensitive measures or larger numbers, we may have detected some difference in outcomes.

It was also apparent that, in at least one authority, some of those receiving the mainstream service could receive substantial support. This possibility could have reduced the apparent effects of the specialist intervention. It remains likely, however, that the specialist teams provided support to some young people who, in other authorities, would have received no support whatsoever.

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[58] Correlations significant at p=.017 (FAD) and p=.010 (Cantril's Ladder). There was a weak but significant correlation between initial SDQ child scores and both the FAD ( .250, p=.001) and Cantril's Ladder ( -.250, p=.001).

It is possible therefore that if there *were* some difference in the effectiveness of the two types of service we have not been able to detect it, either because the specialist teams were working with a more 'difficult' group of young people or because a proportion of those in the comparison group were receiving an enhanced service. In other words, in failing to detect a real effect, it is *possible* that we are making a Type 11 error[59]. Alternatively, of course, it may equally be true that neither service was more effective than the other in producing change. We should not, perhaps, be surprised at the absence of any detectable difference in outcomes between the two groups. As we saw in Chapter 3, numerous large-scale studies of intensive family preservation services in the USA, including a number of experimental studies, also failed to find any major differences in outcomes between intensive and mainstream services. As in this study, none of the American studies have succeeded in resolving the question of whether this lack of observed differences in effectiveness is due to the absence of any real difference, the poor targeting of services or problems in study design.

***The duration, intensity and nature of the service***

We saw earlier that there was considerable variation between local authorities in the amount of face-to-face contact with both social workers and support workers. Young people receiving the specialist service were likely to have more direct face-to-face contact both with support workers and social workers. However, neither the extent of face-to-face contact by workers nor the total duration of the intervention were associated with change on the measures of problem severity, emotional and behavioural difficulties, family functioning, quality of life or parents' mental health used in the study. There have been similar findings in the United States, where the largest randomised experimental study of family preservation services found that the duration and intensity of contact with workers was not associated either with rates of placement or with subsequent child maltreatment (Schuerman *et al.* 1994).

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[59] A Type 11 error occurs when an association between variables *does* exist (e.g. between the type of intervention and the outcome) but a study fails to detect this. In contrast, a Type 1 error occurs when a study wrongly concludes that there is an association between variables but this association *does not* actually exist.

The only exception to this pattern was for young people who reported that they did *not* feel that their situation had improved since referral. For this group, the total duration of contact with social workers was longer (a mean of 21.57 weeks) than for those who rated their current circumstances more positively (mean total duration of contact 13.65 weeks).[60] This is likely to be due to the fact that cases open for a longer period of time are normally those that are most difficult to resolve. Equally, for those who improved, the duration and intensity of contact is likely to be influenced by the interaction between the range, nature and severity of problems, by how rapidly workers manage to engage young people and parents in working to change them and by the pressure of other work. In other words, factors relating to the families themselves and system factors are both likely to be important in determining the amount of worker contact.

The list of different elements of interventions, outlined in Chapter 10, was also examined in relation to change on the five measures used. Change was not associated with any specific type of intervention. This is not surprising, since it is not only the type of intervention *per se* (for example, help with parenting strategies or mediation) but the skill with which it is delivered and its integration with other aspects of the service, in a particular package of family support services, that is likely to lead to change. These processes may be captured more easily through the analysis of case studies in Chapter 14 than through statistical measurement.

## Motivation and change

Qualitative analysis of case study material (discussed later in Chapter 14) suggests that there is some kind of relationship between child and family motivation to work on addressing their difficulties and positive outcomes. My earlier qualitative study of an adolescent support team also found that positive outcomes were closely related to motivation and research on other services supports this hypothesis (Biehal *et al* 2000; Buchanan, 1999). This link between motivation and positive change was therefore

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[60] Significant at p=.037.

explored through statistical analysis. In order to establish whether or not they were motivated, both parents and young people were asked shortly after referral whether or not they 'wanted to try' to work with support workers and social workers to deal with the problems they had mentioned.

Almost all parents using the specialist service (97%) and nearly three-quarters of the young people referred to it appeared to be motivated to work with support workers. Proportions were slightly lower in respect of social workers as 89 per cent of parents and 64 per cent of young people indicated some motivation. For both, motivation was associated with perceptions that each worker understood how they felt, involved them in making decisions and made their plans clear to them. Those who were motivated also indicated that they were optimistic about workers' ability to help them.[61] These associations suggest that motivation and worker skills in engaging service users were closely related to one another. Certainly, young people who were motivated were likely to be easier to engage in a working relationship, but equally, if workers were skilful in engaging young people they might become motivated even if they had not been so initially.

Motivation was also associated with whether problems were long term. Both young people and parents were significantly less likely to indicate motivation if they had been known to social services for three or more years.[62] Having chronic difficulties, which as we have seen were more common among those using the specialist teams, therefore made families less motivated and hence they were likely to be harder to engage. Despite this, young people receiving the specialist service were significantly more likely to indicate that they were motivated to work towards change (65%), in comparison with those receiving the mainstream service (40%). The pattern was similar for parents, and also for cases where both parents and young people were (jointly) motivated. It is therefore possible that support workers, through their more

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[61] Chi-square tests: most associations significant at p=.01, some significant at p=.05.
[62] Chi-square test showed that 57% of young people who indicated motivation and 61% of parents who were motivated had been known to social services for 3 years or less, significant at p= .024 (young people) and p=.047 (parents).

intensive contact with families (particularly in the early stages of the work), were able to engage them more successfully and engender greater motivation for change.

Across the sample as a whole, positive changes in family functioning, measured by the FAD, were more likely if the young person was motivated or if both the young person and parent were motivated.[63] In other words, those who were motivated were likely to make good use of either type of social work service. Since, as we will see in Chapter 14, the principal focus of interventions proved to be on changes in family interaction, it is not surprising that our measure of family functioning reflects this change once motivation is taken into account, rather than the other measures used.

Unlike the studies cited earlier, there was no association between duration of problems and the degree of change. However, the effect of having chronic difficulties may have operated indirectly through its association with motivation, which *was* directly associated with outcomes. The fact that those who were motivated tended to improve upon receiving a service, irrespective of the nature of that service, perhaps swamps any possible differences in outcome between specialist and mainstream services. [64]

Although those who showed motivation at or shortly after referral were the most likely to show improvement in family functioning, the specialist teams were especially successful in working with those particularly difficult young people who did *not* show motivation. Surprisingly, where young people using the specialist teams did not initially appear to be motivated, there was a *greater* improvement in scores for family functioning, although this was not the case for the mainstream service.[65] This may perhaps be evidence of the specialist teams' success in working against the odds to engage a particularly difficult client group. This finding was not predicted and so should be treated with some caution, but may be worth following up. Taken together,

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[63] Controlling for FAD score at referral, significant at p=.022 for 'young person motivated' and p=.004 for 'both young person and parent motivated.'

[64] This effect is not due to differential sample attrition, since those receiving each type of service were equally likely to be interviewed at follow-up, as were those who did or did not show motivation.

[65] Analysis of variance, controlling for FAD scores at referral, showed that FAD scores at follow-up were predicted by the interaction between motivation and the nature of the service used (p=.005).

these findings suggest that those with longer-term problems, higher levels of emotional and behavioural difficulty and the least motivation may perhaps respond better to an intensive, specialist service.

## Young people's and parents' views of outcomes

At follow up, young people and parents were invited to comment on whether or not they felt the young person's situation had improved since referral. The majority of the young people and around half of the parents reported a positive change in circumstances, as shown in Table 11.10.

**Table 11.10 Young people's and parents' views of outcomes at follow-up**

| | **Young people %** (n=98) | **Parents %** (n=122) |
|---|---|---|
| Situation has improved | 79 | 51 |
| Situation has stayed the same | 15 | 28 |
| Situation has got worse | 6 | 21 |

Overall ratings of user satisfaction with outcomes were associated with improvement on other measures of change. Where young people reported that their situation had improved there were improved scores on the child well-being scale, the parent's version of the SDQ and the child's version of the Severity of Difficulties measure. Similarly, parents' ratings of improvement were associated with improved scores on the parent versions of the SDQ and the Severity of Difficulties measure and also on the GHQ.[66] However, there were no significant differences in views of their current circumstances between those referred to specialist support teams and those who received only mainstream social work services.

Young people and parents did not always agree as to whether their situation had changed for the better. While the majority agreed as to whether matters had either

[66] T-test, significant at p=.001 for all tests.

improved or not (59%), in over one third of cases young people felt life had improved but their parents did not, as shown in Table 11.11.

**Table 11.11 Agreement between young people and parents on outcomes (n=88)**

| | Percent | Number |
|---|---|---|
| Agree situation has improved | 44 | 39 |
| Agree situation has not improved | 15 | 13 |
| Parent 'improved' / child 'not improved' | 7 | 6 |
| Child 'improved' / parent 'not improved' | 34 | 30 |
| **Total** | **100** | **88** |

Around three-quarters of parents indicated that circumstances had improved where there had been improvement in child behaviour in the home, in child violence to parents or in staying out late. Two-thirds of those parents who indicated that the situation was 'better' at follow-up reported a reduction in parent-child arguments and in their ability to talk things over with one another. Over half reported general satisfaction where there was improvement in respect of their child's peer group, behaviour outside the home or violence to others.[67]

Despite their positive appraisals of their current situation, 35 per cent of the young people nevertheless said that in the last month they had felt that they would like to leave home and live with someone else. Perhaps surprisingly, nearly one in three (29%) of those who felt life had improved reported that in the past month they had felt that they would like to live elsewhere.[68] Matters may have improved somewhat but clearly some experienced continuing difficulties.

## Family views on the effectiveness of professional help

Young people and parents were asked whether social workers and support workers had helped them in any way in the past six months. Their assessments of the degree to which workers had helped are shown in Table 11.12 and Table 11.13.

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[67] Chi-square tests: p=.001 for all items except 'staying out late,' 'peer group' (both p=.024) and 'violence to other' (p=.002).
[68] Chi-square test significant at p=.035.

**Table 11.12 Parents' views of professional help (n=140)***

| How far professionals helped | Social workers % *(n=85)* | Support workers % *(n=81)* |
|---|---|---|
| Helped improve situation considerably | 24 | 43 |
| Helped a little | 26 | 30 |
| Had no effect on situation | 51 | 27 |

** Percentages do not add up to 100 due to rounding.*

**Table 11.13 Young people's views of professional help (n=106)**

| How far professionals helped | Social workers % *(n=51)* | Support workers % *(n=55)* |
|---|---|---|
| Helped a lot | 39 | 56 |
| Helped a little | 39 | 33 |
| No help at all | 22 | 11 |

Both young people and parents were more likely to report that workers from the specialist teams had helped 'considerably' than that social workers had done so. It is difficult to know how these perceptions were formed. They may be directly related to the comparative skills and efforts of the workers or they may be influenced by the degree to which each worker had succeeded in forming a positive relationship with them. As we saw in Chapter 10, support workers are more likely to undertake direct work with families which may, in itself, be helpful, but which also involves the building of relationships with them. Also, in their role as case managers, social workers may have helped indirectly, by referring the family to a specialist support team.

The vast majority of those using the specialist service who felt that the situation had improved considered that the support workers had helped to bring about this change. Appraisals of help from social workers were also positive, although to a lesser extent, as shown in Table 11.14.

**Table 11.14 Percentage satisfied with outcomes who felt workers had helped**

| | **Parents %** (n=85) | **Young people %** (n=53) |
|---|---|---|
| Social worker helped | 68 | 78 |
| Support worker helped | 86 | 90 |

Parents and young people who were satisfied therefore felt that improvement was directly related to the interventions of support workers and/or social workers, although these were not necessarily the only people thought to have helped them. When asked who else had been helpful, apart from social services, they indicated that schools and family members had been the principal sources of help.

**Table 11.15 Others who helped in last six months**

| **People who helped** | **Parents %** *(n=140)* | **Young people %** *(n=106)* |
|---|---|---|
| Partner | 12 | - |
| Family | 19 | 32 |
| Friends | - | 5 |
| School | 18 | 26 |
| Child psychologist | 2 | - |
| Health professional | 4 | - |

Schools were clearly an important source of support to families, as over a quarter of the young people and nearly one fifth of parents felt they had been helpful. Headteachers, teachers and learning mentors were all mentioned as sources of support in recent months.

However, neither the specific sources of help (from any agency) nor the number of sources of help were associated with change on the five outcome measures.[69] As with the specific elements of social work interventions, it is less likely to be solely the types of help or number of sources of help that predict change but the nature and quality of each intervention and the way in which it interacts with other factors. In

[69] There were no statistically significant associations in this respect.

other words, it is *how* particular interventions combine together to produce change, in the context of support (or a lack of it) from relatives and friends, that is likely to be important.

## Conclusion

At follow-up, around six months after referral, many of the young people and families experienced positive change in a variety of aspects of their lives. The mean number of difficulties reported fell and there was also a marked decrease in the severity of a range of specific difficulties that had troubled families at referral. The greatest change occurred in behaviour within the home and in patterns of parent-child communication and negotiation, that is, in precisely those areas where social work interventions might be expected to have some impact. Behaviour in the community showed less improvement. Scores on measures of emotional and behavioural difficulties, family functioning, severity of difficulties, well-being and parental mental health all improved and there was a decrease in truancy and running away, although not in school exclusion or offending.

Despite this promising result there was, disappointingly, no difference in the extent of change between those receiving a specialist and non-specialist service. The reasons may be various. The specialist group were, on a number of measures, more difficult, but the extent of these difficulties was not sufficient to explain the lack of difference in apparent effectiveness. There may, however, have been other undetected problems which were more severe in the specialist group and which would account for this result. In addition, some of those in the mainstream services group may in fact have received a high standard of service, thus further diminishing the extent of difference likely to be found. Another important point relates to motivation, as those who were motivated tended to show improvement irrespective of the nature of the service.

As we have seen, it is difficult to demonstrate effectiveness if those receiving a specialist service are compared to those receiving another type of service, as a proportion of people in both groups are likely to make use of any good social work service that is offered as a catalyst for change, particularly if they are motivated to

change. As an earlier study found, the simple fact of social services involvement may in itself provoke change in some families (Biehal *et al.* 2000). If the specialist service were instead compared to a 'no service' alternative this issue would be less likely to blur the picture, but such a study could not be undertaken both for ethical and practical reasons.

So the picture we are left with shows positive change overall for many of those referred to both types of service, rather than a clear distinction between the two in terms of effectiveness. Since many of the young people receiving both types of service had considerable difficulties and long-term underlying family problems, punctuated by periodic crises, it is unlikely that brief interventions by either type of service will definitively resolve these difficulties. However, they may defuse tensions, help to resolve crises and bring about positive changes in child behaviour within the home and in parent-child relationships. These changes may or may not persist over the longer term and it is likely that many of the young people with chronic difficulties will need further help from social services from time to time.

# 12 Preventing placement: patterns, policies and resources

The principal objective of all the specialist teams was to provide support to families in order to prevent unnecessary placement, and all of the young people recruited to the study were considered to be at some risk of placement at referral. This chapter examines patterns of placement and considers whether specialist teams were any more successful in preventing it than mainstream services. It also considers the circumstances in which placement occurred and workers' attitudes to placement.

## Patterns of placement

Although nearly half of the parents had requested accommodation at referral, and workers had initially considered that 39 per cent of the young people were at high risk of placement, relatively few were placed. In the period between referral and follow-up, 25 per cent of the young people entered care placements. However, the majority of these were accommodated only short-term, most often in a crisis, as one element of family support provision. Only eight per cent were expected to remain in the care system for the foreseeable future, and a further one per cent were provided with occasional respite care for one to three days a week for a period of time, as shown in Table 12.1.

**Table 12.1 Placement between referral and follow-up (n=196)***

| Placement | Percent | Number |
|---|---|---|
| Short-term placement as family support | 15 | 29 |
| Long-term placement anticipated | 8 | 15 |
| Other placement | 2 | 5 |
| Occasional respite care | 1 | 2 |
| Not looked after | 74 | 145 |

* *One person accommodated at referral but lost to the study by follow-up is included*

The 'other' types of placement included three young people involved in the juvenile justice system, two of whom were placed in secure units and one, briefly, in a remand foster placement. One young person was already on a care order and had been referred due to a placement breakdown and no details of placement purpose were given for another.

There was some ambiguity about what actually constituted 'placement'. Not all of the young people placed with foster carers were accommodated under Section 20 of the Children Act 1989 as, in five of the authorities, a few placements were instead funded under the provision for family support in Section 17 of the Act. In one authority young people were placed with 'network carers', who were people from their local area approved specifically to offer short-term placements to teenagers. These placements were funded under Section 17 rather than Section 20, so that technically these young people were not accommodated. Apart from this administrative distinction, to all intents and purposes their circumstances were no different to those of young people placed short-term with ordinary foster carers so they are included with those 'placed short-term' for the purpose of this analysis. Most placements tended to be short, as shown in Table 12.2:

**Table 12.2 Time accommodated by follow-up (n=39)**

| Time period | Percent | Number |
|---|---|---|
| Less than 1 week | 33 | 13 |
| 1 to 4 weeks | 13 | 5 |
| More than 4 weeks to 3 months | 18 | 7 |
| More than 3months to 6 months | 28 | 11 |
| More than 6 months | 8 | 3 |

Nearly half of those accommodated (18 young people) were placed for four weeks or less, and these constituted 9% of the total sample. Just 11% of the total sample (21 young people) were accommodated for more than one month. When time looked after was considered in relation to placement purpose, it appeared that most of those placed as part of a family support intervention were accommodated for one month or

less and indeed the majority were in fact placed for one week or less. One fifth of this group had remained in placement for three to six months, however.

Most of those placed were looked after in foster placements, as shown in Table 12.3, although placement details were not available for all of the young people.

**Table 12.3 Placement type (n=41)**

| Placement | Percent | Number |
|---|---|---|
| Foster care* | 68 | 28 |
| Children's home | 27 | 11 |
| Secure unit | 5 | 2 |

**Includes four with 'network carers.'*

## Predictors of placement

Previous placement, which can be taken as a proxy measure of persistent child and family difficulties, was the strongest predictor of placement on this occasion.[70] Nearly half (47%) of those placed had been in care at some time in the past. This pattern is consistent with the findings of a number of American studies of family preservation services (Nelson *et al.* 1988; Fraser *et al.* 1991; Schwartz *et al.*1991; Yuan and Struckman-Johnson 1991). There were no significant differences between those using the specialist support teams and those using the mainstream service regarding their histories of past placement.

We then tested whether other factors were also associated with placement, such as emotional and behavioural difficulties, family functioning, child's quality of life, parent's mental health, severity of difficulties and a range of specific issues such as child characteristics, current child protection concerns, past histories of abuse or neglect, duration of contact with social services and involvement in offending. Multivariate analysis showed that most of these factors were not associated with

[70] Chi-square test significant at $p<.001$. Of those previously placed in care, 46% entered care on this occasion and 18% did not.

placement. No distinctions regarding the severity of behaviour problems were apparent between those who entered care and those who did not, due to the fact that complaints about extremely difficult behaviour were a feature of the vast majority of referrals. Nevertheless, behaviour problems were cited in many cases as one of the factors that had ultimately precipitated placement in care, as other research on the placement of teenagers has also found (Packman and Hall 1998).

There was, however, some evidence that young people's own view that their current problems were severe, as indicated by their scores on the Severity of Difficulties measure, were also associated with placement on this occasion.[71] Taken together, these findings suggest that where young people had a history of chronic family difficulties (as indicated by their past placement in care) and a particularly bleak view of their current circumstances, placement on this occasion was more likely.

We also examined whether living in a particular local authority affected the likelihood of entry to care. It is well known that nationally, placement rates vary across local authorities. Consistent with this, we found significant variation between local authorities in the proportion of young people who entered care placements, with young people in Borough the most likely to be placed, followed by those in Midshire, while those in Eastshire were the least likely to be placed, followed by those in City. As samples within each authority were relatively small, we compared these placement patterns to annual statistics on children age 10-15 starting to be looked after (Department of Health 2002c). These showed a pattern that was similar in some respects, with a relatively low placement rate for Eastshire and the highest placement rate for Borough. However, although annual patterns varied considerably between the other authorities these did not reflect the pattern in this sample since they showed that, across the eight authorities included in this study, Midshire had the lowest annual placement rate for 10-15 year olds while City had the second highest.

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[71] Logistic regression, with current placement as the dependent variable, showed that severity of problems on the child version of the Severity of Difficulties Scale (p=.019) and past placement were both significant predictors of placement (past placement significant at p=.001; severity of Child Difficulties significant at p=.035).

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were five times more likely to be placed in what was anticipated to be long-term care than those living with both birth parents, with a lone parent, or in a stepfamily. However, poor family functioning, young people's views that their difficulties were severe and past placement were much stronger predictors of long-term placement than family structure.[74] To summarise, long-term placement appeared to be more likely where:

- young people rated their difficulties as especially severe at referral,
- young people rated family functioning as especially poor at referral
- young people were living with neither birth parent at referral (although this factor was less influential than the other two).

## Placement patterns for those using specialist or mainstream services

As we have seen, there were no significant differences in the predictors of placement outlined above between the young people using specialist or mainstream services. However, the variations in placement rates between authorities suggested that placement might be less likely for young people in authorities which had specialist support teams. On the whole, as we have seen, a smaller proportion of young people tended to be accommodated in authorities which had specialist support teams in comparison with authorities that offered only a mainstream service (although this was not the case for Northshire). City was a clear exception to this and within-authority differences in placement patterns for those using specialist and mainstream services there will be dealt with separately. Since over half of those using mainstream services came from City, the particular pattern observed there meant that there was no significant difference in *overall* placement patterns when users of support teams and of mainstream services were compared. We therefore compared placement patterns in matched groups of authorities offering the different types of service and then compared the two types of service within City itself.

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[74]. Chi-square test showed that 26% of those living with neither parent were placed long term, compared to only 5% of those living with one or both parents ($p<.001$). When tested through multivariate analysis (logistic regression) this factor was no longer significant as its effect was overwhelmed by the effects of FAD scores, Severity of Difficulties scores and past placement.

When placement patterns in the two shire counties, Eastshire and Midshire, were compared it was found that a lower proportion of young people were placed in Eastshire, which had a support team. These counties were similar in terms of socio-economic indicators of deprivation, yet only six per cent of those referred to the Eastshire specialist support team were accommodated compared to 38 per cent of those referred to social workers in Midshire, which did not have a specialist team. With its support team and large pool of sessional staff, Eastshire had far more resources available for working with young people and their families in their home environment.

Similarly Met East and Northshire, both of which had specialist teams, were comparable in terms of socio-economic indicators to Borough, which had a mainstream service only. Two thirds (66%) of the young people from Borough were accommodated and indeed half of all those referred were expected to remain in care long term. In contrast, 19 per cent of those in Met East and 35 per cent of those in Northshire were placed and only seven per cent of those from Met East and 11 per cent from Northshire were expected to remain looked after long term. Placement rates were higher in Northshire than in other areas with support teams, but over half of these placements were short-term admissions.

In City, where within-authority comparisons could be made between the two types of service, the picture was quite different. Overall placement rates were low, as only 15 per cent of the sample in this authority were accommodated and all of these placements were short-term. The pattern, however, was quite the reverse of that found across the other authorities, since those receiving the specialist service were *more* likely to be placed (29%) than those using the mainstream service (7%). [75] There are two possible explanations for this.

First, although there were no apparent differences in the severity of child and family problems between the two groups in this authority, we have seen in Chapter 8 that those referred to the support teams in City were five times more likely to have been

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[75] Chi-square test significant at p=.03.

looked after at some time in the past. As we have seen, both this study and others have found that those with a history of past placement are more likely to experience a further placement. It therefore appears that the two groups of young people in this authority were not strictly comparable in terms of the likelihood of placement, as those more likely to be placed were referred to the support teams.

Second, teenagers using mainstream services in this authority were likely to receive a more comprehensive community-based service than those in the other two authorities where mainstream services were studied, as described in Chapter 6. This may help to explain why placement was less common for those using the mainstream service in City than in Borough or Midshire, in which hard-pressed social workers appeared to have few resources for family support work other than their own (limited) time.

When City was excluded from the analysis, those using mainstream services were found to be twice as likely to enter care placements (50%) compared to those using the specialist support teams (25%). They were also more likely to be placed in long-term care (29%) than those using specialist teams (6%).[76] As we saw in Chapter 8, there was some indication that emotional and behavioural difficulties were more severe among young people using the specialist services, so the severity of these problems cannot explain why those using the mainstream service were more likely to be placed.

However, apart from in City, families using the mainstream service were generally more likely to have a bleak view of their current situation. Young people using mainstream services in Midshire and Borough rated family functioning, the severity of their problems at referral and quality of life significantly worse in comparison with those using the specialist services in other authorities. Equally, as we saw in Chapter 7, parents' scores for psychological distress were significantly worse for those using

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[76] Chi-square test of placement by service type (excluding City) significant at p=.008. Chi-square test of actual/planned duration of placement significant at p=.004.

the mainstream service.[77] This suggests that thresholds for receiving a service were higher in those authorities offering only a mainstream service, which is consistent with the observations of parents and social workers on this issue already outlined in Chapter 10. If these families did not receive a service until they felt both desperate and depressed about their circumstances, this may help to explain why a higher proportion of those young people who *did* eventually receive a service entered care.

## The influence of local policy and resources

As we saw in Chapter 6,the two authorities offering only a mainstream social work service, Midshire and Borough, had a particularly low proportion of their resources for children's services allocated to family support, although the proportion for Northshire was the lowest of all the authorities. These three authorities also had a relatively high proportion of young people who were placed, in comparison with most of the authorities which offered a specialist service. However, nearly half of those placed in Northshire were in care for only one or two days whereas the majority of those accommodated in the other two authorities remained in placement for two weeks or more.

The provision of dedicated resources for undertaking family support work, in most cases through the establishment of specialist support teams, meant that support workers, sessional workers (or, in City, specialist Principal Caseworkers for Adolescents plus sessional staff) were available to work with teenagers and their families. Where resources were not ring-fenced in this way, hard-pressed social workers offering a mainstream service struggled to balance their work with teenagers in crisis against the competing demands of other work. As others have found, adolescents are typically accorded lower priority on field social workers' caseloads than younger children or those in the child protection system (Sinclair *et al.* 1995).

The availability of residential and foster placements is also likely to have an impact on placement rates. Although, on the whole, having specialist support teams appeared

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[77] Mann-Whitney U test: child version of FAD significant at p=0.26; child version of Child Difficulties scale significant at p=.021; GHQ significant at p=.004; Cantril's Ladder significant at p=.017 (City was excluded from this analysis).

to be associated both with lower placement rates for local authorities and less extensive use of long-term care, this was likely to be due to their location within a particular policy and resource context as well as to the quality of their work. If resources are diverted from residential services to outreach work, as had occurred when most of the teams were set up, then fewer young people are likely to receive a residential service. The availability of foster placements for older children and teenagers is also likely to be influential. As one social worker explained:

> No teenager is at risk of placement here because there aren't any beds for them.

The in-depth interviews carried out with workers and parents also suggested that local policy, in terms of the vehement exhortations to workers to avoid placement, was also influential. In situations where workers felt that accommodation was not in the young person's best interests, these policy directives could provide helpful back- up, especially if reinforced by resources, as several of them commented:

> Obviously the local authority's policy and the Government policy on not accommodating children was very helpful because we needed to keep this young person with her family.

> If you have got a parent ranting and raving in Reception about 'you must take this child now' there's got to be a clear policy from management. You are not allowed to say OK.

The impact of local policy and resources is illustrated by the accounts of workers in different authorities. A social worker in Borough, which had no specialist team, explained that two things had hindered her attempts to return home a young person who had been accommodated. First, neither the young person nor her mother would engage in any discussion of alternatives to care and second, there was 'a major issue with local authority funding and resources and policy and procedures affecting outreach work with young people.'

In contrast, a specialist support worker in Met West described how the support team had dealt with a crisis regarding one young person:

> At the time of the initial referral things were so bad at home, she was saying she didn't want to be there and mum was refusing to keep her so she was accommodated, I think, three nights over the weekend and on the Monday we

> held a panel and that was the first thing, the first job if you like, to take her home, to reintroduce her home with a support package.....She was just given an emergency weekend placement because mum was told that we don't accommodate children, we work on relationships and to keep the child at home, unless of course we have to...

Hence, it is clear that the allocation of resources to support work with young people and families, the level of placement resources for teenagers and the local policy context had a strong influence on placement patterns (although this does not mean that the *quality* of the work undertaken may not also have had an influence on whether placement occurred). These system factors appear to account for much of the variation in placement rates between those authorities offering a specialist support service or a mainstream service, rather than differences in the level of children's needs.

# 13 The use and avoidance of placement

The previous chapter described differences in placement patterns across authorities and between young people using either specialist or mainstream services. Its principal focus was on *service outcomes*, such as placement rates. This chapter now considers the experience of placement or other breaks from home for individual young people, and in doing so it focuses on *child outcomes*.

We have already seen that the most likely explanation for placement appears to lie in some interaction between factors related to the child and family (whether child difficulties were long-term, whether young people considered them to be severe at referral and whether parents were experiencing high levels of psychological distress), and system factors, such as policies and the local availability both of placement resources and of resources for outreach work with young people and parents. Qualitative analysis of case histories can shed some light on this complex inter-relationship between child, family and system factors.

This chapter also considers other moves away from home, which served as an alternative to placement for many young people. These informal arrangements involved stays with friends or relatives rather than in formal care placements, but such informal arrangements also raise issues that deserve no less attention than the question of placement in care.

## Short-term placement for emergencies or 'cooling-off'

A number of the placements made were emergency admissions that took place shortly after referral, a phenomenon identified in other studies of social work with teenagers (Sinclair *et al.* 1995; Packman and Hall 1998). The young people were briefly accommodated in an emergency situation, either because they had been thrown out by parents or carers or, less commonly, because they themselves refused to return home.

Short-term accommodation in most cases was requested as respite by many parents, who said they simply could not cope any longer and needed a breathing space. A

'cooling off' period of a few nights was used for those whose relationships had broken down temporarily. Workers often explained that accommodation had been provided short-term to relieve pressure and avoid longer-term family breakdown. In all of these cases, short-term accommodation was used as a strategy for family support. Occasionally, concern for the young person's safety was a factor in short-term accommodation, as in the case of a young person with severe ADHD who was removed for one night because, under extreme stress, her mother feared she might harm her.

There was often more to short-term accommodation than simply a brief separation to defuse tension. Although it might be unplanned, it was often used as an opportunity for workers to help families to rebuild relationships. In some cases placements lasted weeks rather than days to allow for a fuller assessment to be made of young people's behaviour and circumstances or for therapeutic work to be undertaken. Sometimes the young people themselves felt the need for a cooling off period, such as the 12 year old boy whose family was threatened with eviction from a hostel due to his behaviour, who said he wanted time away from his mother 'to calm us both down.' Family stress was exacerbated by living in the hostel, together with the fact that he was permanently excluded from school with no alternative educational provision and so had nowhere else to go during the day. His behaviour improved during six weeks in another environment and he returned to his family once they were settled in new accommodation.

An important ingredient in the rapid rehabilitation of these young people with their families was quite simply the fact that their parents were willing to have them back. Sometimes parents were clearly committed to these young people and simply needed some respite from dealing with their extremely difficult behaviour. In other cases, they were reluctant to have them home but the combination of a steadfast refusal by workers to allow them to stay in placement and the provision of support to parents, with advice about parenting strategies, persuaded parents to accept the young person back. This required workers to be successful in engaging parents in working on their parenting and on family relationships and where this did not happen rehabilitation was less likely to take place. In general, a failure to engage parents in working on family

difficulties was linked to less positive outcomes for young people, an issue that will be discussed further in Chapter 14.

Young people also had to agree to return home. Two young people who were accommodated short-term moved on to stay with friends instead of returning to their families. In one case, this was because a boy's father refused to accept him home but in the other because the young person herself refused to return. The period of accommodation had been short, but it seemed probable that family breakdown would be long term.

Where family breakdown occurred, the availability of staff to undertake immediate work to reunify parents and children was also an important factor in rehabilitation. In Northshire, for example, the support team worked closely with staff in a small children's home used solely for emergency overnight or weekend accommodation. Staff appointed to this home were called residential/community workers, blurring the boundaries between community support to families and the care system. They would work with families where crises occurred out of normal working hours to avoid accommodation but then, if this was not possible, they would care for young people overnight. Two workers from the support team were also linked to this resource and would pick up the work with the young people and parents early the next morning with a view to reuniting them as quickly as possible.

## Longer-term placement

As we saw earlier, young people living with neither of their parents at referral were the most likely to enter long-term care. In at least half of the cases where long-term placement was anticipated, parents or carers (including two adoptive carers) had simply refused to allow the young people home. Some of them had already spent time staying with other relatives or in short-term accommodation, but attempts at rehabilitation had failed and parents or carers said they were no longer prepared to put up with their behaviour.

Some workers commented that a lack of resources for work with families could make successful rehabilitation harder to achieve. As a social worker offering a mainstream service explained:

> The resource we seem to need a lot is outreach....If we could just have taken him out immediately, or an outreach worker could have taken him out for a few hours at the worst part of the day, that is really, really helpful....so that when he returned home there was an outreach worker, or when he started to integrate back home the outreach worker went with him.

The other main reason for long-term placement was the severity of young people's difficulties. Long-term placement was planned for a 12 year old girl with mental health problems whose behaviour was considered extremely dangerous, while a13 year old who experienced abuse and neglect was placed long-term for his own safety. The mother of another child graphically described the severe problems that had led to her long-term placement:

> She went berserk, punching and violent behaviour to everyone. She tried to hang herself. I had to get the police because she was running away – when she came back she was taking drugs. She disclosed that she had been sexually abused by her father and her behaviour deteriorated then. She has overdosed and ended in casualty. She has voices in her head, the devil talks to her.

The likelihood of longer-term placement therefore appeared to be influenced by factors relating to the family, to the young person and to local resources for family support.

## The reluctance to accommodate

Social workers and support workers were extremely reluctant to accommodate young people and often viewed placement as something to be used only as a last resort, as other recent studies have also highlighted (Sinclair *et al.* 1995; Triseliotis *et al.* 1995; Packman and Hall 1998). There were several reasons for this. First, they felt that placement was rarely the best way to meet young people's needs and that parents should be encouraged to accept responsibility for their children. Although some parents insisted that they could no longer be expected to cope with their children's behaviour and that social services should take over, workers made it clear to parents that their children were their responsibility. As Packman and Hall have pointed out, these situations raise the wider issue of parental responsibility and the role of the state

Workers, as well as parents, felt that young people should be discouraged from thinking that life in care would be free from any restrictions, as a number of them appeared to do. A parent commented:

> (*The support worker*) just explained the downfalls if she did go into care, it is not all good, and that the best place for her was at home with her family.

Workers were also concerned about the potentially harmful psychological effects of placement, as one explained in respect of a girl who had not been placed:

> She didn't come into the care system. She's still at home, so she doesn't feel the rejection. Mum still has the self-esteem.

In general, many workers displayed a degree of scepticism as to the value of accommodation for teenagers and few appeared to view the care system as a positive resource that might be beneficial to some young people, in some circumstances. They were particularly concerned to avoid placing young people in residential settings, fearing that they would be 'contaminated' by the behaviour of others. As a social worker commented with regard to a 15 year old boy:

> The staff were very caring and they did do work with him, but the kind of people he was mixing with…He wasn't a bad, bad child he was just having a bad time, and there were some kids there who were, you know, into drugs and things, and he wasn't so it was exposing him to a lot.

This pessimism about residential care was perhaps misplaced, in some instances at least. In several cases, young people's behaviour was said (by parents) to have improved after a period in residential care and one young person placed long-term reflected: 'Things are better since I left the family home and moved to the care unit.'

While social workers' reluctance to accommodate young people was usually grounded in genuine concerns as to whether placement would be beneficial, it was also heavily influenced by local policies on avoiding accommodation. These could be helpful, as they made it easier for workers to resist families' demands for accommodation when they felt strongly that this was not the best course of action. This was not always communicated in a positive manner though, as in at least two

cases (in the same authority) parents claimed that they had been threatened with prosecution for child abandonment if they refused to accept their child back after an emergency placement had been made.

The pressure to avoid accommodation could also mean that practice was sometimes resource-driven rather than needs-led, although social workers were often aware of this and not happy with it. A number of parents and workers commented on the way that decisions about placement were apparently determined as much by local resources as by any practice concerns. For example one social worker, describing her battle to arrange a placement, illustrated the tension between professional judgement and the constraints imposed by financial restrictions:

> At the time he was accommodated there was this huge cut in social services here and no child was being accommodated; yet it just screamed out that there was going to be a complete breakdown. He needed to be away from the family home and mum was very nearly sectioned.

Two parents' comments reveal that some social workers were quite candid about resource constraints:

> Their attitude was 'Sorry, we haven't got no beds, especially for teenagers, we haven't got no foster families.'
>
> And I said, 'When will I hear about respite?' And they says 'Well whoever it was told you we could give you respite shouldn't have, because we can't, we haven't got the availability.'

Bureaucratic delay could also be used as a means of rationing scarce resources as the following case illustrates.

Anthony, age twelve, had run away from his mother to escape abuse and had gone to live with his father. He developed depression and severe behaviour problems but was told that he did not need help as he was no longer living with the abuser. His mental health deteriorated further and his behaviour became very violent, to the extent that his social worker described him as dangerous. An inter-agency assessment concluded that he needed to be placed in a therapeutic community. However, lengthy bureaucratic delays, which did not appear to have occurred entirely by chance, meant that this decision was not implemented. The boy's father was eventually told that, as no resources were available to fund this expensive placement, the family would be offered regular respite foster care instead.

Local policy and practice which was grounded in the assumption that accommodation should be avoided wherever possible could later be perceived as helpful by parents, if it was accompanied by an offer of an alternative form of support. In many cases, when families were in crisis, skilled and intensive work by support workers helped to defuse the situation. One parent, recalling her request for accommodation some months earlier, which had resulted in referral to a support team, reflected:

> She was running away, she was trashing our home, she was just totally out of control and I phoned them up to say 'Get her put in a home.' Well they came in and basically, the reason they came in was to keep him in the home, to see if there was any way to resolve it in the home. They were really helpful.

Another explained how she had made this request in sheer desperation:

> 'Take him away, take him away!' Well actually, that's not what I really wanted, I wanted everything to be better but seriously, I didn't think…The family unit was just breaking up because of his behaviour, but I did wonder whether we would have to have, we needed, some respite. I felt we needed some respite but we didn't get that. I'm glad, because looking back, we got through it.

However, the tendency among social workers to avoid care at all costs could sometimes engender a somewhat blinkered attitude, resulting in a failure to consider fully some children's needs. This was apparent in relation to two children who had suffered severe and long-term rejection and had regularly been re-referred to social services by parents complaining about their difficult behaviour. At each referral, it

seemed that the principal consideration had been to find the best means of resolving the current crisis and maintaining the children at home, even though this may not necessarily have been in their best long-term interests. In one case, a child was continually returned to a situation where he suffered severe emotional abuse. These two cases, which occurred in different authorities, illustrate these dilemmas.

Tom, age 12, had been thrown out by his mother and had been moved by social services to his father and stepmother in another local authority, although he was reluctant to go to them. His social worker reported that he suffered from rejection and had problems in his relationships with both parents and with his stepmother, who was harsh towards him. He truanted, had been temporarily excluded from school, had become involved in offending and was sometimes violent.

Throughout his life he had been shuttled backwards and forwards between his parents *'like a yo-yo'*, as his social worker put it, but each time the situation had broken down. When social services had returned him to his father on this occasion, a support worker initially worked with him on his behaviour and attempted to look at family dynamics with his father and stepmother, but they were reluctant to address this issue. He was returned his mother after his father '*beat him up*', but she said she was unable to have him at present because of her work so he was placed in foster care with his brothers, who were already there. He settled well and said he was happy there.

Gary, 12, who lived with his mother and her partner, described himself as *'naughty'* and *'angry inside'*. His behaviour was causing problems at home and at school. His mother complained that his bad behaviour had commenced when he was five weeks old, at which point she had *'realised'* that *'he just did not like me.'* She was quite candid in saying that *'Basically, I do not like him.'* She had first approached social services when he was six years old and since then both social services and mental health services had tried to help over the years. She felt she understood why she felt so negative about him, but that she could not change this. As she explained:

*'The sad thing is, I treat him the way my mum treated me but I don't the other two, so it's not fair, I know that but I can't help it. 'Cos it happened to me and I know you're supposed to change and not do the same ....I was honest with them, I told them I hated him, I said 'I absolutely hate him.' With me and him there's just something there that doesn't click, you know. As soon as I see his face when he comes home from school I get annoyed.'*

His support worker commented that at referral:

*'The family was in crisis, it was at the point of breakdown. Not that he was doing a lot. The issue was around mum's feelings to him rather than his actual behaviour.'*

The support worker referred the family for family therapy and a mothers' support group, but the mother refused to take up these services, so he worked with her one-to-one on her relationship with her son and at the same time worked with him on his behaviour. At follow-up, the child felt that his mother was now 'nicer' to him, which he ascribed to the work of the support worker. Conflict may also have been reduced because his mother was now preoccupied with her new baby and he was now spending more time with his father, so his mother saw less of him. However, his mother felt that nothing had changed at all and said that she continued to hate him.

The pre-occupation with avoiding accommodation at all costs appeared to have led to short-term thinking rather than a considered review of how these young people's needs might best be met in the longer-term and proper planning for their future. Such

an approach may simply delay placement without any real resolution of serious family problems. The small sub-group of children whose parents show not only low warmth and high criticism but also a continuing lack of attachment towards them may in some cases benefit from long-term care (Thoburn *et al.* 2000). Such cases are, of course, complex and difficult to deal with.

These scenarios are evidence of a phenomenon that Stevenson has characterised as 'bumping along the bottom,' whereby social workers become used to a level of persistent emotional abuse in certain families and tolerate the *status quo* until an incident occurs, such as physical or sexual abuse, which prompts a reassessment of the situation (Stevenson 1996: 16). She argues that the challenge is to judge when, and how far, imaginative work can help to improve children's quality of life at home and when a judgement is needed that removal from home may be in their best interests. Neither option is likely to involve a short-term response. Stevenson suggests that support to such children at home is likely to involve long-term work, which is currently out of favour.

Similarly, researchers in the United States have observed that a fixation with avoiding placement can result in episodic intervention instead of continuing support (Maluccio and Whittaker 1997; Whittaker and Maluccio 2002). They argue against an undue emphasis on whether or not the child is placed, whereby placement is conflated with failure, and for a broader focus on the welfare of the child. Similarly, others have argued that since placement prevention is not always in a child's best interests, the focus of policy should instead be on removing risks to children and achieving continuity of care, either within the home or out of it (Littell and Schuerman 1999). Our evidence suggests that the preoccupation with avoiding care at all costs may lead to a failure to move beyond short-term crisis-resolution to a consideration of the longer-term needs of children, particularly for those experiencing extreme rejection.

To sum up, this reluctance to accommodate could be helpful in some instances, as long as an adequate alternative service was offered to families in crisis. Unnecessary disruption could be avoided and work could be done to resolve family problems in the very environment in which they had arisen. Nevertheless, even where a good

community-based service is offered there are always likely to be some crisis admissions of teenagers to care placements. If staff are immediately available to work intensively with families, in many cases young people can be rapidly returned home where this work can continue.

However, emergency admissions to care might be less common if planned short-term admission as part of a family support intervention were considered more often. As we have seen, these could help to defuse conflict, provide respite from family stress for both young people and parents and provide a platform for further work. Some teenagers may benefit from a short placement, accompanied by intensive work, before stabilising at home. It may be therefore more helpful to view short-term placements for teenagers as a therapeutic intervention that would be available as one of a broad range of services for families under stress, as others have suggested in relation to younger children (Aldgate and Bradley 1999). For some families in extreme difficulty, regular planned respite care for a period of time may be helpful, through arrangements for support care which offer regular overnight breaks to relieve family stress as part of a package of family support services.

### Informal stays with friends and relatives

Although relatively few young people were accommodated, a far higher proportion moved to stay elsewhere for a while, in most cases with friends or relatives, as shown in Table 13.1 (which includes those who were provided with accommodation on an occasional respite basis).

**Table 13.1 Accommodation and informal moves away from home (n=196)**

| Placement status | Percent | Number |
|---|---|---|
| Accommodated only | 16 | 31 |
| Both accommodation and informal placement | 10 | 20 |
| Informal placement only* | 32 | 63 |
| Remained at home | 42 | 82 |
| *Total* | *100* | *196* |

**Two stayed in homeless hostels*

Frequent change is a feature of the lives of many teenagers who come into contact with social work services, as they move backwards and forwards between various addresses (Triseliotis *et al.* 1995). The majority of the young people moved out for a while and only 42 per cent remained with the same parent or carer. In a number of cases it was clear that young people had stayed in two or three different places away from home during the six month study period, including one in ten who both stayed with friends or relatives and were accommodated. Most of these periods away from home were fairly short, as shown in Table 13.2.

**Table 13.2 Time spent away from home (not in accommodation) (n=73)**

| Time away | Percent | Number |
|---|---|---|
| Less than 1 week | 38 | 28 |
| 1 to 4 weeks | 27 | 20 |
| More than 4 weeks to 3 months | 19 | 14 |
| More than 3months to 6 months | 11 | 8 |
| More than 6 months | 4 | 3 |

Nearly two thirds remained in informal placements for less than one month but 15 per cent were away from home for three months or more, evidence of a substantive rupture with their families. Most moved to stay with other members of their families, although over a quarter stayed with friends – either the families of their own friends or, in a few cases, with family friends of their parents.

**Table 13.3 Types of informal placement (n=83)**

| | Percent | Number |
|---|---|---|
| Grandparent | 18 | 15 |
| Other parent (short-term) | 4 | 3 |
| Other relative | 11 | 9 |
| Both relatives and friends | 6 | 5 |
| Friends | 25 | 21 |
| Homeless hostel | 2 | 2 |
| Not specified | 34 | 28 |

In total, over one third (35%) stayed with relatives at some time and nearly a third (31%) stayed with friends. Grandparents played an important role in providing temporary care during crises. Where parents were separated, young people sometimes shuttled between the two. A few stayed temporarily with their other parent before returning home, but six (3%) moved to live long-term with another parent. They were not always happy with arrangements made for them to stay with another parent, as one 13 year old explained:

> Mum sent me to me dad's. It was a week of hell, he does my head in. He drinks too much. No, I just don't like my dad. I'm scared of him because he used to beat me mum.

Some informal placements were arranged by young people or parents themselves and some were arranged by workers. Sometimes young people simply walked out and took themselves elsewhere. This happened in several cases where they were unhappy about a parent's new partner. Where family relationships had broken down, workers were anxious to encourage young people to enter into informal arrangements with relatives or friends rather than to enter care. They took the view that it was better for young people to be in a familiar environment with people they knew, and of course for the agency it was cheaper. Like short-term accommodation, these episodes could give young people and parents in conflict a break and this could lead them to calm down and re-evaluate their relationship. One mother commented:

> I think she thought that life would probably be better by not being here but after three weeks she was coming round more and she kept saying to me 'That's not my home. This is my home.'

Although some walked out, young people did not always choose to leave. A 15 year old boy, who had been thrown out of home, explained:

> I went to stay with my nan as I was not getting on well at home with my step-dad and things were difficult with my mum. I had no choice but to go to my nan as there was nowhere else I could go.

While he was away his support worker offered support to his grandmother and worked with him and his mother on their relationship and on his behaviour. He returned home after a few months.

Some of these arrangements were unstable, with young people walking out or being thrown out of the places they were staying in. These were young people whose behaviour was difficult, so such placements were not likely to be untroubled, and these arrangements put a particular strain on grandparents. Sometimes young people stayed with relatives for a while and were then accommodated once this arrangement broke down, while in other cases they were accommodated first and then moved to friends or relatives when it became clear that a return home was not possible. They could also drift into uncertain and even risky situations, with no plans for a return home, as one mother described:

> It's much the same. She takes herself off all the time, here one day, gone the next. It's been a lot calmer the last six months because she's not been here. From my point of view she hasn't been any trouble to me but I worry about her, 'cos she's only 14 and I don't know where she's living and I know she's on drugs and drink.

Quite apart from the risks that this girl was currently facing, the implications for the future of such young people are worrying. Other research has highlighted the way in which young people with a history of family problems, which may have led to earlier episodes in care, sometimes drift into homelessness once they reach an age at which social services will no longer offer them a care placement (Biehal *et al*. 2000; Pleace and Quilgars 1999). Paradoxically, where family support services 'succeed' in preventing accommodation when they are under the age of 16, perhaps through

encouraging informal arrangements, young people may no longer be able to gain access to support as 'children in need' when they are 16 or 17 years old and may join the ranks of the homeless, as did two young people in this study who reported that they had stayed in hostels for the homeless.

Furthermore, in situations where children's needs might be better met through a period of accommodation, encouraging such informal arrangements or supporting them under Section 17 of the Children Act (1989) may effectively deny vulnerable young people entitlement to future support under the provisions of the Leaving Care Act (2000). Indeed, some authorities may actively wish to avoid accommodating teenagers precisely because of the financial implications for local authorities of the Leaving Care Act, as comments by some workers indicated.

While informal stays with relatives or friends could be helpful in providing a short period of respite with people known to the young person, some such episodes could result in drift for young people and their future remained uncertain at follow-up. Around one in eight of the sample (25 young people) stayed away for more than one month and a small proportion (6%, 11 young people) had been away from home for more than three months by follow-up. Although these placements were informal and in most cases initiated by the young people or parents, for those away for more than a short period planning for their future is just as important as for those formally accommodated.

For both, it is important to address the issues of whether or not a young person and parent wish to be reunited, whether it is desirable for this to happen, and if not, what longer-term alternative arrangements should be made. Such informal arrangements should not, therefore, be seen as a panacea, resulting in a rapid withdrawal by social services before such issues are resolved. Where young people stay away for more than a short period of time careful consideration should be given to plans for their future, particularly when they move to stay with friends rather than relatives.

A further question is whether longer-term stays with relatives should be supported or even formalised. There is some controversy over the role that the state should play in

supporting, or perhaps supervising, relative caregivers (Ainsworth and Maluccio 1998; Hegar and Scannapieco, 1999; Sykes *et al.* 2002). Should informal caregivers be assessed if children stay with them for more than a short period, should they be supervised or financially supported, or would such strategies lead to net-widening, with the state intruding unnecessarily into family life? As in this study, research in the USA has found that many kinship carers are grandparents. While the formal and informal use of kinship carers is consistent with a policy agenda of promoting family responsibility and reducing the costs of public services, such strategies may place an unfair burden on carers, who tend to be older and less well-off financially than foster carers and to have more health and mental health problems (Ainsworth and Maluccio 1998). Older people with problems of their own may need support to care successfully for troublesome young people if they remain with them for more than a short period of time.

## The outcomes of formal and informal placements

In most cases placement was avoided and work was undertaken with young people and parents to resolve problems within the home. In some cases, however, a period of time spent away from home in a care placement or with friends or relatives could help young people to feel better, through defusing tension and allowing time for cooling off. In a few cases a move to a longer-term placement removed them for the foreseeable future from an unhappy situation.

The majority of young people who spent time away from home rated their circumstances as 'better' at follow-up. All but one (96%) of those who were placed in accommodation at some time felt their circumstances had improved, compared to 73 per cent of those not accommodated.[78] All of those who stayed only in accommodation but nowhere else, and 81% of those who stayed with friends or relatives, or had periods away both in these informal placements and in accommodation, also rated their circumstances as 'better' at follow-up, compared to 69% of those who did not stay away at all.[79]

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[78] Chi-square test, significant at p=.017.
[79] Chi-square test, p=.045

A break could help to resolve situations, in the short term at least, particularly if work was undertaken with young people and parents to repair relationships. However, fewer such disruptive episodes away from home might occur if services with lower thresholds were also available, offering support to families at an earlier stage before difficulties became so severe. Equally, the preoccupation with avoiding accommodation at all costs could occasionally lead to a failure to properly consider young people's long- term needs. In a few cases a series of episodic interventions appeared to serve agency needs to manage demand and contain costs rather than young people's needs for longer-term support or for placement away from home.

Informal placements with friends or relatives were fairly common, and may have been the preferred option for many young people as well as being cheaper for local authorities. However, not all of the young people were happy with these arrangements. Also, some informal placements persisted for several months without any evidence of a clear plan for the future of these young people.

# 14 How did the interventions help?

As we have seen earlier, social work with young people takes place in a multi-agency context, involving not only education but often health, mental health or juvenile justice personnel as well as voluntary agencies. The role of social work staff is not only to work directly with young people and families but also to mobilise support both from these other agencies and from wider family, friendship and community networks. The interaction of any social work service with family histories, motivation, changes within the child's family, the actions of other agencies and the local policy and resource context makes it extremely difficult to tease out the effects of a specific intervention. In this complex and shifting family and service environment, qualitative analysis of case histories can enhance our understanding of the relationship between interventions and outcomes.

Through analysis of depth interviews and other qualitative material, this chapter attempts to tease out the interaction between risk and protective factors and social work interventions in order to understand how, and in what circumstances, positive outcomes for young people occurred and the circumstances in which interventions were less successful.

## Moderating the effects of multiple risk factors

We have seen that numerous risk factors were evident in the lives of the young people in this study. Individual risk factors included hyperactivity and learning disabilities, while family risk factors included conflict and violence between parents, parental depression, ill health and social isolation, together with financial worries. Only half of the parents were thought (by workers) to show warmth and two-thirds were thought to show little consistency in their parenting, while one fifth were reported to be harsh in their dealings with their child. Risk factors in the community included detachment from school, through truancy or exclusion, and associating with peers who were thought to exert a bad influence. All of these have been shown to be risk factors for

emotional and behavioural problems in children and young people (Farrington, 1996; Buchanan and Ten Brinke, 1998).

Multiple risk factors were evident for almost all of these young people, as over nine in ten families had reported six or more difficulties at referral and four in ten reported eleven or more. It is in *moderating* the effects of multiple risk factors for young people and in *enhancing* or *developing* protective factors in their lives that social workers and support workers can play an important role in improving their well-being.

## Cases that were more successful

In cases that were 'successful', that is, where both parents and young people felt that circumstances had improved, workers had addressed a range of issues, offering 'multi-faceted solutions to multi-faceted problems' (Sinclair and Burton 1998). Three key elements were usually at play: individual work with young people, support and advice to parents and some mediation between the two. In a number of cases, some change in the young person's environment, including the school environment, also took place. In most of these 'successful' cases, young people appeared motivated to change and parents were willing to try out strategies suggested by workers. Although in a few cases these young people had initially expressed negative or pessimistic views about the possibility of change, they did in fact engage with workers. Either their initial pessimism may have been due to feeling depressed about their circumstances and may have masked an underlying willingness to work on their difficulties, or workers may have been particularly skilled in engaging them - or both.

### *Work with individual young people*

Direct work with young people was undertaken principally by support workers or sessional workers, although some social workers also worked directly with them. It took a variety of forms, depending on the young person's particular circumstances. At the very least, taking young people out of the home and giving them individual attention allowed them the opportunity to talk about their difficulties, to feel listened to and to feel valued. Many workers took the view that the young people had low

self-esteem and one of the aims of this individual befriending and support was to build self-esteem and a greater sense of efficacy. This individual attention was particularly important for those from families with chronic, multiple problems, such as parental depression, marital conflict and histories of neglect and abuse, where young people's needs as individuals sometimes became overlooked in the welter of family difficulties.

The building of a positive relationship between workers and young people was crucial in establishing trust, as a platform for further work. This use of the social work relationship was highly valued by many of the young people and was indeed a vital ingredient of work with them, as without it they were unlikely accept any advice or services. In successful cases good working relationships with young people were not an end in themselves, but a vehicle for delivering the intervention (Buchanan 1999).

Individual work with young people in many cases included a focus on their behaviour and work on strategies to change that behaviour. Workers in the support teams, in particular, delivered much of this through structured programmes, sometimes involving worksheets and 'homework' between sessions. Structured work on anger management was common, as was discussion of boundaries to behaviour and the need to respect them. In effect, in successful cases key elements of the interventions were similar to the cognitive-behavioural strategies that have been found to be effective in other studies, namely help in understanding how a problem manifests itself and the teaching of strategies and skills to cope with this problem (Rutter *et al.* 1998).

Individual befriending, often by sessional workers, was also used as a means of engaging young people in positive activities in the community, such as sport or involvement in clubs, which might help to divert them towards more pro-social peers and build community supports that would continue once the intervention ended. To facilitate improved relations both with parents and with peers, work on social skills was sometimes undertaken too, often in groups.

### *Work with parents*

Engaging parents in changing patterns of communication and interaction within the family was another crucial element. If parents found workers supportive and felt able to accept their interventions, they sometimes felt they could look at the situation afresh. In some cases, just the fact that social workers or support workers had become involved could in itself serve as a catalyst for change. As one parent explained:

> When Social Services intervened they made me stop and sort of take one step back and review the situation. We do talk a lot more now.

The process whereby this parenting support was delivered was important. Parents who felt that circumstances had changed for the better had, on the whole, felt understood by, listened to and involved in decision-making by workers, who appeared to be working in partnership with them. When teenagers have behaviour problems these are often displayed publicly, so parents may feel ashamed and may fear that they will be criticised for failing as parents. Many of the parents in this study were found to suffer from a degree of depression or anxiety at referral and felt despairing about their ability to control their children. In these circumstances, working in partnership with parents and focusing on strengths rather than failings are likely to be important ingredients in engaging them in productive working relationships.

Parents who feel they have little control over their children and develop a sense of helplessness tend to 'give up' and let them go their own way (Coleman 1997). The more successful interventions helped parents to develop a more authoritative parenting style and a greater sense of perceived control. Work with parents in most cases included advice on strategies for dealing with their child, building their confidence in setting and enforcing boundaries and helping them to improve consistency in their parenting. Sometimes this work was done in a structured way through the use of worksheets or parenting groups and sometimes advice was simply offered in discussion.

Work with parents and young people together was also important, as workers mediated between them, helping them to negotiate boundaries and reframe patterns of

communication. Parents and their children were helped to negotiate ground rules with one another that both would find acceptable, a democratic approach that was likely to lead to greater co-operation by the young people. The involvement of a social worker or support worker in this process often helped to legitimise parents' attempts to exert their authority.

Where workers were successful in changing strategies, so that parenting became both more positive and more consistent, this often had an effect on the child's behaviour. Equally, some young people felt that learning to respond differently to frustration could lead to more positive reactions from their parents. The mother of a 13 year old girl described this process:

> (The support worker) spent a lot of time with her explaining about boundaries and things she can do and can't do. He spent a lot of time with me just going over things, basically, and like helping to get my mind straight. I mean, it has improved considerably. I mean it's still going on now, but we know how to handle it. It's better, and the bits that still need working on, we know how to work on them as opposed to banging our heads against a brick wall.

Several young people described how intervention both with them and their parents had led to improvement in their relationships:

> She is ignoring me when I give backchat and it's making me wary not to give her backchat because she will just ignore me more... (The support worker) has made me and mum closer. Like, she gives me cuddles now and again.

> The reason we're getting on better now is because I'm realising what I'm doing wrong now, my mum's being alright with me and we're just getting on.

> When I kick off at home now my mum sits us down and asks what's caused it and that.

Where workers were successful in engaging young people and parents and were able to build on their motivation to change, interventions which addressed both child behaviour and parenting practices could set in motion a virtuous circle, whereby positive change by the parent reinforced positive change in the child, or *vice versa,* and such changes provided further positive reinforcement to both parent and child (and perhaps to the worker too).

### *Changes in the environment*

Changes in the home environment also had an important part to play and often these changes had nothing to do with social work staff. Household membership changed during the period of the study for nearly one fifth (17%) of the young people. This most commonly involved siblings moving in or out, or parents' partners joining or leaving the household. A few young people (3%) also moved to live with their other parent for the foreseeable future, although this was not always by choice.

Siblings, or parents' partners moving in or out could have positive or negative effects, depending on the nature of the young person's relationship with them. For example, one young person was happy that his mother's partner had moved out, another felt more supported when her boyfriend moved in to the family home and others reported that general family conflict had reduced since a sibling they frequently argued with had left. In another case, a mother sent her son to live with a relative some miles away when his offending behaviour intensified and this was successful in reducing his offending through breaking his contact with anti-social friends.

In most cases, the environment changed (usually only for a matter of days or weeks) when young people went to stay with friends, relatives or in residential or foster care. A brief period of respite could at times be helpful in defusing tension in serious conflicts between parents and young people, as sometimes conflicts had become so extreme that one or both needed a breathing space. Such a break could provide the impetus for both to re-evaluate their relationship. If the brief placement away from home was accompanied by rapid intervention by support workers or social workers to negotiate a return and help families agree on the changes that might accompany this, the break could serve as a catalyst for change. Occasional respite arrangements for one or two nights a week were also much appreciated by families, especially for parents of young people with extreme behaviour problems associated with hyperactivity, who were under considerable strain.

Young people's behaviour sometimes improved during a period of time with other relatives, away from the home environment. Several parents also commented on how

their children's behaviour had improved after a period in care, and some young people mentioned that they found their time in residential or foster care a positive experience. Longer-term follow-up would be needed to see if such changes were sustained in the home environment, although earlier research suggests that they may not be (Farmer and Parker, 1991). Any changes occurring away from home may not persist unless they are reinforced within the home environment, and support teams are well-placed to provide this reinforcement.

### *Interventions by other agencies*

Changes in the school environment could also be helpful. A few young people returned to school after a lengthy period of exclusion, while a few others who had special needs moved to special schools offering more intensive support. A lack of adequate alternatives to full time school was a serious problem for those who were excluded from school and workers sometimes tried to put pressure on education authorities and schools to improve their provision for these young people. Young people were positive about these changes:

> I'm now in a special school for EBD, which I like. There's two teachers for six kids.
>
> (School's) brilliant, yeah it is. 'Cos I'm just getting more help and that at school.

More commonly, workers mobilised support from schools. A support worker explained:

> The barrier that had been in before we actually worked the case was that the school didn't have all the information on what this child had been living with..... So we took mum and helped her to tell the headteacher and that was really helpful with school, they really got on board and they had improvements in how he was behaving at school.

This appreciation of the young people's wider difficulties could result in schools excluding the young people less readily or simply providing enhanced individual support to young people in school. Teachers could be an important source of support to young people, so ensuring that support was available to them was an important

aspect of workers' interventions. In recognition of this, one of the support teams had an education worker in post specifically to work on school-related issues. Several young people spoke of the support they received from particular teachers:

> Actually I've seen my head of year to speak to him about my problems with my mum. I'd trust him and that. I can talk to him about anything cos I think he'd understand, cos I'd been to him with my troubles before that.

Facilitating changes in the school environment could bring a positive chain reaction, breaking links with delinquent peers and potentially building self-esteem. As one parent explained:

> Now he's happier in school. Not roaming the streets like he was. Not mixing with the kids he got into trouble with.

Problems in behaviour at school, truancy and exclusion were often a source of stress to parents and a source of conflict between them and their children, so improved school support which helped to diminish these behaviours could contribute to reducing parent-child conflict.

Given the extensive nature of the young people's difficulties, interventions often involved making contact with other agencies too, including health and mental health services, youth offending teams, drug and alcohol abuse projects and voluntary sector projects. In one of the authorities where only a mainstream social work service was offered, several social workers referred families to a 'family workshop' service provided by another agency.

### *The interaction of positive changes*

Just as there was often a productive interplay between changes in parenting style, child behaviour and school provision, changes in other aspects of young people's lives could also be beneficial, although it was unclear whether positive chain effects operated in a single direction or whether changes in different areas of young people's lives all interacted with one another. For example, a mother reported that the social worker had helped her 14 year old daughter to see that she 'had to live by what my rules are', but also said matters had improved because:

> She's not drinking like she was and she's got in with a different group of friends, so that's made it easier.

Rutter and colleagues have suggested that for young people experiencing multiple adversities, as were most of these young people, multi-faceted interventions which reduce stress in different areas of their lives are more likely to be beneficial than those which target one or two risk factors in isolation, particularly as risk factors often interact with and reinforce one another (Rutter *et al.* 1998). In a similar vein, an Audit Commission report (1996) on young people with anti-social behaviour recommended taking an holistic approach which targets all key areas of young people's lives. In this study, such a multi-faceted approach was evident in the most successful pieces of work, irrespective of whether it was delivered by support workers or social workers. These usually involved work with parents on parenting strategies alongside direct work with young people and mediation between the two, as well as liaison with other agencies and, occasionally, mobilising support from the extended family. These interventions also targeted specific problems such as drug or alcohol abuse, a lack of support at school, poor social skills or non-involvement in positive leisure activities, usually through referral to groups or to other agencies.

Although many support workers stated that they focused principally on changing present patterns of interaction and behaviours, in a number of the successful cases workers also paid some attention to dealing with longer–term underlying family problems. Outcomes could be positive even for young people with multiple risk factors if both parents and young people were motivated to work on change and if well-planned and co-ordinated work was undertaken, as the following case examples illustrate.

Abigail, age 13, was reported to have ADHD. She could be abusive and violent at home and at school, was a regular truant and had twice taken an overdose in the months prior to referral. Her mother felt that the support worker had helped them considerably and described the work that she had done:

*'She gave me discipline back. She went through some ground rules with Abigail and myself and the rules we decide in the house, we did them together. It was what she was happy with and I was happy with.'*

Partnership working was important, and this parent clearly valued the way the worker kept her fully involved:

*'The initial meeting was here and I was quite aware of what was going on, what they were going to do with her and how they were going to try and help.'*

The support worker worked with this parent on strategies for setting and enforcing boundaries, while the social worker arranged for her to attend a 'parents of teenagers' course. The support worker contacted Abigail's psychiatrist regarding problems with her medication and also worked directly with her on her behaviour and, in particular, on anger management. The building of a relationship with Abigail was central to her success, as she explained:

*'I know that she enjoyed coming out with me. She fully engaged in the work while I was with her, and the work that I left her in between visits. I think the relationship that we built up helped her to move on.'*

David, 15, had learning difficulties and had experienced neglect, physical, emotional and sexual abuse in the past, often truanted from school, abused drugs and was involved in offending. His mother had alcohol problems, had experienced domestic violence in the past and suffered from depression. However, there was a positive attachment between the mother and child and the support worker was able to build on this. The support worker described this mother as *'basically, very loving in lots of ways, but she could be very erratic in her responses....highly strung, and the slightest falling out led to a full-scale argument between them.'*

The work helped the mother to respond more calmly and to prevent conflicts escalating and gave her advice on strategies to deal with his behaviour. Other family members were closely involved with mother and son and often interfered, so the worker met with them to explain the need for a consistent approach between them; *'a consistent campaign of action plan which they all agreed to.'*

At the same time, a worker from the Youth Offending Team undertook individual work with the young person on his behaviour. Positive changes in the young person's behaviour and the family's parenting style were mutually reinforcing, but it was the quality of the parent-child relationship that allowed this intervention to be successful, as their basically positive relationship made them motivated to work on change.

This family had been known to social services for many years both due to child protection concerns and the previous breakdown in the mother and son relationship. In these circumstances, and with the presence of multiple risk factors, it seems likely that from time to time further work would be needed as one short-term intervention was unlikely to resolve definitively their multiple and long-standing problems.

## Cases that were less successful

Those cases where neither the young people nor the parents felt that circumstances had improved were dispersed between the groups using specialist and mainstream services and across all authorities. A key feature in many of these cases was young people's reluctance to engage with workers. In several cases, they refused to meet with the worker at all and a few would even run off as soon as they saw the worker

arriving. As another study of adolescents and social work services once commented, unlike younger children they may 'vote with their feet' (Sinclair *et al.* 1995). In other cases workers did manage to see the young people but did not manage to strike up a working relationship with them. In a few cases it was clear that young people's distress made them anxious about opening up to a stranger, as the following comments indicate:

> She worked with me but I don't feel……. telling people that I don't know about my problems, it doesn't feel right. I felt listened to but I couldn't tell her all the things I'd want to tell her. I know she would have helped me if she'd been able to help me if I'd told her, but I just didn't feel like telling her (girl, 13 years).
>
> I didn't use to listen to what she was saying 'cos I didn't like having meetings and that and didn't use to listen. She were just making me worse (boy, 15 years).

The first of these lived in what the worker described as 'semi-chaotic household', where she had witnessed domestic violence some years earlier, and had a mother who suffered from depression. This combination of both exposure to domestic violence and maternal depression is thought to be particularly damaging to children, if it results in the mother becoming 'emotionally unavailable' (Hester *et al.* 2000). This girl not only had problems in her relationship with her mother and stepparent, including violent behaviour towards them, but also truanted regularly and constantly said that she wished to leave home. Although at referral she had mentioned that she would like help with managing her anger and stopping her cannabis use, she clearly needed time to build a relationship with the worker. A short-term intensive model of work may not be helpful to wary young people who need time to build trust.

The parents of the second also suffered from depression and the worker considered him to suffer emotional abuse and rejection (by his father) and to have very low self-esteem. This young person engaged in extremely anti-social behaviour, including arson, which had put his family at risk of eviction. He had truanted regularly before being permanently excluded from school and was avoiding engagement with all professionals who tried to help, including the pupil referral unit that he refused to attend and the youth offending team. After breaching his supervision order he spent a

few months in a secure unit, which he found a positive experience. At follow-up his behaviour and relationship with his parents appeared to have improved (but at that point he had only been back in the community for two weeks). Again, this was a young person who needed more time to build trusting relationships with adults in order to engage in work with them - something that is more difficult in short-term interventions and in the context of high turnover rates for social workers. Trust was clearly an issue for some other young people too, who indicated that they feared they would be criticised if they began to talk to workers.

In other 'unsuccessful' cases parents would not engage with workers. There were a variety of reasons for this. Some simply did not see any need for them to talk to workers, as they felt that problems lay solely with their child and did not involve them at all. Others would engage with workers at times of crisis but avoid them at other times, reluctant to engage in any structured work during quieter periods. A few were quite simply rejecting of their children, not prepared to countenance anything other than the child's removal. In a number of cases both parents and young people were reluctant to engage in any work and often failed to keep appointments. For some families, a reluctance to engage with workers was fuelled by distrust of social services either due to a fear that they would be judged or because of earlier experiences of social workers, sometimes in their own childhoods.

Young people could also be suspicious, such as one boy whose friend had been placed in care 50 miles away and was thought to fear that the same would happen to him. Young people who were reluctant to discuss their difficulties with workers were often equally reluctant to take up services offered to them, which may also have contributed to the lack of success of the (attempted) intervention. Where young people or parents lack motivation to change or are difficult to engage in a working relationship, it may be worth exploring strategies for motivational interviewing that have been tried in other services (see Buchanan 1999: 65).

Continuing involvement with an anti-social peer group was a risk factor that could also operate as a barrier to successful work, particularly if this group was involved in offending or substance misuse. One parent described how involvement with anti-

social peers could make young people less motivated to work with the support worker:

> I don't think he wants to change. He's at that age -all his friends are off the rails and he wants to be like them.

The particular nature of family difficulties could also make it more difficult to promote positive changes. In one case, for example, a 14 year old boy felt so upset about his mother's renewed relationship with a man who had been violent towards her (even though this man did not visit the home) that he withdrew into himself in anger and distress, feeling that everything was hopeless:

> I don't care any more, because mum is seeing him again and I think she's being stupid. I don't like it, he's winning all the time after all the things he did.

In a few cases, the root difficulty appeared to be young people's mental health problems, where the professionals most likely to help were mental health services rather than social services. In a number of cases chronic child or parent mental health problems, or other long-term difficulties such as serious marital conflict or domestic violence, appeared to result in entrenched problems for the child and family. It appeared that short-term interventions were only successful in making some impact on these situations of chronic difficulty where family members showed a strong commitment to one another and were particularly motivated to work towards change. In a few cases, a particular combination of child and parent difficulties were associated with particularly entrenched problems, as in small sub-group of young people reported to suffer from ADHD who had also witnessed domestic violence within their families.

## Comparing barriers to success for specialist and mainstream services

A lack of resources was highlighted as a problem both by support workers and by social workers offering a mainstream service. Both felt that the lack of accommodation resources was a hindrance, which made it hard for them to offer respite care to families in crisis, or on an occasional basis as a support to families in extreme stress. They would also have liked more groups and clubs to be available for young people so that they could involve them in activities in the community.

Similarly, social workers' lack of time for work with families was a problem for those using both types of service. This could lead families to feel let down and could even make them hostile to social services.

However, the lack of resources for family support was clearly a far greater problem for social workers unable to refer families to a specialist support team. As we saw in Chapter10, support workers were not only more likely to undertake direct work with families, they were generally likely to intervene on more issues at a time. Social workers offering a mainstream service, on the other hand, complained of a lack of time to undertake adequate direct work with families themselves and a lack of support staff to assist them in offering a family support service. The demands of child protection work were overwhelming, leaving them with little time for preventive work even though they would have liked to devote more time to this. Several social workers commented on their frustration at not being able to undertake more therapeutic work with families and felt that the workload pressures that often restricted their role to the predominantly administrative functions of case management with these families limited what they could achieve.

Where only mainstream services were offered, some parents complained of social services' reluctance to intervene or of the fact that they closed the case after only a brief contact. Some also complained that they had approached social services in the past but had not been offered a service until a serious crisis occurred. Parents in two of the comparison authorities commented:

> Their resources are so very stretched and they deal with priority cases only – but surely the non-priority cases will become priority cases because of the non-intervention. They are dealing with their priorities and they do not see our son as a priority. It's not fair they put their budget first. If they had helped us two years ago this situation would not have happened.

> I'm not bothering with social services no more. I've got no time for them and I think the facilities that they say they offer should be improved, because it is always they have run out of funding, they can't afford to do this or they can't afford to send nobody out and I'm sick of hearing it. I've heard it all my life.

The fact that a support team existed at all in some authorities meant that families in those authorities were more likely to receive a family support intervention, as this was the whole *raison d'etre* of these services, whereas area social workers had many other demands on their time.

## The duration of interventions

There were a number of cases where intervention by social workers or support workers had initially led to positive changes in behaviour, parenting and parent-child relationships but the situation had deteriorated rapidly once workers withdrew. This raises the issue of whether, for some families, short-term interventions may be just too short. Time limited work has long been advocated to improve motivation and concentrate the mind, although undoubtedly it also owes its continuing popularity to budgetary considerations (Reid and Epstein 1972). For families with chronic and severe problems, however, short term intensive work may not in itself be sufficient, as other studies in both Britain and the USA have also found (Szykula and Fleischman, 1985; Nelson *et al.* 1988; Besharov 1994; Schuerman *et al.* 1994; Cleaver and Freeman 1995; Biehal 2000).

While short-term intensive services may be enough for some families in crisis, where problems are chronic and severe an infrastructure of longer-term services may be needed, offering less intensive support, as needed, to both young people and parents. Such secondary preventive services would operate with lower thresholds than current services and could offer help to families in need at an earlier stage, before difficulties reach crisis point. More intensive support could then be available from specialist support teams on an occasional basis, if crises reoccurred, to reassess the situation and help to stabilise it. However, it is important that episodic intervention of this kind nevertheless retains a wider focus on the longer-term welfare of the child rather than concentrating on the short-term goal of placement prevention.

# 15 Conclusion

## What has changed in work with teenagers?

Research since early 1980s has highlighted the dearth of services working in ways appropriate to families with teenagers. With the development of support teams in the last 15 years or so, this situation has changed for the better. There are now some excellent services in place working in age-appropriate ways, which are much appreciated by young people and parents. Some of these specialist services are targeted exclusively at older children and teenagers, while others are offered to all age groups but nevertheless work predominantly with children age 11 or over. Specialisation enables these teams to develop skills and confidence in working with this older age group.

What has not changed is that it is still very difficult for families to receive a family support service before they reach crisis point. Thresholds for receiving a service remain high, as we can see from the severity of difficulties of the majority of the young people in this study, many of whom had multiple and long term problems. Although specialist services are now available, they are offered mainly to those with the highest levels of need. In all authorities, but especially in those that did not have specialist support teams, families complained of their difficulties in obtaining a family support service.

Decisions about rationing are intrinsic to the provision of public services and no doubt contributed to the past failure to provide adequate support services to families with teenagers, prior to the development of support teams. Currently, a number of factors appear to intersect to influence decisions about the allocation of resources to family support. The perennial problem of managing limited resources is now complicated by the demand for councils with social services responsibilities to meet a range of performance indicators set by central government, including those set out in the

*Quality Protects* objectives and the *Performance Assessment Framework* indicators (Department of Health, 1998a and 2002a). Despite the policy imperative towards refocusing services in such a way as to give greater priority to family support, family support services do not constitute a key element in the measurement of social services' performance. The performance of children's services is principally measured by indicators relating to child protection, children looked after and children leaving care. This centralisation of service priorities at national level makes it likely that local provision will be targeted on those services used as the key benchmarks for local authorities' performance. At the same time, professional concerns about protecting children at risk and anxiety about the public scrutiny of child protection decisions when things go wrong also lead to a situation where family support services are accorded a lower priority.

As a result, it remains difficult for families with older children and teenagers to obtain a family support service. Although such a service is more likely to be offered in authorities that have specialist support teams, nevertheless the majority of families who do receive this service are those whose difficulties have become so severe that they are considered to be at risk of family breakdown. In these authorities, it is anticipated that the provision of community-based support services to these families will lead to some reduction in the use of residential and fostering services, which are more expensive.

The picture is one of beleaguered social services holding back the tide of demand for a limited service, which is made even more limited by the national shortage of social workers. In this context, both managers and social workers become preoccupied with gate keeping the limited service available and with the diversion of families who request support. In this respect, agency needs to contain demand sometimes appear to be prioritised over children's needs for support.

These findings are consistent with the observations of the Laming Inquiry, which pointed to major deficiencies in the implementation of the Children Act 1989 (Department of Health 2003c). The Laming Report contends that the provisions of the Act for both family support and for child protection investigations, which sought

to ensure an appropriate response to the differing needs of children, are being used as a means of rationing access to services. This has led to the family support provisions, under Section 17 of the Act, being regarded as having low priority.

## The strengths of support teams

In view of the above pressures to contain demand for family support services, at the most basic level the existence of support teams means that at least some families with older children will receive a family support service, precisely because resources for family support have been ring-fenced. Not only do specialist teams have the opportunity to develop skills in direct work with teenagers. Specialisation also enables them to build links with other local agencies offering services to teenagers.

For most teams, case management functions were carried out by area social workers who retained case responsibility, allowing support team staff to spend more time on direct work with families. Support workers seemed to be better able to engage young people in working with them than area social workers, perhaps because of their more intensive contact with them and their specialist skills in work with older children.

Most support workers had many years of experience in working with older children, often in residential settings, and had a wide range of skills. However, given the contraction of the residential sector in recent years, such a pool of experienced staff will not be available to staff these teams in the long-term. In view of this, and the severity of the difficulties of the families the teams work with, in the longer–term it will become important to appoint staff with professional social work qualifications.

The teams made good use of structured resources for work on behaviour and parenting, but their success in using these methods appeared to be grounded in more traditional social work skills in the use of relationships to promote change. Their more intensive contact with families, informal, participative style and strengths-based approach helped them to build these good working relationships as a platform for the more structured work they undertook. Their mainly short-term interventions focused on bringing about concrete changes in behavioural performance, helping to change

both young people's behaviour and parenting skills, and they appeared to be frequently successful in these tasks.

Crucially, most young people and parents were satisfied with the service they received and perceived the support teams as helpful. They felt that they were listened to and involved in decision-making. Families were more likely to report that support workers had helped to improve their situation than social workers. However, since in many cases social workers had devolved much of the direct provision of therapeutic help to support teams, this is perhaps not surprising. The service should be seen as one comprising the efforts both of support workers and social workers, who often undertake different roles in the provision of the service as a whole.

## Comparing outcomes

### *Changes in child and family functioning*

At six-month follow-up, families using both specialist and mainstream services showed considerable improvement, according to standardised measures of children's emotional and behavioural difficulties and quality of life, family functioning and parents' mental health. Families also reported a substantial overall reduction in the severity of child behaviour problems. Analysis of change in respect of specific problems reported at referral showed that positive change had occurred in between one third to over one half of all cases for each problem reported. Change was more likely on issues within the family environment (behaviour at home, parent-child communication, relationships and problem-solving). In particular, there was a reduction in child violence towards parents and in running away for nearly two-thirds of those young people initially reported to engage in these behaviours. However, behaviour outside the home showed less improvement. There was little evidence of change in problems at school, although the proportion truanting decreased considerably. There was also little improvement in offending behaviour.

Although the support team service and the mainstream social work service differed in many respects, there was no significant difference in extent of change between the groups using the two different types of service. However, the specialist teams

appeared to be working with a somewhat more difficult group, who were more likely to have long-term problems, severe emotional and behavioural difficulties, to have experienced abuse in the past and to have had recent contact with mental health and educational psychology services. So although the *degree* of change was similar for the two groups, the support teams achieved this change with a group that included proportionately more young people with longer-term and severe difficulties.

It is difficult to derive clear-cut findings on the effectiveness of the specialist service when, for ethical and practical reasons, it was not possible to compare support teams to a 'no-service' alternative. Also, the complex multi-agency environment in which services for children are delivered and the impact of informal support from relatives and friends also make it hard to tease out the effects of just one team's work. For example, changes in relation to the school environment often triggered changes in other aspects of the young people's lives. Equally, the severity of family difficulties is influential, as positive change is harder to achieve in families with chronic and severe problems than in those experiencing acute but more recent stress. Young people and parents' motivation to change was another key element and was closely related to their willingness to engage in work with support workers and social workers.

The interaction of this multiplicity of factors may influence the outcomes that *any* type of social work service may achieve. What did not appear to influence outcomes to a significant extent, however, were the precise components of the service offered. If families were offered a service, were prepared to engage with workers and were motivated to change (or were encouraged by workers to become more motivated), then matters improved in many cases. Worker skills in engaging families and providing therapeutic help appeared to be more important than the particular techniques used.

Families who were prepared to engage with workers made good use of either type of service. In essence, family support services helped to bring about positive changes in both child and family functioning irrespective of whether they were delivered by support teams or mainstream social work teams, but in the absence of a specialist

service families were less likely to receive any support of this kind. However it should be borne in mind that, due to sampling problems, the comparison sample in this study was relatively small, which may have made it difficult to detect real differences between the two groups.

### *Preventing placement*

Although one quarter of the young people entered care at some point during the six-month follow-up period, most of these placements lasted for less than four weeks. Only eight per cent of the sample were expected to remain looked after in the long term. In authorities where no support team service was available (that is, Midshire and Borough), young people using a mainstream social work service were twice as likely to enter care placements as those referred to support teams. They were also more likely to enter care placements that were anticipated to be long-term. The support teams therefore appeared to be more effective in preventing placement than mainstream services and, indeed, placement prevention was one of their principal objectives.

However, service outcomes such as a reduction in the use of care placements are strongly influenced by system factors such as local policies on placement and the availability of residential and foster placements. Decisions about placement are, at the very least, influenced as much by the availability of placements as by the circumstances and needs of the child. Most of the support teams had been set up following the closure of children's homes, whose residential staff had been redeployed as support workers. In these authorities, the new support service was therefore provided in the context of a reduction in placement resources, which in itself was likely to bring about a decrease in placement rates. Nevertheless, while these policy and resource factors clearly had an impact on placement rates, the support teams also played an important role in preventing placement through their provision of an alternative, community-based service to families.

A more fundamental issue was the apparent fixation among workers in both the support teams and the mainstream social work teams with avoiding placement at all costs. This derived partly from practice concerns regarding the potentially damaging

effects of care and partly from local policy directives regarding the need to avoid placement. These concerns led to a presupposition that placement was invariably damaging, should be resisted whenever possible and should only be used as a last resort. Yet evidence from this study shows that a short-term placement as part of a plan for family support was often helpful to families under stress, helping to defuse tension and providing time for cooling off before the young person stabilised again at home.

The fixation with avoiding placement also led to a failure to consider the longer-term needs of a small number of children experiencing severe emotional abuse, whose needs may potentially have been better met through placement in long term foster-care than through repeated episodic interventions that focused single-mindedly on keeping them at home. Agency concerns with reducing the use of placement sometimes led to situations where practice was resource-driven rather than needs-led, so that agency needs were prioritised over children's needs. Although such strategies may be effective in reducing expenditure in the short-term, this may be at the expense of meeting the longer-term needs of children. In addition, individual agencies' preoccupation with containing their own costs in the short-term, whether by failing to provide a placement, a school place or a mental health service, might potentially lead to greater social and financial costs to society in the long-term, such as increased use of mental health or criminal justice services.

## Limitations to the study

It is possible that this study's failure to detect any greater effectiveness on the part of the specialist teams in bringing about changes in child and family functioning was due its methodological limitations. It was only possible to identify a relatively small control group, half of which came from a single local authority in which a high level of service was available - and this service was not dissimilar to the specialist service. The service received by this half of the control group was perhaps closer to that provided by the specialist teams than to the mainstream service provided in the other two authorities from which the control group was drawn, which may possibly have skewed the results.

The failure to detect a difference in the effectiveness of the two services may also be due to another limitation of the study, arising from its quasi-experimental design. Despite efforts to sample equivalent groups, there were some clear differences between them, with the experimental group containing a higher proportion of young people with chronic and severe difficulties than the control group. If the specialist teams were indeed working with a higher proportion of young people with long-term and serious difficulties, it would be harder for them to achieve more positive outcomes than mainstream services working with proportionately fewer young people with this level of difficulty. Nevertheless, it remains equally possible that the specialist support teams were no more effective in bringing about positive changes in child and family functioning than mainstream services.

## Implications for policy and practice

### *The impact of abuse, neglect and domestic violence*

Although concerns about abuse and neglect are more common in relation to younger children, who may be more physically vulnerable, the evidence from this study suggests that these issues are of continuing importance in work with older children and adolescents. Research in the United States has shown that the abuse of adolescents is not always recognised as such, and adolescents may display the effects of abuse through troubled or troublesome behaviour (Rees and Stein 1997). We have seen that social workers had had past concerns about abuse in respect of one third of the children in this study and over one in ten were considered to have experienced past neglect. At the time of referral, workers considered that over half of the young people had recently experienced abuse or neglect. Emotional abuse was the most common form, mentioned in respect of one third of the young people in the study. Nearly one fifth were considered to experience neglect and more than one in ten had recently experienced physical abuse.

The parents of 43% of the young people had experienced domestic violence either recently or in the past, and some of the young people had witnessed this violence. Some continued to be troubled by these experiences even many years after they had

occurred. Those children with experience of domestic violence were more likely to have severe emotional and conduct problems at referral. Domestic violence clearly has continuing effects on some children and the effects of abuse may be evident in behaviour such as self-harm, depression, running away and offending (Rees and Stein 1997). There was also a clear association between high scores for emotional problems, which may develop as a result of these difficult family experiences, and young people's violence to their parents. Over half were reported to be violent to parents and over two thirds were violent to others. Clearly many of these young people had difficult histories and complex needs. The continuing impact of both past and current abuse, neglect and domestic violence demonstrates the importance of providing a range of family support services to older as well as younger children.

### *Providing an infrastructure of less intensive services*

Since the late 1980s there has been an increasing focus on parenting, with an emphasis on parental responsibility evident in both the Children Act 1989 and the Crime and Disorder Act 1998. The concern with disruptive behaviour by older children and teenagers at school and in the community and the increasing focus on parental accountability for the actions of their children has led to the introduction of parenting orders and anti-social behaviour orders. Alongside the more punitive policies associated with the Crime and Disorder Act, the Children Act has emphasised the importance of family support as a proactive service to families.

Since the change of government in 1997 there has been a big increase in the provision of family support services, for example through the growth of charities such as the National Family and Parenting Institute and Parentline Plus, but a recent national mapping of family services has found that services often do not place enough emphasis on preventive work with families (Henricson *et al*. 2002). Also, the majority of family services are aimed at families with younger children, for example those funded under the Sure Start and Children's Fund initiatives.

Although the behaviour of teenagers causes much concern, there are no comparable services to support parents and young people at an early stage, before difficulties become more severe. There may perhaps be an assumption that if services are targeted at younger children, fewer problems will emerge in adolescence. Yet even in

the context of preventive services for younger children, support services will continue to be needed for older children in difficulty and their parents.

Findings from this study suggest that intervention earlier in the development of problems is also important. As the Treasury's recent spending review has highlighted in relation to family services in general, most activity is focused on work with families in crisis or in acute stress rather than on prevention and the early identification of need (HM Treasury 2002). As we have seen, parents complained of asking for help on previous occasions but being denied it until they reached crisis point. Service provision was often triggered by demands for a child to be removed and occasionally by parental threats that they might harm their children if no help was provided. The provision of a service at an earlier stage, before problems reach crisis point, may prevent the escalation of difficulties for some, or even many, young people. Such services may have a positive effect not only on the welfare of these young people but also on their behaviour at school and in the community, leading to wider benefits to society beyond the realm of individual families.

### *The need for a continuum of family support services*

For those young people with severe difficulties and high levels of need, the short-term, intensive service provided by support teams was often effective in helping families to resolve crises and in providing them with strategies for addressing their difficulties in the future. Given the multiple and often long-term difficulties of these young people and parents, it is likely that crises will re-occur and that some may need further interventions of this kind from time to time. Specialist support teams therefore have an important role to play in providing these intensive family support services for families with severe difficulties.

However, perhaps fewer families would reach crisis point if this intensive service were located in an infrastructure of less-intensive services providing support to teenagers and their families. Also, given the high proportion of young people in this study with emotional and behavioural difficulties, disabilities or impairments, mental health problems or serious health problems, it is clear that some families are likely to need continuing support. For example, for young people with ADHD, problems are

unlikely to disappear after a short period of intensive work, although there may be moderate improvement. Families experiencing long-term stress are likely to benefit from less-intensive support over a longer period to help them cope with such stresses.

Specialist services, such as support teams, should therefore form part of a continuum of support services for children and families. These should include less-intensive services offering advice and support to parents and children before problems become severe, as well as services to encourage and support vulnerable children to become engaged in age-appropriate local clubs and activities, as the support workers and sessional workers in this study tried to do. These less-intensive services should be multi-professional, involving health, mental health, education and youth work services, as well as voluntary agencies offering parenting skills groups or volunteer befriending services for young people. Social services, with their expertise on family work, should retain a key role in this inter-agency framework.

The first five of the core standards set out in the *National Service Framework* and the objectives of the *Every Child Matters: Change for Children* programme could provide a rationale for the development of family support services. These initiatives, together with the Children Act (2004) also focus on the greater integration of services for children. Closer inter-agency and inter-disciplinary working may help to resolve situations where social services become involved in supporting families whose difficulties have been intensified by the failure of education departments to provide a school place or appropriate specialist resource, or the failure of mental health services to provide a timely service. Universal services are less likely to be perceived as stigmatising and families under stress may be more willing to take up a family support service if it is delivered within a framework which provides universal services, such as day care, education and health services, as well as services targeted at families in difficulty. To enhance access to more specialist services, there could be some integration of these within a framework of universal services (Henricson 2002). However, Children's Trusts are currently in their early stages and it is unclear what models might develop and whether they will indeed succeed in delivering more responsive services.

### *The use of placement*

The proposed service continuum for children's services should range from low-level support to families at one end, via more intensive support such as that provided by support teams, to a range of placement resources at the other end. As well as longer-term placements for the small number of children who need them, the creative use of short-term placements as an element of family support provision would be a valuable service for those experiencing severe stress. These might include emergency and planned short-term residential services such as those developed in Northshire, with work with parents and children undertaken both during and after placement. Regular respite care, such as the single overnight stays with foster carers once a month over a period of several months provided by a small number of Support Care fostering schemes around the country, might also be a valuable resource (Aldgate and Bradley 1999). In Sweden a more broadly based model of Support Care has been developed, known as the contact family service. This scheme links families with a contact person or family, who undertake a range of activities with the child, help the parent with parenting tasks and offer occasional respite care overnight (Andersson 2003). Support Care or contact family services may relieve family stress and may prevent family breakdown in the long-term. Where family breakdown does occur, treatment foster care schemes providing intensive intervention with both children and parents might lead to the successful rehabilitation of more children with their families, but these have yet to be evaluated in a British context (Baker and Chamberlain 1997). Family support and placement should not be seen as competing alternatives. Instead, and consistent with the Children Act 1989, placement should be seen as one form of family support that can help to ensure that children to remain with their families in the long-term.

### *The role of social workers*

Social workers had fewer opportunities than support workers for direct therapeutic work with families as much of their time was taken up with case management tasks. Some social workers mentioned their frustration at not being able to make greater use of their professional skills in working directly with families because much of their time was taken up with tasks they viewed as bureaucratic, which they typically described as 'making sure that all the right boxes are ticked.' Other research has also

found that social workers now have few opportunities for undertaking therapeutic work and, in particular, work on family support (McDonald and Williamson 2002). Such work is increasingly being located to specialist teams, yet these are mostly staffed by people without professional social work qualifications and in most cases, without training in therapeutic work. In authorities where support teams were available, social workers viewed them as a valuable resource that could provide the direct therapeutic work that they themselves had little time to offer.

Given their level of training and their experience with children and families, there is some indication that the professional skills of social workers were often under-exploited. A few support workers who were professionally qualified as social workers said that they had joined support teams precisely because these gave them more opportunities for what they viewed as 'real' social work. Restricted opportunities for the therapeutic work that many view as professionally more satisfying may be one factor contributing to the current shortage of social workers.

***The duration of interventions***

Support teams offered brief, intensive interventions that often helped to bring about changes in parenting style and young people's behaviour. Where successful, these short-term interventions often helped to set in train a virtuous circle, in which improved child behaviour and more consistent parenting were mutually reinforcing, leading to a reduction in family stress. These interventions helped to defuse tension and resolve family crises. However, while time-limited, task-centred support may be helpful for those experiencing acute crises, particularly if problems have emerged relatively recently, short-term work may not be ideal for every family. For families with multiple and long-term problems it may be unreasonable to expect that short-term interventions can bring lasting change, as other studies of parenting support have also suggested (Ghate and Ramella 2002; McDonald and Williamson 2002; Tunstill and Aldgate 2000).

We have seen that some children in this study had received a series of episodic interventions over a number of years to deal with immediate crises, with little evidence of a considered assessment of their longer-term needs. The pressure on

social workers to achieve a steady turnover of cases, particularly in the context of the national social worker shortage and the rapid turnover of social workers, militates against taking a longer-term view of the needs of children outside the care system. Equally, consistent long-term support to children may be hard to provide in agencies that find themselves obliged to rely heavily on agency staff due to difficulties in recruitment. However for some children living with their families, long-term support may be needed, even though this is currently out of fashion. For example, for older children experiencing emotional abuse the co-ordination of longer-term help may be needed to support them at home, if assessment indicates that remaining at home is in their best interests.

## Conclusion

Both types of service were associated with significant change in the lives of young people by six-month follow-up. Many showed improved scores on standardised measures of emotional and behavioural difficulties, family functioning and child perceptions of quality of life. A substantial proportion of parents also showed marked improvement on a standardised measure of mental well-being. Similarly, on most of the specific problems reported at referral, our measure of the Severity of Difficulties showed that positive change occurred in between one third and one half of cases and in particular, there was a reduction of child violence towards family members in nearly two thirds of cases. Although one quarter of the young people were accommodated during this follow-up period, most of these were placed only for a matter of days or weeks. Only 8% were expected to remain looked after in the long-term. There was no significant difference between specialist and mainstream services in terms of changes in child and family functioning, but in authorities without specialist support teams, young people were twice as likely to be accommodated and were five times as likely to enter what was anticipated to be long-term care, compared to those receiving a specialist support team service.

It has been easier to identify factors which did *not* influence positive changes in child and family functioning and child perceptions of well-being, than those which did. There was no association between the nature, duration and intensity of the service

provided and the nature and extent of change. In other words, the characteristics which distinguished the specialist service from mainstream services did not appear to have any direct bearing on outcomes for young people. What *did* appear to influence change was young people's and parents' motivation to change and professionals' ability to engage them in working towards change. Those with long-term difficulties were on the whole less likely to indicate motivation, so it appears likely that having chronic difficulties may have an indirect effect on outcomes. Qualitative analysis indicated that in cases which were more successful, direct work with young people was accompanied by direct work with parents to give them strategies for more consistent and authoritative parenting. Building relationships with young people was a key ingredient, as it was only in the context of a positive relationship with professionals and support workers that young people were prepared to work towards change. Negotiation and mediation both with families and with other relevant agencies were also important ingredients of successful interventions.

As for the specialist teams' apparently high success rate in terms of placement prevention, it is certainly possible that this was to some extent due to the nature and quality of the intensive services. However, this was also likely to be due to the support teams' location within a particular policy and resource context. If resources are diverted from residential services to outreach work, as had occurred when most of the intensive teams were set up, then de facto fewer young people are likely to receive a residential service. Local variation in the availability of foster placements for older children and teenagers is also likely to be influential. There was evidence that the allocation of resources to support work with young people and families, the level of placement resources for adolescents and the local policy context all had a strong influence on placement patterns.

Although it has been hard to arrive at any clear conclusion as to whether support teams are more effective than mainstream services, it is clear from this study that they are highly valued by families and that children and families receiving both types of family support service often improve dramatically in their functioning. However, it is

hard for families to gain access to family support services before problems become severe.

### *Lessons for theories of adolescence*

The findings from this study are consistent with the theories of developmental psychology, and the ecological theories which have emerged from these, which were presented in Chapter 3. These theories suggest that a variety of risk and protective factors for children's development exist in the different domains of their lives and that outcomes for children arise from the interaction between these factors. Given the multiple risk factors for the young people in this study, change was only likely to occur if interventions were multi-faceted and were targeted at the different domains of their lives: at the level of the individual, the family, the peer-group and the school. While motivation was a mediator of positive change, having long-term difficulties appeared to function as a moderator, which made positive outcomes less likely to occur. The building of supportive relationships with young people and parents also functioned as a mediator of change. The old-fashioned social work skill of using relationships was a crucial factor, with these relationships used not as an end in themselves but as a platform for focused work. Skilful interventions by support workers and social workers enhanced protective factors in the young people's lives, for example by giving parents strategies for more effectively setting consistent boundaries and reinforcing good behaviour, or by helping to ensure greater integration in school and engagement in pro-social leisure activities.

### *Lessons for further research*

The limitations of the study identified earlier indicated that the groups of young people receiving the two types of service were not equivalent in terms of their histories and characteristics. An experimental design with a random allocation of young people to specialist and mainstream interventions would have a better chance of avoiding this problem. However, studies with randomised controls are extremely difficult to implement in practice for both ethical and practical reasons, particularly in a social work setting.

A simpler modification would have been to ensure that the control group did not include young people from an authority which also had a specialist support team service. The intention had been to make a within-authority comparison of outcomes, thus controlling for the impact of local policy and resources, but in practice the young people who did *not* receive the specialist service within this authority appeared to have less severe difficulties than those who did. A control group drawn from a greater number of local authorities might also have been more representative of the 'service as usual' condition nationally, but widening the sampling frame in this way was precluded for reasons of cost.

A positive lesson from the study has been the value of using mixed methods. Quantitative methods allowed for comparisons to be made more easily between the characteristics, histories and outcomes of both groups and provided a useful approach to exploring the predictors of change. Qualitative methods allowed an exploration of how, why and in what circumstances change occurred.

### *Lessons for policy on prevention*

Specialist support teams offer a valuable service targeted at those with high levels of need. This intensive service should be located within a continuum of services, offering less–intensive help to families at an earlier stage or as a follow-up service. Multi-professional services could offer an ecological approach to service provision, intervening in different areas of young people's lives to address the multiplicity of difficulties that intersect in the lives of these young people. This approach could co-ordinate interventions to address risk factors at the level of the child, the family, the school and the local community, as necessary. Help that is more or less intensive could be offered in each of these areas, as appropriate. It is clear from this study that many parents of 'difficult' teenagers and many teenagers themselves would welcome such help and our evidence suggests that, where skilled help is offered and parents and young people are motivated to change, many may benefit from it. Since teenagers sometimes externalise their difficulties and manifest them in the form of difficult behaviour outside the home, as well as within it, such help may be of benefit to the wider community too.

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# Appendix: Research instruments

# Appendix Selection of research instruments

***NB Formatting has been changed in order to shrink questionnaires.***

THE UNIVERSITY *of York*

SOCIAL WORK RESEARCH AND DEVELOPMENT UNIT

The cost and effectiveness of specialist support teams for adolescents

T1 Questionnaire to parents

**Code for young person**

**Name of social worker**

**Name of support team worker**

## A BASIC DETAILS

**1. Local authority**

**I'd like to start by asking you for a few basic details....**

**2. What is your relationship to (*name of young person*)?**

| | | | |
|---|---|---|---|
| Birth mother | 1 | Adoptive parent | 3 |
| Birth father | 2 | Other relative(specify) 4 | |

**3. Who does (*name of young person*) normally live with?**

| | | | |
|---|---|---|---|
| Birth mother and father | 1 | Birth father + stepparent/cohab | 5 |
| Birth mother only | 2 | Birth mother + stepparent/cohab | 6 |
| Birth father only | 3 | Adoptive parent(s) | 7 |
| Other relative (specify) | 4 | With friends | 8 |

***4.*** **Has he/she lived with anyone else in the last year for more than 2 weeks**

| | | | |
|---|---|---|---|
| Birth mother and father | 1 | Birth father and stepparent/cohab | 7 |
| Birth mother only | 2 | Birth mother and stepparent/cohab. | 8 |
| Birth father only | 3 | Adoptive parent(s) | 9 |
| Other relative (specify) | 4 | No | 10 |
| With friends | 5 | Other(specify) 11 | |
| In care | 6 | | |

**5. Has *(name of young person)* got any serious health problems or any disability?**
**Enter details of type of health problem/disability in box below e.g. partially sighted etc**

| | | | |
|---|---|---|---|
| Serious health problems | 1 | Sensory impairment | 5 |
| Physical disability | 2 | Mental health problems | 6 |
| Emotional/ behavioural difficulties | 3 | Other (*specify*) | 7 |
| Learning disability | 4 | No | 8 |
| ***Nature of problem:*** | | | |

**6. Has *(name of young person)* been given a Statement of Special Educational Needs?**

Yes *1* No *2*

7. ***If so,*** **What was the reason for this?** ***Note specific problem leading to Statementing e.g. ADHD, EBD etc***

**8. How long ago did you first start being concerned about *(name of young person)*?**

| | |
|---|---|
| *Either* Less than 1 year ago | 1 |
| *Or* Enter number of years ago | |

**9. So whose idea was it to get in touch with Social Services?**

| | |
|---|---|
| Parent | 1 |
| Young person | 2 |
| *Not applicable*: already had own social worker | 3 |
| Other person *(specify)* | 4 |

10. *If it was <u>not</u> this parent who contacted Social Services:*

**And were you happy with Social Services being contacted?**

Yes *1* No *2*

**11. Have you ever seen a social worker before now about *(name of young person)*?**

Yes *1* No *2*

**If no, go to Q.15**

**12. How long ago were you *first* in contact with social services about him/her?**

| | |
|---|---|
| During the last year | 1 |
| During the last 1 - 3 years | 2 |
| More than 3 years ago | 3 |

**13. Has *(name of young person)* ever been in care?** Yes *1* No *2*

14. ***If yes*** How long has he/she spent in care altogether ? **(Enter approximate <u>total</u> duration of all care episodes: *if more than1 year*, in years; *if less than 1 year*, in months; *if less than 3 months*, in weeks**

Years Months Weeks

## B. PROBLEMS

15. Can you tell me what led to your recent contact with Social Services regarding *(name of young person)*? ***Enter problems mentioned in person's own words***

**PASS QUESTIONNAIRE TO PARENT**

16. First of all, can you tell me if any of these have been a problem for you in the last 6 months?

*Please tick the box which best describes how you see things*

| | A major Problem | A moderate problem | A mild Problem | Not a problem at all |
|---|---|---|---|---|
| | *1* | 2 | 3 | *4* |
| I have been upset about my child's behaviour at home | ☐ | ☐ | ☐ | ☐ |
| I have been worried about what my child does when he /she is out | ☐ | ☐ | ☐ | ☐ |
| I am worried about the friends he/she has | ☐ | ☐ | ☐ | ☐ |
| My child has been staying out too late | ☐ | ☐ | ☐ | ☐ |
| He / she has been very argumentative | ☐ | ☐ | ☐ | ☐ |
| He / she has been in trouble with school | ☐ | ☐ | ☐ | ☐ |
| We can't seem to talk things over with each other | ☐ | ☐ | ☐ | ☐ |
| He / she doesn't listen to me | ☐ | ☐ | ☐ | ☐ |
| He /she has run away from home | ☐ | ☐ | ☐ | ☐ |
| My child has been violent to me | ☐ | ☐ | ☐ | ☐ |
| My child has been violent to others | ☐ | ☐ | ☐ | ☐ |
| He / she gets into trouble with the police | ☐ | ☐ | ☐ | ☐ |
| He / she has problems with alcohol | ☐ | ☐ | ☐ | ☐ |
| He / she has problems with drugs | ☐ | ☐ | ☐ | ☐ |

**17. Recently I have felt that I would like him/her to live with someone else** Yes ☐ *1* No ☐ *2*

**18. My child has said recently that he/she wants to live with someone else** Yes ☐ *1* No ☐ *2*

**19. The next list shows some problems that families often have. Can you tell me if you have ever had any of these difficulties?**

| *Please tick the box which best describes how things have been* | Yes, just in the last year | Yes, for 1 to 3 years | Yes, for more than 3 years | No |
|---|---|---|---|---|
| I have been worried or upset about my child's behaviour | ☐ | ☐ | ☐ | ☐ |
| My child has had problems with school | ☐ | ☐ | ☐ | ☐ |
| My child has tried to harm him /herself | ☐ | ☐ | ☐ | ☐ |
| I have often been ill | ☐ | ☐ | ☐ | ☐ |
| I have often felt depressed | ☐ | ☐ | ☐ | ☐ |
| I have had a lot of arguments with my husband/wife/partner | ☐ | ☐ | ☐ | ☐ |
| There has been violence between my husband/wife/partner and me | ☐ | ☐ | ☐ | ☐ |
| My child has sometimes seen this violence | ☐ | ☐ | ☐ | ☐ |
| I have had problems with alcohol | ☐ | ☐ | ☐ | ☐ |
| I have had problems with drugs | ☐ | ☐ | ☐ | ☐ |

**PLEASE GIVE THIS QUESTIONNAIRE BACK TO THE INTERVIEWER NOW**

## C OTHER SOURCES OF STRESS

**I'd like to ask you now about some other difficulties that can cause a lot of stress for many families.**

**20. Have *you (or your partner)* got any serious health problems or any disability?**
**Enter details of type of health problem/disability in box below**

| | | | |
|---|---|---|---|
| Serious health problems (physical) | 1 | Mental health problems | 5 |
| Physical disability | 2 | No | 6 |
| Learning disability | 3 | Other (*specify below*) | 7 |
| Sensory impairment | 4 | | |
| ***Nature of problem:*** | | | |

**21. Do you have any serious problems with your accommodation?**

| | |
|---|---|
| Overcrowded | 1 |
| Threat of eviction | 2 |
| No serious housing problems | 3 |
| Other (give details below) | 4 |

**22. Do you have any serious money worries?**

| | |
|---|---|
| Low income / on benefits | 1 |
| Debt | 2 |
| No serious financial problems | 3 |
| Other (give details below) | 4 |

**23. And may I ask you where your *main* family income comes from?**

| | | | |
|---|---|---|---|
| Wages | 1 | Unemployment / disability benefit | 4 |
| Wages plus family credit | 2 | Other state benefits | 5 |
| Income support | 3 | Other | 6 |

**24. Have you or your child had any experience of racism in the last year?**

Yes *1* No *2*

**25.** *If yes*, **Can you give me some idea of what has happened?** Give brief details: e.g. violence, verbal abuse, harrassment, discrimination? To parent or to young person?

## D CONTACTING SOCIAL SERVICES

**I'd like to ask you some questions now about how things have been when you've seen your support team worker** *(mention name of worker).*

**28. When you talk to the support team worker, do you feel that he/she understands how things are for you?** Yes *1* No *2*

**29. Do you feel that your support worker tries to involve *you* in deciding what is the best thing to do?** Yes *1* No *2*

**30. What would you like the support team to help you with?** *Use persons's own words*

**31. Do you feel clear about what the support team worker plans to do to help you and your child sort out your difficulties?**

| | |
|---|---|
| Yes | 1 |
| No | 2 |
| Not sure | 3 |

**32. What do you think they are planning to do?**

**33. How interested are you in working with your support worker to try and deal with some of the problems you've been having?**

| | |
|---|---|
| I want to try | 1 |
| I don't want to try | 2 |
| I'm not bothered | 3 |

**34. Do you think the support worker might be able to help you sort out some of the difficulties you and your child have been having?**

Yes *1* No *2*

**35. Now I'd like to ask you some questions now about how things have been when you've seen a *social worker*. Have you just seen one social worker since you've been in touch with social services recently?** *Establish name of main social worker seen, if known, and use this in following questions.*

**36. So have you been given a particular social worker for your family?**

| | |
|---|---|
| Yes – since contacting social services on this occasion | 1 |
| Yes – already had a social worker | 2 |
| No – parent or child has just seen a social worker on duty | 3 |
| Don't know | 4 |

**The next 6 questions refer *either* to the SOCIAL WORKER currently working with this young person / family *or* the Duty social worker who saw them initially (or most often, if more than one)**

**37. When you talked to the social worker, did you feel that he/she understood how you see things?**

Yes *1* No *2*

**38. Did you feel that the social worker tried to involve *you* in deciding what is the best thing to do?** Yes *1* No *2*

**if no further contact with a social worker planned, go to q. 44**

39. What would you like the social worker to help you with? ***Use persons's own words***

**40. Do you feel clear about what the social worker plans to do to help you sort out your difficulties?**

| | |
|---|---|
| Yes | 1 |
| No | 2 |
| Not sure | 3 |

**41. What do you think they are planning to do?**

**42. How interested are you in working with the social worker to try and deal with some of the problems you've been having?**

| | |
|---|---|
| I want to try | 1 |
| I don't want to try | 2 |
| I'm not bothered | 3 |

**43. Do you think the social worker might be able to help you sort out some of the difficulties you and your child have been having?**

Yes *1* No *2*

## E SCHOOL

**44. Now I'd like to ask you a few background questions about your child's education**

**IF young person has already answered next question go to q.45**

**First of all, I'd like to ask you about your child's type of education in the last 6 months:**

| Type of school | Attended (yes/no) | No. of wks attended in last 6 months | Days per week | Hours per day | Ratio of staff to pupils |
|---|---|---|---|---|---|
| Mainstream school | | | | | |
| Pupil referral unit (out of school) | | | | | |
| Learning support unit (in school) | | | | | |
| Residential school | | | | | |
| Home tutor | | | | | |
| Classroom support | | | | | |
| Other – please specify: | | | | | |

**45. Does *(name of young person)* ever truant from school?**

| | |
|---|---|
| Often | 1 |
| Sometimes | 2 |
| Never | 3 |

**If never go to Q. 47**

**46. How many days do you think he/she has truanted in the last month?**

**47. Has (name of young person) ever been excluded *temporarily* (or suspended) from school?**

Yes *1* No *2*

**If no go to Q. 49**

**48. How many days, if any, was he/she *temporarily* excluded in the last month?**

**49. Has he/she ever been *permanently* excluded from school? (had to leave a school)**

Yes *1* No *2*

**If no go to Q. 51**

**50. When did this happen?** ***Can tick more than one***

| | |
|---|---|
| In the last month | 1 |
| In the last 6 months | 2 |
| More than 6 months ago | 3 |

**51. Has he/she seen an education welfare officer in the last 6 months?**

| | |
|---|---|
| Yes | 1 |
| No | 2 |

**52. Has he/she seen an educational psychologist in the last 6 months?**

| | |
|---|---|
| Yes | 1 |
| No | 2 |

**56. Has he/she ever seen a child psychiatrist or child psychologist?**

Yes *1* No *2*

**57. Has he/she seen a child psychiatrist or child psychologist <u>in the last 6 months?</u>**

| | | |
|---|---|---|
| Child psychiatrist | Yes | No |
| Child psychologist | Yes | No |

## G. OTHER SUPPORT

I'd like to ask now if you've been in touch with any *other* professionals, *apart from* the people you've already mentioned.

**58. Are there any other professionals that you see at the moment? For example, some people see…….**

| | |
|---|---|
| Family centre staff | 1 |
| Family aide | 2 |
| Own social worker (eg disability social worker) | 3 |
| Community psychiatric nurse (CPN) | 4 |
| Drug or alcohol counsellor | 5 |
| Community group (e.g. church) | 6 |
| Other professional (please specify) | 7 |

**59. And are there any friends or relatives that you turn to for help or advice? If so, who would that be?** *(Can tick more than one)*

| | |
|---|---|
| A parent | 1 |
| Brother or sister | 2 |
| Grandparent | 3 |
| Other relative | 4 |
| Friends (other young people) | 5 |
| Friends (adults) | 6 |
| No-one | 7 |

**Thank you for all your help so far – we've nearly finished.**
**To end up with, I'd like to give you three short checklists to tick for yourself.**
**If you prefer, I can read out the questions and you can tell me which answer to tick.**
**The first one is a short checklist about how you see your family.**

**Pass questionnaire to parent**

**60. Here are a number of statements about families. Please read each statement carefully and decide how well it describes your own family. You may feel that some statements are true for some family members and false for others. If so, answer according to your best overall impression. Each statement has four possible responses:**

***Strongly agree:*** **the statement describes your family very accurately**
***Agree:*** **the statement describes your family for the most part**
***Disagree:*** **the statement does not describe your family for the most part**
***Strongly disagree:*** **the statement does not describe your family at all**

Try not to spend too much time thinking about each statement, but respond as quickly and honestly as you can. If you have trouble with one, answer with your first reaction.

| *Please tick the box which best describes how you feel about your family* | Strongly Agree 1 | Agree 2 | Disagree 3 | Strongly disagree 4 |
|---|---|---|---|---|
| Planning family activities is difficult because we misunderstand each other | ☐ | ☐ | ☐ | ☐ |
| In times of crisis, we can turn to each other for support | ☐ | ☐ | ☐ | ☐ |
| We cannot talk to each other about the sadness we feel | ☐ | ☐ | ☐ | ☐ |
| Individuals are accepted for what they are | ☐ | ☐ | ☐ | ☐ |
| We avoid discussing our fears and concerns | ☐ | ☐ | ☐ | ☐ |
| We can express feelings to each other | ☐ | ☐ | ☐ | ☐ |
| There are lots of bad feelings in the family | ☐ | ☐ | ☐ | ☐ |
| We feel accepted for what we are | ☐ | ☐ | ☐ | ☐ |
| Making decisions is a problem for our family | ☐ | ☐ | ☐ | ☐ |
| We are able to make decisions about how to solve problems | ☐ | ☐ | ☐ | ☐ |
| We don't get along well together | ☐ | ☐ | ☐ | ☐ |
| We confide in each other | ☐ | ☐ | ☐ | ☐ |

***(FAD)***

**61. The next checklist is about how you see your child. It would help us if you answered all the items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of how things have been over the last month. *(SDQ)***

| ***Please tick the box which best reflects the behaviour of your child.*** | **Not True** *1* | **Somewhat True** *2* | **Certainly True** *3* |
|---|---|---|---|
| Considerate of other people's feelings | ☐ | ☐ | ☐ |
| Restless, overactive, cannot stay still for long | ☐ | ☐ | ☐ |
| Often complains of headaches, stomach-aches or sickness | ☐ | ☐ | ☐ |
| Shares readily with other children and young people (treats, games etc) | ☐ | ☐ | ☐ |
| Often has hot tempers | ☐ | ☐ | ☐ |
| Rather solitary, tends to keep to him self/herself | ☐ | ☐ | ☐ |
| Generally obedient, usually does what adults request | ☐ | ☐ | ☐ |
| Many worries, often seems worried | ☐ | ☐ | ☐ |
| Helpful if someone is hurt, upset or feeling ill | ☐ | ☐ | ☐ |
| Constantly fidgeting or squirming | ☐ | ☐ | ☐ |
| Has at least one good friend | ☐ | ☐ | ☐ |
| Often fights with other children or bullies them | ☐ | ☐ | ☐ |
| Often unhappy, down-hearted or tearful | ☐ | ☐ | ☐ |
| Generally liked by other children | ☐ | ☐ | ☐ |
| Easily distracted, concentration wanders | ☐ | ☐ | ☐ |
| Nervous in new situations, easily loses confidence | ☐ | ☐ | ☐ |
| Kind to younger children | ☐ | ☐ | ☐ |
| Often lies or cheats | ☐ | ☐ | ☐ |
| Picked on or bullied by other children | ☐ | ☐ | ☐ |
| Often volunteers to help others (parents, teachers, other children) | ☐ | ☐ | ☐ |
| Thinks things out before acting | ☐ | ☐ | ☐ |
| Steals from home, school or elsewhere | ☐ | ☐ | ☐ |
| Gets on better with adults than with other children | ☐ | ☐ | ☐ |
| Has many fears, is easily scared | ☐ | ☐ | ☐ |
| Sees tasks through to the end, good attention span | ☐ | ☐ | ☐ |

**62. Finally, here is a short checklist to help us find out whether the difficulties you have been having have affected your general health and well-being.**

**The following questions deal with how your general health has been over the past few weeks. Please tick the most appropriate box for each question**

| *Have you recently…..* | Better than usual | **Same as usual** | **Less than usual** | Much less than usual |
|---|---|---|---|---|
| been able to concentrate on whatever you're doing? | ☐ | ☐ | ☐ | ☐ |
| lost much sleep over worry? | ☐ | ☐ | ☐ | ☐ |
| felt that you are playing a useful part in things? | ☐ | ☐ | ☐ | ☐ |
| felt capable of making decisions about things? | ☐ | ☐ | ☐ | ☐ |
| felt constantly under strain? | ☐ | ☐ | ☐ | ☐ |
| felt that you couldn't overcome your difficulties? | ☐ | ☐ | ☐ | ☐ |
| been able to enjoy your normal day to day activities? | ☐ | ☐ | ☐ | ☐ |
| been able to face up to your problems? | ☐ | ☐ | ☐ | ☐ |
| been feeling unhappy and depressed? | ☐ | ☐ | ☐ | ☐ |
| been losing confidence in yourself? | ☐ | ☐ | ☐ | ☐ |
| been thinking of yourself as a worthless person? | ☐ | ☐ | ☐ | ☐ |
| been feeling reasonably happy, all things considered? | ☐ | ☐ | ☐ | ☐ |

***(GHQ)***

**Thank you for all your help.**

**We would like to get in touch again in 6 months to see how things have turned out for you and whether social services have been of any help.**

THE UNIVERSITY of York

SOCIAL WORK RESEARCH AND DEVELOPMENT UNIT

# The cost and effectiveness of specialist support teams for adolescents

## T1 Questionnaire to support teams for adolescents

| Name of support team worker |
| --- |
| |

We would be grateful if you would complete and return this questionnaire to us in the enclosed Freepost envelope within one week if at all possible.

## A BASIC DETAILS

| | | |
|---|---|---|
| **Q. 1** | **Date of family's first contact with support team (current referral)** | day / month / year |

*PLEASE CIRCLE THE APPROPRIATE NUMBER*

| | | | |
|---|---|---|---|
| **Q. 2** | **How long has this young person been known to your team?** | Less than 1 month | 1 |
| | | 1-6 months | 2 |
| | | More than 6 months | 3 |
| **Q.3** | **Has this young person any serious health problems or disability?** | Physical illness | 1 |
| | | Physical disability | 2 |
| | *Please circle all that apply* | Sensory impairment | 3 |
| | | Learning disability | 4 |
| | | Mental health problems | 5 |
| | | No | 6 |
| | | Don't know | 7 |

**Q.4 *If yes*, please enter details of any ill health/disability e.g. partially sighted, depression etc**

| | | | |
|---|---|---|---|
| **Q.5** | **Has this young person been given a statement of Special Educational Needs?** | Yes | 1 |
| | | No | 2 |
| | | Don't know | 3 |

**Q.6 *If yes*, what specific difficulty led to this statement of SEN? e.g EBD, ADHD**

## B. HISTORY OF CONTACT WITH YOUR TEAM

| | | | |
|---|---|---|---|
| Q. 7 | **Has your team ever worked with this young person before?** | Yes: re-referral | 1 |
| | | No: new referral | 2 |

**If this is the first time your support team has ever worked with this young person, please go to Q. 10**

**Q.8** **How many previous referrals to your team have there been for this young person?** ☐

**Q.9** **Please give brief details of reasons for previous referrals**

## C. HISTORY OF CONTACT WITH SOCIAL SERVICES

| | | | |
|---|---|---|---|
| Q.10 | **Over how long a period has this young person been known to Social Services, either here or in another local authority?** | No previous contact | 1 |
| | | During last year only | 2 |
| | | 1-3 years | 3 |
| | | More than 3 years | 4 |
| | | Don't know | 5 |

**If no previous contact with social services, please go to Q.20**

| | | | |
|---|---|---|---|
| Q.11 | **What have been the main reasons for <u>past</u> contact with Social Services regarding this young person?** | Young person's behaviour | 1 |
| | | Potential/actual abuse | 2 |
| | | Neglect | 3 |
| | | Breakdown of relationship between young person and family | 4 |
| | | Parent unable to provide care | 5 |
| | *Please circle all that apply* | Other | 6 |

| | | | |
|---|---|---|---|
| Q.12 | ***Prior to current referral*, has this young person ever been the subject of:** | A child protection case conference | 1 |
| | | Child protection registration | 2 |
| | | Neither of the above | 3 |
| | | Don't know | 4 |

**If no/don't know, please go to Q. 14**

| | | | |
|---|---|---|---|
| **Q.13** | **Were *past* child protection concerns in respect of: Please circle all that apply** | Neglect | 1 |
| | | Physical abuse | 2 |
| | | Sexual abuse | 3 |
| | | Emotional abuse | 4 |
| | | Don't know | 5 |
| **Q.14** | **Has parent ever requested accommodation of this young person in the past?** | Yes | 1 |
| | | No | 2 |
| | | Don't know | 3 |
| **Q.15** | **Has this young person ever been looked after in the past, *prior to current referral*?** | Yes | 1 |
| | | No | 2 |
| | | Don't know | 3 |

**if no/don't know, please go to Q.20**

| | | | |
|---|---|---|---|
| **Q.16** | **How many times has he/she been looked after In the past ?** (not including current placement, if any) | Once only | 1 |
| | | 2-4 times | 2 |
| | | 5 or more times | 3 |
| | | Don't know | 4 |
| **Q.17** | **How old was he/she when *first* looked after?** | Under 1 year old | 1 |
| | | 1-10 years old | 2 |
| | | 11 years old or over | 3 |
| | | Don't know | 4 |
| **Q.18** | **Has he/she been looked after during the last 6 months?** | Yes | 1 |
| | | No | 2 |

**If no, please go to Q.20**

| | | | **Yes** | **No** | **No. of days** |
|---|---|---|---|---|---|
| **Q.19** | ***If yes*, which placements has he or she lived in, in <u>the last 6 months</u>?** | Children's home | 1 | 2 | |
| | | Foster home | 1 | 2 | |
| | *Please enter number of days in each placement type* | Placement with relative (*not* including informal arrangements) | 1 | 2 | |
| | | Secure accommodation | 1 | 2 | |
| | | Any other placement in care or accommodation – specify type: | 1 | 2 | |
| | | | | | |

## D. CONTACT WITH OTHER AGENCIES

**Q.20** Has this young person received any other professional support in the last 6 months?

| | |
|---|---|
| Education welfare officer | 1 |
| Educational psychologist | 2 |
| Child psychiatrist /psychologist | 3 |
| Youth Offending Team | 4 |
| Drug or alcohol project | 5 |
| Young Carers group | 6 |
| Family centre | 7 |
| None | 8 |
| Don't know | 9 |
| Other- please specify: | 10 |

**Q.21** Has the *parent* that this young person normally lives with received any other professional support in the last 6 months?

*Please circle all that apply*

| | |
|---|---|
| Family centre | 1 |
| Family aide | 2 |
| Own social worker (adult team) | 3 |
| Community psychiatric nurse | 4 |
| Adult psychiatrist/psychologist | 5 |
| Drug or alcohol project | 6 |
| Probation | 7 |
| None | 8 |
| Don't know | 9 |
| Other – please specify: | 10 |

**Q.22** **Have you (or other team members) recently been in touch with any of these agencies in the course of your work with this young person?**

*Please circle all that apply*

| | |
|---|---|
| Education | 1 |
| Youth offending team | 2 |
| Child health | 3 |
| Mental health services | 4 |

| | |
|---|---|
| Parent's social worker (adult team) | 5 |
| Drug/alcohol project | 6 |
| Housing | 7 |
| Other – please specify below | 8 |
| Family not in contact with any of above | 9 |
| No contact made with other agencies | 10 |

*Any other agencies contacted:*

**Q.23 Has this young person been cautioned or convicted for a criminal offence in the last 6 months?**

| | Yes | No | Don't know |
|---|---|---|---|
| **Cautioned** | 1 | 2 | 3 |
| **Convicted** | 1 | 2 | 3 |

| **Q.24** | | Yes | No | No. of days |
|---|---|---|---|---|
| **In the last 6 months, has this young person stayed in a:** | Secure training centre | 1 | 2 | |
| *If yes, please enter number of days* | Detention and training centre | 1 | 2 | |
| | Prison | 1 | 2 | |

## E. REASONS FOR REFERRAL

**Q.25 At the point of referral to Social Services, was anyone requesting the accommodation of this young person?**
*Please circle all that apply*

| | |
|---|---|
| Parent | 1 |
| Young person | 2 |
| No-one | 3 |
| Other person– please specify: | 4 |

**Q.26 At the point of referral to your team what, in your opinion, was the level of risk that this young person might be accommodated <u>within 1 month</u> if a service was not provided?**

| **Was the risk of accommodation:** | **High** | **Moderate** | **Low** | **None** |
|---|---|---|---|---|
| | 1 | 2 | 3 | 4 |

| | | | |
|---|---|---|---|
| **Q.27** | **Did a specific incident or event trigger this referral?** | Yes | 1 |
| | | No | 2 |

**Q.28** ***If yes*, please give brief details:**

| | | | |
|---|---|---|---|
| **Q.29** | **Is this young person <u>currently</u> the subject of:** | A child protection enquiry | 1 |
| | | Child protection registration | 2 |
| | | Neither of the above | 3 |

**If no, please go to Q.31**

| | | | |
|---|---|---|---|
| **Q.30** | **Are <u>current</u> child protection concerns, if any, in respect of:** *Please circle all that apply* | Neglect | 1 |
| | | Physical abuse | 2 |
| | | Sexual abuse | 3 |
| | | Emotional abuse | 4 |
| | | Not applicable | 5 |

**Q.31 Was there evidence of any of the following problems <u>regarding this young person</u> when current referral was made to the support team** *(Please circle a number for every question)*

| | Yes | No | Don't know |
|---|---|---|---|
| **Behaviour problems (at home)** | 1 | 2 | 3 |
| **Relationship problems with parent** | 1 | 2 | 3 |
| **Relationship problems with stepparent** | 1 | 2 | 3 |
| **Abuse (physical or sexual)** | 1 | 2 | 3 |
| **Abuse (emotional)** | 1 | 2 | 3 |
| **Neglect** | 1 | 2 | 3 |
| **Parental rejection** | 1 | 2 | 3 |
| **Running away** | 1 | 2 | 3 |
| **Behaviour at school** | 1 | 2 | 3 |
| **Truancy** | 1 | 2 | 3 |
| **School exclusion** | 1 | 2 | 3 |
| **Offending** | 1 | 2 | 3 |
| **Petty theft from family** | 1 | 2 | 3 |
| **Sexual behaviour putting self/others at risk** | 1 | 2 | 3 |
| **Mental health problems** *(give details below)* | 1 | 2 | 3 |
| **Self harm/suicide attempts** | 1 | 2 | 3 |
| **Drug or alcohol problems** | 1 | 2 | 3 |
| **Violence to parent** | 1 | 2 | 3 |
| **Violence to others** | 1 | 2 | 3 |
| **Recent separation from a parent** | 1 | 2 | 3 |
| **Bereavement** | 1 | 2 | 3 |
| **Other problems** *(please specify in box below)* | 1 | 2 | 3 |

**Other problems or further details of above problems:**

**Q.32 Is there evidence of any of the following problems among his/her usual adult carers?**

**These may be:**

- **the parent that young person normally lives with, if only with one parent, *or***
- **either parent, if he/she lives with both or has done so until recently**

| | Evidence of serious problem | Evidence of moderate problem | No evidence of problem |
|---|---|---|---|
| **Physical illness/disability** | 1 | 2 | 3 |
| **Depression** | 1 | 2 | 3 |
| **Psychiatric illness (not including depression)** | 1 | 2 | 3 |
| **Parent has learning disability** | 1 | 2 | 3 |
| **Past or current domestic violence** | 1 | 2 | 3 |
| **Other marital disharmony (*current* partner)** | 1 | 2 | 3 |
| **Parent has recently separated from other parent or from cohabitee** | 1 | 2 | 3 |
| **Parent on drugs** | 1 | 2 | 3 |
| **Parent has alcohol problems** | 1 | 2 | 3 |
| **Parent involved in crime** | 1 | 2 | 3 |
| **Financial problems** | 1 | 2 | 3 |
| **Housing problems** | 1 | 2 | 3 |
| **Social isolation** | 1 | 2 | 3 |
| **Other problems** *Please specify in box below* | 1 | 2 | 3 |

**Notes / details of other problems of adult carers**

## F. PARENTING STRENGTHS AND DIFFICULTIES

For the next question, we would like you to answer in the following manner:

- if young person normally lives with only one parent, just complete the *Parent 1* box
- if he/she normally lives with two parents, or a parent plus a stepparent, please complete both boxes.

**Q.33 At referral, did parent(s) / stepparent that this young person normally lives with appear to:**

| | *Parent 1* | | | *Other parent/stepparent (if applicable)* | | |
|---|---|---|---|---|---|---|
| | **Most of the time** | **Only some times** | **Hardly ever** | **Most of the time** | **Only some times** | **Hardly ever** |
| **Make their expectations of young person clear to him/her** | 1 | 2 | 3 | 1 | 2 | 3 |
| **Be consistent in their responses to young person** | 1 | 2 | 3 | 1 | 2 | 3 |
| **Be warm towards young person** | 1 | 2 | 3 | 1 | 2 | 3 |
| **Be encouraging when young person does something well** | 1 | 2 | 3 | 1 | 2 | 3 |
| **Be able to set clear boundaries** | 1 | 2 | 3 | 1 | 2 | 3 |
| **Be harsh towards young person** | 1 | 2 | 3 | 1 | 2 | 3 |

## G. CURRENT SITUATION

**Q.34 Has young person been accommodated since this referral was made?**

Yes 1

No 2

**IF no, please go to Q.38**

**Q.35 *If yes*, what was the reason for this young person being accommodated?**

**Q.36** **What is the purpose of this placement?**

**Q.37** ***If this young person has already returned home*, how long did he/she remain in this placement?**

Days ☐

**Q.38** **Has this young person stayed anywhere else (apart from local authority accommodation) since this referral was made?**

| | |
|---|---|
| Yes | 1 |
| No | 2 |
| Don't know | 3 |

**If no / don't know, please go to Q.41**

**Q.39** ***If yes*, where has he/she stayed?**

| | |
|---|---|
| With other relative | 1 |
| With friend | 2 |
| With informal/network carer | 3 |
| Other – please specify: | 4 |

☐

**Q.40** **Who arranged this stay away from home?**

| | |
|---|---|
| Young person | 1 |
| Parent | 2 |
| Social worker | 3 |
| Support team worker | 4 |
| Other – please specify: | 5 |

**G.PLANS**

**Q.41** **Are there any plans for your team to do further work with this young person or parent?**

| | |
|---|---|
| Yes | 1 |
| No | 2 |

**If no, please go to Q.43**

**Q.42** **What are the main aims of the planned intervention by you and/or other team members, *apart from preventing unnecessary accommodation?***

| | | | |
|---|---|---|---|
| **Q.43** | **Has a social worker been allocated to family to work on young person's current problems?** | Yes | 1 |
| | | No | 2 |
| **Q.44** | **Who is the caseholder for work with this young person?** | Support team member | 1 |
| | | Area social worker | 2 |

**Q.45** **What are the main aims of intervention by the social worker, if any, *apart from preventing unnecessary accommodation?***

**Q.46** **If there are any other comments you would like to make, please use the space below**

THE UNIVERSITY of York

SOCIAL WORK RESEARCH AND DEVELOPMENT UNIT

The cost and effectiveness of specialist support teams for adolescents

# T2 Questionnaire to young people

## *Standard*

| |
|---|
| **Code for young person** |

| |
|---|
| **Name of social worker** |

| |
|---|
| **Name of support team worker** |

| |
|---|
| **Name of sessional worker** |

| |
|---|
| **Local authority** |

| |
|---|
| **DATE OF FIRST INTERVIEW** |

## ABOUT WHAT HAS HAPPENED SINCE WE LAST SAW YOU

**Today I want to start by asking you about what has been happening since I last saw you around 6 months ago, in .....***(before interview, write in month of first interview).*

**Q.1 First of all, can you tell me who you or your mum/dad have seen from social services since that time?** *(Check job titles against names on front page).* Please enter names. Tick to show who has been working with parent and who has been working with child.

| | *Name* | **Saw child** | **Saw parent** |
|---|---|---|---|
| Area social worker | | | |
| Specialist support worker | | | |
| Sessional worker | | | |
| Other (specify) | | | |

**Q.2 Are you still seeing (any of) them?**

| | **Yes** | **No** |
|---|---|---|
| Area social worker | ☐ | ☐ |
| Specialist support worker | ☐ | ☐ |
| Sessional worker | ☐ | ☐ |

**Q.3 Are you still going to the same school as you were last time I saw you?**

Yes 1

No 2

**Q.4** How have things been going at school in the last month?

No problems 1

Problems(*give details below*) 2

**Q.5** And how have things been going at home? ***Explore, if he/she mentions any difficulties.***

No problems 1

Problems(*give details below*) 2

**Q.6** **Can you tell me, have you been living at the same address all the time, since I last saw you 6 months ago?** *Apart from routine visits to another parent for weekends/ holidays.*

*Please circle all that apply*

Stayed at the same address 1

Moved to live with other parent 2

Stayed with another relative 3

Stayed with friends 4

Went into care ('looked after') 5

Moved to residential school 6

Secure unit 7

Stayed somewhere else (give details below) 8

**If stayed at the same address all the time please go to Q.13**

**Q.7** **Can you tell me why you went to stay there?**

**Q.8** Whose idea was it for you to go there?
***Tick more than one if appropriate.***

Young person 1

Parent 2

Area social worker 3

Specialist support team worker 4

Other person (give details below) 5

**Q.9** **Did you want to go?** *(Explore why/why not.)*

**Q.10** **So since *(date given above)*, how long have you spent away from home altogether?** (*not counting* routine visits to another parent for weekends / holidays)

☐ Months *OR* ☐ Weeks *OR* ☐ Days

**If YOUNG PERSON IS NOW BACK AT HOME AGAIN, go to Q.13**

**Q.11 So do you know if there is any plan for you to go home?** *(If so, what is the plan? If not, what do they think will happen?)*

**Q.12 What do you want to happen?** *(i.e. about where they are going to live)*

**Q.13 Since *(date given above)*, has anyone moved in to live with you and your family?**

Yes 1

No 2

**If no, please go to Q.16**

**Q.14 Who was this?** *(e.g. parent's new partner, another child – NOT the person's name)*

**Q.15 What do you think about him/her moving in?** *(Explore whether they think it's a good thing or a bad thing)*

**Q.16 Since *(date given above)*, has anyone moved out of your house?**

Yes 1

No 2

**If no, please go to Q.19**

**Q.17 Who was this?** *(e.g. partner, another child– NOT the person's name)*

**Q.18 What do you think about him/her moving out?** *(Explore whether they think it's a good thing or a bad thing)*

**Q.19 While we're talking about people coming and going, can I just ask if you have run away from home or been thrown out in the last 6 months?**

Run away 1

Thrown out 2

No 3

**If no go to Q.24**

**Q.20 Can you tell me what happened.....why did you run away/get thrown out?**

**Q.21 How many times has this happened**
in the last 6 months? (Ask for estimate if unsure)

☐ **Times**

**Q.22 And how long did you stay away?**
(If more than once, how many days in total?)

☐ **Days**

**Q.23 What made you go back?**

**Q.24** Now I have to ask you some more questions about school.
**In the last 6 months, have you been going to school all the time, every day?**

All the time 1
Most of the time 2
Hardly ever 3

**If all the time go to Q. 29**

**Q.25 So, you've only been going sometimes - is this because you decided to stay away or is there some other reason?**

Truanted 1
Excluded 2
Other reason (Write details below) 3

**If has not truanted go to Q. 27**

**Q.26 How many days do you think you have truanted from school in the last month?**

☐ **Days**

**Q.27 Have you been excluded from school at all in the last 6 months?**
**IF YES,was this:**
- **temporary exclusion** *(i.e. suspended)*
- **permanent exclusion** *(i.e. expelled)*

No 1
Temporary exclusion 2
Permanent exclusion 3

**If HAS NOT BEEN TEMPORARILY excluded, go to Q.29**

**Q.28** ***IF <u>temporarily</u> excluded:*** **How many days were you temporarily excluded <u>in the last month</u>?**

☐ **Days**

**Q.29** Can I just check, have you been in trouble with the police at all <u>in the last 6 months?</u>

Yes 1

No 2

**<u>If no</u> go to Q.31**

**Q. 30** **So have you been given a reprimand or final warning, or been charged with an offence *in the last 6 months*?** *Note what the offence was below e.g. theft, burglary, car crime, assault etc.*

Reprimand or final warning 1

Charged 2

## ABOUT HOW YOU FEEL AT THE MOMENT

**The next set of questions is about how you're feeling at the moment.**

**Q.31 Have you got any worries about your family at the moment?**

**Q.32 And have you got any worries about yourself, at the moment?**

**Q.33 How are you getting on with your mum/dad** *(as applicable)* **at the moment?**

**Now you may remember I gave you some checklists to tick last time I saw you. I'd like to ask you to do this again to see how you feel now.**

**Pass questionnaire to young person and GO through checklists Together**

Q.34 First of all, can you tell me if any of these have been a problem for you during the last month?

| *Please tick the box which best describes how you see things* | A major problem | A moderate problem | A mild problem | Not a problem at all |
|---|---|---|---|---|
| My parent (or stepparent) complains about my behaviour at home | ☐ | ☐ | ☐ | ☐ |
| I think there are problems with my behaviour | ☐ | ☐ | ☐ | ☐ |
| My parent (or stepparent) gets upset about what I do when I'm out | ☐ | ☐ | ☐ | ☐ |
| My parent (or stepparent) gets upset about the friends I have | ☐ | ☐ | ☐ | ☐ |
| My parent (or stepparent) says I stay out too late | ☐ | ☐ | ☐ | ☐ |
| We are always arguing at home | ☐ | ☐ | ☐ | ☐ |
| My parent (or stepparent) gets upset about problems I have with school | ☐ | ☐ | ☐ | ☐ |
| I find it difficult to talk things over with my mum or dad | ☐ | ☐ | ☐ | ☐ |
| My mum or dad doesn't listen to my point of view | ☐ | ☐ | ☐ | ☐ |
| Mum /dad are always changing their minds about what I'm allowed or not allowed to do | ☐ | ☐ | ☐ | ☐ |
| I get into trouble with the police | ☐ | ☐ | ☐ | ☐ |
| I have problems with alcohol | ☐ | ☐ | ☐ | ☐ |
| I have problems with drugs | ☐ | ☐ | ☐ | ☐ |

**Q.35 Here are a number of statements about families. Please read each statement carefully and decide how well it describes your own family. You may feel that some statements are true for some family members and false for others. If so, answer according to your best overall impression. Each statement has four possible responses:**

***Strongly agree:*** **the statement describes your family very accurately**
***Agree:*** **the statement describes your family for the most part**
***Disagree:*** **the statement does not describe your family for the most part**
***Strongly disagree:*** **the statement does not describe your family at all**

| *Please tick the box that best describes your family* | Strongly Agree | Agree | Disagree | Strongly disagree |
|---|---|---|---|---|
| Planning family activities is difficult because we misunderstand each other | ☐ | ☐ | ☐ | ☐ |
| In times of crisis, we can turn to each other for support | ☐ | ☐ | ☐ | ☐ |
| We cannot talk to each other about the sadness we feel | ☐ | ☐ | ☐ | ☐ |
| Individuals are accepted for what they are | ☐ | ☐ | ☐ | ☐ |
| We avoid discussing our fears and concerns | ☐ | ☐ | ☐ | ☐ |
| We can express feelings to each other | ☐ | ☐ | ☐ | ☐ |
| There are lots of bad feelings in the family | ☐ | ☐ | ☐ | ☐ |
| We feel accepted for what we are | ☐ | ☐ | ☐ | ☐ |
| Making decisions is a problem for our family | ☐ | ☐ | ☐ | ☐ |
| We are able to make decisions about how to solve problems | ☐ | ☐ | ☐ | ☐ |
| We don't get along well together | ☐ | ☐ | ☐ | ☐ |
| We confide in each other | ☐ | ☐ | ☐ | ☐ |

**Q.36** **Have you felt <u>in the last month</u> that you would like to leave home and live with someone else** Yes ☐ No ☐

**Q.37** **Has your mum or dad said <u>in the last month</u> that they would like you to live somewhere else?** Yes ☐ No ☐

**Q.38 Now here is a checklist about how you see yourself. For each item, please tick the box for *not true, somewhat true* or *certainly true*. It would help us if you answered all the items as best you can even if you are not absolutely certain or the item seems daft!**

| ***Please give your answers on the basis of how things have been for you <u>over the last month</u>.*** | **Not True** | **Somewhat true** | **Certainly True** |
|---|---|---|---|
| I am considerate of other people's feelings | ☐ | ☐ | ☐ |
| I am restless, overactive, cannot stay still for long | ☐ | ☐ | ☐ |
| I get a lot of headaches, stomach-aches or sickness | ☐ | ☐ | ☐ |
| I share readily with others (treats, games etc) | ☐ | ☐ | ☐ |
| I have hot tempers. I often have temper outbursts | ☐ | ☐ | ☐ |
| I am rather solitary, I tend to keep to myself | ☐ | ☐ | ☐ |
| I usually do what adults ask me to do. | ☐ | ☐ | ☐ |
| I have many worries. I am often worried. | ☐ | ☐ | ☐ |
| I am helpful if someone is hurt, upset or feeling ill | ☐ | ☐ | ☐ |
| I am constantly fidgeting or squirming | ☐ | ☐ | ☐ |
| I have at least one good friend | ☐ | ☐ | ☐ |
| I fight a lot. I use my power to get what I want. | ☐ | ☐ | ☐ |
| I am often unhappy, down-hearted or tearful | ☐ | ☐ | ☐ |
| Other people my age generally like me. | ☐ | ☐ | ☐ |
| I am easily distracted, my concentration wanders | ☐ | ☐ | ☐ |
| I am nervous in new situations. I easily lose confidence. | ☐ | ☐ | ☐ |
| I am kind to younger children | ☐ | ☐ | ☐ |
| I am often accused of lying or cheating. | ☐ | ☐ | ☐ |
| Other young people often pick on me or bully me | ☐ | ☐ | ☐ |
| I often volunteer to help others (parents, teachers, others) | ☐ | ☐ | ☐ |
| I think things out before acting | ☐ | ☐ | ☐ |
| I take things that are not mine from home, school or elsewhere | ☐ | ☐ | ☐ |
| I get on better with adults than with others my own age | ☐ | ☐ | ☐ |
| I have many fears. I am easily scared | ☐ | ☐ | ☐ |
| I see tasks through to the end. My attention is good. | ☐ | ☐ | ☐ |

## ABOUT YOUR CONTACT WITH SOCIAL SERVICES

Now I'd like to ask you about what people from social services have done since I last saw you.

**IF NO SOCIAL WORKER SEEN by young person, GO TO Q.43**

**Q.39 When you've seen (*name of social worker*), what sort of things did he/she talk to you about?**

**Q.40 And has he/she arranged anything for you or got you involved in doing anything?**

**Q.41 Do you think the social worker has helped you in any way?**

Helped a lot 1

Helped a little 2

No help at all 3

**Q.42 Why was this, do you think? (i.e. *how* did social worker help OR *why* did he/she have little or no effect?)**

**IF NO Support team WORKER SEEN, GO TO Q.48**

**Q.43 You've (also) seen (*name of support worker*). What have you done with him/her?**

**Q.44 What sort of things did he/she talk about with you?**

**Q.45 Has he/she arranged anything for you or got you involved in doing anything?**

Q.46 Do you think that he/she has helped you in any way?

Helped a lot 1

Helped a little 2

No help at all 3

**Q.47 Why was this, do you think? (i.e. *how* did support worker help OR *why* did he/she have little or no effect?)**

**IF NO sessional WORKER SEEN, GO TO Q.52**

**Q.48 You said you've also seen *(name of sessional worker).* What did you do with him/her?**

**Q.49 What sort of things did he/she talk to you about?**

Q.50 Do you think that he/she has helped you in any way?

Helped a lot 1

Helped a little 2

No help at all 3

**Q.51 Why was this, do you think? (i.e. *how* did sessional worker help OR *why* did he/she have little or no effect?)**

**Q.52 Have any other people talked to you about any worries or problems that you've been having <u>in the last 6 months</u>? For example someone at school, or at a club, or a relative or friend.....**

*Specify type of person or group (e.g. youth worker, teacher, grandparent, family friend, Young Carers group etc).*

**Q.53** **Is there anyone who has helped you in any way <u>over the last 6 months</u>?**

*Please tick all that apply.*

Social worker 1

Support worker 2

Sessional worker 3

School staff 4

Group *(specify)* 5

Other family member*(specify)* 6

Other professional*(please specify)* 7

No-one 8

**Q.54** *If applicable:* **How did they help?** *(What did they do that was helpful?)*

## ABOUT YOUR LIFE NOW

**Q.55** **If you look back to the way things were when I last saw you 6 months ago, would you say that overall your life has got better or worse since then? Or has it stayed the same?**

Better 1

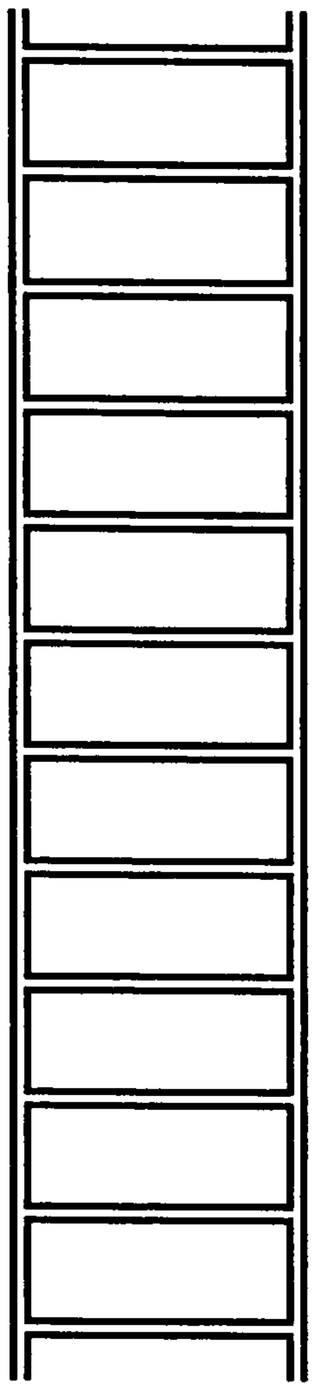
Stayed the same 2

Worse 3

**Q.56** **Here is a picture of a ladder. Imagine that the top of the ladder shows your life when things couldn't be better and the bottom of the ladder shows your life when things couldn't be worse.**

**Please mark the ladder with an '*X*' in the place that shows how far up or down the ladder you feel that your life is at the moment.**

Things couldn't be better



*You can place your 'X'*

*anywhere on the ladder*

Things couldn't be worse

**Q.57** **Can you name anything that would help to make your life better than it is now?**

a. _____

b. _____

c. _____