



# Key Themes in Supporting Children & Young People in the North West: Public Health Policy & Practice

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March 2003

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## Foreword

The North West Public Health Observatory (NWPHO) is comprised of three zonal units: Greater Manchester, Merseyside & Cheshire and Lancashire & Cumbria. Each zonal unit has produced Public Health Information Reports on various health issues.

### Public Health Information Reports:

- bring together local and national information resources, so as to generate and disseminate public health intelligence, and evidence-based practice, to a wider policy-making audience;
- provide analysis and interpretation of data to identify inequalities across the North West Region; and
- offer examples of innovative practice from around the North West Region in the use of public health information in policy and practice development.

This report represents the Greater Manchester zone's second Public Health Information Report. Its first report, entitled '*Tackling Coronary Heart Disease in the North West: Policy and Practice*', was produced in 2001. It highlighted the evidence-base for tackling coronary heart disease at primary and secondary level, and provided examples from the North West Region where good, innovative practice was allied to a strong evidence base.

The full report can be accessed at : [www.nwpho.org.uk/reports/chd.pdf](http://www.nwpho.org.uk/reports/chd.pdf)

This report is concerned with key themes in supporting children and young people in the North West. It has been structured as follows:

- **Introduction**

An introductory session explains the national policy background.

- **Section 1 : Children, Poverty and Health in the North West**

Section 1 examines health inequalities among children and young people in the North West in comparison with other English NHS Regions as reflected by statistical data compiled by the Compendium for Clinical Health Indicators (2001).

The health indicators explored are all cause mortality (in the age ranges 1-4 and 5-14), perinatal and infant mortality, low birthweight, vaccination for measles, mumps and rubella, and oral health.

- **Section 2 : Acute Care Services for Children and Young People**

Section 2 focuses upon children's and young people's experience of acute care services. It also considers the incidence of road traffic accidents and serious accidental injury in the North West in comparison with other English NHS Regions. Furthermore, it provides examples of innovative practice in improving acute care services within the North West Region.

- **Section 3 : Child and Adolescent Mental Health Services**

Section 3 considers the prevalence of child and adolescent mental health morbidity in the North West compared to other English NHS Regions. It also provides an overview of the national policy context, and highlights some key messages from the evidence base regarding effective ways of supporting children and young people with mental health problems. It offers examples from the North West Region of innovative ways to offer support to children and young people.

- **Section 4 : Teenage Pregnancy**

Section 4 considers the issue of teenage pregnancy. It summarises recent national policy in relation to teenage pregnancy, and highlights key messages from the evidence base in reducing teenage pregnancy. It also offers examples from the North West Region of innovative ways of reducing teenage pregnancy.

- **Section 5 : Vulnerable Children and Young People**

Section 5 considers some of the key issues in relation to supporting vulnerable children. It summarises key messages from the national policy framework. It also summarises the evidence base in relation to what is effective practice in supporting vulnerable children. It then provides examples of the work of voluntary organisations in offering innovative solutions to supporting vulnerable children and young people within the North West Region.

- **Section 6 : Health Promotion in Schools**

Section 6 summarises the national strategy for promoting health in schools. It also summarises the key findings from a Health Technology Assessment review of health promotion measures to promote child health in relation to the four selected themes.

**Explanatory Note: Statistical Information**

This report presents a large amount of statistical information in tabular form.

- A ‘CI’ (Confidence Interval) refers to the interval within which we are 95% confident that the true population value will lie.
- A ‘statistically significant’ difference is implied between any two values for which the corresponding CI s do not overlap.

**Explanatory Note: Examples of Innovative Practice in the North West**

- It must be emphasized that this report is not a mapping exercise, and so does not aim to capture ALL examples of innovative practice in supporting children and young people in relation to the four themes identified.
- It aims to bring together the national policy context, key messages from evidence-based research as well as some examples of initiatives within the North West Region that can serve as a resource for local policymakers.

## **Introduction**

In recent years there has been significant national emphasis on supporting children and young people in a variety of diverse social contexts. The setting up of a Children and Young People's Unit<sup>1</sup> illustrates an explicit aim of developing an overarching strategy covering all services for children and young people. It champions a collective approach to securing the well-being of young people, which includes the participation of the NHS, youth and social services, the education service, the police and young people themselves. Its strategy is aimed at creating a comprehensive network, so that all public services fit together for the benefit of all children and young people. It seeks a clear framework that recognises families as the foundation of society, and which offers a coherent service to children that utilises the expertise of a vast range of partners operating within statutory, voluntary and community sectors.

Some of the Institute for Public Health Research and Policy's recent work programme has centred upon children and young people, such as developing a children's web-based virtual resource centre, and the evaluation of a Sure Start initiative in Salford.

Public health reports produced by NWPHO have focused largely upon issues that impact significantly upon children and young people ie drug abuse and alcohol services. However, there remains a pressing need to explore inequalities in health experience amongst children and young people in the North West, and to develop the evidence base on providing support to them. Given that much of the emphasis of current national policy is directed at supporting children and young people, this seemed to be a significant omission.

This report seeks to address this information gap by exploring four key themes in supporting children and young people. These are:

- ❑ **Acute Care Services**
- ❑ **Child and Adolescent Mental Health Services (CAMHS)**
- ❑ **Teenage Pregnancy**
- ❑ **Vulnerable Children and Young People**

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<sup>1</sup> Building a Strategy for Children and Young People, Consultation Document, 2001

- **Why Have These Themes Been Selected ?**

The themes have been primarily selected as they all figure strongly in the government's plans for creating a National Service Framework for Children's Services, which is expected in 2003.

National Service Frameworks (NSFs) set national standards and define service models for a particular service or care group. They aim to create strategies to support implementation, and establish performance milestones against which progress within an agreed time-scale can be measured. The net ambition is to raise quality and decrease variations within the NHS.

Thus far a range of NSFs have been established across a variety of themes, including cancer, mental health, coronary heart disease, and older people. Each NSF is developed with the assistance of an External Reference Group (ERG) which brings together health professionals, service users and carers, health service managers, partner agencies, and other advocates. ERGs adopt an inclusive process to engage the full range of views. The Department of Health supports the ERGs and manages the overall process.

- **National Service Framework for Children's Services**

This NSF will develop new national standards across the NHS and social services for children. These new standards aim to ensure better access and a smoother progression for children, from the initial contact with the NHS (via GP consultation or NHS hospital), through to social services support. Furthermore the NSF for Children seeks to improve standards for health and social care, as well as to meet the objectives outlined in the NHS Plan<sup>2</sup> of narrowing the longstanding gap in infant and early childhood mortality and morbidity between different socio-economic groupings. It envisages children having access to a variety of modern services, as well as being involved (with their parents / carers) in making choices concerning their care.

The NSF will tackle some important cross-cutting themes, especially:

- Tackling inequalities and access problems;
- Supporting children with disabilities and special needs;

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<sup>2</sup> The NHS Plan, A Plan for Investment, A Plan for Reform, Department of Health, July 2000

- Involving parents and children in choices about care;
- Integration and partnership (including breaking down professional boundaries); and
- Children growing up (for example, the transition to adult services).

- **North West Children's Taskforce**

The Children's Taskforce was established in November 2000 to drive forward all aspects of the NHS Plan that relates to children. There are 8 regional taskforces which include a wide range of stakeholders, including front line staff drawn from the NHS, local government, private sector and voluntary organisations.

Taskforce members provide support, wisdom and encouragement to the work at regional level; offer expertise and knowledge of the programme area; as well as scrutinise various activities. They are involved in developing children's services across health and social care at a strategic level.

Children's Taskforces focus on improving children's health and social care services and tackling health inequalities. They:

- Ensure that the voice of the child is heard and correctly acted upon;
- Improve the life chances of vulnerable children, including looked after children;
- Bring field experience to bear on appropriate aspects of implementation; and
- Support two-way communication with the field to inform the implementation process.

Members of the North West Children's Taskforce have been extremely helpful in identifying key issues in relation to each of the four themes considered within this public health information report.

- **Child Health and Inequalities**

Enhancing child public health necessarily involves wide-ranging interventions in health, education and public policy.

Child public health is improving in the UK. However, there are highly significant and deeply entrenched structural inequalities in child health. A child from the lowest social class is twice as likely to die before the age of 15 in comparison with a child from the highest social class<sup>3</sup>. Furthermore, research indicates that the gap between the most and least disadvantaged children, in relation to the main cause of child deaths (ie accidents), has widened in recent years<sup>4</sup>. Moreover, there is some evidence that the psychological problems experienced by roughly a fifth of children and adolescents are more likely to affect those children living in poverty<sup>5</sup>.

The Acheson report<sup>6</sup> further highlighted gross inequalities in health experience, but also emphasised that tackling such inequalities cannot be the sole responsibility of the National Health Service. Effective methods of tackling health inequalities have more to do with a reform of the tax and benefits system, and of education, employment, housing and environmental policies. Three specific policy recommendations arose from the report:

- Policies likely to affect health should be evaluated according to their potential impact upon health inequalities;
- Much higher priority should be accorded to the health of families with children; and
- Initiatives should be introduced to both reduce income inequalities, as well as improve the living standards of poorer households.

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<sup>3</sup> Woodroffe, C et al (1993), 'Children, Teenagers and Health: The Key Data' Open University Press, Buckingham

<sup>4</sup> Roberts, I and Power, C (1996) 'Does the decline in child injury mortality vary by social class? A comparison of class specific mortality in 1981 and 1991, BMJ, 313,pp.784-786

<sup>5</sup> Mental Health Foundation (1999) Bright Futures: Promoting Children and Young People's Mental Health, Mental Health Foundation, London

<sup>6</sup> Acheson, D (1998) Independent Inquiry into Inequalities in Health, The Stationery Office, London

# 1 Children, Poverty and Health in the North West

Tackling child poverty has become a central theme of national policy. The current Labour government has set itself the target of eradicating child poverty within 20 years. The following summary seeks to provide a brief overview of the range of measures designed to tackle child and family poverty in deprived neighbourhoods through addressing the root causes of poverty (ie the social determinants of health).

This national Regeneration Strategy<sup>7</sup> has a specific remit for improving living conditions within the UK's most deprived areas through joint working across a range of activities, including health, housing and employment. It includes:

- **New Deal programme** for young people, lone parents, long-term unemployed people aged over 25, partners of unemployed people, disabled people and people aged over 50 focuses upon paid work as a route out of poverty;
- **Tax Credits** for working families and disabled people aim to increase family income;
- **Education Action Zones (EAZs)**, combined with the 'Excellence in Cities' programme, aim to modernise inner city schools in major cities, in order to enhance the potential of young people;
- **On-site Learning Support Units** enable short-term teaching and support outside the classroom for pupils at risk of school exclusion;
- **Sure Start** aims to reach a third of children under four years of age living in poverty. Through promoting the health and well-being of pre-school children, the programme aims to help them succeed at school;
- **Connexions** works with all young people, but has a particular emphasis upon supporting the needs of those in poor neighbourhoods who face particular obstacles during their teenage years;

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<sup>7</sup> A New Commitment to Neighbourhood Renewal: National Strategy Action Plan. A Report by the Social Exclusion Unit (January 2001)

- **Strategy for Teenage Pregnancy** aims to halve the rate of teenage conceptions among under-18s by 2010, as well as support more teenage parents in education and employment;
- **The Cabinet Committee on Children and Young People's Services** co-ordinates policies to prevent poverty and under-achievement among children and young people, co-ordinates and monitors the effectiveness of delivery, and works with voluntary sector organisations to create a new alliance for children. It is supported by the cross-departmental **Children and Young People's Unit**;
- **The Quality Protects programme** has been set up to increase the effectiveness of services for children in need through promoting 11 Government Objectives for Children's Social Services;
- **Health Improvement Programmes** create cross-cutting plans for tackling the causes of ill-health;
- **New Opportunities Fund** programme aims to enable additional sports facilities for schools and wider community use. Most funding is targeted at areas of high deprivation, both urban and rural;
- **NHS Plan** sets out commitments for reducing health inequalities, and reflects upon the geographical allocation of NHS resources to different parts of the country; and
- **The NHS Performance Assessment Framework** has been created to measure and manage local NHS action on tackling health inequalities, to enable more equitable access to health care.

## 1.1 What is Poverty and How Can We Measure It ?

There has been considerable debate about how best to define and measure poverty. One method used by the Department of Social Security involves developing a poverty line based on household income. This Households Below Average Income<sup>8</sup> (HBAI) method defines poverty as living with 50% of average income after deducting housing costs. According to this approach, in 1999/2000 roughly

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<sup>8</sup> Department of Social Security, Households Below Average Income, 1994/1995 – 1999/00, Corporate Document Services (2001)

14 million UK citizens (or a quarter of the population) were living in poverty. This marks a threefold increase since 1979, when roughly 5 million citizens (or 9% of the population) were living in such circumstances. This equates to 4.3 million children living in poverty, or a third of the total number – a rise from 1.4 million (or 10% of the total) in 1979.

However, other measures of poverty use a different approach. The Poverty and Social Exclusion Survey<sup>9</sup> defines poverty as a set of circumstances whereby people lack two or more essential items because they cannot afford them. According to this survey, carried out in 1999, 14.5 million people (or 26% of the entire population) were living in poverty. This poverty measure equates to roughly 20% of all British children.

The Child Poverty Action Group<sup>10</sup> (CPAG) underlines the way certain key socio-economic factors can combine to increase the likelihood of poverty. People without work, and families with children, are more likely to be poor. Roughly 40% of poor children now live with a lone parent, and 60% of all lone parents are living in poverty. Upon separation or divorce, mothers with children suffer an average 20% drop in income. Some minority ethnic communities are more affected by poverty than others: roughly 60% of people from Pakistani or Bangladeshi backgrounds are in the lowest fifth income group. They are three times more likely to be in the bottom 20% than white people, and nearly twice as likely to be there as black people.

Being in receipt of income support is also a key indicator of poverty: roughly 2.4 million children in the UK are reliant upon this, which represents a fifth of all children. Furthermore, being either a local authority or housing association tenant also increases the likelihood of poverty. Disabled people are more at risk of poverty due to extra disability-related living costs and having low incomes. Roughly a third of disabled people spend more on transport, and 40% more on heating, whilst household incomes can be very significantly lower for disabled than non-disabled adults.

## **1.2 The Impact of Poverty on Children**

Poor health is common among families suffering poverty. Low birth-weight is 25% higher in children from social classes IV/V (ie semi-skilled and unskilled manual)

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<sup>9</sup> Poverty and Social Exclusion in Britain, Joseph Rowntree Foundation (1999)

<sup>10</sup> Child Poverty Action Group (2001), Poverty: The Facts (summary)

than I/II (ie professional and managerial), and 45% greater for lone mothers registering their baby without the father. The social class differential is stark: children are nearly twice as likely to die within their first year of life if their parents are from unskilled manual rather than professional classes.

Recent research undertaken by Barnardo's<sup>11</sup> illustrated the grim facts of early deprivation on young lives. It pointed out that a failure to invest in children's lives can have repercussions not only for their own childhood experience, but also increases the risks of them becoming disadvantaged parents who will themselves become unable to provide for their own children. Using a case study approach, the Barnardo's report compared the economic costs of a deprived childhood (such as exclusion from school, local authority care costs and youth offending costs) with the actual cost of providing greater support to the child and family (through initiatives involving educational support, assistance with overcoming drug and alcohol abuse, and support with parenting costs). In all of the eight case studies provided, the financial cost of not offering early investment and support in tackling the root causes of poverty ultimately produced far greater costs for society. Consequently, a failure to invest is far more expensive than investment at an early age, and macroeconomic policies aimed at supporting children and families from such deprived backgrounds can have a positive impact on alleviating much of their distress.

Barnardo's emphasised that growing up in poverty can lead to ill health, poor educational attainment and unemployment. It called upon the government to provide better community-based services (such as health visiting or family/parental support), particularly during the first five years of a child's life, as being of crucial value, particularly in relation to maximising educational opportunity. Breaking the cycle of disadvantage by helping parents deal with their problems is extremely important. The key problems to address in this respect are alcohol and drugs misuse, mental health issues and poor physical health. It called for parenting education and support to be made available alongside services addressing the needs of parents.

Ending child poverty, therefore, calls for:-

- a coherent national strategy for preventing child poverty;

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<sup>11</sup> 'Counting the cost of child poverty', Barnardo's, (2000)

- establishing a minimum income standard (which includes targeted support, particularly for disabled children);
- provision that is ‘joined up’ and based on a strong evidence base, so that there are clearly positive outcomes for health, education and regeneration. This would stop children falling between education, health and social welfare services;
- ensuring that short-term initiatives are strongly linked with more mainstream initiatives, so that services for children continue beyond the end of targeted programmes;
- offering equal access to affordable child care, an inclusive education system and accessible health, leisure and transport facilities; and
- Involving children, families and communities in the development of policies to end social exclusion.

In another recent publication, Barnardo’s<sup>12</sup> considered the relationship between a variety of social factors and living in poverty. It made further additional recommendations:

- Ensure that welfare-to-work policies interact effectively with the benefits system to help people move from benefits into work without being financially worse off; and
- Adopt a more inclusive and flexible social insurance system that offers protection for disabled people and others with interrupted employment records, so that parents having caring duties do not suffer through being economically inactive.

### **1.3 Child Health and Inequalities in the North West**

There are extremely high inequalities in child health across the UK. This section seeks to explore these geographical inequalities by comparing the health experience of children in the North West with that of other English regions.

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<sup>12</sup> ‘Parliamentary briefing on poverty’, Barnardo’s, (2001)

All of the following tabular information has been derived from the Compendium of Clinical Health Indicators (2001)<sup>13</sup>, which comprises a record of mortality and morbidity data for the UK population in recent years. Key health indicators form this analysis:

- All Cause Mortality: Age ranges 1-4 and 5-14
- Perinatal mortality
- Infant mortality
- Low birth weight: <1500g and <2500grams
- Vaccination for measles, mumps and rubella
- Oral health in children: decayed teeth

### 1.3.1 All Cause Mortality: Age ranges 1-4 and 5-14

Age specific death rates (per 100,000), 1998 to 2000 Pooled Data

The North West has a slightly higher rate of all cause child mortality than the average for England in both age categories. Of the eight English regions, there are only two that have higher rates of mortality than the North West: Northern & Yorkshire and Trent.

<b>Region</b>	<b>Ages 1-4</b>	<b>Ages 5-14</b>
<i>Northern &amp; Yorkshire</i>	30.0	14.2
<i>Trent</i>	29.6	14.8
<i>West Midlands</i>	25.8	13.4
<b><i>North West</i></b>	<b>26.2</b>	<b>14.1</b>
<i>Eastern</i>	22.8	10.9
<i>London</i>	26.0	12.6
<i>South East</i>	21.3	11.5
<i>South West</i>	23.9	11.4
<b><i>England</i></b>	<b>25.5</b>	<b>12.9</b>

<sup>13</sup> Compendium of Clinical and Health Indicators, Department of Health, 2001

### 1.3.2 Perinatal Mortality: Stillbirths and Deaths of Infants < 7 Days, 2000

The North West Region has a slightly higher rate of stillbirth deaths in comparison with the average for England. However, in relation to the other NHS regions the rate of deaths in the North West falls within the middle range: higher than some regions (Eastern, South West) yet lower than others (West Midlands).

<b>Regional Offices</b>	<b>Number of Observed Cases</b>	<b>Rates per 1000 total births</b>	<b>95% CI Lower Level</b>	<b>95% CI Upper Level</b>
<i>Northern &amp; Yorkshire</i>	616	9.0	8.3	9.7
<i>Trent</i>	471	8.5	7.8	9.3
<i>West Midlands</i>	597	9.7	8.9	10.5
<b><i>North West</i></b>	<b>636</b>	<b>8.6</b>	<b>7.9</b>	<b>9.2</b>
<i>Eastern</i>	432	7.0	6.4	7.7
<i>London</i>	954	9.1	8.5	9.6
<i>South East</i>	660	6.7	6.2	7.2
<i>South West</i>	333	6.6	5.9	7.4
<b><i>England</i></b>	<b>4699</b>	<b>8.2</b>	<b>7.9</b>	<b>8.4</b>

### 1.3.3 Infant Mortality: Deaths within First 12 Months, 2000

The North West Region has a statistically significantly higher rate of infant death than the average for England. Rates of death are significantly higher in some regions (London, South East and South West).

<b>Regional Offices</b>	<b>Number of Observed Cases</b>	<b>Rate per 1000 total births</b>	<b>95% CI Lower Level</b>	<b>95% CI Upper Level</b>
<i>Northern &amp; Yorkshire</i>	468	6.9	6.3	7.5
<i>Trent</i>	334	6.0	5.4	6.7
<i>West Midlands</i>	427	6.9	6.3	7.6
<b><i>North West</i></b>	<b>466</b>	<b>6.3</b>	<b>5.8</b>	<b>6.9</b>
<i>Eastern</i>	268	4.4	3.9	4.9
<i>London</i>	570	5.4	5.0	5.9
<i>South East</i>	437	4.5	4.1	4.9
<i>South West</i>	233	4.7	4.1	5.3
<b><i>England</i></b>	<b>3203</b>	<b>5.6</b>	<b>5.4</b>	<b>5.8</b>

### 1.3.4 Low Birthweight Births:

#### Percent of Live and Stillbirths <1500 and <2500 grams, 2000

In relation to births less than 1500g, the North West Region has virtually the same rate compared to the average for England and Wales. However, some English Regions have a lower rate of low births (South West, South East), whilst the London Region has a higher rate.

Regional Offices	< 1500 grams			< 2500 grams		
	Percent	95% CI Lower	95% CI Upper	Percent	95% CI Lower	95% CI Upper
<i>Northern &amp; Yorkshire</i>	1.5	1.4	1.6	8.2	8.0	8.4
<i>Trent</i>	1.5	1.4	1.6	8.2	8.0	8.4
<i>West Midlands</i>	1.6	1.5	1.7	8.7	8.5	8.9
<b><i>North West</i></b>	<b>1.5</b>	<b>1.4</b>	<b>1.6</b>	<b>8.2</b>	<b>8.0</b>	<b>8.4</b>
<i>Eastern</i>	1.3	1.2	1.4	7.1	6.9	7.3
<i>London</i>	1.7	1.7	1.8	8.5	8.3	8.7
<i>South East</i>	1.3	1.2	1.3	7.0	6.9	7.2
<i>South West</i>	1.2	1.1	1.3	6.8	6.6	7.1
<b><i>England</i></b>	<b>1.5</b>	<b>1.4</b>	<b>1.5</b>	<b>7.9</b>	<b>7.8</b>	<b>7.9</b>

### 1.3.5 Vaccination for Measles, Mumps and Rubella:

#### Percentage Vaccinated by 2<sup>nd</sup> Birthday, Financial Year 2000/2001

The North West has a statistically significantly higher rate of MMR vaccination than the average for England, as well as London and the South East. However, some of the English regions (Northern & Yorkshire, Trent and the West Midlands) have a statistically significantly higher rate than the North West.

It is noticeable that the London region has a lower rate of vaccination compared with all of the English regions.

<b>Regional Offices</b>	<b>Percent</b>	<b>95% CI Lower Level</b>	<b>95% CI Upper Level</b>
<i>Northern &amp; Yorkshire</i>	89.5	89.3	89.8
<i>Trent</i>	91.3	91.0	91.5
<i>West Midlands</i>	89.3	89.1	89.6
<b><i>North West</i></b>	<b>88.5</b>	<b>88.3</b>	<b>88.7</b>
<i>Eastern</i>	89.2	88.9	89.4
<i>London</i>	79.4	79.2	79.7
<i>South East</i>	87.3	87.1	87.5
<i>South West</i>	88.4	88.1	88.6
<b><i>England</i></b>	<b>87.4</b>	<b>87.3</b>	<b>87.5</b>

### **1.3.6 Oral Health in Children – Decayed Teeth: Mean Number in Children Aged 14, Survey 1998/1999**

Oral health is often used as a useful indicator of relative deprivation. The North West Region has by the worst oral health of all English regions.

The table below illustrates that a statistically significantly higher proportion of 14 year old children in the North West have tooth decay in comparison with all other English Regions.

<b>Regional Offices (Weighted Mean)</b>	<b>Permanent Teeth</b>		
	<b>Mean</b>	<b>CI Lower</b>	<b>CI Higher</b>
<i>Northern &amp; Yorkshire</i>	0.69	0.66	0.72
<i>Trent</i>	0.47	0.46	0.49
<i>West Midlands</i>	0.30	0.29	0.32
<b><i>North West</i></b>	<b>0.82</b>	<b>0.79</b>	<b>0.85</b>
<i>Eastern</i>	0.45	0.42	0.48
<i>London</i>	0.47	0.45	0.50
<i>South East</i>	0.40	0.38	0.43
<i>South West</i>	0.47	0.42	0.51
<b><i>England</i></b>	<b>0.52</b>	<b>0.51</b>	<b>0.53</b>

## **1.4 Exploring the Relationship between Poverty and Child Health Indicators in the North West**

The following exercise seeks to explore whether a relationship exists between social disadvantage and certain child health indicators. The Department of Social Policy and Social Work (University of Oxford) have produced an Index of Deprivation<sup>14</sup>, which reflects the belief that multiple deprivation is comprised of six separate dimensions of deprivation, which each reflect different aspects of deprivation. There are six key dimensions of deprivation:

- Income (ie measures people in receipt of a low income).
- Employment (ie measures people who wish to work but are unable to do so due to unemployment, sickness or disability).
- Health, Deprivation and Disability (ie measures people whose quality of life is impaired due to either poor health or disability).
- Education, Skills and Training (ie measures education deprivation).
- Housing (ie measures people living in unsatisfactory housing or homeless).
- Geographical Access to Services (this measures solely people with low incomes able to access a post office, food shops and a GP).

A variety of indicators were produced for each dimension of deprivation for all English wards, gained through accessing a variety of information sources, including Department of Social Security benefits data and University Colleges Admissions Service (UCAS) data.

Through using various statistical techniques, it is possible to provide a score for each ward with respect to each of the six dimensions given above. This allows us to describe each type of deprivation within a particular geographical area, and to compare this across other wards. Consequently all English wards can be ranked relative to each other for each of the dimensions. Given that there are 8,414 wards in England, a rank of 1 is assigned to the most deprived ward and a rank of 8,414 is assigned to the least deprived ward.

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<sup>14</sup> Indices of Deprivation 2000, Regeneration Research Summary, DETR (2000)

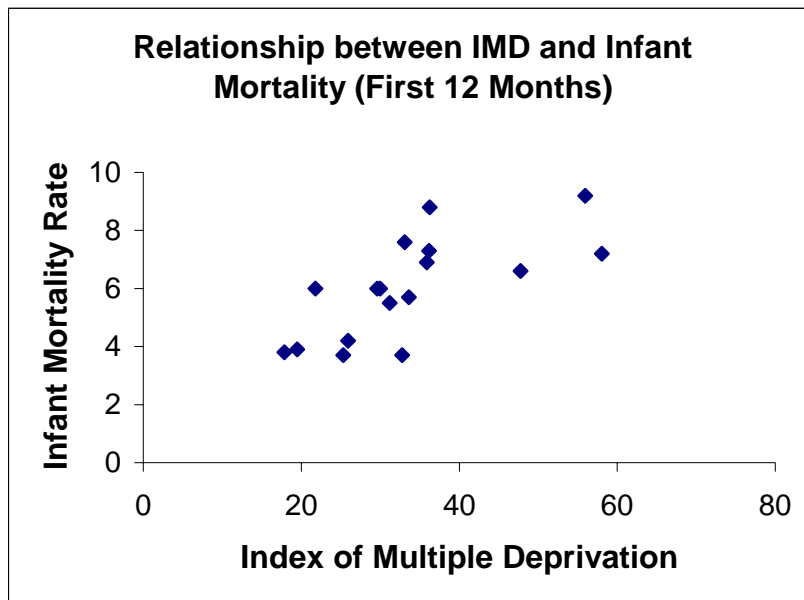
The overall Index of Multiple Deprivation (IMD) is produced by combining information from all six dimensions of deprivation through a system of weighting data from each dimension of deprivation. The IMD 2000 score is the combined sum of the weighted dimension rank, and it allows comparison between different geographical areas for relative multiple deprivation.

Each of the former North West health authorities (prior to April 2002) have been scored according to the index of relative multiple deprivation. The following exercises seek to compare two key child health indicators with relative multiple deprivation in the North West.

The Spearman's rho coefficient is the statistical tool used to measure the relationship : a coefficient score between 0 and 1 indicates a positive correlation between both factors, and the greater the score, the stronger is the association between multiple deprivation and the child health indicator. Where a Spearman's rho coefficient is greater than 0.7, this indicates an extremely strong association between both factors.

### 1.4.1 Infant Mortality (First 12 Months) and Index of Multiple Deprivation

The scatterplot below illustrates a strong positive relationship between perinatal mortality and relative deprivation (ie as the level of deprivation increases, so does the rate of mortality, and vice versa). The Spearman's rho coefficient is 0.75.

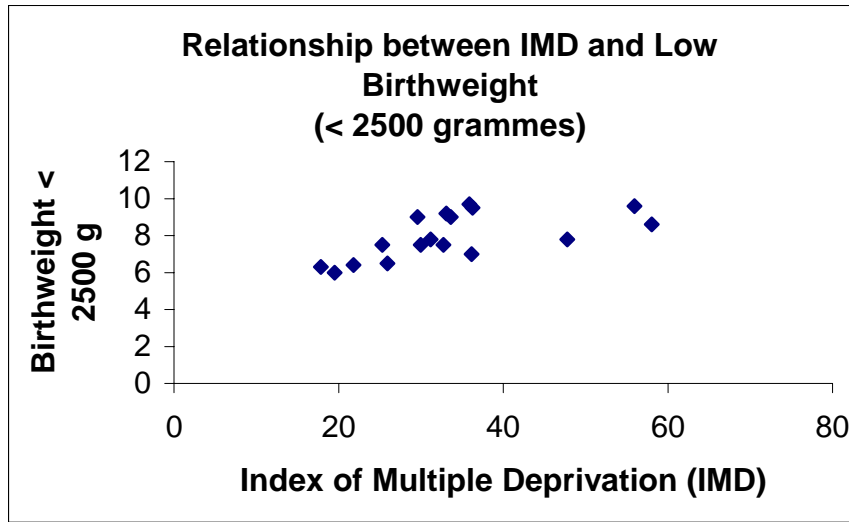


**Infant Mortality Rate**

This is the rate of infant deaths (within first 12 months) per 1000 live births

### 1.4.2 Birthweight < 2500 grammes and Index of Multiple Deprivation

The scatterplot below illustrates a strong positive relationship between having a birthweight less than 2500 grammes and relative multiple deprivation (ie as the level of deprivation increases, so does the rate of low birthweight, and vice versa). The Spearman's rho coefficient is 0.71.



**Birthweight < 2500 grammes**

This is the percentage of live and still births weighing less than 2500

It should be noted that in both cases, the Spearman's rho coefficient was statistically significant ( $p < 0.01$ ).

We can conclude, therefore, that there is a clear relationship between multiple social disadvantage and low birthweight / infant mortality. As multiple deprivation increases, low birthweight and infant mortality also increase, and vice versa.

## **2 Acute Care Services for Children and Young People**

This section seeks to summarise some of the key issues in supporting children in need of hospital services. It then considers hospital-based care in relation to comparative rates of deprivation within the North West, before offering some examples of innovative practice in the North West.

In recent years, the challenge of providing high quality acute care services for children has attracted much attention. A wide range of policy analysis has been undertaken, and certain issues have been identified as particularly relevant for all children requiring acute care services.

Child inpatient admissions to hospital are at a rate of one per 11 children per year. A very significant proportion of paediatric admissions are children aged under 1 year, yet those admitted to surgical specialities are more evenly spread across different age ranges. Virtually all admissions to paediatrics are emergencies, as compared with two-thirds of children admitted for surgery.

### **2.1 Audit Commission Report**

An Audit Commission report<sup>15</sup> highlighted six key issues in relation to children in receipt of hospital-based care:

- child and family-centred care;
- specialist staff;
- separate acute care facilities for children;
- appropriate hospitalisation; and
- the role of strategic commissioning.

#### **□ Child and family-centred care**

This is centred upon the need for acute hospital services to recognise children's physical and emotional maturity. The Audit Commission felt that care was often too narrowly focused upon the condition at hand, rather than meeting the emotional needs of child development. Indeed there is evidence<sup>16</sup> that greater psychological

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<sup>15</sup> Children First: A Study of Hospital Services, Audit Commission, HMSO (London) 1993

<sup>16</sup> Robertson, J Young Children in Hospital (1958) Tavistock Publications

harm is caused to children if they are separated from their mothers, and that such an emotional strain is greater if the child is aged under 5, remains in hospital for a longer period, and is admitted more frequently. Maintaining close and continuous involvement of a child's family is vitally important; using play (for younger children) to explain a child's treatment can enhance their confidence in both staff and treatment. Older children, however, require further support that incorporates counselling, peer group contacts and a stronger involvement in their care. Children from minority ethnic backgrounds may require culturally specific attention to their needs.

The Audit Commission report highlighted an absence of written policies, which would ensure that child-family centred care was applied consistently throughout the hospital. Furthermore, where such policies existed, they were often the result of practices developed by junior staff, and not a consequence of initiatives from senior staff. The absence of a consistent approach in supporting child-family centred care was made worse by parents feeling that their experiential knowledge in caring for their child was not valued, and ignored, by hospital staff.

A clear management focus was deemed necessary. The management team should include a consultant, senior children's nurse and appropriate managerial/financial support. Such management teams could then set targets based on good practice, identify key individuals to co-ordinate the achievement of standards and measure local performance against those standards. Furthermore, better involvement of parents meant encouraging them to provide care and support for their child as they would at home. Staff should spend more time with parents. Similarly, having a 'named' nurse as being responsible for the child's care throughout their stay was deemed a valuable improvement. Clear written information should be provided through leaflets and given to parents upon arrival at hospital, in order to enhance communication with the child's family.

#### □ **Specialist staff**

Staff sometimes lacked specialist skills, and children were not always referred to tertiary care when required. Many categories of hospital staff providing care to children also provide care to adults, and the Commission argued that they should be cognisant of the special needs of children. Furthermore, the Commission identified the need for more experienced resident medical staff who can support junior hospital doctors inexperienced in paediatrics. In relation to surgeons and anaesthetists, the report highlighted the importance of both groups of specialists not carrying out occasional paediatrics: a recent confidential study had highlighted

a large proportion of surgery and anaesthesia being carried out on children less than six months old by specialists who had performed such procedures on less than ten occasions per year.

A lack of skilled nurses was also identified. Most wards were found to be staffed by only one Registered Sick Children's Nurse (RSCN), despite the Department of Health's target standard of "at least two RSCNs on duty 24 hours a day in all children's hospital departments and wards"<sup>17</sup>. A national study found that NHS managers failed to value the need for RSCNs, as well as poor career prospects in relation to sick children's nursing. Dedicated, trained play specialists were seen as an essential requirement for service development.

#### □ **Separate acute care facilities for children**

The report highlighted the need for specialist tertiary care to be provided, pointing out the higher survival rates for childhood cancer if it was treated at paediatric oncology centres. Solutions to these problems could be provided, according to the report, by grouping children requiring surgery into separate operating lists and minimising the number of anaesthetists and surgeons. This was seen as a way of facilitating a more child and family centred approach, that should include operating theatre and recovery staff.

Managerial initiatives were also seen as providing a potential solution, through positively attracting newly qualified and existing RSCNs back to children's nursing and ensuring that RSCNs work directly within children's services, rather than elsewhere in the hospital. With regard to ensuring access to tertiary care services, the report called for greater "shared care" between large tertiary centres (eg those offering cancer treatment) and secondary centres (ie outpatient clinics), so that staff at the tertiary level could advise on care, yet care could be provided at the secondary level.

Facilities for children that provide an opportunity for play, leisure and recreation were highly valued, and these needed to be separate from adult facilities. The parental need to be with their child at all times meant having rooms available for this purpose. Adolescents were found to have particularly poor facilities that did not acknowledge their need for privacy, peer contact and a less restrictive set of conditions in comparison with younger patients. Parental provision was another

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<sup>17</sup> Department of Health Welfare of Children and Young People in Hospital HMSO (London) 1991

key issue, with parental accommodation located some distance from their children, with inadequate facilities.

The Audit Commission also highlighted the need to monitor whether treatments for children were effective or otherwise, so that any potential shortcomings could be remedied. It suggested that some agreed procedures (eg glue ear) were carried out which may not be entirely necessary, particularly in view of the risks inherent in all general anaesthesia, and the potential risks of invasive surgery. Monitoring was also necessary for low birth-weight babies suffering disabilities, so that suitable intervention could be undertaken.

#### □ **Appropriate hospitalisation**

A related issue is that of appropriate hospitalisation: effective primary care can reduce the need for secondary care and offer support at home, so that children can be discharged sooner. The main motivation for this is an economic one: home care is certainly more cost effective than care in hospital. The Audit Commission identified three key problems: poor management of in-patient admissions, excessive lengths of stay in some hospitals and the absence of home-care services.

Poor management relates to the variation of admission rates for children from one place to another. However, the Commission recognised that this may be due to the misrecording of children as paediatric admissions rather than as referrals to a particular surgical speciality. It also emphasised that higher admission rates are a consequence of increased social deprivation<sup>18</sup>, which reflects poor environment, diet and higher rates of accidental and non-accidental injuries. In Section 1, we explored the relationship between multiple deprivation and key child health indicators. Later in this section, we shall explore the different rate of hospital episodes and motor vehicle accidents within the North West region and other English regions.

A key focus of the Audit Commission report is on improving the management of in-patient admissions, so that the number of beds is properly matched to demand. Further emphasis is placed on drawing up written guidelines agreed between all staff, which cover the complete management of the condition, out-patient attendances and long-term care. The report also called for short-term observation

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<sup>18</sup> Marsh, GN & Channing, DM 'Comparison in Use of Health Services Between a Deprived and an Endowed Community, Archives of Disease in Childhood', 1958, Volume 62, pp 392-396

facilities, whereby hospital staff could observe children for up to 8 hours without an automatic admission.

Offering advice in hospitals on how to avoid accidents in the home was seen as a useful strategy for reducing A&E attendances, as well as later subsequent admissions. The Commission argued for more teams of RSCNs who could offer secondary care at home.

#### □ **Role of strategic commissioning**

The relevance of an efficient and effective commissioning strategy was emphasized. This required clear and detailed information to inform decision-making. The solution to this issue was seen to be in a recognition of children's needs, and an appreciation that service provision might not meet those needs. Documenting the contribution of each element of the hospital service to meeting needs was seen as an important first step in providing better all-round services to children.

## **2.2 The Bristol Royal Infirmary Inquiry**

Some of the issues raised by the Audit Commission were to reappear as a consequence of the Bristol Royal Infirmary Inquiry Report<sup>19</sup> (chaired by Professor Kennedy) into children's heart surgery between 1984 and 1995. The Report indicated that between 30 and 35 more children, aged less than 1 year, died after open heart surgery than was typical of similar heart units elsewhere in England. Despite morbidity rates falling in other parts of the UK, those at Bristol did not. The hospital lacked both resources and specialist staff: cardiac care was divided between two sites. Furthermore, children's services were entirely subordinate to adult services, and the decision-making process became concentrated in too few hands. As a consequence of this, the Bristol Report emphasised the closed world that the hospital became, such that a 'club culture' developed whereby problems were neither identified nor solved. It concluded that a paternalistic attitude towards patients coexisted with rivalries between professions.

Despite concerns being raised regarding open-heart surgery in Bristol as long ago as 1986 (first within the hospital, and later within the Department of Health), no effective action was taken to protect the welfare of the children who were patients

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<sup>19</sup> Learning from Bristol: Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 –1995, Command Paper: 5207 (July 2001)

there. The Bristol enquiry concluded that there was a tragic combination of events. Senior clinicians failed to reflect upon their practice (they felt that, over time, the situation was bound to right itself). Senior managers failed to comprehend the gravity of what was going wrong. Many others in a range of capacities (including the Department of Health) failed to act.

The Report made 198 wide-ranging and challenging recommendations concerning the organisation and culture of the NHS. At the centre of its view of how health services should be organised is the patient. All of its recommendations result from the key principle that all patients should be entitled to expect:-

- respect and honesty;
- care in a setting that is well led;
- competent health care professionals;
- care that is safe;
- care of an appropriate standard; and
- inclusion and involvement in the NHS, both as patient and as members of the public.

At the heart of its recommendations is an attempt at wholesale cultural shift<sup>20</sup>, so that appropriate systems and relationships should be in place to provide a safe framework whereby clinical care can be offered to a high and recognised standard; outcomes can be monitored and evaluated; staff are well regulated, trained and supported and error is minimal. However, where errors do occur, lessons should be both learned and shared. Moreover, patients should become genuine partners in the decision-making process.

### **2.3 The DH Response to the Kennedy Report**

The Department of Health's response<sup>21</sup> to the Kennedy Report accepted its broad principles. It recognised that the absence of national standards, and the different levels of care and service provision across the UK had had a damaging impact,

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<sup>20</sup> CMO's Update (31) A communication to all doctors from the Chief Medical Officer (October 2001)

<sup>21</sup> Learning from Bristol: The Department of Health Response to the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 –1995, Command Paper: 5363 (January 2002)

especially when combined with uncertainty as to where clinical and managerial responsibilities lay.

However, it pointed towards the new independent standard setting and inspecting bodies created since 1997 – the Commission for Health Improvement<sup>22</sup> (CHI) and the National Institute for Clinical Excellence (NICE). They had a key role in creating new standards and new organisational systems to both improve clinical quality and ensure patient safety. The development of two new bodies – the National Patient Safety Agency (NPSA) and the National Clinical Assessment Authority (NCAA) – would, it argued, play a leading role in tackling poor clinical practice where it had been identified. Furthermore, the development of National Service Frameworks had a powerful part to play in raising and regulating national standards. The NHS Modernisation Agency had clear responsibility for helping NHS organisations improve their performance level. In relation to general strategic management within the NHS, the Department of Health highlighted the way resources and responsibilities had been devolved, so that they were increasingly located in front-line services that were innovative and responsive to the needs of patients.

Much of this devolvement, it argued, allows the Department of Health greater freedom to set the overall framework for the regulation and inspection of NHS care services, whilst the actual regulation is undertaken by independent bodies working to a framework of standards drawn up by patients, professionals, health service and government. The separation of responsibility, therefore, was clearly aimed at tackling the confusion that had underpinned much of the Bristol tragedy.

The Department of Health recognised the value of greater integration in services relating to children, and pointed towards the Sure Start Programme and the appointment of a National Clinical Director for Children as evidence for ensuring high quality and safe services.

Further managerial changes included appointing senior staff members with responsibility for children's services in each Strategic Health Authority, PCT and NHS Trust. The creation of a National Service Framework for children, with a specific module on hospital care for children, is currently being drawn up. Further measures related to NHS cultural change are meant to engender greater integration of primary, community, acute and specialist health care across professions and

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<sup>22</sup> Commission for Health Improvement established under Health Act 1999 as an executive non-departmental public body

agency boundaries, including closer working with local authority social services departments. Parents are to become fully engaged in discussion about their children's care and treatment, which would challenge the NHS's prevailing culture. In a more concrete sense, the Department of Health pointed towards the provision of paediatric training in an appropriate setting for all staff operating on children, as well as the review (by the Paediatric and Congenital Cardiac Services Review) of specialist cardiac services for children.

## **2.4 National Co-ordinating Group**

Other agencies have drawn up guidelines for the care of children in acute and speciality hospitals in recent years. In 1996 the National Co-ordinating Group on the Provision of Paediatric Intensive Care (NCG) was set up, and given the task of drawing up a policy framework for paediatric care. Much of the Group's focus<sup>23</sup> has been on developing a long-term vision for a high quality, integrated service that is organised and run around the health needs of individual children. Intensive care can be defined as 'a service for patients with potentially recoverable diseases who can benefit from more detailed observation and treatment than is generally available in the standard wards and departments'<sup>24</sup>.

It is usually provided to parents having threatened or established organ failure that may have occurred after an acute illness, trauma or else as a predictable part of a planned treatment programme. Paediatric intensive care, therefore, relates to the most critically sick children who require the attention of highly trained specialist staff. As a service that is very costly and of low volume, it cannot be provided to every locality, and yet it should be available to every child irrespective of where they live.

The National Co-ordinating Group Report highlighted the unplanned manner in which the service had historically developed, but also the lack of evidence in the UK on the standards providing the best outcomes for critically ill children. Similarly, there are few specialist referral services that transport critically ill children to the nearest specialist centre, and often this service is not provided on a continuous 24-hour basis. Few clinicians and nurses were found to have the required paediatric intensive care skills. They also found that although there were 223 designated paediatric intensive care beds, many of them were located in small

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<sup>23</sup> Paediatric Intensive Care 'A Framework for the Future', Report from the National Co-ordinating Group on PIC to the Chief Executive of the NHS Executive (1997)

<sup>24</sup> Intensive Care in the UK: King's Fund Panel, May 1989

units which have less than 3 beds. Recommendations drawn up by the National Co-ordinating Group fall into two areas: audit; and the range of hospitals providing services for critically ill children.

#### □ **Audit**

NCG called for all hospitals and former health authorities to audit the numbers of children in their area requiring intensive care annually, and the location of where their current care is being received. This would establish the numbers of children per 1,000 needing intensive care, a profile of local demand, and the current configuration of their service. It would also indicate the average length of stay in each hospital, the numbers of children requiring long-term ventilation and the level of need for high dependency care to help relieve pressure on intensive care beds.

In relation to hospital services, it recommended that all paediatric intensive care be provided within 4 types of hospitals:

The district general hospitals (which should be able to begin paediatric intensive care);

lead centres (which provide localised intensive care, as well as supporting service provision for the whole area through advice and training);

major acute general hospitals having large intensive care units; and

specialist hospitals (that provide some intensive care to support the speciality, such as cardiac or burns).

The NCG Report called for each hospital to comply with devised standards, relating to:

- training and experience of medical/nursing staff;
- competencies and equipment for specific forms of treatment;
- access to either specialist services or advice on particular specialities;
- family-friendly facilities;
- supporting services on site or on call; and
- requirements for training, quality control and management.

## □ Services for critically ill children

As part of an action plan, the NCG Report also called for an immediate end to the provision of additional single, isolated intensive care beds. Similarly, it pointed out that children needing intensive care should no longer be looked after in general children's wards, which it deemed highly unsuitable for that purpose. It drew an important distinction between "high dependency" (provided by general hospitals, involving resuscitating and stabilising children) and "intensive care" (offered by lead centres where most critical intensive care is provided). It called for a designated lead centre in each area, and for children not to be cared for in centres that did not meet recognised standards.

### 2.5 Chief Nursing Officer's Task Force

There are significant similarities between the work of NCG and the Clinical Nursing Officer's (CNO) taskforce, which endorsed the framework proposed by NCG. In its report, the Chief Nursing Officer's Task Force<sup>25</sup> provided an account of how nursing standards, education and workforce planning should operate within this new framework. The report promoted specific nursing standards for properly resourced Paediatric Intensive Care (PIC) according to the level of care required. The main standards highlighted were as follows:

- High Level Cover (Level 3): involves at least one PIC nurse at the child's bedside throughout every 24 hour period. This may require two nurses at all times, supervised by an experienced PIC nurse.
- One-to-one Intensive Care (Level 2): one children's nurse with intensive care qualifications at the child's bedside throughout every 24 hour period supervised by an experienced PIC qualified nurse with intensive care qualifications.
- High Dependency Care (Level 1): a registered children's nurse carrying out close monitoring and observation supported by an experienced nurse with intensive care qualifications.
- Retrieval: PIC teams should include an experienced children's nurse with intensive care qualifications and training in the movement of critically ill children.

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<sup>25</sup> 'A Bridge to the Future' Nursing Standards, Education and Workforce Planning in Paediatric Intensive Care. Report of the Chief Nursing Officer's Taskforce (July 1997)

The CNO Task Force's standards cited above, the report argued, could be measured through certain initiatives, such as reviewing the skills mix and competence profile of intensive care staff, or having Registered Children's Nurses with intensive care qualifications present on all shifts. Other measures, it suggested, could include having a local written policy on nurse staffing standards identified by the CNO Task Force, or identifying required staffing levels for the emergency retrieval of children. An important element of the framework, and its associated standards, is that lead centres become not merely the main providers of care, but also the focus for professional education and training, retrieval services, as well as a key resource of research, professional advice and support to both acute and district general hospitals.

In relation to nursing education, the CNO Task Force called for greater flexibility in the training programmes necessary to become fully qualified PIC nurses. This would involve using a variety of techniques to provide education and training in a way that suits the work and personal lifestyles of trainee nursing staff. It called for further post-registration students to be funded by consortia charged with assuring provision of qualified staff, to ensure a more comprehensive Paediatric Intensive Care service. Moreover, the specialist training required in retrieval practice, it argued, should be added to the existing training content. This should be combined with advanced life support courses, so that the skills of existing PIC qualified nurses can be enhanced through acquiring valuable skills in stabilisation, resuscitation and establishment of intensive care for acutely ill children.

The CNO's strategy for nursing team planning is centred upon recognition of the specific character of PIC and its attendant fluctuating workload. It reflected upon the need for flexibility through adopting working practices that are in tandem with, rather than against, the tenor of nurses' personal and professional circumstances. It also requires finding new ways of maximising the contribution from highly skilled PIC nurses across the complete framework of children's care, so that skills may be updated and maintained. Sharing good practice has a valuable part to play in accelerating the development of the speciality, and the same applies to the establishment of professional development programmes for nurses, which can build professional partnerships within the PIC framework.

## **2.6 Hub and Spoke Model**

The greater value for money provided by moving towards a 'hub' and 'spoke' model in providing acute paediatric care has been a key theme in recent years.

Taylor<sup>26</sup> emphasised that PCUs tended to be too small, and consequently unable to provide safe and cost effective treatment. Smaller units ought to be adjacent to the major children's hospital. This would help to form a truly comprehensive specialist children's service, which would comprise specialist community care and additional day care facilities.

The changing nature of paediatrics is underlined, in that there are currently fewer deaths from causes such as cancer and cystic fibrosis, yet other chronic conditions (including diabetes, asthma, eczema) are more prevalent. Such conditions, it is argued, are not critical and ought to be provided on an out-patient or ambulatory basis, near to where the family lives, so as to cause minimal disruption to the child's relationships and schooling. This would go some way to creating a paediatric service that offered child and family focused care, rather than care that is hospital focused.

A recent study<sup>27</sup> considered the issue of whether a paediatrician out-patient service was an effective and acceptable replacement for an in-patient unit. The study found a marked reduction (ie 47% from 3 years previously) in paediatric medical hospital admissions. Furthermore, a postal survey questionnaire found that 84% of local GPs found the service beneficial, and nearly all of the GPs had referred patients to the service. They found it easy to access, and virtually all GPs felt that the feedback was appropriate. A very high percentage of parents surveyed (82%) felt their child had benefited by not being admitted to hospital. There was a similar level of satisfaction regarding the information they had received concerning their child's illness.

## **2.7 Specialists in Paediatrics**

The Royal College of Paediatrics and Child Health (RCPCH) recently produced a profile of acute care services for children in the UK. This has led to the creation of a database<sup>28</sup> that provides a comprehensive picture of NHS hospitals in the UK that supplied acute paediatric in-patient services in 1998/1999. It is particularly

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<sup>26</sup> Taylor, B 'How many inpatient paediatric units do we need?' Arch Dis Child 1994;71: 360-364

<sup>27</sup> Macleod, C et al 'Ambulatory paediatrics; does it work?' Article located at: [www.rcpch.ac.uk/publications/recent\\_publications/AmbulatoryJJ1.pdf](http://www.rcpch.ac.uk/publications/recent_publications/AmbulatoryJJ1.pdf)

<sup>28</sup> Royal College of Paediatrics and Child Health, Profile of Children's Acute Services in the UK in 1999 (May 2001). Database available at : [www.rcpch.ac.uk](http://www.rcpch.ac.uk)

noticeable that, despite considerable pressure over many years for child and family-centred paediatric services, there were a high number of children (90 in total) admitted to adult beds. Similarly, in relation to staffing numbers and hospital size, the average number of consultants in large hospitals is 6.6, and in medium hospitals 5.7. However, the RCPCH had recommended<sup>29</sup> a total of 7 or 8 general paediatric consultants necessary to sustain the service even in a medium sized unit.

- **Ratios of Consultants and Non Consultants to Child Population in English Regions**

There are substantial variations in the ratios of consultant and non-consultant specialist staff within the different English NHS Regions<sup>30</sup> (see below).

<b>NHS Region</b>	<b>Consultants per 100,000 children</b>	<b>NCCGs per 100,000 children</b>	<b>Total cancer grades per 100,000 children</b>
<i>North West</i>	<b>18.8</b>	<b>14.4</b>	<b>33.2</b>
<i>London</i>	29.6	12.4	42.0
<i>Northern &amp; Yorkshire</i>	20.2	10.9	31.1
<i>South East</i>	14.6	9.7	24.3
<i>South West</i>	15.6	9.6	25.1
<i>Trent</i>	16.3	11.6	27.9
<i>West Midlands</i>	22.0	13.4	35.4

(Note: ‘NCCG’ refers to ‘Non Consultant Clinical Grades’)

The North West Region is in the middle range in relation to the number of consultants per 100,000 children: more than the South East, South West, and Trent, yet less than Northern & Yorkshire, West Midlands and London. However, in relation to NCCGs, the NW has a higher proportion than all other English NHS Regions. On balance, taking all career grades into account, the North West has the second highest total number of staff in total career grades per 100,000 children.

<sup>29</sup> ‘A Charter for Paediatricians’, RCPCH, 2000

<sup>30</sup> Office for National Statistics (ONS), General Register Office for Scotland, Northern Ireland Statistics and Research Agency

### **2.7.1 Next Ten Years**

More recently an exploration of the future policy options for paediatric care over the next decade<sup>31</sup> highlighted key issues that are essential to maintaining and improving services in the context of recent government policy: workload, workforce and the working time directive.

#### **□ Workload**

Although children are healthier than before, parents are more likely to seek advice for their child's acute illness, especially at A & E departments within inner city areas. Moreover outpatient referrals have increased, there are more investigations for children with complex disorders and the range of community child health services has significantly grown. This is compounded by chronically disabled children surviving for longer, increased parental expectation and increased prevalence of emotional and behavioural difficulties. The net impact is that a range of additional demands are made on consultants' time, which include matters of clinical governance, continuing education, audit, teaching and patient liaison.

#### **□ Workforce**

Although consultant numbers have expanded, this has not happened at a sufficient rate, which means considerable constraints on meeting existing levels of service, let alone having enough capacity to meet additional demands.

#### **□ Working time directive**

Implementation of the working time directive will mean a significant reduction in the working week for all staff. This will have a marked impact on services, especially in relation to fewer hours worked by trainees and consultants.

The discussion paper argued that any review of paediatric services should focus on the needs of children, including areas such as basic neonatal care, acute assessment and care of the sick or injured child, child protection, adoption and fostering services and access to child and adolescent mental health services (CAMHS). Paediatric services, it argued, should be developed upon essential principles:

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<sup>31</sup> Royal College of Paediatrics and Child Health, 'The Next Ten Years, Educating Paediatricians for new roles in the 21<sup>st</sup> Century', January 2002

- Offering a service provided by a trained workforce, rather than depending on trainees;
- Utilising a flexible and adaptable workforce with care provided by the person most appropriate;
- No paediatrician working in isolation;
- All parents and children having ready access to paediatric services at primary, secondary or tertiary levels as necessary;
- Services being in close proximity to the family home;
- Having clear pathways linked between primary, secondary and tertiary services;
- All local areas having the full range of skills to deal with all aspects of paediatrics.

The challenge of meeting future service needs, therefore, relates to the decline of the traditional hierarchical model of health care, and the move towards care being delivered by fully trained doctors. This change inevitably means an evolving consultant career, that moves from front line acute work, through enhanced specialisation, before gradually taking on responsibilities for teaching, management and strategic development.

Furthermore, the challenge of providing safe acute services on a 24 hour basis, with fully trained doctors in all units, is both difficult and expensive. Most children seen out of hours have relatively minor ailments that do not require the expertise of a doctor. Although logic might suggest a reduction in the number of acute units offering 24 hour cover, political pressures reflecting the public's support for local acute care services mean that this is an unrealistic option. A more likely option might be for units to consider a switch to providing mainly daytime service and (assisted by NHS Direct) route emergencies to larger units.

As the public accesses children's services in different ways (such as through NHS Direct or their GP), it is vital that primary and secondary care provide for the assessment of undifferentiated illness around the clock. Inevitably this will mean that the boundaries between both become blurred, and the development of closer links with A & E medicine, so that smaller A & E departments can support

emergency assessment for children and short term observational care (with the assistance of staff trained in acute paediatrics).

Similarly the boundaries between specialist paediatric care in the community and in the hospital are also increasingly irrelevant, given that children with disabilities may have their conditions diagnosed in hospital, yet most of their time is spent at home or in school. As most of their care is delivered at home, it is vitally important to create a seamless care service. There are various ways in which this could be supported, which could include:

- Core training for clinicians that incorporates an introduction to disability, child protection issues and CAMHS;
- All clinicians to have experience of paediatric practice in primary care settings and in A & E departments; and
- All clinicians to have a basic competence in social paediatrics (ie child protection, looked after children and adoption / fostering issues).

In relation to non-acute consultations, a high proportion of patients attending A & E require care relating to psychological and psychiatric issues. Therefore it is vitally important that a much closer relationship is developed with CAMHS which incorporates an enhanced emergency support service.

The discussion paper offers two possible models of future paediatric care and training that could be summarised as follows:

#### □ **‘Polyclinic’ model**

Services provided by a team of doctors and nurse practitioners, which could handle common problems. This team would collectively have a range of skills appropriate to local need, such as newborn care, diabetes and child protection. The team might include specialist paediatricians, as well as GPs with an interest in child health.

#### □ **Networks and regionalisation**

A regional centre would serve its District General Hospitals and provide a full range of specialties. Paediatricians employed here would be primarily specialists, doing little or no general paediatrics. There would be a combination of academic

and NHS appointments.

No paediatrician (either consultant or NCCG) would work in isolation. There would be horizontal team working (ie with locally based colleagues) and vertical team working (ie with colleagues in other parts of the region, as part of managed networks).

Managed networks would be responsible for ensuring high quality services in the District General Hospitals and local communities, linking with community nurses, GPs and paediatricians.

## **2.8 Acute Care Services in the North West and other English Regions**

There are significant differences in the need for acute care services in England. This section of the report seeks to explore these inequalities between the North West and other English regions. All of the following tabular information has been derived from the Compendium of Clinical Health Indicators (2001), which comprises a record of mortality and morbidity data for the UK population in recent years. Key health indicators from this analysis:

- Hospital Episodes: Serious Accidental Injury Relating to Hospital Admissions (ages 0-4). Age standardised rates per 100,000 of the population.
- Hospital Episodes: Serious Accidental Injury Relating to Hospital Admissions (ages 5-14). Age standardised rates per 100,000 of the population.
- Mortality from Motor Vehicle Accidents, Pooled data: 1998-2000  
Age specific death rates (per 100,000)

### **2.8.1 Hospital Episodes: Serious Accidental Injury Relating to Hospital Admissions, Directly Standardised Rates, ages 0-4, Financial Year 1999/2000**

There are striking differences across England in relation to hospital admissions in the 0-4 age range. The table below indicates that the North West has a much higher rate than the average rate for the whole of England. Only Northern & Yorkshire, Trent and the West Midlands have higher admission rates.

<b>Regional Office</b>	<b>Observed cases</b>	<b>Rate</b>	<b>95% CI Upper Level</b>	<b>95% CI Lower Level</b>
<i>Northern &amp; Yorkshire</i>	446	120	109	131
<i>Trent</i>	332	110	98	121
<i>West Midlands</i>	392	119	107	131
<b><i>North West</i></b>	<b>457</b>	<b>115</b>	<b>104</b>	<b>125</b>
<i>Eastern</i>	300	90	80	100
<i>London</i>	482	96	88	105
<i>South East</i>	465	88	80	96
<i>South West</i>	294	107	94	119
<b><i>England</i></b>	<b>3168</b>	<b>104</b>	<b>101</b>	<b>108</b>

### **2.8.2 Hospital Episodes: Serious Accidental Injury Relating to Hospital Admissions, Directly Standardised Rates, ages 5-14, Financial Year 1999/2000**

The differences between hospital admissions in the 5-14 age range in the North West and the rest of England are remarkable. The table below indicates that the North West has a rate of hospital admission that is statistically significantly greater than all other English Regions, with the exception of West Midlands.

Furthermore, the North West region has a rate of hospital admissions (ie 121 per 100,000) that is far greater than the average for England (ie 96 per 100,000).

<b>Regional Office</b>	<b>Observed cases</b>	<b>Rate</b>	<b>95% CI Upper Level</b>	<b>95% CI Lower Level</b>
<i>Northern &amp; Yorkshire</i>	865	103	97	110
<i>Trent</i>	660	99	92	107
<i>West Midlands</i>	844	118	110	126
<b><i>North West</i></b>	<b>1082</b>	<b>121</b>	<b>114</b>	<b>128</b>
<i>Eastern</i>	521	75	68	81
<i>London</i>	740	82	76	88
<i>South East</i>	851	76	71	81
<i>South West</i>	619	100	93	108
<b><i>England</i></b>	<b>6182</b>	<b>96</b>	<b>94</b>	<b>98</b>

### 2.8.3 Mortality from Motor Vehicle Accidents: Pooled data, 1998-2000 Age specific death rates (per 100,000)

It can be assumed that a significant portion of the high rate of hospital episodes for the North West in the tables above are a consequence of motor vehicle accidents.

The table below illustrates that the North West region has the highest mortality rate from motor vehicle accidents, in comparison with all other English regions, for the 5-14 age range.

<b>Regional Offices</b>	<b>Age 1+</b>	<b>Age 1-4</b>	<b>Age 5-14</b>
<i>Northern &amp; Yorkshire</i>	5.9	1.5	2.3
<i>Trent</i>	7.5	1.5	2.3
<i>West Midlands</i>	6.0	1.1	2.3
<b><i>North West</i></b>	<b>5.5</b>	<b>1.1</b>	<b>2.6</b>
<i>Eastern</i>	6.4	0.7	1.6
<i>London</i>	4.1	0.8	1.1
<i>South East</i>	6.1	0.8	1.9
<i>South West</i>	5.6	0.9	1.6
<b><i>England</i></b>	<b>5.9</b>	<b>1.1</b>	<b>2.0</b>

## 2.9 Examples of Innovative Practice in Developing Acute Care Services for Children in the North West

### 2.9.1 Partnership in Nursing Care (PINC): Blackburn Royal Infirmary

Partnership in care reflects the ability to develop relationships with patients and their families, so that a collaborative approach to health care can be developed. It can only succeed if it is underpinned by constructive and effective communication.

The Blackburn model has shifted the balance of power away from the children's nurse to all involved parties. Consequently PINC in Blackburn is not an add-on aspect of nursing, but instead lies at the heart of the care given to children and their families in Blackburn. A measureable outcome that has resulted since the introduction of new documentation has been a clear reduction in the number of written complaints to the paediatric unit. This is a reflection of improved communication and more clearly defined caring roles.

Following discussion with the child, family, carers and nurse in relation to the presenting symptoms, a written management plan of care is identified and agreed. Furthermore, the care that has been discussed and the negotiation involved in producing the management plan of care is recorded. A joint medical and nursing history is taken prior to the assessment of the child's condition; this has been developed in partnership between the medical and nursing staff and has served to reduce the duplication of questions that parents and children are asked upon admission to the unit. The assessment aims to identify presenting symptoms, as well as assess the child's condition. It enables the nurse to produce a plan of care in partnership with the child and family / carers according to three areas of assessment: physical; assessment and psychosocial / transcultural.

Within each area of assessment, there is a prompt list of areas of nursing care which the nurse may choose to explore, and reflects what the child / parent / carer regard as the main problems or needs, and is the major trigger for developing the management plan. The management plan aims to treat and alleviate the child's symptoms. A plan of action is identified according to the points identified by the child / parent / carer. Thus it is the perspective of how the child's illness is viewed in the context of the hospital environment that is helpful in producing a successful outcome for the child / family / carer / nurse. Where the intended outcome is not met, then the plan of action is revised in consultation with all concerned in the care planning process.

Perhaps the most important contribution to the paediatric clinical development team, which meets on a monthly basis, is made by the parent representatives. Their contribution to the development of the documentation has been invaluable. They regularly visit the children's unit to obtain comments from children / parents / carers, and their suggestions are acted upon. They also report to the paediatric respiratory nurse specialist / out-patient co-ordinator on a regular basis, regularly attend clinical development and quality meetings with managers and staff of the directorate, and feed back the views of children / parents / carers to the nursing team.

Clinical audit is used to evaluate the documentation, and the parent representatives are strongly involved in this data collection.

### **2.9.2 Observation and Assessment Unit for Children: Burnley General Hospital**

This unit has four beds, with a waiting room and three cubicles. Having opened in January 2000, the unit provides a child centred environment that is both safe and secure, and offers play facilities. It is staffed by three permanent, dedicated senior staff and one junior staff nurse on rotation from the children's ward, which results in their being two nurses on duty at all times.

Patients are accepted from GPs, A&E departments, the hospital at home nursing team and via self referrals from children themselves, who have open access to the unit. Children are assessed on arrival using the Manchester triage system. Facilities enable children to be observed for upto six hours, so that any necessary investigations can be performed. The unit aims to provide families with written information upon the child's discharge, and the hospital at home nursing team has a role to play in this aspect of service provision. Discussions take place with carers, nursing staff, doctor and child regarding the most appropriate way to proceed, and consequently decisions are made as to whether or not to admit the child. Subsequently a letter is sent by fax to the family GP upon the child's discharge.

The unit has established fast-track access to x ray and pharmacy departments, as well as the pathology service, from before the unit opened in 2000.

An audited assessment indicates a 26% reduction in the rate of admission. Furthermore, the unit has an extremely low admission rate of 3-4 %. Level of parental satisfaction is measured through annual audits, and these have indicated extremely positive feedback combined with very high levels of satisfaction. The unit is committed to team working and regular monitoring of the service.

### **2.9.3 The Department of Paediatrics and Child Health: Royal Bolton Hospital**

The Department's ethos is built upon the belief that it can offer the best quality of service to children and their families by working as closely together as possible. Acute, Community and Child Mental Health Services are provided from two trusts: Community Services from the PCT, and the other children's services from the acute trust.

In order to discuss and plan service delivery in a combined way, all the consultants meet together regularly. The benefits of this integration can be seen in the

provision of multidisciplinary services where two or more elements work closely together. For example, the Department has developed a Bowel Management Clinic, so that paediatricians, clinical psychologists, and community paediatric nursing teams all work together to help manage children with the most intractable soiling, constipation and emotional difficulties.

In the sphere of Eating Disorders, the Department has developed a team of professionals, including a child and adolescent psychiatrist, paediatrician, child mental health case manager, dietician, and a children's nurse, who work together to deliver a specialist service in this field. There is also close liaison between the community paediatric teams and child mental health teams in the areas of attention deficit hyperactivity disorder and in autistic spectrum disorders.

The department is currently exploring ways in which the training of junior staff in acute and community paediatrics can be usefully combined with elements of child mental health service training.

The department is still exploring ways in which it can improve delivery of services and training staff in ways that will best help children and their families. This is an ongoing process, and the department has a firm belief that developing close working relationships between all elements of services for children is the best way of making significant progress.

#### **2.9.4 Children's Community Nursing: Booth Hall Children's Hospital, Manchester**

Clinic located at Brunswick Health Centre, Chorlton-on-Medlock

The children's community nursing team have been looking after chronic and acutely ill children in the home and community setting since the team was established in 1984. However, in 1998 the team was given additional funding in order to extend the hours of service and to enable more acute care, so as to prevent unnecessary admission. The service is available from 8.30 am to 10 pm on every day of the week.

The aim of the extended service was to identify children attending the A&E department at Booth Hall Children's Hospital due to an acute illness. Traditionally many of these children would have been admitted to hospital either for continued observation, or due to parental anxiety and lack of home support, or may have returned repeatedly to the A&E department.

The illnesses identified as being the most common were: acute asthma, bronchiolitis, febrile convulsions, pyrexial/viral illness, gastroenteritis, herpes, stomatitis and constipation. Using agreed criteria and following a joint assessment with the children's community nurse (CCN) based in the A&E, the child can be discharged home to the care of the parents, supported closely by the CCN team, subject to the parent's agreement. If necessary, the child can be reviewed at home within 2 hours of discharge from the department, and will then be reviewed and supported in the home on a regular basis until recovery takes place. Should the child's condition deteriorate, the child is returned to A&E for admission. The service is available to all Manchester children.

Five members of the CCN team work on a rota basis within the A&E department between 2pm and 8pm six days per week. These times were chosen as the most appropriate times following discussions with hospital and community staff. Although the CCN staff are supernumary to the A&E staff, they work collaboratively with them.

The care is carried out to agreed protocols. The service has been shown to be extremely successful and of enormous value to both hospital and community services. A satisfaction audit has indicated positive results.

### 3 Child and Adolescent Mental Health Services (CAMHS)

#### 3.1 Variations between the North West and other English Regions

There are highly marked differences between mental health indicators in the North West compared to the rest of the UK. This section seeks to explore these geographical inequalities through analysing information from the Compendium of Clinical Health Indicators. Key mental health indicators from this analysis:

- Suicide
- Neuroses
- Schizophrenia.

Although the tabular information provided here does not directly reflect child and adolescent mental health outcomes, it is important to recognise differential mental health outcomes between the North West compared with other English Regions. We can then explicitly focus upon child and adolescent mental health services.

##### 3.1.1 Mortality from Suicide: Directly Standardised Rates, 1998-2000 Pooled Data, Age Standardised Mortality Rates per 100,000

The table below shows that the North West has a statistically significantly higher rate of suicide mortality than all of the other English Regions, apart from South West and Northern & Yorkshire. It is also appreciably higher than the average rate for the whole of England.

<b>Regional Offices</b>	<b>Number of Observed Cases</b>	<b>Directly Standardised Rate</b>	<b>95% CI Lower Level</b>	<b>95% CI Upper Level</b>
<i>Northern &amp; Yorkshire</i>	1338	6.8	6.4	7.2
<i>Trent</i>	1072	6.7	6.3	7.1
<i>West Midlands</i>	1085	6.6	6.2	7.0
<b><i>North West</i></b>	<b>1538</b>	<b>7.6</b>	<b>7.2</b>	<b>7.9</b>
<i>Eastern</i>	964	5.6	5.2	6.0
<i>London</i>	1296	5.7	5.3	6.0
<i>South East</i>	1769	6.4	6.1	6.7
<i>South West</i>	1105	7.2	6.7	7.6
<b><i>England</i></b>	<b>10,167</b>	<b>6.5</b>	<b>6.4</b>	<b>6.6</b>

### 3.1.2 Hospital Episodes: Neuroses

#### Directly Standardised Rates, Ages 15-74, Financial Year 1999/2000

The table below illustrates that the North West has a statistically significantly higher rate of hospital episodes for neuroses than all other English Regions, with the exception of Trent and South West.

<b>Regional Offices</b>	<b>Number of Observed Cases</b>	<b>Directly Standardised Rate</b>	<b>95% CI Lower Level</b>	<b>95% CI Upper Level</b>
<i>Northern &amp; Yorkshire</i>	2125	45.3	43.4	47.2
<i>Trent</i>	1866	48.8	46.6	51.1
<i>West Midlands</i>	1453	36.9	35.0	38.8
<b><i>North West</i></b>	<b>2412</b>	<b>49.3</b>	<b>47.4</b>	<b>51.3</b>
<i>Eastern</i>	1192	29.4	27.7	31.1
<i>London</i>	1070	19.4	18.2	20.6
<i>South East</i>	1714	26.6	25.3	27.9
<i>South West</i>	1870	52.3	49.9	54.6
<b><i>England</i></b>	<b>13,702</b>	<b>37.0</b>	<b>36.4</b>	<b>37.7</b>

### 3.1.3 Hospital Episodes: Schizophrenia

#### Directly Standardised Rates, Financial Year 1999/2000

#### Age Standardised Rates per 100,000

The table below indicates statistically significantly higher rates of hospital episodes for schizophrenia than other English Regions, apart from London.

<b>Regional Offices</b>	<b>Number of Observed Cases</b>	<b>Directly Standardised Rate</b>	<b>95% CI Lower Level</b>	<b>95% CI Upper Level</b>
<i>Northern &amp; Yorkshire</i>	3390	73.0	70.5	75.5
<i>Trent</i>	2902	76.2	73.4	79.0
<i>West Midlands</i>	2332	59.6	57.1	62.0
<b><i>North West</i></b>	<b>4656</b>	<b>95.8</b>	<b>93.0</b>	<b>98.6</b>
<i>Eastern</i>	1879	46.7	44.5	48.8
<i>London</i>	6049	105.1	102.4	107.8
<i>South East</i>	3865	60.0	58.1	61.9
<i>South West</i>	2816	79.9	76.9	82.9
<b><i>England</i></b>	<b>27889</b>	<b>75.3</b>	<b>74.4</b>	<b>76.2</b>

## **3.2 Psychiatric Morbidity in Children and Young People**

In recent years there has been much greater acknowledgement of the distress that mental health problems can cause for children and young people and their families. Such distress can have wide-ranging implications. Some studies have suggested that roughly a fifth of all children and adolescents suffer from a variety of mental health problems<sup>32</sup>. However, the realisation that child and adolescent mental health problems are a significant issue in their own right is a very recent phenomenon. This is partially due to a greater understanding of the emotional and psychological development of children. It is also due to a stronger awareness of the longer term impacts of emotional and behavioural disturbance of children and young people. There are clearly identified relationships between such mental health problems and particular behavioural issues, such as alcohol abuse, drug misuse, self-harm and eating disorders.

### **3.2.1 Impact of Psychiatric Morbidity**

Although mental health problems can impact adversely upon all children, there is a significant socio-economic gradient in psychiatric morbidity. Children living in disadvantaged, inner city environments are more likely to suffer mental health problems than other children from more affluent backgrounds<sup>33</sup>. Other factors can also enhance the likelihood of mental health disorder: being in the care of a local authority<sup>34</sup>, or having a parent with mental health difficulties<sup>35</sup>, are examples of these.

Many young people who fall foul of the criminal justice system also have high levels of physical and psychiatric morbidity, which may include learning difficulties, epilepsy and alcohol abuse. Behavioural problems amongst schoolchildren can often lead to poor educational attainment, low self-esteem and

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<sup>32</sup> NHS Health Advisory Service, 'Together we stand: The commissioning, role and management of child and adolescent mental health services', HMSO, (1995)

<sup>33</sup> Rutter, M et al 'Attainment and adjustment in two geographical areas – 1: The Prevalence of psychiatric disorder', *British Journal of Psychiatry*, Vol. 126, 1975, pp. 493-509

<sup>34</sup> McCann, J et al, 'Prevalence of psychiatric disorders in young people in the care system', *British Medical Journal*, Vol. 313, 1996

<sup>35</sup> Rutter, M & Quinton, D 'Parental psychiatric disorder: Effects on children', *Psychological Medicine*, Vol. 14, 1984, pp. 853-880

ultimately expulsion from school. This can in turn affect employment opportunities in later life, which can enhance the likelihood of further psychological problems. A failure in adolescence to create long term relationships can significantly impair the ability to act as a competent parent, which may well enhance the risk of socio-psychological morbidity in the next generation. A lack of resolve in providing an adequate child and adolescent mental health service (CAMHS) can, therefore, lead to lifelong mental illness in adulthood.

The Mental Health Foundation<sup>36</sup> (MHF) have also highlighted the relationship between socio-economic disadvantage and wide-ranging societal changes with the likelihood of suffering mental health problems. Changes in the labour market, for example, has led to economic marginalisation of a proportion of young men through the decline in unskilled or semi-skilled work. The absence of social contacts through work, and an allied sense of belonging, can have an extremely damaging impact upon young men's sense of self esteem. Similarly the changing role of 'communities' in recent years has led to a decline in support networks provided through extended families, resulting in poorer, disadvantaged households. Many families (particularly lone parents) struggle to cope with a lack of play space through living in cramped accommodation, leading to stress-related mental health problems without effective family support systems. Furthermore, income inequalities can themselves have a highly damaging impact upon the ability of parents to provide effective parenting to their children, especially those most at risk of poverty, such as lone parents and families with disabled children.

Child and adolescent mental health services (CAMHS) are provided by a combination of the NHS, local authorities (especially social services), voluntary organisations and the independent sector. They range from primary care to more highly specialist services. Presently there is a 4 tier model developed by the Department of Health<sup>37</sup> to reflect the severity of psychiatric morbidity and the NHS response (see following page).

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<sup>36</sup> Kay, H 'Bright Futures: Promoting Children and Young People's Mental Health', Mental Health Foundation, 1999

<sup>37</sup> Department of Health and Department for Education, A Handbook on Child and Adolescent Mental Health, HMSO, 1995

### 3.2.2 Department of Health: 4 Tier Model of Psychiatric Morbidity

<p>□ <b>Tier 1</b></p>	<p>This is a primary care level service.</p> <p>It suggests intervention by GPs, health visitors, youth workers, school nurses and teachers to:</p> <ul style="list-style-type: none"> <li>▪ Identify mental health problems, and</li> <li>▪ Offer general advice</li> </ul>
<p>□ <b>Tier 2</b></p>	<p>This reflects services provided by professionals working on their own, who can relate to others through a network rather than a team. The range of professionals providing services include clinical child psychologists, paediatricians, community child psychiatric nurses or nurse specialists and child psychiatrists.</p> <p>CAMHS provides:</p> <ul style="list-style-type: none"> <li>▪ Training and consultation to other professionals</li> <li>▪ Consultations for professionals and families</li> <li>▪ Outreach work to identify severe or complex needs</li> <li>▪ Assessments that can trigger treatments in Tier 2 or another Tier.</li> </ul>
<p>□ <b>Tier 3</b></p>	<p>This is a specialist service for more severe, complex and persistent disorders. It is provided by a different range of professionals from Tier 2 which include social workers, clinical psychologists, community psychiatric nurses, child and adolescent psychiatrists, art, music and drama therapists, child psychotherapists and occupational therapists.</p> <p>It is a multidisciplinary service that can operate in a community child mental health clinic, or as part of a child psychiatry outpatient service.</p> <p>It contributes to consultants for Tier 1 and Tier 2. It provides:</p> <ul style="list-style-type: none"> <li>▪ Assessment for disorders</li> <li>▪ Assessment for referrals to Tier 4</li> </ul>
<p>□ <b>Tier 4</b></p>	<p>This service is used infrequently, but offers essential tertiary services, including day units, specialised outpatient teams, inpatient teams for children and adolescents suffering severe mental illness, or else at risk of suicide.</p>

### 3.3 Recent policy initiatives for developing CAMHS

Recent years have seen an explosion of interest in developing CAMHS. The handbook on CAMHS wholly supported the concept of a more multidisciplinary, multi-agency approach. The NHS Advisory Service report '*Together We Stand*'<sup>38</sup> produced an important guide to the process of commissioning and delivering services. Moreover the setting up of an interdepartmental Social Exclusion Unit (SEU) emphasized the value of early involvement with children at risk of being excluded from school and youth crime. The consultation paper '*Supporting Families*'<sup>39</sup> suggested proposals for improving support to parents and families, which included the creation of a new family and parenting institute, a new national parenting helpline and an enhanced role for health visitors.

Greater awareness and support for CAMHS was evidenced by the Mental Illness Specific Grant (1999), which included, for the first time, a dedicated component for child mental health<sup>40</sup>. Furthermore, the Department of Health provided extra funding for CAMHS (initially for three years) with guidance as to how these funds ought to be used. In 2000 the Department of Health provided guidance<sup>41</sup> to both social services and health services for the first time, in order to enhance the valuable process of interagency working.

#### 3.3.1 The Audit Commission

The Audit Commission highlighted wide variations in the services that children and young people receive from the NHS<sup>42</sup>. It pointed out that the amount spent by former health authorities or specialist CAMHS per head of child population varied by a factor of 7. Other significant variations existed in relation to resources, so that Trusts varied substantially in the level and mix of staff that could be deployed.

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<sup>38</sup> cited earlier

<sup>39</sup> Department of Health, Supporting Families Consultation Paper (1998)

<sup>40</sup> Department of Health, Health Service Circular and Local Authority Circular, NHS Modernisation Fund and Mental Health Grant for Child and Adolescent Mental Health Services 1999/2002, HSC 1999/126: LAC (99) 22, May 1999

<sup>41</sup> Department of Health, 'Modernising Health and Social Service: National Priorities Guidance 1999/00 to 2001/02'

<sup>42</sup> Audit Commission, 'Children in Mind, Child and Adolescent Mental Health Services', (1999)

Furthermore, the Audit Commission suggested that CAMHS professionals in NHS Trusts spend a greater proportion of their time providing consultation and advice to assist staff in other services to manage children with less severe problems, and also to refer appropriately to specialist services. High variations in waiting times existed between different NHS Trusts, and also within individual CAMHS. The absence of national standards was seen as highly detrimental to the well-being of children and adolescents with mental health problems.

The auditing exercise also revealed that only half of all of the former health authorities had put in place agreed arrangements for emergency and 24 hour cover. In addition, 'did not attend' rates were a clearly identified problem, with high rates occurring due to clinics being inappropriately located, services not being offered within a parental home, school or GP surgery or voluntary organisation setting, or else as a consequence of the clinical setting not being regarded as user friendly.

The Audit Commission's recommendations were wide-ranging. It called upon former health authorities and Trusts to review resources, which would involve them establishing separate budgets for each CAMHS, so that demand for services could be considered when taking into account the level and type of resources required. It argued that Trusts should review staffing arrangements, paying particular attention to how they support staff, as well as matching the skills of employed staff with the local problems to be confronted by them. Enhancing the relationships between Tier 1 staff and CAMHS would mean reviewing administrative set-ups, so that specialist professionals could have time to offer such support. The process of gaining access to CAMHS should be improved, and Commissioners of services ought to set maximum waiting times and also review emergency cover with Trusts in order to ensure that local arrangements are met.

More generally, the Audit Commission emphasized the importance of the commissioning function in enhancing CAMHS, and for health authorities to work with partner agencies in assessing needs, reviewing services, planning priority setting to meet unmet needs and setting up effective monitoring systems. It called for agencies to map groups of children and those local areas where needs are greatest, and from where most referrals are made. In addition to consulting with users and carers, it called upon health authorities to take stock of current services, and develop information systems which can support clinical work and enable audit / service evaluation to be linked with agreed outcomes.

The Commission also recognised the value of a strong research evidence base, and concluded that the Cochrane data bases could act as an extremely important reference resource in updating CAMHS professionals on contemporary findings.

### **3.4 *Mental Health Foundation: Recommendations for CAMHS***

The *Mental Health Foundation* (MHF) have made numerous recommendations in connection with early interventions to support CAMHS. These range from pre- and post-birth support to parents (whereby the Department of Health develops earlier pre-birth support to parents that covers emotional and relationship issues) to comprehensive parenting programmes (which should engage more strongly with fathers, so that their confidence and self-esteem can be increased).

Mainstream schools are seen as having an important role to play. MHF called for all teachers in mainstream schools to have continuing training on child development issues, combined with an understanding of the sources of mental health difficulties. Furthermore, educational psychologists should offer advice to schools on interventions, programme planning and direct therapeutic interventions. Recent research<sup>43</sup> has provided strong support for early intervention work in schools. Kolvin et al<sup>44</sup> concluded that school-based interventions can offer significant potential for helping children, and that the majority of children reached through such programmes would not otherwise have obtained such support. A later section of this report considers the impact of healthy schools programmes. The following summarises the key elements of MHF's recommendations:

- **Primary Health Care**

Social services and primary health care can play an important preventative role in the early years. Family centres provide a supportive environment for families under pressure through the provision of toy libraries, coffee mornings and other drop-in facilities. MHF recommended further development and evaluation of models of preventive practice by mainstream social work provision for families whose children are at risk of developing mental health problems.

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<sup>43</sup> Durlak, J A 'School-based prevention Programmes for Children and Adoloscents', Sage, Thomas and Oaks (1995)

<sup>44</sup> Kolvin et al 'Help Starts Here: The maladjusted child in the ordinary school'. Tavistock Publications, London (1981, cited in 'Bright Futures', see above)

MHF also called for GPs to be more proactive in early assessment and intervention for children with mental health problems. This would necessitate additional training for GPs in everyday child mental health, developing better partnerships between GPs and specialist mental health services and long-term funding and support for community-based services working collaboratively with GPs.

- **Current Service Provision**

MHF argued that CAMHS is largely unplanned and historically determined, as well as being vulnerable to financial and political factors. It made key recommendations in this regard, such as a statutory duty for health authorities and local authorities (ie social services and education departments) to co-operate in promoting children's mental health. MHF emphasised the lack of specialist services, and highlighted that where services are available, they are often located far from the family home.

- **Joint Commissioning**

The interractional process of cooperation, collaboration and integration of services across agencies is an extremely important area of service development for children and young people. It includes joint commissioning across agencies, the ownership and sharing of both strategy and an agenda for action, collaboration at all levels of service management and close working relationships between practitioners from a wide variety of disciplines. The MHF called for models of good practice in co-ordination between various agencies to be developed, evaluated and effectively disseminated.

### **3.5 What works in supporting children and young people with mental health problems ?**

One of the commonly identified problems facing the development of CAMHS is the lack of knowledge concerning what actions are effective in supporting children and young people with mental health problems. However, in recent years, some findings have begun to emerge<sup>45</sup>. Most of the research relates to treatments for defined psychiatric conditions in children, rather than problems presented at school or in a clinic.

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<sup>45</sup> Kurtz, Z 'Treating Children Well', Mental Health Foundation (1996)

Similarly there is greater knowledge about treating single conditions than those linked to other conditions, or else conditions that do not involve complex educational and social problems. A great deal more is known about the effectiveness of treatments involving younger children than those concerning adolescents. The impact of shorter term treatment is better known than that for longer term treatment.

### 3.5.1 *Action for Sick Children*: Effective treatment approaches

*Action for Sick Children*<sup>46</sup> highlighted the importance of developing effective management systems upon an accurate assessment, diagnosis and investigation of mental health problems in children and families.

The table below offers a summary of treatment approaches based upon some of the scientific evidence available.

<b>Condition</b>	<b>Treatment Approaches</b>
<ul style="list-style-type: none"> <li>□ <b>Psychotic disorders</b></li> </ul>	<ul style="list-style-type: none"> <li>▪ Schizophrenia responds to medication and appropriate psychiatric care. Composite home-base intervention programmes have been shown to be effective in relation to autism and other similar disorders. In later years, this approach can be reinforced and supplemented by educational programmes through the school.</li> <li>▪ Home-based programmes ought to consist of behavioural approaches to different aspects of disability, language, social handicap and behaviour problems. Furthermore, the family should also receive treatment which acknowledges the home environment.</li> </ul>
<ul style="list-style-type: none"> <li>□ <b>Attention Deficit Disorder (ADD)</b></li> </ul>	<ul style="list-style-type: none"> <li>• Both behaviour modification, as well as treatment with cerebral stimulants, have been found to be effective. The composite approach is extremely important, in that it allows flexible use of different treatments in addition to support for the family.</li> </ul>

<sup>46</sup> Kurtz, Z 'With Health in Mind, Mental Health Care for Children and Young People' Action for Sick Children in Association with South West Thames RHA (1992)

<b>Condition</b>	<b>Treatment Approaches</b>
<ul style="list-style-type: none"> <li>□ <b>Anorexia Nervosa</b></li> </ul>	<ul style="list-style-type: none"> <li>▪ A family therapy can have a beneficial impact, and the same applies to a composite in-patient programme that needs to be intensive and undertaken early in the course of the disorder. Adequate support staff must be provided, so that young people with this condition are not left in limbo for a long period before help and treatment become available.</li> </ul>
<ul style="list-style-type: none"> <li>□ <b>Physical Child Abuse</b></li> </ul>	<ul style="list-style-type: none"> <li>▪ This has been shown to respond to family approaches, as well as attempts to improve the quality of family interaction, thereby reducing the likelihood of re-abuse.</li> </ul>
<ul style="list-style-type: none"> <li>□ <b>Depressive Disorder</b></li> </ul>	<ul style="list-style-type: none"> <li>▪ Making use of psychodynamic theories involves measuring thoughts and feelings. However, there is some evidence that tailored programmes of psychodynamic therapy are as effective as other therapies, and in many situations preferable.</li> </ul>
<ul style="list-style-type: none"> <li>□ <b>Neurotic and Conduct Disorders</b></li> </ul>	<ul style="list-style-type: none"> <li>▪ The milder type of disorder responds to the group therapy approach for both younger and older children, as well as behavioural approaches. Conduct disorders respond well to residential educational approaches in older children and younger people. To support younger children, family intervention approaches have also been shown to be extremely helpful, and these should be provided by a properly staffed child psychiatry service.</li> <li>▪ Ongoing research is, over time, producing more effective management techniques for a range of mental health problems. Obsessional disorder, for example, responds well to behavioural approaches. The same is true for sleep disorders in young children, as well as enuresis.</li> <li>▪ Family therapy can also make a contribution to disorders that have a psychosomatic component, such as recurrent abdominal pain.</li> </ul>

### **3.5.2 HEA Review and Children's Mental Health: Key Findings**

The Health Education Authority (HEA) recently commissioned a review of health promotion interventions from 1980 to 1995 that were intended to tackle various mental health problems. The review's aim was to identify the kinds of interventions that had been effective in preventing some mental disorders, as well as promoting positive mental wellbeing. All aspects of mental health promotion practice were considered. Evaluation studies of programmes which took account of outcomes, such as improved self-esteem, were also considered. It should be noted that studies undertaken in the United States comprise almost 75% of all studies reviewed. The review makes separate recommendations for both children and young people.

- The review suggests that interventions already undertaken within school health education programmes to promote self-concept, self-esteem and coping skills are reasonably effective.
- General skill-based interventions, and others which focus upon specific life events, have succeeded in developing coping skills.
- Interventions in US schools for children whose parents are in the process of divorcing have been effective, although they may not be successful within a British context.
- The importance of assessing the needs of educationally disadvantaged children during the early years of education is well established. Nonetheless, the most effective means of doing this depends upon the way pre-school and early years education is structured and carried out.

### **3.5.3 HEA Review and Children's Mental Health: Recommendations**

The reviewers highlight the need for more evaluation of ongoing practice within the UK. They recognise that as most of the studies took place in the United States, this may not translate directly into a British context, although they do offer some useful pointers:

- All children should have access to a health education curriculum that incorporates work relating to mental health.

- Structured classroom activity programmes in the United States could be piloted and evaluated in the UK, in order to draw comparisons with existing practice.
- An approach based upon specific life events might raise anxiety amongst children.
- It is preferable to concentrate upon general life skills work within classroom settings.
- Children with needs arising from specific life events should be helped through the co-ordinated activities of education, health and social care professionals, involving parents where appropriate.
- Existing good practice in identifying children with particular needs in early years education should be continued. Furthermore, disadvantaged children would benefit particularly from access to quality nursery education.
- There should be more community based interventions for families who have been bereaved.

#### **3.5.4 HEA Review and Young People's Mental Health: Key Findings**

- Health education programmes aimed at developing self-concept should be thoroughly implemented with appropriate staffing and education methods if they are to succeed.
- The 'Outward Bound' programme provides a good basis for examining the advantages of participating in outdoor pursuits as a means of developing self-concept.
- Developing coping skills in readiness for stressful situations within the school curriculum is an effective approach.
- Children who have particular difficulties, such as those who have been recently bereaved, may benefit from tailored interventions.
- Separate self-concept activities may be effective with minority groups.
- General health promotion activities, such as safe exercise in pregnancy with teenage parents, can have a positive impact on mental health.

### **3.5.5 HEA Review and Young People's Mental Health: Recommendations**

- The needs of young people in terms of developing self-concept and self-esteem should be met through the whole school curriculum, as well as specialist activities in personal, social and health education.
- The mental health needs of young people experiencing major life events, which cannot be addressed during whole-class interventions, should be identified and met. Tailored interventions should be developed if necessary. Youth clubs should be considered as a suitable setting for tailored activities.
- Education in general should be concerned with developing the self-esteem of all children in a multi-racial society.

### **3.6 CAMHS in the North West: An Overview**

Research into the development of CAMHS in the North West<sup>47</sup> has revealed wide differences in the planning and development by the former 15 North West health authorities. Estimated spending rates varied by almost five fold between individual health authorities, and large differences existed in organisational models for supporting service delivery.

Some local education and social services were poorly developed in certain areas, yet in other parts of the North West they formed an integral part of multidisciplinary service teams. Parts of the North West were found to benefit from explicit academic support, which helped to maintain a focus on CAMHS service developments. However, in other areas CAMHS were widely dispersed and consequently were highly dependent upon a few key personnel. This points towards potential professional and organisational isolation, especially given the multi-agency needs of children and young people requiring services.

Service units were often located in secondary health care settings, which meant that many local communities had little or no access to day or inpatient facilities. The absence of a clearly defined model of service by purchasers was highlighted by the fact that local provision was often very narrowly drawn. This could only be addressed by more developed strategic commissioning by health authorities, which

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<sup>47</sup> NHS Executive North West, Child and adolescent mental health: A review of services in the North West (1996)

could then be taken forward by partner agencies. This would facilitate much more coherent CAMHS planning.

The North West study made recommendations for health authorities. They should be more reflective of local need, and should engage more with partner agencies (including primary care services and specialist providers). Moreover, CAMHS should be clearly costed with distinct service outputs. The Regional Office was urged to identify and promote positive CAMHS provision that is clearly co-ordinated, draws on positive practice (both within and beyond the Region) and helps to disseminate positive practice throughout the Region.

Most significantly, health authorities were called upon to identify the extent of local unmet need and redress funding deficits in CAMHS, through taking account of the local investment shortfall, the alignment of CAMHS spend with that of adult mental health services, as well as the potential shared funding of service development with partner agencies.

Further recommendations for the Regional Office included building on survey evidence of local commitments to develop CAMHS provision and ensure service availability to:

- Address a variety of local needs;
- Build on multi-agency interest and investment;
- Provide a variety of CAMHS care;
- Have clear links to primary care that are informed by research findings and current understandings of good practice; and
- Establish an appropriate system of periodic review of local service development plans that develop performance management frameworks. It suggested that this could be undertaken with Social Services Inspectorates and result in Region-wide stocktakes of services.

Recently the NHS Executive North West Regional Office commissioned an assessment of the key issues regarding the future development of education and

training for CAMHS. The need for a scoping exercise had been highlighted<sup>48</sup> as an important planning issue as a consequence of a review of progress made in the North West in implementing CAMHS initiatives and to discuss future activities. The preliminary assessment's key finding was that, despite significant developments being underway, there remained a pressing need in the North West for greater consistency in the commissioning process, so that quality and value for money could be assured. Better co-ordination of education and training would also help to avoid repetition, as well as facilitate more cross-boundary working.

However, the scoping exercise advised against a region-wide approach, as it concluded that significant progress was being made locally. It highlighted 10 short and medium term goals which could form the nucleus for a concerted inter-agency operation to improve CAMHS in the North West:

1. Local partner agencies need to make realistic workforce projections closely linked to their joint strategies, and keep these updated.
2. Monitoring should include an inventory of staff shortages and a record of attempts to fill vacancies.
3. Where incomplete, comprehensive training needs analyses should be undertaken.
4. A region wide exercise must be undertaken to map existing provisions which describes and analyses the sizes, locations, objectives, structures and costs of existing provisions.
5. Training outcomes are of particular importance. Special consideration needs to be given as to the quality of existing training. An audit of training programmes might be required to establish this, with a special emphasis on access eg Accredited Prior Learning (APL), Accredited Prior Experiential Learning (APEL), and Accredited Work Base Learning (AWBL).
6. Some form of benchmarking exercise might be a way of sharing information on good training practice and setting targets among service providers and perhaps

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<sup>48</sup> CAMHS Training and Education Scoping Exercise, A project commissioned by the NHSE North West Regional Office and the Social Care Group in the North of England Region (February – May 2000)

educational institutions (although the Department of Education subject reviews offer other ways of determining course quality).

7. Skill gaps need to be identified with education and training provisions, and costed to see if additional spending is required.
8. A directory of education and training programmes for child and adolescent mental health work should be created, maintained and made easily available.
9. Future collaborative commissioning should be guided by a set of core competencies linked to the emerging occupational standards frameworks.
10. Users and carers should be involved in planning, providing and evaluating education and training.

### **3.7 Examples of Innovative Practice in the North West to Support Child and Adolescent Mental Health Services**

#### **3.7.1 Joint Agency Management Board (JAMB), St Helens PCT**

CAMHS within St Helens have been subject to a number of reviews since 1994. The NHS Executive North West Review of all District CAMHS services placed St Helens and Knowsley 13<sup>th</sup> out of 15 District CAMHS services in terms of level of resourcing. Subsequently Young Minds were commissioned to review services and assist with policy formulation and development, and they focused upon the balance of provision between the four Tiers, available services for adolescents, out of hours services and support to education services.

The creation of a JAMB was a key recommendation of the Young Minds review. It provides essential coordination, and is the key driver in terms of integrated policy development and service progression across St Helens. Furthermore, it discharges a duality of functions, capturing commissioning, purchasing and provision. Representatives to its Board include St Helens Social Services, St Helens Education, St Helens PCT, 5 Boroughs Partnership NHS Trust, Connexions, Youth Justice Board and Voluntary Children's Services. The JAMB is a sub-group of the multi-agency Children's HIMP, which is the main planning forum within St Helens. JAMB's representatives are senior officers with authority to deploy resources on behalf of agencies represented, and there is widespread recognition that the JAMB is a dynamic entity with an over-arching strategy to determine vision and direction.

The JAMB manages the Community Homes Health Team (CHHT), which carries responsibility for identifying the health needs of the client group, creating a system to cater for their needs and providing comprehensive detailed assessments for every client. CHHT also runs an on-call system, sets up and delivers an ongoing programme of joint training and professional development, establishes a baseline for health intervention and uses its knowledge and expertise to establish and continue evidence-based research.

CHHT provides a comprehensive CAMHS delivery. The main outcome it seeks is for seamless, holistic care for CAMHS users who have not characteristically accessed the support of health, education and social services, both while they are in residence and also on transfer. A multidisciplinary, multiagency approach to a wide range of very complex difficulties, such as developmental disorders, mental health and learning difficulties, lies at the heart of its approach.

The key elements to the service are:

- **Assessment**

Detailed assessment undertaken by a clinician is followed by a report and, if necessary, referral to other team members. Discussion of the whole assessment process takes place at a multi-agency meeting, with Care and Education staff as appropriate. Recommendations for intervention are set up, with support for the proposed Care Plans;

- **Intervention**

Interventions may take the form of individual or group sessions within any of the clinical disciplines, and may consist of a 'one-off' or a course of therapy over a prescribed time. Timetabling of therapy sessions is negotiated with the education staff on each site, in order to ensure regularity of input from both health and education. Typical courses of intervention can include social skills, life skills, anger management, assertiveness, cognitive behavioural therapy and music / art as means of communication. Summary reports of all courses of intervention are written and distributed;

- **Transfer**

Where a young person transfers to another institution, copies of all reports and recommendations are forwarded to that institution. Where a young person transfers back to his or her home locality, the relevant school / college / health professionals / social services are contacted and given relevant information. Successful reintegration with adequate and appropriate support reduces the risk of some clients not engaging in re-offending behaviour;

- **Training**

Team members have regular opportunities to establish a sound base of understanding and evidence of the service provision through sessions of mutual training within the Team. There are plans to provide joint training across disciplines, agencies and sites, which includes training bought in from outside agencies. Members of the Health Team also provide training for care and/or education staff around health issues on request or on offer; and

- **Research and Development**

The Team has a strong commitment to the pursuit of evidence-based practice. It has set up a baseline upon which to build successive annual evaluations, so that outcome measures can be established. Evaluation is both individual to each discipline, and composite for the whole Team. This R & D aspect is fully supported by the Knowledge Management Services of the 5 Boroughs Partnership Trust, including library and expertise access and the establishment of links with local universities.

### **3.7.2 The Knowledge (Call Centre), Social Services Departments and 5 Boroughs Partnerships NHS Trust**

The integration of mental health services has been a dominant issue in improving CAMHS. The social services departments of Warrington, Halton, St Helens, Knowsley and Wigan, in collaboration with the 5 Boroughs Partnership NHS Trust, have jointly set up the Knowledge (Call) Centre. It reflects the shared aspiration of all the partnership bodies to develop a new way of working that was responsive to the needs of the populations they serve in an integrated and person-centred way.

This involves a commitment to remove all of the traditional organisational barriers that can cause confusion and difficulty of access to children, young people and their families who require these services. All of the five boroughs are moving towards multi-disciplinary organisational teams, and several are in the process of achieving single line accountability within its mental health services. The planning process has enabled senior managers to consider solutions at both a borough specific, as well as at a cross borough level. This model of planning illustrates how partnership working can enable the development of responses to need that can bring economies of both skill and scale, whilst retaining local access and delivery.

The Knowledge (Call) Centre provides appropriate, comprehensive and up-to-date information around specific stakeholders' needs, which can help callers do their job more effectively, or else make better informed choices about the care they receive. It offers the opportunity to:

- Make information more easily available to all;
- Provide better quality information (ie more up-to-date and more relevant, as well as more 'standardised') across the five boroughs;
- Challenge stigma by promoting access to accurate knowledge and information;

- Reduce inequality and exclusion by the use of a ‘free phone’ number;
- Create efficiencies of effort and economy to ensure maximum investment in front line services; and
- Bring together some of the central corporate functions of the organisation and streamline processes to the benefit of its staff, service users and its communities.

Mental health client based information systems exist in all five boroughs, but currently employ a range of different solutions. The Knowledge (Call) Centre aims to bring these disparate systems together to provide a unified source of information.

- **Intranet and Knowledge Management**

The Partnership is also endeavouring to create an intranet / secure extranet system for disseminating information and knowledge to staff throughout the organisation. It will directly support user-focused activity, and administrative / managerial communication. It also aims to provide hyperlinks to many external websites. Access is via a web browser that operates securely within the NHSnet, and details of all services, interventions, facilities and admission criteria have been collected and are currently being updated onto the website.

- **Internet website**

The Partnership is establishing a new website specific to the 5 Boroughs Partnership that is accessible to the public, other organisations and the world. It will enable the local population, service users and carers to find information about the services provided by the Partnership and how to access them. It will also facilitate direct user / community communication with the Partnership and provide links to sources of related information provided on other organisations’ websites.

### **3.7.3 Primary Child Mental Health Team: Ashton, Leigh and Wigan PCT**

The Primary Child Mental Health Team (PCMHT) are a multi-disciplinary team of experienced professionals offering support, consultation, training, liaison and intervention strategies to primary care professionals working with children, both pre-school and primary school aged, in the borough of Wigan. The Team comprises professionals from Education, Social Services and Health, and is supported by all statutory agencies. It offers an integrated, coherent and long-term

approach to child mental health and operates across the borough on a three 'patch' model ie Ashton, Wigan and Leigh. The PCMHT's key concepts are:

- Early Intervention;
- Prevention; and
- Mental Health Promotion.

All of its work is undertaken in relation to the Tier One level of care ie primary care professionals from all agencies, including GPs, social workers, school nurses, primary school teachers and health visitors. The PCMHT offers a joint assessment and joint working strategies, as well as the possibility of short-term intervention appropriate to Tier One. Its strategies are intended to alleviate the need for involvement from specialist services through a preventive model of action.

The PCMHT's referral criteria are:

- Children of pre-school or primary school age (ie 0-11 years);
- Children presenting with problems that are not long-standing or chronic;
- Children whose difficulties are not complex or require formal diagnosis; and
- Children whose difficulties can be both addressed and resolved in no more than six intervention sessions.

Examples of mental health problems include anxiety, low self-esteem, temper tantrums, sleeping problems, feeding difficulties and bullying.

The roles of the PCMHT are, therefore, to provide consultation, support and advice to a variety of primary care professionals, liaise between services at Tier One and Tiers Two and Three, and to facilitate referrals as appropriate. In addition, the PCMHT undertakes a needs analysis of primary care workers so that training needs relating to child mental health issues may be identified. The PCMHT also facilitates training, maps current service provision across all agencies for children and families, undertakes specific time limited interventions and, through early intervention and liaison, prevents the development of more serious mental health problems.

It seeks to offer relevant services, such as an 'advice-consultation line' between 9am-5pm (weekdays) for use by primary care professionals seeking advice, as well as developing up-to-date information leaflets on a wide range of child mental health issues. The PCMHT works alongside professionals in a way that is

appropriate to the needs of children and their families, and is developing a proactive, long-term preventive approach to mental health across all agencies and the voluntary sector. It adopts a flexible approach in relation to appointment times and venues, and offers named contacts for each of its three 'patch' areas (ie Ashton, Leigh and Wigan).

### **3.7.4 ROSTA Project, Liverpool**

The Rosta Project is a jointly commissioned and jointly provided mental health treatment and care programme, comprising a therapeutic fostering service with wraparound support. It is one of 24 Department of Health CAMHS Innovation Fund Projects. It is led by the Royal Liverpool Children's Trust in partnership with Liverpool Social Services and the National Teaching & Advisory Service (NTAS). Locally the Project is funded by Liverpool City Council (Education & Social Services) and North Liverpool PCT. Initially set up in 1999, the Project is centred upon supporting 12-17 year olds with complex social, emotional and behavioural problems that have affected their ability to function in home, care and educational settings.

The Project also provides:

- Multidisciplinary assessments;
- Individual, family and group psychotherapy;
- Systemic consultation;
- A range of day programmes;
- Educational reintegration and support;
- Psychiatric consultation; and
- After-care services.

The Project is also engaged in a long-term research programme with the University of Liverpool.

Since its conception, the Project has admitted young people to therapeutic foster homes, and served other young people in its day treatment provision. The Project has also undertaken a limited amount of case consultation to both social workers and CAMHS clinicians. It has also supported the development of a therapeutic fostering programme on the Wirral, and provided consultation to various local authorities and CAMHS services on the development of similar services.

The Project offers roughly nine foster placements and one respite care placement at any one time. Foster carers are seen as professionals who are part of a therapeutic team working with the child. The Project's philosophy is that problems should be dealt with by increasing the intensity of support and intervention, and not by moving the child. Any change for the child or young person is seen as needing to be in the context of a stable relationship.

- **Placement Stability**

During the period March 2001 – March 2002, there were no unplanned discharges from the Project. Two young people discharged themselves after reaching the age of 16, and were subsequently placed within independent living projects, where they continued to be supported by the Project. In comparison with the broader looked after children population in Liverpool, the Project has had a highly significant impact upon placement stability: in 2000/2001 14.8% of looked after children had three or more placements.

- **Re-integration to less intensive setting**

The Project's focus is more centred upon long-term provision, which reflects both lower ages on admission, as well as the lack of adolescent foster placements in Liverpool.

- **Family Contact**

Approximately 90% of young people in foster placements or after-care provision have at least fortnightly contact with their family.

- **School Attendance**

In April 2002, 78% of young people in therapeutic or supported foster homes or aftercare were in full-time education or training, and 11% in part-time education. This compares with a figure of 11% of the same young people upon admission to the Project. Young people are generally reintegrated into education, and supported through far more suitable provision. Consequently the Project must be perceived as relatively successful in returning young people to full-time education.

- **Agency Involvement**

The Project provides consultation to other mental health and social care providers. Through its Director, it remains involved in the North West Taskforce for Children and its CAMHS sub-group. The Project has also played an active role in advising CAMHS services in Liverpool on providing services for children with complex mental health problems.

- **Summary**

The ROSTA Project has succeeded in providing an effective service for some of the most challenging young people in Liverpool. The long-term impact of the work remains unknown, but research suggests that the prognosis for young people could be significantly improved. It should be emphasised that the service is cost effective, matching the average cost of children's home provision in England. Over the next few years, the Project is expected to contribute more fully to an understanding of the needs of the young people served.

### **3.7.5 Home and School Support Project (HASSP), Bury and Rochdale**

HASSP is one of 24 Department of Health CAMHS Innovation Fund Projects, initially set up as a three year research project. However, since its completion, it has received additional funding so that its services can continue. HASSP is a multidisciplinary service, which comprises an educational psychologist, nurse therapist, social worker and play worker. Through working in partnership with schools, parents and young people, its remit is to help people at risk of social and educational exclusion. Referrals to HASSP were initially triggered by children's exclusion from school, and the aim of the Department of Health study was to find out how effective early, multidisciplinary interaction is for young people at risk of developing mental health problems.

The research study, undertaken at the University of Manchester, concluded that multi-agency early intervention with children at risk of exclusion can have positive results. A key finding was that the prognosis for success is most likely where there is a high degree of motivation, on the part of parents and other professionals, to work in partnership with HASSP.

Since the completion of the research study in 2002, HASSP has developed new referral criteria to improve its relationships with key agencies (ie Education,

Health and Social Services), as well as targeting its interventions more appropriately.

Its revised remit is to work with primary school aged children who have been, or are, at risk of being excluded, and who are looked after. It aims to address issues of school and social exclusion, and so prevent the development in children of more serious mental health problems. The project has a clear child mental health focus, and operates from a community base as a bridge between the specialist Tier 2/3 CAMHS (Child and Family Services) and Tier 1 services across health, social services, education and voluntary agencies. Similarly, HASSP has a revised eligibility criteria, which can be summarised as follows:

- Children of primary school age who are at risk of school exclusion and/or who are looked after;
- Where concerns exist about a child's emotional and behavioural disposition, and there is a risk of the child developing more serious mental health difficulties;
- Where front line support services within a single agency have been involved (eg School Health Advisor, Family Advice and Support Team) and have found it difficult to effect change;
- When a multi-agency, multidisciplinary approach is therefore indicated; and
- When discussion has taken place between school and home, and consent obtained from parents/carers for HASSP involvement.

HASSP's role in supporting the work of professionals involved with primary school children with complex needs include:

- Offering advice and support as a result of discussions, observations of the child and/or attendance at meetings/conferences;
- Providing joint assessments with colleagues in mainstream services with the agreement of both child and family;
- Providing individual or multidisciplinary assessments within HASSP;

- Bridging work between home, school and other agencies;
- Directing work with individual children/families in their school or home environment; and
- Supporting fast track referral onto Tier 2/3 CAMHS.

## 4 Teenage Pregnancy

Reducing the rate of teenage pregnancy has become a key element of national policy in relation to children and young people. Teenage birth rates in the UK amongst 15-19 year olds are the highest of any country in Western Europe. The UK teenage birth rate is twice as high as in Germany, three times as high as in France and six times as high as in the Netherlands.

Young women differ in their ability to cope with the responsibilities of being a parent. However, there is some evidence that, in comparison with older women, teenage mothers have a higher risk of worse health, and experience adverse educational and socio-economic conditions<sup>49</sup>, though it is unclear whether early pregnancy or the social disadvantages that accompany it are responsible for the poorer health of young mothers. Enhanced health risks include hypertension, anaemia, depression and a sense of isolation.

Teenage mothers are also at greater risk of suffering educational disadvantage through dropping out of school. Poorer socio-economic outcomes include fewer employment opportunities, inadequate housing and unhealthy nutrition. Furthermore, the offspring of teenage mothers also have considerable disadvantages through an increased likelihood of being born prematurely, being hospitalised due to accidental injuries, having delayed development during pre-school years and, more generally, living in poverty.

### 4.1 Social Exclusion Unit report

A Social Exclusion Unit report<sup>50</sup> has highlighted two key goals for national policy:

- Reducing the risk of teenage conception, with a specific aim of halving the rate of births among under 18s by 2010; and
- Encouraging more teenage parents into education, training or employment, so that their risk of being socially excluded in the long term becomes reduced.

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<sup>49</sup> NHS Centre for Reviews and Dissemination (CRD) University of York (1997) 'Preventing and reducing the adverse effects of unintended teenage pregnancies', Effective Health Care Bulletin 3 (1): 1-12

<sup>50</sup> Teenage Pregnancy (June 1999) CM 4342. Social Exclusion Unit

The national campaign to achieve these goals is a multi-faceted programme of work that incorporates a variety of agencies. It comprises a ten year programme to improve the climate in which young people prepare for adulthood.

The Governments' action plan for achieving its goals comprises four categories:

#### **4.1.1 The National Campaign**

This involves Government, media, voluntary sector and other organisations to both improve understanding of the issue, and change patterns of behaviour. It aims to change the culture surrounding teenage pregnancy, so that teenagers receive much clearer information about sex and pregnancy. It targets young people and parents with advice on how to cope with the pressures to have sex, and the importance of using contraceptive methods to prevent unwanted pregnancy. Local campaigns in areas of high teenage pregnancy are intended to reinforce this message through working collaboratively with local media and faith organisations. A free national helpline, *Sexwise*, supports the campaign and gives advice to young people.

#### **4.1.2 Joined-up multi-agency action**

This involves creating structures that can co-ordinate action both locally and nationally. Locally it places responsibility with Teenage Pregnancy Co-ordinators to pull together all of the local services that can prevent teenage pregnancy, or else support those that become parents. Nationally, the creation of an independent national advisory group on teenage pregnancy both monitors the effectiveness of the entire strategy, as well as provides advice to the Government.

Reducing teenage pregnancy is also an NHS Plan commitment. '*Delivering the NHS Plan*'<sup>51</sup> promises to provide extra help in this regard, which will support delivery of the Department of Health's Public Sector Agreement to deliver the headline conception rate reduction targets. The Cabinet Committee on Children and Young People's Services oversees delivery of the Teenage Pregnancy Strategy. In an effort to strengthen co-ordination between local authorities and Primary Care Trusts, teenage pregnancy funds have been channelled through local authorities. A further indication of the importance attached to reducing teenage pregnancy is that halving the rate of teenage conceptions (by 2010) is one of the Department of Health's National Public Service Agreements. Furthermore, several

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<sup>51</sup> Department of Health, 'Delivering the NHS Plan - Next Steps on Investment, Next Steps on Reform', April 2002

local authorities have included a teenage pregnancy target as part of a Local Public Service Agreement (LPSA)<sup>52</sup>, which not only sets a more challenging target for reduction than that already agreed but, if met, can result in additional funding for those local authorities.

The *Connexions* Service has been introduced to provide integrated information, advice, guidance and personal development opportunities for all 13-19 year olds in England. Both the *Connexions* Service and the Teenage Pregnancy Unit have produced a set of guidelines<sup>53</sup> aimed at integrating support for vulnerable young people. This suggests way in which *Connexions* and Teenage Pregnancy Strategies can work together, so that they can avoid duplication of services yet ensure that the young person receives the help and support they need. An example given is for a Sure Start Plus Advisor to be able to deliver the Personal Advisor role. Another example is for the *Connexions* personal advisor to work with other people involved in delivering the local teenage pregnancy strategy, and continuing to offer the one-to-one support and overall case management, with others taking on specific roles where this is beneficial to the young person.

#### **4.1.3 Better prevention**

This strand of the action plan revolves around preparing young people in dealing more effectively with sex and relationship issues. Specific measures that have been introduced include new guidance for schools on sex and relationships education, which assists young people in dealing with the pressure to have sex too young, and to use contraception if they do have sex. Further measures include new school inspection and better training for teachers, information campaigns for parents which explain what support is available to them when talking to their children about sex and relationship matters, and new health service standards for effective and responsible contraceptive advice and treatment for young people.

The setting up of a national helpline to advise teenagers on sex and relationship issues, targeting young men with information regarding the consequences of sex and fatherhood and directing Social Services to place greater emphasis on preventing teenage pregnancy for the children in their care, are further important elements of this part of the strategy.

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<sup>52</sup> Government Response to the First Annual Report of the Independent Advisory Group on Teenage Pregnancy, June 2002

<sup>53</sup> Jointly produced by the *Connexions* Service, the Teenage Pregnancy Unit and Sure Start 'Working together: *Connexions* and teenage pregnancy' (2001)

#### 4.1.4 Better support

This aspect of the action plan has been developed to ensure that parents do not miss out on opportunities for the future. It emphasises young parents being able to complete their education, as well as receive additional housing support that is appropriate to their circumstances. Fulfilling this part of the action plan involves mothers under 16 years of age being given support to complete full-time education through enhanced support with child care. It also involves greater help for teenage parents claiming benefits to find work, and a support package to help young parents with their housing, health care, parenting skills, education and child care needs. It argues that 16 and 17 year old mothers who cannot live with either their parents or partner ought to obtain supervised, supported semi-independent housing.

#### 4.2 Teenage Pregnancy Rates (ages 16 and under) in the North West and other English Regions: 1997-1999

There is strong variation in the rate of conceptions in the under 16 age range across England. Some English Regions (ie Eastern, South East and South West) have much lower conception rates than the average for England. The rate of conception in the North West region is slightly higher than the average. However, it is statistically significantly lower than some other English Regions (ie Northern & Yorkshire, Trent, London and the West Midlands).

<b>Regional Offices</b>	<b>Number of conceptions</b>	<b>Rate per 1000 women aged 13-15</b>	<b>95% CI Lower level</b>	<b>95% CI Upper level</b>
Northern & Yorkshire	3612	10.2	9.9	10.5
Trent	2733	9.9	9.5	10.3
West Midlands	2937	9.8	9.5	10.2
<b>North West</b>	<b>3333</b>	<b>8.8</b>	<b>8.5</b>	<b>9.1</b>
Eastern	1893	6.7	6.4	7.0
London	3350	9.5	9.2	9.8
South East	3202	7.0	6.7	7.2
South West	1909	7.4	7.1	7.7
<b>England</b>	<b>22969</b>	<b>8.6</b>	<b>8.5</b>	<b>8.7</b>

#### 4.2.1 Teenage Pregnancy Rates (ages 18 and under) in the North West and other English Regions: 1997-1999

Similarly there is strong variation across England with regard to the rate of teenage conceptions at under 18 years. The North West Region has a rate that is greater than the average rate for England.

Some Regions have higher rates of conception (ie Northern and Yorkshire, Trent, West Midlands and London) whereas other Regions have appreciably lower rates (ie South East, South West and Eastern).

<b>Regional Offices</b>	<b>Number of conceptions</b>	<b>Rate per 1000 women aged 15-17</b>	<b>95% CI Lower level</b>	<b>95% CI Upper level</b>
Northern & Yorkshire	18086	51.6	50.9	52.4
Trent	13625	49.8	49.0	50.6
West Midlands	15141	51.2	50.4	52.0
<b>North West</b>	<b>18423</b>	<b>49.4</b>	<b>48.7</b>	<b>50.1</b>
Eastern	10499	36.8	36.1	37.5
London	17977	51.0	50.3	51.8
South East	17295	37.4	36.9	38.0
South West	9731	37.9	37.1	38.6
<b>England</b>	<b>120777</b>	<b>45.6</b>	<b>45.3</b>	<b>45.8</b>

Just as teenage rates of conception vary widely from one Region to another, there are significant differences within the North West Region. The table below (provided by North West Teenage Pregnancy Unit, and compiled by the Office for National Statistics) illustrates under 18 conception data for top-tier local authorities for 1998, 1999 and 2000. It clearly demonstrates that the conception rate has fallen overall across the North West during this period, and this is in accordance with the general trend across England.

However, there are some notable differences between top-tier local authorities in reducing the conception rate. Some top-tier local authorities (ie Bury, Stockport, Oldham, Cheshire and Liverpool) have experienced a consistent, year-on-year reduction in conception rates. However, within other top-tier local authorities (ie Halton, Bolton, Wigan and Sefton) the conception rate in 2000 was higher than in

1998. Indeed in Bolton, the conception rate has actually increased year-on-year during this period.

#### 4.2.2 Under-18 Conception Data for top-tier Local Authorities in the North West (Aged 15 – 17 years)

NW Local Authorities	Conception Rate: 1998	Conception Rate: 1999	Conception Rate: 2000	Reduction Target: 2010
<b>NORTH WEST</b>	<b>50.1</b>	<b>48.6</b>	<b>47.4</b>	
Blackburn with Darwen	58.2	58.4	58.2	55 %
Blackpool	63.8	73.2	67.9	55 %
Halton	46.6	54.0	53.2	55 %
Warrington	48.6	49.0	47.5	50 %
Cheshire County	37.6	37.5	33.7	50 %
Cumbria	41.8	40.4	41.3	50 %
<b>Greater Manchester</b>	<b>54.1</b>	<b>52.4</b>	<b>49.9</b>	
Bolton	49.7	53.8	55.0	50 %
Bury	55.2	45.0	42.5	50 %
Manchester	60.8	56.0	58.2	55 %
Oldham	65.7	57.3	54.5	55 %
Rochdale	61.2	54.4	57.6	55 %
Salford	61.5	61.9	53.3	50 %
Stockport	42.6	42.3	31.0	45 %
Tameside	53.1	50.0	52.5	50 %
Trafford	33.7	39.1	32.5	45 %
Wigan	53.4	58.5	54.5	50 %
Lancashire County	48.9	43.4	46.2	50 %
<b>Merseyside</b>	<b>50.5</b>	<b>49.4</b>	<b>48.2</b>	
Knowsley	54.1	46.9	49.7	50 %
Liverpool	58.4	55.4	50.9	55 %
Sefton	33.4	37.8	40.6	45 %
St Helens	55.5	64.5	52.3	50 %
Wirral	50.0	44.4	48.2	50 %
<b>England</b>	<b>46.5</b>	<b>44.7</b>	<b>43.6</b>	<b>50 %</b>

### **4.3 What works in Reducing Teenage Pregnancy?**

There has been a great deal of research in recent years concerned with this vexed question. Roger Ingham's work at the University of Southampton focused on conception rates between 1991 and 1997. It suggests that there are certain key factors that distinguish areas with decreasing rates of conceptions from other areas with increasing rates of conception. These factors are:

- Having an inter-agency group, so that different organisations can be linked together to achieve a shared goal;
- Having new staff in education to offer advice and support in sex education;
- Additional training around sexual health and relationship issues for teachers involved in Personal, Social and Health Education;
- Consultation and health promotion targeted at young people on sexual health matters;
- New young people's sexual health services; and
- Youth service initiatives in the field of sexual health .

A review of the effectiveness of the research evidence to reduce unintended teenage pregnancies<sup>54</sup> considers two main approaches:

- educational interaction (usually school-based), and
- the provision and delivery of contraceptive and counselling services.

It also reviews strategies for allocating health, educational and social outcomes.

#### **4.3.1 Educational approaches**

Most of the evaluations of educational approaches were conducted in the US, and are largely comparisons of new methods of sex education compared with those programmes that are routinely provided.

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<sup>54</sup> NHS Centre for Reviews and Dissemination (CRD) University of York (1997) cited earlier

<ul style="list-style-type: none"> <li>• <b>Abstinence programmes</b></li> </ul>	<ul style="list-style-type: none"> <li>□ These programmes aim to delay sexual activity until later in the teenage years. They do not generally include information about contraception. Compared to the usual sex education, such programmes were not found to either delay sexual activity or reduce pregnancy.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>School-based skills building combined with factual information</b></li> </ul>	<ul style="list-style-type: none"> <li>□ Programmes explaining the postponement of sexual activity, through developing more sophisticated skills than in abstinence programmes, combined with factual information on contraceptives and how to access them, have had some success in changing young people's sexual and contraceptive behaviours. Not providing guidance on contraceptives, and where to access them, seems to reduce effectiveness.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Programmes encouraging vocational development</b></li> </ul>	<ul style="list-style-type: none"> <li>□ Programmes that increase life options for young people can help motivate them to avoid pregnancy. Such programmes provide guidance, encouragement or support to complete education or improve employment prospects. Similarly programmes that combine sex education with career planning or work experience during summer holidays have highlighted some success in increasing contraceptive use, and also in reducing contraceptive use.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>School-based programmes linked with contraceptive services</b></li> </ul>	<ul style="list-style-type: none"> <li>□ A combination of sex education with access to contraceptive services have been shown to be effective in increasing contraceptive use. A community approach which combined peer-led skills, confidence-building, access to condoms and transport to contraception clinics showed, over a 2 year follow-up, a large reduction in pregnancies.</li> </ul>

### 4.3.2 Features associated with successful educational programmes

There is consistent evidence that providing sex and contraceptive education within school settings does not lead to an increase in sexual activity or rate of pregnancy.

Providing clear information about contraceptive methods, and how and when to access contraceptive services, appears important to the success of educational

programmes. The timing of these educational programmes also seems to be important: young people who are sexually active at the beginning of the interventions, for example, are less likely to alter their sexual and contraceptive behaviour.

It is important to bear in mind, therefore, that young people are not homogeneous, and so programmes should be carefully tailored to the group they serve.

The few studies that have demonstrated a reduction in teenage pregnancy delivered multi-faceted programmes linked to contraceptive services or work experience. Most of the evaluated programmes have tried to address individual factors linked to teenage pregnancy, and have shown some success.

Few of these programmes, however, have attempted to tackle underlying social, economic and other environmental factors associated with increased risk of pregnancy.

### 4.3.3 Methods of contraceptive service delivery

<ul style="list-style-type: none"><li>• <b>Effectiveness of different ways of delivering contraceptive services</b></li></ul>	<ul style="list-style-type: none"><li>□ Studies show an association between conception rates and the level and type of contraceptive services available locally. The effect of such services in terms of use and pregnancy rates seems to be stronger when they are provided by clinics or youth-oriented clinics.</li><li>□ UK studies tend to be limited to less reliable before and after studies of conception rates, audits of service use and qualitative studies of users. Some studies have tried to evaluate the effect of publicity on awareness of use of contraceptive services. However, this does not provide clear evidence of the effectiveness of different approaches to contraceptive counselling and contraceptive provision.</li><li>□ A review of descriptive studies in the UK (concerned with use, needs or experience of contraception) indicate low levels of knowledge amongst boys in relation to reproduction and contraception. Sources of information include: parents, siblings, peers and the media, but rarely health care professionals.</li><li>□ Developing services in the light of descriptive studies means taking into account, in a systematic way, local circumstances and needs. However, a recent survey found that few agencies undertake systematic local needs assessments before developing services.</li><li>□ In order to encourage young people to use services, they need to be well-advertised, easily accessed outside school hours, informal and, for under 16-year-olds, confidential. Furthermore, they should be developed through a process of collaboration, with key statutory agencies, and relevant voluntary and community groups. They should also be broad-based, and staffed by people trained in working with young people.</li></ul>
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<ul style="list-style-type: none"> <li>• <b>Emergency contraception</b></li> </ul>	<ul style="list-style-type: none"> <li>□ This may be an extremely useful method for preventing pregnancy given the nature of teenagers' sexual activity, which may be both sporadic and unplanned.</li> <li>□ There is some evidence that many young people are poorly informed about its method of use. Furthermore, concerns by women and GPs about perceived health risks have been identified as a reason for not using this method.</li> <li>□ There appears to be a need for greater publicity, as well as programmes directed at educating teenagers, GPs and others to allay their fears about the absolute risk.</li> </ul>
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#### 4.4 Preventing adverse health and social outcomes

Given that roughly half of under 16 year olds, and two thirds of 16-19 year-olds continue with their pregnancies, it is important to explore how health, education and social services can intervene effectively to promote the health and well-being of teenage parents and their children.

The table below summarises the evidence base for the key approaches.

<ul style="list-style-type: none"> <li>• <b>Antenatal care</b></li> </ul>	<ul style="list-style-type: none"> <li>□ Studies indicate that good antenatal care is linked to improved pregnancy outcomes for teenagers, as well as older women. Teenage girls' ambivalence regarding their pregnancy or fear of discovery can delay their uptake of antenatal care.</li> <li>□ There is a consistent evidence for the effectiveness of comprehensive programmes in reducing maternal outcomes.</li> </ul>
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<ul style="list-style-type: none"> <li>• <b>Social support and parenting</b></li> </ul>	<ul style="list-style-type: none"> <li>□ Reviews of RCTs (randomised controlled trials) of home visiting and psychological support for disadvantaged mothers conclude that they have the potential to reduce significantly the incidence of babies having incomplete immunisation, hospitalisation during the first year of life, childhood injury or being suspected victims of child abuse.</li> <li>□ Home-based parenting support programmes are effective in improving teenage mothers' interaction with their child and/or helping the infant's development. In the UK, voluntary organisations providing such support for families under stress include Homestart and Newpin.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Pre-school education and support</b></li> </ul>	<ul style="list-style-type: none"> <li>□ Parenting skills programmes or support to continue formal education have been shown to improve teenage mothers/child interaction, and enhance child development. Similarly, early education programmes of good quality can improve longer term outcomes for disadvantaged children.</li> <li>□ Longer term evaluations of Project Head Start - a US project aimed at providing pre-school education to children from disadvantaged backgrounds - have shown improvements in cognitive ability, self-esteem, educational attainment and social behaviour.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Parental education support</b></li> </ul>	<ul style="list-style-type: none"> <li>□ A number of approaches provide the opportunity to continue formal education. These include programmes offering young teenagers general curriculum education together with education courses relevant to child bearing and parenting.</li> </ul>

A Cochrane Review<sup>55</sup> of individual and group-based parenting programmes for improving psychosocial outcomes for teenage parents and their children offered some interesting findings. Both types of parenting programmes produced results that favoured the intervention group on a range of maternal and infant measures of outcome. These include mother-infant interaction, language development, parental attitudes, parental knowledge, mealtime communication and maternal self-confidence. The reviewers concluded they may be effective in improving outcomes for teenage mothers and their infants.

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<sup>55</sup> Coren, E & Barlow, J 'Individual and group-based parenting programmes for improving psychosocial outcomes for teenage parents and their children', Cochrane Library, Issue 2, 2002

The Health Education Authority<sup>56</sup> has undertaken research into reducing teenage pregnancy in the UK. This work resulted in a series of recommendations for both policy and practice, which are summarised below.

<ul style="list-style-type: none"> <li>• <b>For policy makers</b></li> </ul>	<ul style="list-style-type: none"> <li>□ Reinforce the climate where it is acceptable to talk more openly about sexual issues and teenage pregnancy in a supportive, respectful and non-threatening way.</li> <li>□ Encourage the pursuit of socially valued alternatives to teenage pregnancy and young parenthood.</li> <li>□ Enhance educational and training opportunities.</li> <li>□ Facilitate the transition from welfare to education, training and work.</li> <li>□ Enhance the support facilities to young mothers and fathers.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>For health service professionals</b></li> </ul>	<ul style="list-style-type: none"> <li>□ Provide a wide range of sexual / reproductive health services for young people, which includes services to young people with special needs (eg those looked after by social services, children with learning difficulties, etc).</li> <li>□ Make existing services acceptable, accessible and appropriate to young people.</li> <li>□ Train staff in communicating with young people and understanding their needs.</li> <li>□ Integrate contraceptive services with those providing STD advice, testing and treatment.</li> </ul>
<ul style="list-style-type: none"> <li>• <b>For headteachers and teachers</b></li> </ul>	<ul style="list-style-type: none"> <li>□ With parents and children, develop whole school policies on education around sex, sexuality and relationships that includes teenage pregnancy.</li> <li>□ Include work on teenage pregnancy in the curriculum.</li> <li>□ Address young women <u>AND</u> young men's interests.</li> <li>□ Give young people the opportunities to develop skills in sexual communication.</li> <li>□ Create working alliances with local sexual and reproductive health services for young people.</li> </ul>

<sup>56</sup> Aggleton, P et al (Health Education Authority) 'Reducing the rate of teenage conceptions: the implications of research into young people, sex, sexuality and relationships', 1998

## **4.5 Examples of innovative practice in the North West to Reduce Teenage Pregnancy and Support Teenage Parents**

### **4.5.1 Liverpool & Sefton Sexual Health Team : Teenage Pregnancy Strategy**

The Teenage Pregnancy Co-ordinator for Liverpool is also a member of the Liverpool *Connexions* local management committee. Furthermore the local teenage pregnancy partnership board is accountable for the Liverpool Ten Year Teenage Pregnancy and Parenting Strategy.

An analysis of the profile of teenage pregnancy in Liverpool reveals that the under 18 conception rate for 2000 fell to 50.9% (ie 50.9 conceptions per 1000 women), which represents an 8% reduction from 1999. Furthermore, Liverpool has also experienced a slight reduction in the under 16 conception rate.

There has been high levels of investment in Liverpool's family planning services in recent years, and there are a series of well-established clinics across the city. Sexual health promotion and prevention is undertaken outside of school by a variety of agencies. Local teenage pregnancy monies have funded '*So to Speak*', a young people's sexual health resource that undertakes face to face advice with young people, as well as provides training and awareness raising around sexual health issues for workers who are in contact with young people eg youth offending team staff, social workers and foster carers.

- **Reducing the rate of conceptions: *Connexions***

The strategy has partly arisen out of an identified interest expressed by *Connexions*' Personal Advisers (PAs) in finding out more about sexual health and young people. Consequently the Teenage Pregnancy Co-ordinator (TPC), *Connexions* Area Manager and Greater Merseyside's *Connexions* Training Manager collectively agreed to arrange sexual health awareness raising sessions for *Connexions*' PAs. The sessions would focus upon the roles and responsibilities of PAs in relation to sexual health and young people, and appropriate signposting for specialist help where appropriate. Consequently, '*So to Speak*' and the Armistead Project (a resource offering advice and support to gay and bisexual men in Liverpool and Sefton) devised and delivered training to PAs across Merseyside.

The first training sessions were piloted in July 2002. A training manual has been published entitled '*Young People and Sexual Health*', and the second training session is currently being planned in Wirral. The work that has been undertaken in

Liverpool has received acclaim from the Teenage Pregnancy Unit, as it has been recognised as a model of good partnership working.

- **Supporting pregnant teenagers and young parents: Sure Start Plus Team**

The role of the Sure Start Plus service is two-fold:

- provide personal advice and support for teenagers who discover they are pregnant, so that they can make well informed decisions in relation to their personal circumstances; and
- co-ordinate a tailored support package for people deciding to continue with their pregnancy, which would address healthcare, employment, education and training, childcare, housing and other needs.

Sure Start Plus has developed links with the ‘Young Mums To Be’ (YMTB) course in Liverpool, which provides a 12 week holistic training programme for young women aged 16-19. The training programme covers the antenatal process of pregnancy whilst including a range of basic skills, and successful attendees receive the equivalent of an NVQ level 1. A partnership agreement with the training provider (JHP) of ‘YMTB’ has been developed, so that all young women referred to *Sure Start Plus* are informed about YMTB, and links facilitated where necessary. Roughly a third of the young women engaged with Sure Start Plus are on the YMTB course.

An equivalent course for postnatal young women is deemed highly appropriate, and this has been recently explored. *Sure Start Plus* would aim to build upon their status as a resource offering specialised advice and information to pregnant teenagers, their partners and young parents if such an accredited course could be developed. *Sure Start Plus* would be in a strong position to engage with young teenage mothers given that they will have supported most of them through their pregnancy.

#### **4.5.2 Young Parents Service offering Specialised Teenage Pregnancy Care: St Mary’s Hospital, Manchester**

The Young Parents Maternity Service at St Mary’s Hospital in Manchester offers specialised teenage pregnancy care with a Lead Consultant Obstetrician and Teenage Pregnancy Liaison Midwife, who co-ordinates both hospital and community-based care.

The majority of wards in Manchester have conception rates for under-18 year olds which are much higher than the average for England and Wales, which has a strong correlation with the high level of socio-economic deprivation within Manchester. The project has specific features which have been designed to respond to the needs of the young pregnant woman, her baby and her family, and they can be summarised as follows:

- A Teenage Pregnancy Liaison Midwife has responsibility for developing the Young Parents Service, co-ordinating the care of young women under 19 years old and developing links with other agencies involved with supporting pregnant young women;
- Two Community Groups offer outreach ante natal clinics;
- A specialist Young Parents Antenatal Clinic in St Mary's Hospital offering midwifery-led care for low risk pregnancies and a combined consultant/midwife clinic for teenagers with obstetric problems, which is attended by a lead consultant in teenage pregnancy;
- Although most referrals are made by GPs, all agencies involved with teenage young women can refer to the service. Young women are seen as soon as possible, so that an assessment of ALL their needs can be made, including social circumstances, housing and benefit needs, child protection issues, education and career prospects;
- Parent education sessions are offered informally at both community groups and hospital based groups; and
- All pregnancy options are discussed with young women, and fully qualified staff are available to discuss these options with the young women. An abortion clinic is available at St Mary's, which allows a direct self-referral by the teenager or other agencies.

The Young Parents Service has made some progress in developing service provision, which include:

- Written guidelines for the development of the service;

- Enhanced awareness of the need for maternity care for pregnant teenagers, so that sensitive support can be provided for them to not only have a successful pregnancy, but also to become effective parents; and
- Parenting education is offered informally at the community groups, so that it is shaped around the young women's needs. The parenting sessions focus upon issues most keenly felt by the young women: baby care, child development and general health issues (eg nutrition). Other professionals taking part in these sessions include dentists, health visitors, dieticians, speech therapists and paediatric nurses.

#### **4.5.3 Young Parent Project to Support Education and Training for Young Parents: Early Excellence Centre, Stockport**

This project is funded by the Department for Education and Skills (DfES), and is centred upon enabling 16-18 year olds remain in, or return to, education. It is one of a number of pilot projects around the country, of which only one other is connected to an Early Excellence Centre. Although Stockport does not have extremely high rates of teenage pregnancy, there are, nonetheless, pockets of deprivation in which there are high ratios of teenage parents.

The project may be summarised as follows:

- It was set up and managed by a co-ordinator, who is supported by a part-time administrative assistant. The co-ordinator processes all referrals and supports young parents in making decisions about what courses they are interested in accessing. This support includes assisting young parents with their college enrolment;
- The project finances necessary childcare and travel costs for participants. Young parents are enabled to locate appropriate childcare, and the project subsequently enters into a contractual arrangement with the provider. The project then provides the young parents with a free bus pass so that they can travel to and from their college, as well as to the childminder / nursery;
- The project is currently located at the local Pupil Referral Unit for pregnant schoolgirls and schoolgirl mothers, and many of the young parents have been referred to the project from the Pupil Referral Unit; and

- Most referrals come from health visitors, although any agency or individual can make referrals.

The Young Parent project's key achievements include:

- Assisting twenty young parents taking part to access education for varying lengths of time during the academic year. Although some parents did not complete their course of study, the majority were successful in either obtaining their qualifications, or else finding work that they wished to do; and
- Enabling a higher take up of childcare places, with a variety of options being utilised, including private nursery places and supported registration for the young mothers' relatives to be paid as childminders.

The Young Parent project has learnt some important messages from its work thus far, which can be summarised as follows:

- Most participants only wish to study for one year, whereas it was initially thought that the young parents would complete two years of further education;
- The age range of participants ought to be extended to at least 25, given that many young mothers need time to adjust to their new maternal role and they are often beyond the project target age by the time that they are able to undertake qualifications or skills;
- Additional on-site childcare needs to be provided within colleges and training centres. This reflects young people's preference, yet it is often not available;
- The local specialist Pupil Referral Unit plays a highly significant role, which provides an extremely nurturing and supporting environment, is attentive to the young parents' needs and offers full-time on-site creche facilities. Having attended the Pupil Referral Unit, young mothers are sufficiently motivated to embark upon college courses; and
- Within areas of high deprivation in Stockport, it is far more difficult to motivate young parents into valuing education and appreciating the opportunities that it might offer to them. Some young women from such highly deprived communities have extremely low educational or work aspirations, and much

more needs to be done in raising their aspirations at a much younger age so that they are willing to engage with the educational process.

#### **4.5.4 Young Black People's Peer Education Project: Black Health Agency, Manchester**

This is a peer education project that works with 13-25 year old Black African Caribbean people in inner city areas within Greater Manchester to both raise awareness of sexual health and also reduce high risk behaviour. The project was set up as a consequence of a feasibility study, which highlighted high rates of sexually transmitted infections and high rates of teenage pregnancy.

The Peer Education Project can be summarised as follows :

- The project works with socially excluded young Black people in Manchester, Salford and Trafford using peer education models to raise awareness around sexual health issues, develop skills and confidence to make positive life choices and reduce high risk behaviour;
- Sexual health information sessions are used to reach young people in a range of voluntary, statutory and community settings (eg schools, local youth agencies and community groups). These help raise awareness and encourage behavioural changes through safer sex: respect, protection for self and others, confidence and skills building;
- Different ways are used to involve young people ie via the information sessions, encouraging them to train as peer educators themselves, and to take on further training to be employed on a sessional rate;
- There are two full-time peer educators, two peer education development workers and an administrator. It is intended to have a training and development worker to focus on skills, educational attainment and increasing employment opportunities;
- Different creative activities are used to reach and work with the diverse needs of young people, such as drama, dance, video, and overseas visits to other peer education projects; and

- The project plans to employ more peer educators, diversify the work programme to include refugee groups, lesbian and gay young people, young people in care, teenage mothers and young people at risk of offending.

The Peer Education Project has made some progress in reaching young Black people, which includes the following:

- Developing and delivering its own model of peer education as an approach to working with young Black people, including those on the verge of school exclusion and who are likely to engage in high risk activity, such as street crime, alcohol and drug use. The approach is relevant to their background, culture and experience;
- It has grown from one worker focused on young men's work into a team of five, which includes a young women worker, and over fifteen volunteer peer educators;
- A number of young people have attended residential or overseas field trips to see how sexual health programmes are offered in different cultural frameworks; and
- The project works in partnership with all major sexual health providers in Greater Manchester, and works strategically at a national level to support policy development.

#### **4.5.5 Morecambe Bay PCT: Combined Young People's Family Planning / GUM Clinic**

The Young Person's Clinic<sup>57</sup> (known as 'YPC') was initially set up in 1994. Central Morecambe is affected by significant levels of social deprivation, and suffers high levels of unemployment.

YPC operates for one session per week (two hours duration) in order to fit in with the movement of young people after leaving school (ie 4pm – 6pm). Since 1997 YPC has been located within the Young People's Information Shop, which is based within a town centre building that houses a range of voluntary and statutory welfare services for young people. The clinic is staffed by one doctor with clinical

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<sup>57</sup> Bloxham, S et al 'Combining GUM and contraceptive services for young people: profile of an innovative clinic', *The British Journal of Family Planning*, 1999:25: 18-21

experience in family planning and GUM (genito-urinary medicine), as well as family planning nurses, a receptionist and a youth worker. YPC's activities are publicised through other professionals, particularly school nurses, and through the distribution of its own publicity information.

Through offering GUM and family planning services, YPC seeks to encourage a more holistic view of sexual health amongst both staff and attenders. It seeks to provide a confidential service to all young people, a safe environment in which to talk about sexual health and related issues, accurate information, non-judgemental advice and assistance with all aspects of sexual health and related issues (including drugs and relationships). The service includes free pregnancy testing, contraceptives and treatment for sexually transmitted diseases.

Nurse protocols have been devised for administering emergency contraception, and re-issuing the pill and Depo-Provera. The protocols aim to improve the efficiency of the clinic staff by providing an enhanced role for the nurse, thus reducing pressure on the doctor with a resulting reduction in attender waiting time. Upon arrival, attenders are shown a list of services written in simple language (eg 'condoms', 'emergency contraception') and asked to point at the service they require. A youth worker is available to speak with those waiting to be seen, and to provide a link to other services. Referrals are made from YPC to other agencies for issues such as housing or benefit problems, and other services refer young people to YPC where appropriate.

### **Young Person's Clinic: A Service Profile**

A profile of YPC's work has been obtained from reviewing attendances over a period of one year, which included information about the sex of the attender, whether it was a first or follow up visit, their age, whether GUM or family planning services were used, whether GUM tests were conducted and any GUM diagnosis made. Data was also gathered from attenders regarding how they had become aware of the clinic. This was compared with young people's attendances at the local family planning clinic during the year prior to the establishment of YPC. The review's findings can be summarised as follows:

#### **Clinic attendance**

YPC enjoys a high rate of attendance, which compares well with Brook Advisory Centres in relation to attracting younger teenagers and males. It also enjoys a high rate of return attendances. Family planning services are a key element of YPC that

is most likely to be used by under 18 clients, with 81% of family planning visits being taken by under 18s compared with 33% of GUM visits. A comparison of these results with prior use by young people of the Morecambe family planning clinic suggests that YPC is attracting attenders, particularly males, who may not have used family planning services in the past.

## **GUM services**

Roughly a fifth of all first visits during the research period were recorded as resulting in GUM services. Although the diagnoses for STDs tend to focus upon older attenders, there were 9 recorded cases of chlamydia among the under 18s (all of whom were female), which clearly highlights the value of such a combined clinic. YPC uses sensitive inquiry of personal medical history, as well as other factors, to determine whether or not STD screening should be suggested to young people attending for family planning services.

Thus there are a high number of ‘crossovers’ between services for individual attenders, 25 of whom received family planning services on their first visit, and were provided with GUM services on one or more subsequent visits. Similarly 16 attenders crossed over from GUM to family planning services. This evidence clearly supports the view that combined sexual health services for young people may be more successful at targetting attenders who are not aware that they may require GUM services.

## **Young Person’s Clinic: Concluding Comments**

YPC has enjoyed high attendance levels, especially amongst young teenagers and males, which reflects the pattern of attendance in other specialist clinics. Some of the criteria which recent research has identified as being essential for young people’s family planning services include:

- not having to make an appointment;
- having convenient opening times and location;
- offering advice on any health problem (or being able to act as a conduit to other services meeting other health needs);
- offering free pregnancy testing;

- having women staff available (including doctors);
- allowing attenders to obtain services in the company of friends; and
- offering telephone advice and support.

YPC fulfils all of these criteria. Its location within a youth information shop produces a comfortable environment for young attenders, as the sexual health nature of their visit is not obvious to observers. Furthermore, outreach work in local schools, through school nurses and youth workers, has also helped to secure high attendances.

YPC has also aimed to target vulnerable young people, such as those with poor educational backgrounds, drug users and others with little family support. Much of this is due to YPC's location in a multi-agency youth project having close links with other services for young people. YPC's ethos places great importance upon building relationships with young attenders, so that adequate time is provided for consultations.

However, YPC's major innovative achievement seems to be the diagnosis of STD infections among attenders who would not have used a GUM facility due to feeling embarrassed, not knowing where to seek help or else being unaware of the symptoms. Whilst young people might be aware that sexual activity can lead to pregnancy, many will be unaware of the risks of contracting chlamydia (or other STDs) without professional intervention to alert them to the risks. YPC's success, therefore, suggests that youth-centre based combined services for young people are an accessible and cost-effective method of promoting young people's sexual health.

#### **4.5.6 Bolton Primary Care Trust and Octagon Theatre: 'SCORE'**

'Score' is a recently commissioned play (by Debbie Oates) and is Activ8's theatre in education production<sup>58</sup>. It is centred upon teenage pregnancy, and young men's attitudes to sex, young women, contraception, sexually transmitted infections, pregnancy, relationships, peer influences, rights and responsibilities. It was aimed at young people in Bolton aged 13 years and above, and was devised following extensive consultation with over 100 young people from various groups in Bolton and in collaboration with Bolton Specialist Health Promotion Service.

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<sup>58</sup> Score: A Teacher's Resource Pack, Bolton PCT / Octagon Theatre Trust (2002)

The target audience was specifically schools in Bolton which have a high incidence of teenage pregnancy, hard to reach young people and outreach groups. Although the regional and national rate of teenage conceptions is falling, the rate has increased in Bolton over recent years, and the play seeks to address this issue. It is a partnership production between Bolton PCT and Bolton's Octagon theatre, with whom the PCT has carried out previous theatre in health education work. The project was mainly funded by Bolton PCT, Bolton Octagon theatre, Activ8, New Opportunities Fund, North West Arts Board, Bolton MBC, Bolton Healthy Living Centre and Teenage Pregnancy Strategy.

The play was premiered at Bolton's Octagon theatre in October 2002 and subsequently embarked on an extensive tour of schools, youth groups and youth clubs in the North West. The process of staging the play involved the establishment of an advisory / steering group, whose membership included the local teenage pregnancy co-ordinator, Director of Octagon Theatre, the heads of PHSE from various local secondary schools and representatives from outreach groups. Furthermore, it involved consulting with young people in Bolton within a variety of settings, including a young mother's unit and a couple of pupil referral units.

The project has also produced an extensive teacher resource pack, which has been designed to enable schools to follow up issues raised in the play: attitudes and responsibilities, rites of passage, image and identity, relationships, peer group dynamics and sexual health.

The rationale for the project centres upon effective school-based sex education, and its importance in enhancing young people's knowledge, attitudes and behaviour. Evidence-based research suggests that effective school programmes contain various elements, including :

- A focus on reducing specific risky behaviours;
- A basis in theories which explain what influences people's sexual choices and behaviours;
- A clear and continuously reinforced message about sexual behaviour and risk reduction;

- Providing accurate information about the risks associated with sexual activity, contraception and birth control, and methods of avoiding or deferring intercourse;
- Using various approaches to teaching and learning that are appropriate to young people's age, experience and cultural background; and
- Using various approaches to teaching and learning that involve and engage young people, and help them to personalise the information.

### **Concluding comments**

The project recognises that tackling teenage pregnancies is a highly complex issue, and that effective action requires many agencies becoming involved. It is built upon the premise that trying to force young people to behave in a particular way is more likely to alienate them, and that encouraging young people to listen requires approaching them in a manner that earns their respect and which they can relate to. Consequently the play has been written from a young person's perspective, and is regarded as being highly accessible. The project is in the process of being independently evaluated, and initial feedback has been extremely positive.

## 5 Vulnerable Children and Young People

In recent years, support for vulnerable children in society has become a major theme of UK government policy. The *Quality Protects* Programme<sup>59</sup> is a key element of a wider strategy to tackle social exclusion, and has a direct focus on improving the lives of the most disadvantaged children: those looked after by local authorities, those within the child protection system and other children in need.

The *Quality Protects* Programme aims to transform the management and delivery of social services for children, so that local authorities are better able to provide safe, effective and high quality children's services. Its chief elements are:

- ❑ new national objectives for children's services which set clear outcomes for children, and these may include precise targets that local authorities are expected to meet;
- ❑ close partnership between central and local government; and
- ❑ an important role for local councils in delivering the programme.

### 5.1 National Policy and Supporting Vulnerable Children and Young People

National policy is illustrated largely through the NHS Plan, *Connexions* and the National Care Standards Commission

- ***Connexions***

*Connexions*<sup>60</sup> is a new service that is providing advice and support to all teenagers in England, but places particular emphasis on supporting those at the greatest risk of not making a successful transition to adulthood. Although led by the DfEE, the work of *Connexions* cuts across various departments to provide information, advice and guidance for all young people aged 13 – 19 to help them make the most of choices and opportunities.

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<sup>59</sup> The Quality Protects Programme: Transforming Children's Services, Local Authority Circular, LAC(98) 28

<sup>60</sup> Quality Protects: Transforming Children's Services, Issue 7 April 2001  
[www.qualityprotects.gov.uk](http://www.qualityprotects.gov.uk)

The service will be provided by a variety of partners at the local level, including statutory services, private sector companies and voluntary/community organisations. Collectively they form *Connexions Partnerships*, which develop and co-ordinate the delivery of support services. The key role in the service is played by the Personal Advisor, who will provide a single point of contact to support young people, help access to specialist services such as health and housing, and ensure that one person has an overview of their needs.

Despite operating a universal service, the *Connexions* service has targets to reduce social exclusion, prevent truancy or young people leaving school without any qualifications. Consequently, its emphasis will inevitably be on targeting young people.

- ***The NHS Plan***

The *NHS Plan*<sup>61</sup> set out key commitments for children, which included a renewed commitment to improving the life chances of children in care. It contained challenging targets:

- Improve the level of educational attainment, training and employment outcomes for young people leaving care to at least 75% of levels achieved by all young people in the same area by March 2004;
- Increase to 15% by 2004 the percentage of children in care who achieve at least five grade A\* to C GCSEs;
- Provide children in care with the necessary guidance required to narrow the gap by 2004 between the proportion of children in care and their peers who are cautioned or convicted; and
- Maximise the contribution that adoption can make to providing permanent families for children. Indeed a new national target has been set to increase adoptions by at least 40% by 2004/5 and if possible exceed this by achieving a 50% increase.

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<sup>61</sup> Delivering the NHS Plan, Department of Health, April 2002 Cm 5503

- ***National Care Standards Commission***

Other support services for children and young people have been set in motion by the Care Standards Act 2000, which led to the setting up of the *National Care Standards Commission*<sup>62</sup>. This new body has the task of regulating social care settings, including children's homes. New national minimum standards for children's homes have been set, and the *Commission* will inspect and regulate such homes against these standards.

The aim is for standards to be consistently applied and enforced. The standards are comprehensive, incorporating issues such as food quality and other day-to-day issues. The standards are to support providers of care to enable higher quality placements for children, through enabling young people to benefit from a care environment that is positively geared to improving life chances for them. Irrespective of whether children's homes are provided by statutory, private or voluntary sector organisations, they must all reach a comprehensive set of standards.

## ***5.2 Working Together To Safeguard Children***

Current policy places extremely high emphasis upon an integrated approach to child support. *Working Together To Safeguard Children*<sup>63</sup> provided a comprehensive guide to inter-agency working to safeguard and promote the welfare of children. It described how actions to safeguard children fit within the wider context of support to children and families. It summarised the roles of different agencies, and set out the way joint working should be agreed, implemented and reviewed through Area Child Protection Committees. It also set out processes which should be followed where concerns are raised about a child, so as to safeguard and promote the welfare of children who are suffering, or at the risk of suffering, significant harm.

*Working Together To Safeguard Children* differentiated between abuse and neglect. Abuse is defined as being caused by inflicting harm, or failing to act to prevent harm. It may be caused physically (for example, through hitting a child) or emotionally (for example, through causing a child to feel worthless or unloved). Physical abuse can lead to neurological damage, physical injuries, disability or

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<sup>62</sup> National Care Standards Commission <http://www.carestandards.org.uk/>

<sup>63</sup> Department of Health / Home Office / DfEE, *Working Together to Safeguard Children*, 1999

death. It has been associated with aggressive behaviour in children, emotional and behavioural problems, as well as educational problems. Emotional abuse has a damaging impact upon a child's mental health, behaviour and self-esteem. Domestic violence, adult mental health problems and parental substance misuse are sometimes associated with families where children are exposed to such abuse.

#### ❑ **Sexual abuse**

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, so that they are encouraged to behave in sexually inappropriate ways. The severity of impact on a child is believed to increase the longer that the abuse takes place, the more extensive the abuse and the older the child. Some adults who sexually abuse children have themselves been sexually abused as children, and may also have been exposed to domestic violence.

#### ❑ **Neglect**

Neglect is defined as the persistent failure to meet a child's basic physical and / or psychological needs. It can occur in various ways, such as failing to provide sufficient food or not responding to a child's emotional needs. Both abuse and neglect can have major long-term effects on a child's health, development and well-being. Sustained abuse is likely to have a highly damaging impact on the child's self-image and self-esteem, and the problems that result may well extend into adulthood. Neglect is associated with very significant impairment of growth and intellectual development.

Government policy calls for effective collaboration to support vulnerable children. Statutory agencies, professionals, the voluntary sector and the wider community have a vital role in working together across the planning, management, provision and delivery of services:

#### • **Local Authority Responsibilities**

Looking after children is a responsibility of the entire local authority. All services impact upon the lives of children, and there is a particular responsibility on helping those most at risk of social exclusion. Local authorities should take the lead responsibility for establishing effective *Area Child Protection Committees* (ACPCs) ie the inter-agency forum that acts as a focal point for co-operation in safeguarding children.

Under the *Children's Act 1989*, the local authority is duty bound to make enquiries where there is reasonable cause to suspect that a child is suffering, or likely to suffer, serious harm. The concept of 'significant harm' is defined as the threshold that justifies compulsory intervention in family life in the best interests of the child. Establishing significant harm requires a consideration of various factors, such as the family context, the child's development in the context of their family and wider social environment, whether the child has any special needs, and the adequacy of parental care.

- **Social Services Responsibilities**

Through providing a broad range of social care and support to families, there is enormous capacity for integrating the diversity with which different needs can be met. Social services departments have a duty to make enquiries where they suspect that a child is suffering, or likely to suffer, harm. They also have responsibility for co-ordinating an assessment of a child's needs, and the ability of parents to keep the child safe and promote the child's welfare.

Where the risk of significant harm continues, social services must co-ordinate an inter-agency plan to safeguard the child, which draws upon contributions from family members, professionals and other agencies. Where a child's welfare cannot be adequately safeguarded within the home, social services can apply to the courts for a Care Order that commits the child to the care of the local authority.

- **Education Services**

All schools and colleges should create and manage situations where there are child welfare concerns. Children can be taught what is acceptable and unacceptable behaviour towards them, as well as how to stay safe from harm. The curriculum itself can play a preventive role in developing awareness and resilience, as well as in preparing children for their future responsibilities as adults, parents and citizens.

Through daily contact with pupils and working with families, education staff have a crucial role in noticing indicators of possible abuse or neglect, and in referring to the appropriate agency, usually the social services department. There is a requirement throughout the education service for all staff to be alert to the signs of abuse or neglect, to be aware of the child protection procedures established by ACPCs and to have procedures for handling suspected cases of abuse. Effective policies to tackle bullying is a key responsibility for all schools.

- **Youth Services**

Youth and Community Workers (YCWs) have close contacts with children and young people, and so should be alert to signs of abuse and neglect, and be able to act upon concerns about a child's welfare. Written procedures that are consistent with ACPC procedures should be in place to determine how YCWs should consult with colleagues, line managers and other statutory authorities when concerns about children are raised.

- **Health Services**

All health professionals (in a variety of primary and secondary care settings) have a key role in protecting children, as they are often the first to be aware that families are experiencing difficulties in looking after their children. Their role includes recognising children in need of support and safeguarding them, assessing the needs of children and how well a child's parents can meet those needs and planning / providing support to vulnerable children and their families. They can also provide therapeutic help to abused children and families under stress.

- **The Police**

The police have a duty to investigate criminal offences committed against children, and this should be carried out sensitively, thoroughly and professionally. All local forces have *Child Protection Units (CPUs)* which usually take primary responsibility for investigating child abuse cases. However, all police officers should consider safeguarding children as an important part of their responsibility. Thus patrol officers attending domestic violence incidents should be aware of the effects of violence on children within the household, and Community Beat Officers should be aware of any children in their area on the Child Protection Register.

- **Probation Services**

Probation services have a duty to supervise offenders, so as to reduce offending and protect the public. In carrying out this responsibility, they will be supervising some people (usually men) who have convictions for offences against children. Other offenders will have children who may be in need. Probation services also supervise dangerous child sex offenders on license after release from prison, and will also work with offenders who have less serious convictions for offences against children.

- **The Prison Service**

Risk assessments take account of progress made during the sentence, and inform decisions on sentence planning for individual prisoners, including sex offender treatment programmes. The prison service is required to notify social services and the probation service of plans to release prisoners convicted of offences against children and young people, so that necessary action can be taken by various agencies to minimise any risk. Within prisons, protecting the well-being of children may involve disallowing visits by a person under 18 years of age.

- **Youth Justice Services**

Through creating Youth Offending Teams (YOTs), the *Crime and Disorder Act (1998)* introduced an inter-agency approach to responding to children and young people involved in offending behaviour. A significant number of children and young people who fall within the remit of YOTs will also be children in need, including some whose needs will require safeguarding. There should be clear links, therefore, between youth justice and child protection services.

- **The Voluntary and Private Sectors**

Both voluntary organisations and private sector providers have a valuable role in children's services. National helplines can have a strong impact: the *Childline Helpline* (for children in trouble or danger) and the *National Society for the Prevention of Cruelty to Children Helpline* (for adults who have concerns regarding children's welfare) are examples of these. *Parentline* is also developing a national support helpline for parents under stress. Such services provide routes into statutory and voluntary services for children in need, or who require safeguarding from harm.

Direct services for children and families is centred upon family support and day care services. Further direct services include advocacy projects for looked-after children, home visiting and befriending / support programmes, work in schools and other areas with peer support programmes, and therapeutic work with children and families (especially in relation to child sexual abuse). Voluntary organisations also play an important role in providing information and resources to the wider public regarding the needs of children and resources to assist families. The NSPCC has sole authority (amongst voluntary organisations) to initiate proceedings under the terms of the *Children Act 1989*. However, various voluntary organisations provide assessments of need, and offer therapeutic and other services to children who have

been abused. These services are often provided through child protection plans for children whose names are on the *Child Protection Register*.

### **5.2.1 Area Child Protection Committees (ACPCs)**

*Working Together to Safeguard Children* also demanded that local authorities set up ACPCs which bring together representatives from agencies and professionals responsible for protecting children from abuse and neglect. ACPCs act as inter-agency forums for agreeing how different services and professional groups should co-operate to safeguard children in their respective geographical areas. Specific recommendations include:

- Developing / agreeing local policies and procedures for inter-agency work to protect children;
- Auditing / evaluating how well local services are effectively working together;
- Putting in place objectives and performance indicators to protect children;
- Encouraging and helping to develop effective working relationships between different services and professional groups;
- Improving local ways of working in the light of knowledge gained through national and local experience and research; and
- Undertaking case reviews where a child has died or – in certain circumstances – been seriously harmed, and abuse / neglect are suspected or confirmed.

ACPCs are accountable to their main constituent agencies, whose agreement is required for all work which has implications for policy, planning and the allocation of resources. Programmes of work should be agreed and endorsed at a senior level in each of the main member agencies within the framework of the children's services plan. Local authorities are responsible for establishing ACPCs, and ensuring that they function effectively.

### **5.2.2 ACPCs and Children's Services Planning**

Local authorities provide children's services plans to bring together all aspects of local services for children. These look widely at the needs of local children, and

ways in which local services should work together to meet those needs. They include specific priorities and proposals for improving children's services.

National government requires ACPCs to contribute to, and work within, the overall framework provided by the children's services plan. Similarly they are required to have a clear role in identifying children in need at risk of significant harm (or who have suffered harm), and in identifying resource gaps (ie funding needs) and better ways of working. National government also demands that different services within the children's services planning framework act together to plan co-ordinated action in relevant areas (eg early years development, substance abuse, domestic violence and youth offending).

ACPCs' memberships are determined locally, and include local authorities (ie education and social services), health services (including managerial and professional expertise), the police, the probation service, the NSPCC and the domestic violence forum. ACPCs are required to involve other agencies in their work where necessary, including adult mental health services, CAMHS, Crown Prosecution Service, drug and alcohol misuse services, the judiciary, prisons and youth detention centres, sexual health services and youth offending teams.

### ***5.2.3 Framework for the Assessment of Children in Need and their Families***

This provides a systematic basis for collecting and analysing information to support professional judgements about how to support children and families in the best interests of the child<sup>64</sup>. It requires practitioners to use the framework to deliver 3 objectives:

- Gain an understanding of the child's developmental needs. This requires an appreciation of the health, educational, emotional and behavioural development of the child. It also requires an understanding of the child's sense of identity (including factors of race, sexuality and disability), family and social relationships, how the child presents itself socially, and the child's ability to care for itself;
- Gauge the capacity of parents / carers to respond appropriately to those needs (including their ability to keep the child safe from harm). This requires evaluating parental provision of basic care, ensuring the child's safety, and

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<sup>64</sup> Department of Health, Framework for the Assessment of Children in Need and their Families, 2000

providing emotional warmth. It also includes promoting the child's learning, enabling the child to regulate its own emotions and behaviour, and providing a stable family environment; and

- Understand the impact of wider family and environmental factors on the parents and child. These factors include family history and functioning (including psycho-social factors), wider family issues, housing and employment. It also includes taking into account the level of family income, the social integration of the family and the availability of community resources.

### **5.3 Safeguarding Children from Commercial Sexual Exploitation**

*Safeguarding Children Involved in Prostitution*<sup>65</sup> highlighted the damaging impact for such children through loss of childhood, self-esteem and opportunities for good health and education. The report offers guidance for police, health, social services, education and all other agencies that may work with children, some of whom may be involved, or at risk of becoming involved, in prostitution.

It aims to enable all agencies and professionals to work together to:

- recognise the problem;
- treat the child involved primarily as a victim of abuse;
- safeguard children and promote their welfare;
- work together to prevent abuse and provide children with opportunities and strategies to exit from prostitution; and
- investigate and prosecute people who coerce, exploit and abuse children through prostitution.

The *National Plan for Safeguarding Children from Commercial Sexual Exploitation*<sup>66</sup> is an important part of the drive to protect vulnerable children. It recognises that such exploitation cannot be separated from the wider issues of

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<sup>65</sup> Department of Health, *Safeguarding Children Involved in Prostitution*, Supplementary Guidance to *Working Together to Safeguard Children*, 2000

<sup>66</sup> Home Office, *National Plan for Safeguarding Children from Commercial Sexual Exploitation*, 2001

poverty, family conflict, child abuse, domestic violence and homelessness. The Plan's definition of commercial sexual exploitation is necessarily wide: it includes prostitution; the sale, marketing and possession of child pornography; the distribution of pornographic photographs over the internet; trafficking in children and sex tourism involving children.

The Plan underlines 5 key areas where action has already been undertaken to improve safeguards for children and combat commercial sexual exploitation:

- Co-ordination and co-operation;
  - Prevention;
  - Protection;
  - Recovery and Reintegration; and
  - Children's and young people's participation.
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- **Co-ordination and co-operation**

Much of the work around co-ordination and co-operation is laid down in *Safeguarding Children Involved in Prostitution* (see above). Similarly, wide-ranging reviews undertaken by the Home Office and the Department of Health have sought to gain a greater understanding of sexual abuse and the exploitation of children, so that more effective methods can be developed to combat it. Such research has centred upon a variety of issues, including an evaluation of the UK Sex Offender Register, the relationship between sex and drugs markets and exploring the comparative costs and outcomes of different interventions for sexually abused children.

The establishment of *Internet Watch Foundation (IWF)* as a self-regulatory body financed by voluntary contributions from the UK internet industry is an important step in addressing child pornography on the internet. The IWF hotline enables members of the public to report child pornography discovered in a newsgroup or website. Where the material is considered illegal, IWF passes details to police to initiate action against the originators, and asks British Internet Service Providers to close down links to the site. Where the originators are located abroad, IWF passes the information to the *National Criminal Intelligence Service (NCIS)*, who liaise with the law enforcement agencies of the countries concerned.

Some adults use internet chat rooms to try and establish contact with children, in order to 'groom' them for inappropriate or abusive relationships. Chat rooms

create a particular problem as they occur in ‘real time’, and there is no record of the material held. A sub-group of the Internet Crime Forum (comprising the police, the industry and the government) was established in 1999 to consider this issue, and its report – *Chat Wise, Street Wise* – made a number of recommendations for Internet Service Providers, the police, government and children’s charities. The Department for Education and Skills published *Superhighway Safety* guidance for children, which contains advice for children (provided by the charity NCH) around safe use of the internet and chat rooms. It is available at: [www.safety.ngfl.gov.uk/](http://www.safety.ngfl.gov.uk/)

- **Prevention**

*The Sex Offenders Act 1997* obliges offenders who have been cautioned or convicted of sex offences against children, to notify police of their name and address, and to inform police when they intend to travel abroad. This enables police to be aware when a sex offender moves into their area, as well as to monitor sex offenders.

Following the disappearance and death of a child, Sarah Payne, the Government introduced amendments to strengthen the *Sex Offenders Act 1997*, including a new requirement on registered offenders to notify the police when intending to travel abroad for 8 days or longer; and an increased maximum penalty for failure to comply with the Act’s requirements of 5 years’ imprisonment.

Preventing unsuitable people from working with children is another key element of the National Plan. An Interdepartmental Working Group put forward 4 key recommendations in 1999:

- Identify and ban unsuitable people from working with children;
- Create a new criminal offence which an ‘unsuitable person’ would commit if they worked with children;
- Provide a new definition of ‘working with children’; and
- Create a ‘one-stop shop’ (provided through the Criminal Records Bureau) to provide access to information on people deemed unsuitable to work with children.

*The Protection of Children Act (1999)* has imposed a duty on regulated child care providers to check the names of anyone they propose to employ in posts involving

regular contact with children against the Protection of Children Act List and the Department for Education and Skills' List 99, and not to employ them if their names appear on the list.

A key element of preventing child abuse is provided by partnership working between the statutory and voluntary sector. Many services are provided by leading voluntary organisations, such as Barnardo's, the Children's Society, NSPCC and NCH. Such organisations are very active in the area of family support and in running family centres. Government provides national support to voluntary organisations through programmes of funding administered through the Department of Health, the National Assembly for Wales, the Scottish Executive and the Northern Ireland Executive.

- **Protection**

Various reports during the 1990s (eg *Children's Safeguards Review, 1997*) made recommendations for improving safeguards for vulnerable children. The Government has acted upon these recommendations through pursuing a vigorous programme of reform<sup>67</sup>. This has included the development of the *Quality Protects* initiative to transform children's social services, the Cabinet Committee for Children and Young People, creating a Minister for Young People, the Children's Fund, *Sure Start*, *Connexions* service and providing various other protective legislation.

*Area Child Protection Teams (ACPTs)* have a key role to play in co-ordinating the work of local agencies in investigating abuse and the exploitation of children.

- **Recovery and Reintegration**

The need for counselling and support services, both for children who have been abused and for the child's family, is well recognised. A range of services are available through primary health care, CAMHS, social services and the voluntary sector. Government grants have been made available under the centrally funded child abuse treatment initiative to support projects by voluntary organisations providing different types and ranges of treatment.

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<sup>67</sup> Department of Health, *The Government's Response to the Children's Safeguards Review, 1998*

- **Children’s and young people’s participation**

The important role of children’ participation has been recognised through *A National Voice*, youth participation on the Ministerial Task Force for the Children’s Safeguards Review, and the establishment of the Children’s and Young People’s Shadow Reference Group as part of the *Quality Protects* programme. Similarly the Department of Health is working with the Association of Directors of Social Services, the Local Government Association and a range of children’s organisations to deliver a sustainable children and young people’s participation programme.

- **The Way Forward**

Current government action is to ensure that the guidance on *Safeguarding Children Involved in Prostitution* is properly implemented. The *Guidance Review*<sup>68</sup>, based upon assessing how well the guidance has been implemented nationally, involved a telephone survey of all ACPCs (followed by in-depth follow up of 50 ACPCs) and a seminar for ACPC representatives. Its key conclusions in relation to safeguarding children involved in prostitution were:

- Some ACPCs had a definition of ‘prostitution’ which was too narrow;
- The most common way for ACPCs to discover and monitor the situation is through multi-agency steering groups formed specifically to share information;
- Girls seem to be far more likely to be involved in prostitution than boys;
- Children involved in prostitution may be a hidden problem through activity in non traditional street locations (eg private flats, bedsits or their own homes); and
- The Internet is being increasingly used for the purposes of prostitution. Pimps use it to advertise individual children, whilst perpetrators use it as a forum for meeting individual children through utilising chat rooms and bulletin boards.

The *Guidance Review* makes key recommendations, including the following:

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<sup>68</sup> Department of Health, *Safeguarding Children Involved in Prostitution: Guidance Review*, 2001

- ACPCs should be given advice on how to enquire into whether young people are involved in, or at risk of becoming involved in, prostitution in their area;
- Areas with no perceived problem should be given information on methods for identifying the issue;
- ACPCs should be provided with a proforma template, which would support more clarity in definitions, consistent language, processes and procedures. It could also help support monitoring and review, as well as developing young people's participation; and
- An Internet web-site for ACPCs should be set up to communicate and share information, as well as to highlight good practice, particularly in relation to successful prosecutions.

#### **5.4 The Victoria Climbié Inquiry**

The public inquiry into the abuse and murder of Victoria Climbié highlighted a catalogue of administrative, managerial and professional failures in child protection. Chaired by Lord Laming, the public inquiry report<sup>69</sup> made a number of wide-ranging recommendations, half of which were to be implemented within 3 months, and the remainder within 2 years. These included:

1. Establish a ministerial **Children and Families Board**, to be chaired by a minister of Cabinet rank and to have ministerial representation from government departments concerned with the welfare of children;
2. Set up a **National Agency for Children and Families**. This would:
  - Assess and advise the Children and Families Board on the impact on children and families of proposed policies;
  - Scrutinise legislation and guidance;
  - Advise on implementing the UN convention on child rights;
  - Ensure that policy and legislation are implemented at local level and are monitored through its regional offices; and

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<sup>69</sup> The Victoria Climbié Inquiry Report, Chaired by Lord Laming, CM 5730, 2003

- Review serious cases or oversee reviews by other agencies.
- 3. At a local level, all local authority social services should establish a **Committee for Children and Families**, with members drawn from the authority's relevant committees, the police authority and the local NHS. It should oversee the work of a Management Board for Services to Children and Families. The Board should be chaired by the local authority chief executive, and include senior officers from the police, social services, NHS, education, housing and probation.
- 4. The above local arrangements should be overseen by national inspectorates. The local committees should report through regional government offices to the National Agency for Children and Families. The ministerial board should report annually to parliament.
- 5. Data protection law should be changed to allow a **national database on children**, which would mean that every new contact with a child by a member of staff from any of the key services would initiate an entry. This would build up a picture of the child's health, developmental and educational needs.

The inquiry report also stressed that it was not possible to separate the protection of children from the wider task of supporting families: effective support could not be provided by a single agency, but required a multi-disciplinary approach.

The inquiry report concluded that although the legal framework for protecting children was essentially sound, there was a need for more effective management and leadership. It argued that Area Child Protection Committees (ACPCs), which aim to link all of the key agencies, had become "unwieldy, bureaucratic and with limited impact on front-line services". Public service managers should see their role in relation to the quality of services delivered to the public, rather than in administering bureaucratic procedures. The report criticised poor communication between social services, health and police authorities.

## **5.5 NSPCC Study of Child Maltreatment in the United Kingdom**

A recent study<sup>70</sup> by the *NSPCC* of the prevalence of child abuse and neglect in the UK reflects an appreciation of the role of research in developing strategies to stop cruelty to children. It considered the childhood experiences of 18-24 year olds,

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<sup>70</sup> NSPCC, Cawson, P et al, *Child Maltreatment in the United Kingdom*, 2000

with the aim of repeating the study after ten years, so that changes in the treatment of children and young people could be charted. Through interviewing a sample of young people from all parts of the UK, it aimed to evaluate the extent and effects of child maltreatment in the general population.

The study's conclusions found that virtually all children and young people grew up in loving homes where family discipline was based on reasoning, explanation and non-physical punishment. However, families could also be the source of stress and difficulties for a distinct few. The study drew an interesting analogy with a full double decker school bus to provide some indication of the extent of the problem: 7 children on the bus would belong to families that are not loving or close, 10 children have a 'double shift' burden of housework and caring for parents that are incapacitated by health and / or social problems, 2 or 3 children would go home in fear of violence between their parents and a further 2 or 3 children would go home to regular beatings.

The study also found strong gender divisions : girls are far more at risk of sexual abuse, as well as physical abuse and maltreatment. Although perpetrators of sexual abuse were mostly male, women were just as likely to be involved in physical and emotional maltreatment. A social class pattern also emerged, whereby children and young people from lower social classes were more likely to be rated as seriously physically abused than those from other groups. High levels of bullying, discrimination and violence were uncovered by the study, prompting its authors to call for better education of children and young people in relation to social and sexual relationships.

The study's findings also challenged some widely-held stereotypical views. It highlighted the complex relationship between physical punishment and abuse, so that parents were either using very little physical punishment very lightly on rare occasions, or else regularly and severely. Very little physical or emotional abuse was carried out by step-parents, and very little sexual abuse by strangers or in public places. The report emphasised that hardly any sexual abuse was carried out by professionals and none by careworkers or youth workers, and that this should reduce the sense of 'moral panic' that can prevent parents giving their children greater freedom for childhood development.

The *NSPCC* made the interesting conclusion that the respondents' clarity regarding unacceptable ways to treat children was not consistent with how they assessed their own treatment. Consequently young people can experience severe lack of care, physical violence or sexual assault, and yet may not rate themselves as having been

abused. It called for an informed public debate regarding acceptable standards for the treatment of children.

The study made some important recommendations, which include:

- A national incidence study of all cases of maltreatment, which can be developed as part of regular service monitoring;
- A permanent database of all fatal child abuse and neglect cases (maintained by the Department of Health and the Home Office);
- Further research should be undertaken to explore the basis for the differential assessments of child maltreatment by victims and professionals;
- Better and more accessible public information is required by children and their families on the nature of child maltreatment;
- Given that physical, sexual and psychological attacks from siblings are the most common abusive experiences, there is a need to address the cultural issues that promote physical and sexual aggression amongst young people; and
- Agencies providing child protection services should review their training and management support for identifying and working with maltreatment within middle class families.

### **5.5.1 NSPCC Report on Child Deaths from Abuse: Key Recommendations**

The NSPCC's FULL STOP campaign, launched in 1999, aims to end cruelty to children. In its report *Out of Sight*<sup>71</sup>, it argued that the UK had lost sight of the children killed by abuse and neglect, and that most attention tended to be focused on children killed by a stranger or a distant relative, such as Victoria Climbié. The NSPCC emphasised that, through being out of sight of the public eye, children killed by abuse and neglect tended to be forgotten. Approximately 1 or 2 children are known to die in this way every week (although the true number is likely to be significantly higher), yet many such deaths can remain unreported, uninvestigated and unnoticed.

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<sup>71</sup> NSPCC, *Out of Sight* : Report on Child Deaths from Abuse (1973 to 2000), 2001

Through bringing together accounts of some of the children who have died following abuse between 1973 and 2000, the report highlighted the reality of child deaths through abuse and neglect. The main reasons for such deaths not being accorded greater attention are:

- A lack of clear statistical data on child deaths;
- Difficulty in determining the cause of death; and
- The problem of co-ordination and learning from Inquiry findings.

The NSPCC reports makes some important recommendations for making child deaths visible:

1. There should be a **national target aimed at halving child deaths**, where maltreatment is a contributory factor, by 2010;
2. Many child deaths are preventable, yet there is no systematic review and analysis of all child deaths that can provide essential information for developing preventive strategies. In order to undertake consistent, regular and thorough analysis of all child deaths from 0-17 years of age, independent multi-disciplinary **Child Death Review Teams (CDRTs)** should be established on a statutory footing.

CDRTs should be able to review the circumstances of a death (unless it is clearly identified as not being due to abuse or neglect). They should have a statutory obligation to report on all child deaths and instigate a joint investigation if they feel there are suspicious circumstances surrounding a child's death.

3. A **UK-wide agreed protocol for the joint investigation of child deaths** should be developed in consultation with all agencies that take part in these procedures as part of the proposed national strategy.
4. Specialist paediatric pathologists, or general pathologists with special paediatric training, should undertake all post mortems on infants and children. There should be a commitment to ensuring multi-agency training on a regular basis, which should include:

- Training for health care professionals who work with families and babies on factors that influence the risk of sudden death in infancy and those which are protective;
  - Integrating lessons from child deaths into professional training at all levels on a regular basis;
  - Providing training on how to respond to child deaths for key professionals (eg police, coroners and paediatricians);
  - Providing evidence-based, up-to-date training on assessing and evaluating information about need and risk; and
  - Equipping professionals with appropriate skills to deal sensitively with families in extremely difficult circumstances.
5. The Home Office should produce an annual bulletin on homicides similar to that of the Scottish Executive. Data included in annual reports on Deaths Reported to Coroners should be broken down by age to distinguish between child and adult deaths, which would enable child protection professionals to monitor the effects of prevention measures.
6. Public education on preventing child abuse should include programmes to increase parents' understanding of the way in which children develop, and the dangers associated with shaking and smacking children. It should include information regarding the benefits of positive, rather than punitive, action.
7. The creation of **Children's Commissioners**. The Commissioner would have a unique and powerful role in protecting children from abuse and neglect. Established by statute to act as a champion and watchdog for children's welfare and interests, Children's Commissioners would have specific child protection functions:
- Receive all overview reports of child deaths, and monitor responses from government departments and public agencies;
  - Oversee and / or carry out inquiries into major child abuse and child death scandals; and

- Examine the adequacy of public agencies' practices in terms of their responsibilities for children.

## **5.6 Social Services Performance Assessment Framework Indicators: Focus on North West Local Authorities, 2001-2002**

There are 150 English councils with social services responsibilities. 50 indicators of the Personal Social Services (PSS) Performance Assessment Framework provide tools for investigating social services performance, thus enabling comparison between the performance of different councils over time<sup>72</sup>. Councils are encouraged to use the information to better understand their own performance, to benchmark themselves against others and to help decide which areas need improvement. However, the indicators can only illustrate part of the picture, and ought to be considered as part of a broader set of performance information about social services.

### **• Performance Assessment Framework**

The performance assessment process is intended to promote real improvements in the performance of councils in delivering care and support to vulnerable people in need of social services. It seeks to achieve this by:

- helping councils develop their performance management arrangements and contribute to the government's objectives and priorities by improving their performance;
- ensuring social care issues are appropriately addressed in Best Value Performance Plans;
- ensuring that councils work effectively with the NHS to address joint health and social care policy and service delivery issues;
- ensuring that councils work effectively with other local government departments and external agencies;
- identifying and promoting good practice; and

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<sup>72</sup> National Statistics and Department of Health, Social Services Performance Assessment Framework Indicators 2001-2002

- identifying councils that are performing poorly and ensuring that they take action to improve.

- **Performance Banding**

The Department of Health evaluates information provided by councils in relation to the performance indicators. It provides each council with a banding for their performance against each of the 50 indicators. The bands range as follows:

### **Performance Bands**

#### **1. Investigate urgently**

*Very urgent need for council to investigate practices that have led to this performance and to consider complementary indicators, contextual information and other performance evidence.*

#### **2. Ask questions about performance**

*Serious need for council to investigate practices that have led to this performance and to consider complementary indicators, contextual information and other performance evidence.*

#### **3. Acceptable, but room for improvement**

*Worth probing, but there is reason to believe that, compared with other councils, there is scope to shift performance.*

#### **4. Good**

*Performance seems to conform reasonably well with commonly accepted good practice.*

#### **5. Very good**

*Performance at a level that is very good given current knowledge and understanding. The potential for achieving good practice should be shared.*

There has been an overall improvement in performance across England. However, there is considerable variation between councils for many of the indicators. Within the North West of England, there are 22 councils:

- 15 of them comprise Metropolitan Districts (Bolton, Bury, Knowsley, Liverpool, Manchester, Oldham, Rochdale, Salford, Sefton, St Helens, Stockport, Tameside, Trafford, Wigan and Wirral);
- 3 of them comprise Shire Counties (Cheshire, Cumbria and Lancashire); and
- 4 of them comprise Unitary Authorities (Blackburn with Darwen; Blackpool; Halton; and Warrington)

The following review seeks to highlight some of the key performance indicators that directly relate to supporting 3 key categories of vulnerable children (see below). It also seeks to underline highly significant differences in the performance of councils in the North West in relation to each of these performance indicators.

It focuses attention on local authority performance at the extreme ends of the banding structure. Thus it identifies North West councils situated within performance bands 1 and 2, as well as North West councils situated within performance bands 4 and 5. This information is considered in the context of the overall performance across England for each performance indicator.

The 3 key categories of vulnerable children and young people considered here are:

1. Creating stability for looked after children;
2. Protecting children and young people from harm; and
3. Preparing children for later life after leaving the care system.

### **5.6.1 Creating Stability for Looked After Children**

#### **□ Stability of placements of looked after children**

This indicator considers the percentage of children looked after with 3 or more placements during the previous 12 months. It is the best available measure of the stability of care that a child has experienced, as stability is generally associated with better outcomes.

Across England, good performance is low. Only 1 North West council falls within band 1 (ie investigate urgently) out of a total of 3: Trafford. There are 2 North West councils within band 2 (ie ask questions about performance) out of a total of 18: Halton and Lancashire. All of the other North West local authorities are placed within the 'very good' category.

#### □ **Adoptions of looked after children**

This indicator considers the number of looked after children adopted during the year as a percentage of the total number of looked after children. The rationale for this indicator is the government's belief that more should be done to increase adoption, which offers the only legally secure placement for children unable to return to their birth families.

Across England, good performance is generally high. Only 1 North West council falls within band 1 (ie investigate urgently) out of a total of 4: Wirral. There are 5 North West councils within band 2 (ie ask questions about performance) out of a total of 43: Lancashire, Sefton, Salford, Liverpool and Bury. However, there are 8 North West councils within band 5 (ie very good) out of a total of 50: Wigan, Oldham, Trafford, Bolton, St Helens, Knowsley, Blackpool and Warrington.

#### □ **Long term stability of looked after children**

This indicator concerns the percentage of children who had been looked after continuously for at least 4 years, who were currently in a foster placement where they had spent at least 2 years. It is designed to illustrate the relative effectiveness of councils in achieving longer term stability. For children looked after for such a long period of time, it is reasonable to expect that a substantial amount of time is spent with the same foster carers, or that an adoptive placement would be found.

Across England, good performance is generally high. Only 1 North West council falls within band 1 (ie investigate urgently) out of a total of 17: Tameside. There are 8 North West councils within band 2 (ie ask questions about performance) out of a total of 53: Halton, Bolton, Oldham, Lancashire, St Helens, Blackburn with Darwen, Manchester and Warrington. Only 1 North West council falls within band 4 (ie good): Cheshire.

## **5.6.2 Protecting Children and Young People from Harm**

### **□ Re-registrations on the Child Protection Register**

This indicator concerns the percentage of children registered during the year on the Child Protection Register who had previously been registered. The aim of registration on the Child Protection Register is to devise and implement a child protection plan that leads to lasting improvements in the child's safety and overall well-being. Some re-registrations are essential in order to respond to adverse changes in circumstance. However, high levels of re-registration may suggest that the professionals responsible for the child's welfare are not intervening effectively, either to bring about the necessary changes in the child's family situation, or else to make alternative plans for the child's long term care.

Across England, good performance is generally low. Only one North West council falls within band 1 (ie investigate urgently) out of a total of 6: Halton. There is only 1 North West council within band 2 (ie ask questions about performance) out of a total of 8: Cumbria. There are 6 North West councils within band 5 (ie very good) out of total of 51: Tameside, Bolton, Rochdale, Warrington, St Helens and Blackpool.

### **□ Reviews of child protection cases**

This indicator concerns the percentage of child protection cases which should have been reviewed during the year that were reviewed. The rationale for this indicator is that it tries to measure the effectiveness of interventions provided to children on the Child Protection Register.

Across England, good performance is generally 100%. None of the North West councils fall within band 1 (ie investigate urgently). Only 1 North West council falls within band 2 (ie ask questions about performance) out of a total of 7: Manchester. All other North West councils are either in bands 3, 4 or 5.

### **□ Duration on the Child Protection Register**

This indicator concerns the percentage of children de-registered from the Child Protection Register during the year who had been on the Register for 2 years or more. The reasoning for this indicator is that professionals, the child and the family should be working towards specified outcomes which should lead to the child's name being taken off the Register within 2 years.

Across England, good performance is generally low. Only 1 of the North West council falls within band 1 (ie investigate urgently) out of a total of 17: Knowsley. There are 2 North West councils that fall within band 2 (ie ask questions about performance) out of a total of 14: Liverpool and Oldham. There are 55 English councils in which performance falls within band 4 (ie good), of which 7 are located in the North West: Manchester, Wigan, Tameside, Warrington, Wirral, Blackpool and Cumbria.

#### □ **Inspections of children's homes**

This indicator concerns the percentage of inspections of residential care homes for children which should have been carried out that were carried out. The reasoning for this indicator is that the Regulatory system provides essential safeguards against harm and poor standards of care, and that councils are required to undertake 2 inspections of each council and private children's home each year. At least one of these inspections should be unannounced.

Across England, good performance is virtually 100%. Only 1 North West council falls within band 1 (ie investigate urgently) out of a total of 4: Manchester. All other North West councils fall within band 5 (ie very good).

### **5.6.3 Preparing looked after children for later life**

#### □ **Educational qualifications of looked after children**

This indicator concerns the percentage of young people leaving care aged 16 or over with at least 1 GCSE at grade A\* to G or a GNVQ. The rationale for this indicator is that educational attainment is one of the most important determinants of future outcomes. Clearly there is a need for social services, education authorities and schools to improve attainment levels of looked after children. This indicator, therefore, is intended to reflect the corporate responsibility of councils for the education of vulnerable children.

Across England, good performance is generally high. None of the North West councils fall within band 1 (ie investigate urgently). There are 13 North West councils within band 2 (ie ask questions about performance) out of a total of 82: Stockport, Sefton, Lancashire, Cheshire, Tameside, Manchester, St Helens, Liverpool, Bolton, Rochdale, Blackpool, Knowsley and Salford. None of the North West councils fall within band 5 (ie very good). There are 4 North West councils within band 4 (ie good) out of 32: Wigan, Wirral, Halton and Warrington.

## □ **Employment, education and training for care leavers**

This indicator concerns the percentage of young people who were looked after on April 1<sup>st</sup> in their 17<sup>th</sup> year (aged 16), who were engaged in education, training or employment at the age of 19. The rationale for this indicator is that care leavers experience high levels of unemployment, and are at risk of social exclusion. It supports the targets in the National Priorities Guidance and *Quality Protects* to show that the level of employment, training and education (amongst young people aged 19 in 2001-02) who were looked after at age 16 is at least 60% of the level amongst all young people of the same age in their area.

Across England, good performance is generally high. There are 2 North West councils which fall within band 1 (ie investigate urgently) out of a total of 16: Lancashire and Salford. There are 3 North West councils within band 2 (ie ask questions about performance) out of a total of 30: Oldham, Stockport and Manchester. There are 7 North West councils within band 5 (ie very good) out of 51: Tameside, Bolton, Halton, Liverpool, St Helens, Knowsley and Blackburn with Darwen.

## □ **Health of looked after children**

This indicator concerns the averages of the percentages of looked after children who had been looked after continuously for at least 12 months, and who had routine immunisations up to date, had their teeth checked by a dentist during the previous 12 months, and had an annual health assessment during the previous 12 months. The rationale for this indicator is that these are basic health requirements for all children which should not be overlooked for looked after children.

Across England, good performance is generally high. Only one North West council falls within band 1 (ie investigate urgently) out of a total of 12: Stockport. There are 7 North West councils within band 2 (ie ask questions about performance) out of a total of 19: Cumbria, Warrington, Liverpool, Oldham, Manchester, Bury and Salford. There are 4 North West councils within band 5 (ie very good) out of a total of 48: Tameside, Wigan, Cheshire and Halton.

## □ **Looked after children absent from school**

This indicator concerns the percentage of children who had been looked after continuously for at least 12 months and were of school age, and who missed a total of 25 days of schooling for any reason during the school year.

The rationale for this indicator is that access to school is an important factor both in securing qualifications and in providing normal social interactions. Social services, educational authorities and schools need to work together to ensure that looked after children are not excluded or playing truant.

Across England, good performance is generally low. Only one North West council falls within band 1 (ie investigate urgently) out of a total of 9: Manchester. There are 3 North West councils within band 2 (ie ask questions about performance) out of a total of 30: Trafford, Sefton and Wirral. None of the North West councils feature within band 5 (ie very good). However, there are 5 North West councils within band 4 (ie good) out of 32: Tameside, Oldham, Liverpool, Knowsley and Blackburn with Darwen.

## **5.7 How Can Vulnerable Children in Foster Care Be Effectively Supported ?**

Barnardo's have undertaken an important review of the evidence concerning this important group of vulnerable children<sup>73</sup>. It seeks to highlight key messages from research in relation to supporting children in temporary and permanent foster care, their natural parents and their foster carers. It also highlights key messages from research in relation to long-term or permanent family placement.

The following summary seeks to highlight some of these key issues.

### **5.7.1 Supporting Children in Temporary Foster Care**

Foster care tasks include receiving children at short notice during a family crisis, and working inclusively both with parents, social workers and other professionals. It also involves providing a high standard of direct care, as well as supporting parents and young people leaving care or accommodation.

The main outcome measure used in evaluating success in providing foster care is whether or not the placement broke down or lasted for as long as was needed. However, there are a range of other qualitative measures which can include:

- whether the child could participate in decisions affecting the placement;
- whether the child's well-being improved as a consequence of the placement;

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<sup>73</sup> Barnardo's, *What Works in Creating Stability for Looked After Children?*, 2000

- whether health and educational needs were successfully met; and
- whether the child's racial, cultural and religious identity was respected.

**Parental indicators of success include:**

- whether parents felt fully involved in day-to-day decisions affecting their child;
- whether parents felt their child's physical and emotional needs were cared for;
- whether parents felt that they retained a sense of parental authority and responsibility; and
- whether parents could assimilate their child back into the family with undue stress.

**Foster carers' indicators of success include:**

- whether the fostering experience provided anticipated rewards;
- whether the foster carers' own children enjoyed and felt a part of the fostering experience;
- whether foster carers were effectively supported by social services; and
- whether the fostering experience supported the carers' skills and confidence.

The evidence for effective support is based upon a variety of studies, and some of the key messages can be summarised as follows:

- Success in short-term and intermediate placements is linked with rigorous selection procedures for foster carers, sensitive matching and introductions, regular contact between children and families, frequent link worker visits and strong efforts by social workers to work with the child's family.
- Good practice commences before the child leaves home, with a carefully negotiated agreement and choice of placement informed by the wishes of child and parents. It is best, if at all possible, to avoid emergency admissions which preclude such planning.

- A close working relationship between the child's social worker, the carer's link worker, the foster carer, parents and older children is the central feature that succeeds in reuniting families.
- The casework practice and negotiations that go on before, during and after each review are vitally important if the negotiated agreement is to lead to actions being taken which will produce necessary change in the behaviour of the children or parents.
- It has been strongly suggested that the chances of successful placement back home are increased if social workers maintain a clear sense of purpose. Consequently the child should continue to have a role in the family throughout the stay away (eg by keeping toys or clothes at home, or maintaining the child's bedroom).

### **5.7.2 Effective Recruitment and Retention of Short-Term Foster Carers**

Essential prerequisites of fostering include an enjoyment of children's company, having a flexible, non-judgemental approach, coupled with a readiness to use authority when appropriate.

Further evidence on achieving permanence by returning children home has highlighted certain characteristics associated with a successful return:

- Children being under the age of two when returned home;
- Parents having regular contact with the child whilst he or she was away;
- Parents attending reviews when the child was away;
- Parents being willing to talk to each other and the social worker about the problems they may encounter when the child returns home; and
- Being able to negotiate with children, parents and social services. Further skill include being able to understand and empathise with a child who has been neglected or abused, and being able to empathise with a parent who was maltreated or unable to protect their child.

Further research has clarified characteristics of foster carers likely to underpin (or undermine) their successful practice. Positive factors include foster carers who:

- Do not perceive the foster child as seriously problematic (or respond positively to the challenge of such behaviour);
- Do not expect a return from the child but wish instead to ‘give something back’. This is particularly relevant for older foster carers who have successfully raised their own children who now live independently;
- Welcome opportunities for training and support, and who can work positively with social workers; and
- Are inclusive of the birth family, and empathetic to parents (some of whom have maltreated their children).

The Barnardo’s report also highlighted the key requirements of foster carers from both social workers and link workers. The following summary highlights some of the key needs:

- Link workers and children’s social workers who combine professional competence with various personal qualities;
- Social workers who are well informed, purposeful, accessible and reliable and who establish a trusting working relationship, build rapport with foster carers and fully acknowledge the personal costs to them and their families;
- Children’s social workers who provide immediate placement-related support. The need for alternative points of contact in the absence of the link or child’s social workers (especially outside office hours) is often highlighted by foster carers;
- The opportunity to take part in support groups and informal networks of foster carers, so that they can share experiences and tackle common problems together; and
- Link workers and children’s social workers who ensure that expert and accessible specialist advice is available, especially from local health, education and psychological services.

### **5.7.3 Long term or Permanent Family Placement**

The Barnardo's report emphasised that few studies describe in detail specific aspects of practice and evaluate them using specified outcome measures. However, key messages emerge from the review of the research into permanent placements, which may be summarised as follows:

- Long-term placement with relatives or friends has been found to be more successful for the full range of children than placement with families not previously known to the child;
- Research into the placement of infants (at the request of the birth parent) concludes that about 5% of these placements will break down. Other studies show that 80% of adopters and adopted adults express satisfaction with their relationship, with 20% being generally dissatisfied;
- Successful adoptive parenting of children placed as infants is linked with the ability to accept the child's dual identity and the emotional significance which the family of origin will always have for the child, and for themselves as substitute parents;
- For older age children, age at placement is important. Beyond the age of 6 months, the level of vulnerability to emotional problems around attachment increases with age at placement;
- Individual characteristics of children have an impact. Being described as institutionalised, having behavioural or emotional difficulties (and having a history of abuse or neglect) are all linked with a greater risk of placement breakdown;
- Children of mixed racial heritage are more likely to experience placement breakdown than either black or white children;
- It is important for substitute parents to feel comfortable about integrating the child's early history into their family life;
- Studies of placements of infants and older children show that where the new family has a child close in age to the child to be placed, this can have a negative impact on the success of the placement;

- Providing information to substitute parents in advance of placement can help to lessen the problems that can arise for families adjusting to the needs of children who have been sexually abused or who have serious behavioural problems; and
- Continued contact with birth parents, relatives or siblings can provide continuity for children in forming new attachments to substitute families.

#### **5.7.4 How Can Vulnerable Looked After Children Be Offered Lasting Stability ?**

Another report from Barnardo's highlighted the effects of instability on children's well-being and development, as well as the factors promoting and maintaining stability<sup>74</sup>. Although sexual abuse attracts much more attention, instability creates a great deal of harm to children who need to be looked after away from home. Coming often from chaotic backgrounds, too many children enter into a system which may inflict further damage to their social, emotional and cognitive development by failing to provide a place where they can be confident of staying for any length of time, and which can then label them as disturbed and disruptive.

Instability affects roughly half of all children needing long-term care away from home, and almost all who enter the system as teenagers. It has a particularly damaging impact on their education, as well as their ability to form trusting relationships. For some young people, it sets a pattern of dealing with problems – by moving on – which continues disastrously into their adult life.

Barnardo's underlines the strong evidence base from research that instability, and many changes of placement, are extremely damaging to children. However, the evidence base is less clear on what can be done to avoid this. The report defines stability as remaining in the same place or with the same people, although it recognises that a child may be in a stable situation but have substantial unmet needs. It is not in a child's interest to remain in a placement that is not meeting his or her needs, simply for the sake of stability. The report makes an important distinction between 'stability' (ie the child staying in the same place or with the same people) and 'continuity' (which applies to the child's education and health care, networks of relationships, and their personal / cultural identity).

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<sup>74</sup> Barnardo's, *What Works in Creating Stability for Looked After Children?*, 2001

## **Key Factors that Contribute towards Instability**

- Placement at an older age;
- Child's behaviour seen as problematic by carers;
- Placement in residential unit with frequent emergency admissions;
- School problems (especially if leading to exclusion);
- Child separated from siblings;
- Foster parents' children very young or close in age to foster child;
- Lack of social work support;
- Exclusion of birth parents from placement;
- Child having a history of abuse or neglect; and
- Poor coordination of services.

## **Key Factors that Contribute towards Stability**

- Adoption (especially if under 4 years);
- Remaining with own family despite difficulties;
- Returning home within 6 months;
- Placement with relatives;
- Regular school attendance and average or better attainment;
- Intensive social work support during early stages of placement;
- Absence of behavioural problems;
- Maintaining child's social networks;
- Parental involvement in child's life; and
- Older, more experienced foster carers.

## **Common Elements of Good Practice in Temporary and Permanent Placement**

- Staying at home offers the best chance of stability: family preservation has a higher success rate than reunification (although this must be balanced against the risk of harming the child);
- Placement with relatives is preferable to placement with strangers if a suitable person is available and willing;
- For school age children, equal attention should be given to the school placement and the care placement. Continuation of school placement and education should receive very high priority;

- Long-term placements with carers who have young children close to the age of the children to be placed should be avoided;
- The child's existing social networks should be maintained as far as possible in the new placement;
- There should be good preparation for the placement, and parents should be positively involved both in the preparation and placement;
- A solid pattern of social work support for carers, parents and the child should be built in from the start of the placement; and
- Where children have particular difficulties, extra support should be provided from the outset, rather than waiting for things to go wrong.

The report concluded that instability of placement is made worse by a failure to involve children in decision-making and listen to what they want. It emphasised that children's own accounts of being looked after too often convey a sense of bewilderment and helplessness, of being pushed around without explanation and for reasons that have more to do with adult agendas than their own. Research into placement breakdown places too much attention on child factors, and not enough on the carers and their motivation, as well as the institutional factors that create instability. A single failure in what is intended to be a long-term placement should cause considerable alarm, given that each move makes the next one more likely to happen, thereby creating an accelerating pattern of instability.

However, the report underlined existing scope for developing new and imaginative ways of keeping children within their own homes and families. Non-stigmatising intensive family support at times of crisis, providing care where children live instead of removing them to new homes, rapid-response services for families and teenagers in conflict, social support for the education of disadvantaged young people, open-access counselling for children with family problems: all of these have been tried with success in various places. The report calls for such initiatives to be more widely available, which would result in fewer children having to suffer the disruption of removal from home and the risk of unstable local authority care.

### **5.7.5 Supporting the Educational Needs of Looked After Children: The National Teaching and Advisory Service (NT&AS)**

NT&AS was formed in 1998 as the first national education organisation for looked after children and children in need<sup>75</sup>. It offers practical, strategic, training and consultancy services to local authority and social work departments, as well as the independent sector. These include direct education casework with children and young people themselves, which aims to research, plan and support mainstream school placements, as well as to raise standards for all children poorly served by the public care and education system.

NT&AS has a strong belief in the effectiveness of providing high quality casework for significantly improving aspects of the social work system. This can include helping to prevent placement breakdowns within foster and residential care, improving the safety of children who need protection and reducing the possibility of them drifting into homelessness, unemployment, poverty and crime.

Research indicates that a renewed and positive emphasis on the educational needs of the most vulnerable children is likely to make a vast contribution to meeting many of the key objectives within the *Quality Protects* initiative, as well as being central to realising broader objectives around social inclusion. Further research suggests that high quality education placements within mainstream schools can help children and young people develop the personal resilience to help them to come to terms with other difficulties in their lives. Such placements also provide opportunities that emphasize children's right to normal lifestyles and contacts with other peers that are so often denied them through the current workings of the education / social work system.

The aims and objectives of NT&AS can be summarised as follows:

- Promote the educational and wider interests of looked after children and children in need within international, national and local contexts;
- Provide services that enable children and young people to become full and active participants in their schools, neighbourhoods and communities rather than disengaged, alienated and excluded from them;

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<sup>75</sup> <http://www.ntas.org.uk/>

- Support close links with other professional childcare and educational organisations to encourage and facilitate joint action to address the educational needs of looked after children; and
- Ensure that services are managed and delivered in a child-centred, multi-disciplinary and anti-discriminatory framework, in close partnership with professional colleagues within the public care system, school teachers, children, parents and carers.

The casework model of practice provided by NT&AS recognises that the combination of factors and complex difficulties faced by a looked after child, or a child in need, are unique to the individual child. Consequently there is a potentially unique set of barriers between the child and the universal education system. The casework model of education support builds on an assessment of the child's educational needs in the context of their lives as a whole. A teacher allocated to a particular case takes responsibility for the development, co-ordination and implementation of an education plan for the child. A child's teacher will advocate on his or her behalf, as well as providing direct support to the level commissioned by the purchaser.

## **5.8 How Can Vulnerable Children Be Protected from Abuse and Neglect ?**

A recent Barnardo's report considered the multi-faceted issue of child protection in relation to primary, secondary and tertiary prevention of abuse and neglect<sup>76</sup>. It emphasised the importance of developing effective child protection services based upon clear research evidence that beneficial outcomes for children and families are produced by agency interventions. Therefore research designs that are robust and replicable are needed to enable confident statements to be made concerning cause and effect.

The report recognised that randomised controlled trials (RCTs) are an underused method of evaluating the effectiveness of various social interventions. However, it also argued that some important questions about child protection cannot be considered using RCTs, and that quasi-experimental and single case designs, surveys, cohort studies and other studies using qualitative methods can provide crucial sources of information, especially where they produce patterns of similar results.

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<sup>76</sup> Barnardo's, *What Works in Child Protection ?*, McDonald, G & Winkley, A, 1999

Research on effective practice illustrates that the type of practice undertaken (ie what practitioners do) strongly influences outcomes for children, and that research findings on effective practice need to be disseminated to practitioners. Whichever research design is used, Barnardo's emphasises that a failure to learn from robust findings on effective practice is both unethical and unprofessional.

### **5.8.1 What is Effective in the Primary Prevention of Abuse and Neglect ?**

Primary prevention strategies generally focus upon children's well-being in general, and the correlates of good parenting, provided in the context of supportive communities and enabling social and economic policies. Primary prevention of physical abuse and neglect, therefore, focuses upon reducing socially determined, violence-provoking stress; promoting social organisation and adequate networks of family support; and developing educational programmes that reduce the likelihood of abuse and neglect. Such educational programmes should eliminate norms that legitimate and glorify violence in society and the family, promote anti-sexist norms, values and expectations and challenge violence in the family by teaching alternatives to violence as a means of controlling children and managing conflict.

Poverty is clearly associated with child maltreatment. It affects the lives of individuals both at a community level (with the social and economic decline of neighbourhoods) and at the level of family life. At the community level, it appears that poverty is linked to lower levels of social cohesion and social organisation, leaving families without networks of support. Similarly, inadequate income influences the material quality of life that parents can provide for their children (ie home, diet and clothing) as well as the social and economic environments in which children grow up. Preventing child neglect, therefore, requires public social programmes that can target the root causes of poverty, including poor education, teenage parenthood, unwanted pregnancies, unemployment and substance abuse. Educational programmes can also play a leading role in reducing the likelihood of early school failure and placement in special education, which are key turning points in the lives of many children. Such approaches can include teaching parenting skills, preventing teenage pregnancy and teaching conflict negotiation skills to young people.

### **How to Support the Primary Prevention of Abuse and Neglect**

- More resources should go into primary prevention. This would move the emphasis of work towards children's overall well-being and encourage good parenting within supportive communities;

- Poverty is strongly associated with maltreatment, so preventing child abuse and neglect requires economic and social reforms that target the root causes of poverty;
- Many effective social interventions aim to help families increase their incomes or reduce the effects of poverty;
- Community-based projects may protect children by developing formal and informal support networks for parents and by helping professionals to work together;
- There is good evidence that good quality day care and pre-school education, with parental involvement, can protect children;
- Schools can play a key role in promoting attitudes that challenge violence and sexism and develop good interpersonal skills;
- Effective preventive programmes which aim to protect children from sexual abuse are characterised by length and intensity. They include behavioural training in self-protection, opportunities for repeated learning over time and specific tailoring to their audience; and
- Children from lower socio-economic groups seem to benefit most from programmes aimed at preventing child sexual abuse.

### **5.8.2 What is Effective in the Secondary Prevention of Abuse and Neglect ?**

Secondary prevention refers to parents who are thought to be at high risk of abuse or neglect, but where this has not yet occurred. Effective secondary prevention programmes are characterised by a clear rationale based on what is known about the causes and triggers of child physical abuse and neglect. They draw heavily on social or ecological models of child maltreatment, seeing child abuse and neglect as a function of the stresses of poverty, social disadvantage, diminished social resources to manage those stresses and personal difficulties in dealing with key aspects of parenting. Programmes often comprise elements of education or parent-training, social and emotional support and assistance to cope with stress.

Effective secondary prevention programmes are based upon reliably identifying factors that place individuals, or groups, at increased risk of abuse. In some areas,

such as pre-natal screening, there is evidence that this can be done fairly accurately, and that effective interventions can be made. In principle, the range of problems that might be targeted within the concept of secondary prevention is considerable, given the range of factors associated with increased risk. As an example, it is known that the children of teenage mothers have an enhanced risk of inadequate child care and child maltreatment, so targeting those with unwanted or unplanned pregnancies would fall within this category. Similarly, interventions aimed at breaking a cycle of inter-generational abuse and neglect try to equip vulnerable young people with the skills (and attitudes) necessary for developing non-violent means of conflict negotiation. This can help them manage the inevitable stresses of adult life, and intimate relationships in particular. Such approaches may be particularly beneficial.

- **Home Visiting**

A particularly developed area of secondary prevention relates to identifying women thought to be at risk of experiencing problems with parenting, potentially leading to abuse and neglect. Most of these programmes comprise home visiting by a trained nurse, other professional or lay person. The emphasis is on shaping parenting skills, enhancing the parent-child relationship and improving relationships with formal and informal networks. In general terms, the programmes focus on interpersonal relationships (both within and outside the family) and aim to pre-empt or help remedy problems as they arise. Only one secondary prevention programme (fairly long term and consisting of visiting by trained nurses) seemed effective in preventing abuse and neglect, whereas other such interventions seemed to make little difference.

- **Parenting Programmes**

Parenting programmes are often seen as an effective tool, and the rationale for such programmes is based upon certain key premises. Parenting skills are learned, so parents acquire them on the basis of their experience of parenting and from observing others. However, for some adults, their own experience of parenting does not provide a reasonable starting point for satisfactory parenting. Secondly, some children are more temperamentally challenging than others, and this can make them difficult to manage. Where clashes occur between a particular parenting style and a child's temperamental behaviour, the parent-child relationship can become particularly fraught. Thirdly, some children can develop patterns of behaviour that are extremely challenging to manage. Environmental

factors can help to create this situation through lax discipline, poor socialisation or coercive patterns of family interaction.

It has been noticed that parents referred to such programmes have similar behavioural traits: they give more commands to their children in a threatening, nagging or angry fashion; and are more critical of their children's behaviour and respond to their children with negative behaviours (eg shouting). Children labelled as 'aggressive' have particular similarities: they also tend to display more coercive behaviours (eg hitting); are more likely to experience a clustering of problems; show a lack of desirable behaviours (eg laughing and talking); and tend to come from 'distressed' family types.

Parenting programmes seek to enhance parents' abilities to manage their children's behaviour, reduce conflict and confrontation and increase compliance, cooperation and pleasant interaction. These may cover a variety of initiatives, which include: providing information about child development, health, hygiene and safety; enhancing the quality of child-parent relationships (eg through teaching play skills) and developing parents' ability to monitor and track their children's behaviour and respond appropriately.

A review of the effectiveness of parenting programmes between 1970 and 1997 in improving behavioural problems amongst children aged 3-10 years produced the following results:

- Group-based programmes generally produced better results compared to individual programmes;
- Behavioural programmes produced better results compared to Parent Effectiveness Programmes (PET) or other programmes focused upon developing relationship (ie Adlerian); and
- One study showed that a behavioural programme produced significant changes in child behaviour regardless of the type of administration (ie group or individual; telephone or home visit).

This review concluded that all group-based parent-training programmes produced changes in children's behaviour, but that behavioural programmes had a much more positive impact.

### **5.8.3 Breaking the Cycle of Violence**

#### **The Intergenerational Cycle of Violence: Four Key Factors**

The Barnardo's report considered the evidence for the intergenerational cycle of violence, and highlighted four key factors:

- Children who witness persistent parental violence (or whose parents resort to violence as a disciplinary tool or as a strategy for conflict resolution) are at risk of repeating such behaviours as adults;
- Children who have been victimised can develop 'hostile beliefs and power assertive behaviour regarding male-female relationships', which are reinforced by social pressures towards highly gendered and sexist patterns of behaviour;
- Earlier patterns of learned behaviour can be more entrenched when certain problem situations arise, so there is a tendency to fall back on earlier strategies internalised from childhood experiences; and
- Wider social factors, such as general exposure to violence and the active devaluation of women, can have a strong impact.

#### **How to Support the Secondary Prevention of Abuse and Neglect**

- Effective secondary prevention depends on our ability to identify factors that place people at increased risk of abuse;
- Home visiting programmes are likely to be particularly effective when they use either professional visitors or well trained lay people, are multi-dimensional, intensive and long-term and visiting starts before the birth of the child;
- Parenting programmes are most effective when they are group-based rather than individual based, are behavioural in design rather than primarily based on relationship work and use modelling as a way of helping parents learn new skills;
- Parenting programmes are only rarely sufficient, especially when there are a number of problems within the family; and

- Anger-control training for parents offers a promising avenue for further research.

#### **5.8.4 What is Effective in the Tertiary Prevention of Abuse and Neglect ?**

Cognitive-behavioural approaches comprise a good starting point for developing interventions designed to prevent the recurrence of abuse and neglect. Such programmes often combine parent training with self-management techniques (eg anger control) and problem-solving delivered in ways that recognise the broader social context in which children and families live. One such programme concluded that families who participated made significant improvements in their child management skills, reported fewer child behaviour problems and were seen by caseworkers to have noticeably fewer problems.

#### **5.8.5 Issues in Working with Abusive Parents**

Changing the behaviour of parents who have been deemed to have abused their children, through the process of making detailed assessment and monitoring progress, can make parents feel that they are providing evidence that can be used against them.

The Barnardo's report explored behavioural family therapy, social network interventions, ways of responding to psychological maltreatment and child-centred treatments. It concluded that there are clear trends in the tertiary prevention literature favouring cognitive-behavioural approaches to a range of problems associated with child physical abuse and neglect. At their most successful, interventions are multi-faceted and pay particular attention to process factors, such as careful engagements with families (particularly parents), who may not share the same view as professionals, or may feel victimised by the protection process.

#### **How to Support Tertiary Prevention of Abuse and Neglect**

- Cognitive-behavioural approaches are important interventions for preventing the recurrence of abuse and neglect;
- It can be concluded from cognitive-behavioural studies that:
  - long-standing, complex problems may require longer term programmes of support as well as intensive periods of task-centred activity, and

- the use of cognitive-behavioural approaches is best integrated within a broad-based and flexible approach;
- Cognitive-behavioural parent training appears to be effective for parents with learning disabilities;
- Families in trouble are likely to need help with a number of problems in addition to child management skills. Behavioural family therapy and eco-behavioural therapy are two broad-based approaches which enjoy some empirical support;
- The effectiveness of systemic family therapy as an intervention in child protection is not yet clear but merits further investigation;
- Where serious maltreatment has occurred, programmes that combine family work with day care services show some promise;
- Effective direct work with children who have been sexually abused needs to focus specifically on the trauma of the abuse itself and the longer term effects; and
- There is some evidence that in cases of child sexual abuse, abuse-specific programmes that offer help to non-offending parents and to children at the same time are more helpful than those with a sole focus on either parents or children.

## **5.9 Examples of Innovative Practice in the North West to Support Vulnerable Children and Young People**

### **5.9.1 Cornerstone Project, Barnardo's and Salford Social Services**

The Cornerstone Project has been developed to provide a caring, professional and therapeutic service to children and their families or carers, where there has been an experience of sexual abuse, or where there are concerns about sexualised behaviours.

The Project recognises the importance of working alongside the child, their family and other professionals by providing direct work to the child, sibling or safe carer, and consultation / training to professionals where appropriate. The Project also recognises that although the child is the most important person, other family

members can be affected indirectly by sexual abuse and may need help in their own right, so that they can be strong enough to support and help the child. Through this approach, the project aims to promote best practice and focus interventions that can meet the child's individual needs in the most appropriate manner.

The Project's key functions can be summarised as follows:

- To develop services for children and their families in Salford who have been sexually abused;
- To develop services for children, families and other professionals where there are concerns about sexualised behaviours;
- To provide information, consultation and support to colleagues on a multi-agency basis;
- To work with colleagues to develop and promote good child-centred practice, especially in relation to child protection, therapeutic work, and safe caring policies and practice for children in need;
- To co-ordinate and facilitate the development of skills and knowledge among professionals from differing agencies undertaking individual direct work with children who have been sexually abused;
- To develop and deliver group-work programmes for children, young people and non-abusing carers, and to offer support and guidance to professionals offering group-work to adult survivors;
- To maintain and promote up-to-date knowledge of legislation, policy and practice in relation to child abuse;
- To ensure the involvement of children, young people and their families in the service by actively promoting practice that enables their views to be heard;
- To provide age-appropriate information for children, young people and their families about their experiences and the support and services available to them; and

- To link with the wider work of Salford Child Protection and Reviewing Unit and Barnardo's 'Keeping Children Safe Project' (in Liverpool) to ensure open and effective communication.

There are 8 types of activity that the project undertakes:

1. Direct work with children and young people, as well as with professional carers offering residential or fostering services;
2. Advisory and support work with colleagues on a multi-agency basis;
3. Group-work with children and young people, as well as providing facilitation support to non-abusing carers and also adult survivors of abuse;
4. Production of relevant materials, such as the 'Looking Glass Workbook', which provides a framework for use by residential social workers to enhance their communication and relationship with the young people they are supporting. Similarly, Sexual Abuse Investigation Booklets have been produced for different children's age groups (ie 6-9 year olds, 10-12 year olds and 13-16 + year olds);
5. Training activities, both as part of established multi-disciplinary courses, as well as writing and developing new courses;
6. Running practice based workshops for social workers that are centred upon specific areas of working with children and young people;
7. Using a recently developed database to collate information regarding unmet needs with the local authority; and
8. Undertaking policy development in relation to pertinent issues.

### **5.9.2 5A Project, Barnardo's and Merseyside Local Authorities**

Since 1999 the 5A Project has developed its work with young people displaying sexually problematic behaviour throughout Merseyside, particularly through developing links with Merseyside Local Authorities and Youth Offending Teams. It is able to provide a range of services for young people and their carers, including assessment and direct work, and offers resources and support for practitioners involved in the work.

Assessments aim to gather information and establish the young person's and carer's views and perceptions of the abusive behaviour. An important element in this process is the identification of circumstances that may have contributed to the behaviour in some way. A multi-factoral model of assessment can provide a framework for gathering and using significant information in order to:

- develop an understanding of the behaviour (including specific risk factors and areas of need);
- make recommendations to other professionals regarding sentencing options and placement issues; and
- consider the need for further intervention, and the young person's motivation to engage and manage their behaviour.

The 5A Project's services include undertaking individual direct work with young people using a cognitive behavioural approach. A process of engagement describes the initial relationship building period between project workers and the young person and their carers at the start of direct work. This significant period provides an opportunity for a safe and trusting environment to be created, so that young people can be allowed to explore sensitive issues, including their sexually problematic behaviour. The process of engagement can highlight a young person's social inadequacies, which can include a range of factors (eg relationships, self-esteem, parenting, anger management and control).

The assessment process includes:

- Initial assessment - to gather information and decide the appropriateness of the referral. It enables the young people and carers to obtain information about the 5A Project, and establish their initial attitudes to undertaking direct work. Psychological input and testing may take place during this period;
- Comprehensive assessment – carry out a programme of direct work to assess the need and determine factors that can predispose, precipitate or perpetuate problematic sexual behaviour;
- Long term intervention – carry out a programme of ongoing intervention that focuses on needs and issues identified during the assessment; and

- Relapse prevention – undertaken after comprehensive assessment or long term intervention, and involves a programme of development and rehearsal of relapse prevention plans and behaviour management strategies.

Other methods of intervention offered by the 5A Project include:

- Group-work programmes for specifically focused areas of work for identified groups of young people; and
- Work with families and / or primary carers in order to assist in creating protective environments for young people.

The 5A Project undertakes consultation and support activities in the following ways:

- Case discussions with social workers and other professionals concerned about the sexual behaviours or attitudes of a particular young person;
- Advice and information on issues and methods of working (ie access to research, resources etc via 5A Project resource library); and
- Facilitation of a bi-monthly focus group for professionals to discuss practice issues.

The 5A Project offers training as follows:

- Training modules in the development of practice with young people displaying sexually problematic behaviour comprising of awareness raising, knowledge and practice skills and methods; and
- Specifically designed training packages for social work teams, residential units and other professionals.

Monitoring and evaluating activities is an ongoing process within the 5A Project. A variety of methods are used to monitor progress, which include:

- Routine monitoring, providing largely quantitative information about service users and their behaviours;

- Post-session debriefing and evaluation between co-workers to assess impact and effectiveness of session content, methods and performance;
- Random systems checks to highlight incidents of further abusive behaviour or offending;
- Three monthly progress reviews where views and opinions are sought from young people themselves; and
- External evaluation, including psychological testing to measure change in young people's behaviour and the effectiveness of practice methods.

### **5.9.3 Barnardo's Action With Young Carers Project, Liverpool**

The Action with Young Carers Project is one of eleven young carer projects managed by Barnardo's nationally. It works primarily with children and young people who are carers, although there have been a number of other developments managed and supported under the umbrella of young carers. The Project has two key aims:

- To work with children and young people whose lives are affected by caring responsibilities, by ensuring that a range of support is available to them and their families; and
- To raise awareness of the issues concerning young carers and influence policy and practice within statutory and voluntary agencies.

The Action with Young Carers Project in Liverpool offers a range of activities and services, and the main elements can be summarised as follows:

- **Awareness Raising**

The range of support services offered include individual and family support, groupwork, multi-agency working, awareness raising and development work. Although the process of awareness raising remains a significant part of the work, this has moved much closer to link with participation and service user involvement.

- **Groupwork and Activities**

A number of 'break' services funded by the Carers Grant are provided, which include regular groupwork and leisure activities during the school holidays. The Young Carers in Liverpool also have had the opportunity to join in activities provided by Bolton Youth Service. In total there are 5 groups which meet, supported by a member of staff and a sessional worker. Activities provided during school holidays include arts and crafts, producing banners and theatre trips.

- **Individual and Family Support**

Individual work with young carers and family support form the core services of the project. Every young carer has an initial assessment of their caring needs, and areas of work are agreed. The young carer's assessment form was devised in conjunction with young people at the project, and Liverpool Social Services have adopted an amended version of this form for their own Young Carer Assessment.

- **Service User Involvement**

The involvement of children and young people is crucial to the work of the project. In addition to involvement in individual work plans, assessments and group activities, there are a number of other areas which young people have recently contributed to. These include producing displays and participating in workshops, making a presentation at a *Connexions* conference and taking part in recruitment and selection of Personal Advisers for *Liverpool Connexions*. Young carers have also been involved in recruiting and selecting Children's Workers based at Liverpool Drug Dependency Unit.

- **Multi-agency Working**

Project staff are involved in various multi-agency forums. Young carer representation is available on the Liverpool Carers Association, and the Project is represented on SHADO Advisory Group, Better Care Higher Standards Working Group and Barnardos Participation Group. Furthermore, some young carers affected by parental drug and alcohol misuse have devised scripts, in collaboration with a theatre group, to be presented at training and awareness raising performances and workshops. Another project provides individual and group support to parents / carers who have children living with HIV within their respective families. It offers individual work with young people around the impact

of HIV and AIDS, and offers groupwork to offer peer support, so as to reduce the potential isolation and stigma of HIV.

#### **5.9.4 Barnardo's Manchester Leaving Care Service**

The Manchester Leaving Care Service has existed since 1995, and represents a joint initiative between Manchester Social Services and Barnardo's North West Division, whereby Barnardo's manages and operates a Leaving Care Service in partnership – and on behalf of – Manchester Local Authority.

Since 1995 the most important issue facing Manchester Leaving Care Service (MLCS) has been the ever increasing numbers of young people qualifying for the service, such that the number of young people known to the service in 2002 was double the total number in 1995. '*Quality Protects*' monies became conditional upon 3 targets being reached in relation to young people leaving care:

- Keeping in touch with as many young people as possible as they leave care and providing them with support;
- Maximising the numbers of such young people accessing employment / training / further education; and
- Maximising the numbers of such young people living in 'suitable' accommodation.

Access to these monies have enabled MLCS to increase the basics of the service, in terms of sheer numbers of staff, managers and administrative support. It has also been used to employ a Development Worker (responsible for employment, training and education) and to create two posts (ie Trainee Leaving Care Workers) occupied by young people who themselves had once been in care. Further funds have enabled another Development Worker (Preparation) to be appointed, with a responsibility for leading young people to be better prepared whilst in care, and leaving care later rather than sooner. In all designs to the MLCS, efforts have been made to preserve the strong initial investment in groupwork / projectwork, additional to individual work, and to keep involving young people as much as possible in Service design and delivery.

The aims and objectives of Manchester Leaving Care Service is to support all young people aged between 16 and 21 (and occasionally beyond) who are either in,

or who have left, the care of Manchester Local Authority, or who are now living in Manchester having been in the care of other local authorities.

MLCS aims to provide, either directly or through other Agencies, a high quality advice and support service which addresses three phases of leaving care:

1. Preparation whilst in care;
2. Intensive planning around the time a young person is due to move on; and
3. Support and assistance up until the age of 21 (and sometimes beyond) once a young person has left care.

Rooted in Barnardo's organisational '*Basis and Values*' approach, the key principles of the service are:

- To be 'young person centred', listening to and respecting young people's views, and seeking to involve young people in choices and decisions affecting their lives;
- To try to maximise the individual potential of each and every young person, taking into account their differing needs and cultural backgrounds;
- To try to fully integrate young people leaving care back into the community by establishing and re-establishing their networks of support; and
- To try to build the confidence and self-esteem of such young people back into the community by establishing and re-establishing their networks of support.

Through adopting a holistic approach, MLCS aims to achieve certain goals for each young person by the age of 21:

- That they live in stable, suitable accommodation;
- That they maximise their sources of income and can budget without being in continual crisis;
- That they are in employment / training / education or have a realistic plan in this regard;

- That they are registered with primary health care services (and know how to access specialist health care services);
- That they have leisure / social interests;
- That they have established networks of support in the community;
- That they have explored whether or not to re-establish / keep in touch with their natural families; and
- That young people themselves have a significant measure of self-esteem and confidence in their own ability to cope independently.

- **Individual Work with Young People**

This core service delivery is divided into 2 parts – North / East and South / West – to reflect the way Manchester Social Services Departments are organised. Each team has a Service Delivery Team Manager with responsibility for allocating and supervising work to workers in their district, and who can take an overview of a young person's leaving care 'career' from the point of being referred to MLCS, to the time when the young person reaches the age of 21 or no longer requires ongoing support.

In order to meet the requirements of the Leaving Care Act, MLCS has created 2 posts (one per district) of Assessor / Planner to ensure that the 'front end' of the Leaving Care Act is best carried out in Manchester. Thus social workers make referrals to MLCS of all young people legally 'Looked After', and such referrals are allocated to the Assessor / Planner who works jointly with the social worker, primary carer, other involved adults and the young person themselves to produce an assessment of their situation and produce an Initial Pathway Plan. This process is facilitated by using an assessment document for young people (*Thinking About My Future*), which has been designed in a user friendly style. This enables the young person to have a direct input into the Pathway Plan.

A mixture of qualified Project Workers, unqualified Support Workers and Trainee Leaving Care Workers develop links with young people prior to them leaving care, and remain involved with them until they are 21. They try to ensure that the aims of the Pathway Plan are carried out, reviewed or updated. These workers are able to help young people adjust to the practical issues of living independently,

encourage them to deliver skills in education, training and employment and deal with issues of loneliness, isolation and the need for social support.

- **Groupwork / Drop in work**

In addition to providing a responsive and high quality service, MLCS aims to supplement this work with a combination of group / drop in / project-type work which involve young people collectively in activities and issues, and wherever appropriate, encouraging young people themselves to become directly involved in the design and delivery of such activities.

Examples of such activities include:

- ❑ Black Young Women's Group;
- ❑ Black Young Men's Group;
- ❑ Young Person's Newsletter;
- ❑ Pre and post pregnancy parenting service (with the Health and Youth Service);
- ❑ Work with gay and lesbian young people; and
- ❑ 'Yippee Group': a group of young people leaving care who have delivered training on 'care' issues to groups of social work and related professionals in Greater Manchester.

### **5.9.5 *Safe in the City Project*, The Children's Society, Manchester**

*Safe in the City Project* works with young people aged 17 and under who may be at risk of running away from home, or have run away and may find themselves at risk on the streets of Manchester. Its initial role was to provide streetwork, and offer resources to young people, such as new underwear, socks, toiletries and useful information, so that a process of engagement could be developed. Through befriending these young vulnerable people, and developing bonds of trust over time, Project workers are eventually able to support them through practical means.

Project workers are drawn from a variety of backgrounds, including social work, teaching, youth work and counselling. They are skilled in engaging with young people who may be distrustful and wish to remain missing or on the run. Contacting young people on the streets remains an important element of the project's work. There is an expectation that workers phone the on-call manager at the beginning of the session to debrief and discuss issues raised during the session. An on-call service is available during the session to discuss any child protection issues or concerns.

The Project is located within the ‘*Safe on the Streets*’ programme, which includes streetwork projects, an alternative refuge, drop in services, an advice centre, counselling and a young person’s drugs service.

- **Key outcomes**

The Project is working towards achieving chief outcomes, which include:

- Making services available to young people on the streets, or at risk of being on the streets through recognising and responding to the distinctive needs of those who run away from differing communities and cultures;
- Developing child-centred services to meet the needs of children and young people who run away, or are on the streets, where substance and drug misuse is an influence;
- Establishing regional and co-ordinated multi-agency strategies to address the needs of young people who run away, or are on the streets, where substance and drug misuse is an influence; and
- Protecting young people who have been sexually abused through prostitution, not criminalising them.

- **External links**

The Project makes use of positive links with external agencies, including the police and social services. This enables the project to challenge statutory responses, and develop more appropriate services specifically for young people.

- **Campaigning**

In recent years, ‘*Safe in the City*’ has initiated and actively led a number of campaigns that have supported changes in government policy. Campaigning has led to new guidelines for working with young people who are involved in prostitution, and has ultimately changed how these young people are viewed. It has also contributed to a number of publications, such as ‘*The Game’s Up*’ (1995), ‘*Child Prostitution in Great Britain*’ (1997) and more recently a ‘*Good Practice Guide to Working with Young People Who Run Away*’ (2001).

- **Research**

Much of the Project's activities are underpinned by research. This includes national research undertaken by *The Children's Society*, such as '*Running the Risk*' (1994) and '*Still Running*' (1999), as well as more localised research, including '*Home and Away*' (1999).

- **'No One Asked Us Before': Research Report**

An example of the research undertaken by the Project is provided by '*No One's Asked Us Before*', which looked exclusively at the experience of Asian young people. It showed that they are less likely to approach support services than other children as they feel they may not have the knowledge and skills to meet their cultural needs. Moreover, the research found that Asian runaways are at more risk of violence and abuse on the streets than others who run away because support services do not understand them.

Based on interviews with Asian girls and young women, some of whom had run away in Manchester, the research also identified the problems they might face when accessing support services and dispels the myths about why Asian children run away from home.

- **Key Findings**

- Some of the girls and young women thought support services, such as the Police and Social Services, assumed they ran away to escape forced marriages and failed to look at wider causes, such as sexual abuse, mental health and issues regarding their sexuality;
- Many of those interviewed also found services, such the Police and Child Protection Teams, were not adequately trained to understand the additional cultural problems Asian children face when they run away from home;
- Asian young people are more likely to be bullied at school. Due to a number of pressures, they often feel unable to talk about this to their parents; and
- A growing number of Asian children and young people are not being reported missing to the police because of the shame it brings to their families. The isolation, triggered by the lack of information about support groups for Asian children, was a reason for running away as it caused feelings of anger and

frustration. Asian children in care can suffer ‘identity confusion’ as there are not enough trained carers from diverse backgrounds to meet their needs.

#### □ **Key Recommendations**

- Key services, such as the Police and Social Services, to have professional training on cultural awareness that extends beyond the stereotypes of Asian communities;
- More skilled Asian workers in key agencies, such as the Police and Social Services, who can understand and address the cultural needs of Asian runaways;
- A national network of refuges that address the needs of young runaways from all communities;
- Information leaflets, developed by services such as Child Protection Teams and Accommodation Centres and Care Homes, to be produced in different community languages; and
- Agencies to increase their profile by making contact with Asian communities and informing them of the services they provide.

#### • **Recent developments**

In recent years, ‘*Safe in the City*’ has broadened its work and currently engages with young people in care and in schools. This work not only focuses on the risks of running away, but also explores with young people how they equip themselves to become safer. Issues such as self-perception, self-esteem and being heard are all contributory factors for young people becoming vulnerable, running away and placing themselves in risky situations.

Additional funding has enabled the Project to become located closer to Manchester city centre. This has enabled the basement area to be converted for use by young people. It has a lounge / group work area, a computer room and a kitchen. There is also a shower and cooking facilities. The expansion has enabled an increased number of workers to carry out the work of the Project. Presently the Project has two dedicated teams: one working with Black young people; and a Citywide team supporting the needs of young runaways. The Citywide team has a worker who provides specific support to young people who are sexually exploited.

### **5.9.6 Tamarind House, NSPCC, Manchester**

Tamarind House aims to provide a professional, credible holistic child protection and support service that meets the needs of a Black community that is racially, culturally and ethnically diverse in Manchester.

Tamarind House works with children and young people, as well as holistically with the family. It takes referrals from a variety of sources, including social services, CAMHS, GPs, health visitors, schools and self-referrals. It offers a wide range of family support services involving the parent, carer and child, which include individual therapeutic work, as well as group work with children.

Tamarind House has recently begun undertaking court assessments for the first time, which involve making comprehensive assessments to identify whether a parent is capable of being in care of a child, and the resolving of disputes. It also undertakes educational assessments, which can focus on the under-achieving of Black children in schools or the higher rate of exclusion. This can involve school visits, and work with children and parents.

- **Project Work**

In conjunction with Manchester Social Services, Tamarind House has begun a three-year project funded by CAMHS to work with children aged 5-12 who have experienced sexual abuse. Further work has been undertaken with family members having problems as a consequence of the abuse. In partnership with the Broad African Representative Council (BARC), Tamarind House has set up a project, funded by the Children's Fund, to work with Black children in schools who are not achieving their full potential and are at risk of exclusion

Tamarind House also undertakes some advisory consultancy work with a variety of external agencies, such as education authorities, where the emphasis is on supporting Black children.

#### **Key Aims and Objectives:**

- To provide and develop appropriate services in recognition of the historical lack of accessibility, minimal information, knowledge and support given to Black families;

- To develop trust with Black children and families in place of mistrust with regard to child protection processes, and experiences of personal, institutional and structural racism;
- To contribute to the debate and discussion with Black communities in relation to child abuse;
- To involve statutory, NSPCC, community and other agencies in the wider systems, with an additional emphasis on racial abuse as constituting considerable harm; and
- To establish and maintain a Management Group for the service, in order to retain vision, focus and a clear Black and anti-racist / anti-oppressive perspective as the pivot and core of the service.
- **Underlying Philosophy**

Tamarind House's philosophy is rooted in a recognition and acknowledgement of 'the struggle' faced by Black families in relation to issues of prevention, intervention and child protection. It seeks to embody a holistic approach to Black children and families, which involves:

- Not seeing the child in isolation;
- Recognising the importance of family relationships for the child and other family members;
- Retaining a child-centred approach which recognises the detrimental impact of abuse upon the Black child;
- Valuing the experiences, knowledge and strength of Black families; and
- Involving service users in the development of the total service.

A fundamental principle of the service is to take into account, and acknowledge, that Race, Racism, Culture and Identity are key issues for Black children, young people and families.

## **6 Health Promotion in Schools: Healthy Schools Programme**

In recent years the UK government has placed a strong emphasis on promoting health in schools. The Healthy Schools Programme is an essential part of the drive to improve standards of health and education, as well as tackle health inequalities. It aims to make children, teachers, parents and communities more aware of the opportunities that exist in schools for improving health.

The Healthy Schools Programme was announced in the Department of Health's Green Paper *Our Healthier Nation*<sup>77</sup>. The aim of helping all schools become healthy schools was outlined in the White Paper *Excellence in Schools* (produced by the Department for Education and Skills) in 1997.

Within the North West Region, there are a variety of local healthy schools partnership programmes.

### **6.1 The Healthy Schools Programme**

The Healthy Schools Programme involves the following:

- **National Healthy Schools Standard**

This provides guidance on the criteria that local partnerships should use in making judgements about achieving school success in relation to a variety of themes, including healthy eating and physical activity. Local healthy schools can gain national accreditation if they meet national quality standards, which are organised under three general themes: partnerships, programme management and working with schools.

- **Wired for Health Website ([www.wiredforhealth.gov.uk](http://www.wiredforhealth.gov.uk))**

This enables young people and teachers to access relevant and appropriate health information, which has links to further accurate, clear and credible websites on a variety of health issues. As a joint initiative between the Department of Health and the Department for Education and Skills, the website also contains information regarding national health policies and initiatives.

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<sup>77</sup> Department of Health, *Our Healthier Nation: A Contract for Health*, Cm 3852, 1998

- **National Healthy Schools Newsletter**

Launched in 1998, the newsletter is aimed at everyone working to support school-based health promotion and education. It aims to provide information on the National Healthy School Standard, and also to improve communication between individuals and organisations working to build healthy schools.

- **‘Healthy Schools, Healthy Teachers’**

This consists of a series of conferences aimed at enabling teachers to play an active part in developing plans to promote the health of teachers, thereby reducing absence through ill health. The conferences have identified a variety of projects that have contributed to the well-being of teachers.

- **Strategies for Safer Travel to School**

This focuses on strategies to reduce car journeys to school where safer, healthier alternatives exist. A key strategy which has been developed is *the School Travel Advisory Group* (STAG), which has identified practical ways of reducing car use, and ensuring that policies and initiatives affecting school travel are integrated across transport, health and education.

- **Young People’s Health Network ([www.hda-online.org.uk/yphn](http://www.hda-online.org.uk/yphn))**

The Young People’s Health Network encourages the exchange of information, ideas, research findings and good practice. It develops the participation of young people in health promotion initiatives, and promotes links with other networks and organisations. The website contains copies of its newsletter, and provides updates about project activities.

- **Cooking for Kids**

This scheme runs during school holidays to give young people experience of food preparation. It highlights the importance of food safety and healthy eating.

## 6.2 Evaluating the Effectiveness of School-Based Health Promotion

A recent study<sup>78</sup> concerning the effectiveness of school-based health promotion interventions has been undertaken using a two-stage approach:

**Stage A:** A systematic review of primary studies of the effectiveness of the health promoting schools approach; and

**Stage B:** A systematic review of existing reviews of the effectiveness of other health promoting interventions in schools relating to diverse themes.

Some of the themes within the latter stage of the evaluation are highly relevant to this report:

- Accident prevention;
- Sexual health;
- Psychological aspects; and
- Personal safety

A rigorous inclusion criteria was applied to reviews in both Stages A and B. In total, 12 reviews of the health promoting schools approach met the inclusion criteria for Stage A. There were 32 reviews of reviews of the effectiveness of schools health promotion which met the inclusion criteria for Stage B.

In relation to **Stage A reviews** (ie health promoting schools approach), the study concluded that it is a promising approach, but that the optimum method of evaluation has yet to be decided. Nonetheless, the development of programmes to promote mental and social well-being are likely to improve overall effectiveness, and the impact of staff health required greater consideration.

In relation to **Stage B reviews** (ie health promotion in schools), the study concluded that school health promotion initiatives can have a positive impact on children's health and behaviour, but that this does not occur consistently. Most interventions seemed able to increase children's knowledge, yet changing other

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<sup>78</sup> Health Technology Assessment NHS R&D HTA Programme, Health Promoting Schools and Health Promotion in Schools: Two Systematic Reviews, 1999; Vol 3: 22

factors which influence health (such as attitudes and behaviour) is much harder to achieve. It suggested that a multi-faceted approach was more likely to be effective, combining a classroom programme with changes to the school ethos and / or environment and / or with family / community involvement.

The following summary highlights some key messages in relation to the four key themes of this report:

### **6.3 School-Based Health Promotion and Accident Prevention**

- **Stage A**

Many interventions included changes to the school or community environment. Those involving environmental change were more likely to be effective in changing behaviour or reducing injury. Behaving in a way which distinguishes young people from their peers is likely to require a similar level of personal autonomy and self-esteem, regardless of whether the behaviour involves substance misuse or wearing cycle helmets.

- **Stage B**

Most road safety interventions were judged to be effective or partially effective. Programmes involving changes to the road environment were successful in reducing injuries. Seat belt campaigns were effective. Providing subsidised helmets increased the effectiveness of cycle helmet education on helmet wearing behaviour. Pedestrian and driver skill development programmes had variable results: most were positive, some had potentially harmful effects, and many were ineffective. Road safety studies did not report knowledge outcomes, and there were mixed results in terms of knowledge for burn prevention programmes. One review noted that the involvement of parents or peers is useful, and that programmes where children and young people are actively involved, and which concentrate on one or two specific messages rather than many, are more effective.

### **6.4 School-Based Health Promotion and Sexual Health**

- **Stage A**

The reviews covered studies of a wide range of interventions, from classroom instruction and skill development through school-based clinics and involvement of parents alone and in various combinations.

- **Stage B**

A few interventions were shown to have a positive impact on outcomes predictive of safe sexual behaviour (in terms of teenage pregnancy and sexually transmitted diseases), but most were shown to be ineffective. The effective interventions frequently included provision of services such as special clinics. Some studies involved parents or peers, but none were able to show that these approaches increase effectiveness. Knowledge gains were reported in all studies where they were assessed, as well as desirable effects on attitudes in the majority of studies.

## **6.5 School-Based Health Promotion and Psychological Aspects**

- **Stage A**

Most interventions were almost entirely confined to the classroom, and led by mental health professionals rather than teachers. They were designed to increase knowledge and life skills related to mental health. Despite the absence of extra-curricula activities, roughly half the programmes showed a positive impact on outcomes relevant to mental well-being. Gains in knowledge were found in all programmes, and positive attitude change was also reported. Programmes which included stress management were effective in improving coping skills, anger management, anxiety and self-esteem. Positive programme effects were also found for self-concept. Programmes specifically targeted at suicide prevention were the only ones where the results showed the potential for harmful effects.

- **Stage B**

The influence of the intensity and duration of the programmes, and of the personnel used to deliver them, could not be determined from the evidence provided by the reviews.

## **6.6 School-Based Health Promotion and Personal Safety**

- **Stage A**

Interventions were generally successful in teaching prevention skills, and increasing knowledge about personal safety. Behaviour skills training is a feature of the most promising programmes, together with curricula tailored to the age group and the use of a variety of materials for young children and young people.

- **Stage B**

A narrow range of approaches has been used in schools to promote children and young people's personal safety. There are some indications that these curricula can increase children and young people's knowledge and skills under experimental conditions, but the reviews do not provide evidence as to whether they can reduce child abuse.