
FAMILIES, PARENTS AND CARERS

RESEARCH REVIEW 1

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



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

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

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Summary

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

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

Key messages

- A range of central and local government departments shares responsibility for maximising the safety, health and wellbeing of children through improving the physical and mental health of mothers, fathers and carers. Implementation at the local level is by a wide group of professional and non-professional staff in the community.
- While there is no single source of purposely collected national data for identifying parents with either physical or mental health conditions, data collected in the context of government labour surveys suggest that 1.7 million (12 per cent) of parents in the UK have a disability as defined under the *Disability Discrimination Act 1995* (GB Statutes 1995).
- There are estimated to be: 150,000 young carers in the UK, 30 per cent of whom are believed to be caring for adults with mental health needs; 200,000 to 300,000 children and young people living with a parent whose drug use is problematic; and 1.4 million children are living with at least one parent who drinks excessively.
- The current service configuration – especially the split between adult and children's services – poses a key challenge to the effective delivery of services that can meet the needs of both children and their families.
- Adult services can provide valuable examples of providing a **personalised** approach to problems in order to produce personalised outcomes, so that targeted support is not seen as stigmatising by parents, children and young people.
- Access to services by family members is impeded by the current system of gate-keeping by means of thresholds; i.e. an access point at which access to one or more service/s is judged necessary on the basis of risk or need.
- Service usage is likely to be influenced by the real and perceived characteristics of the services, especially in relation to the fear of stigma, a deterrent most obvious in respect of those who are referred to services against their wishes rather than those who either self-refer or are in agreement with a referral to a service.
- It is essential that services are provided for children and their families at each of the tiers of need. In addition 'bridges to access' need to be ensured between the levels of need; and between the different services on offer from a number of professions and agencies.

- It is important to offer the opportunity for parents and carers to access services at different points in time over a sustained period, so that early access to services can be made possible, at whatever stage of the problem.
- Much health-related data fails to identify patients as parents, so that the needs of children in these families often remain invisible (even if most of this group manage with the support of universal services and informal networks). Better data would facilitate better understanding of their needs. Services across the spectrum of need must be sensitive to the circumstances of the children and families using them especially with regard to poverty, ethnicity and disability.
- There is a positive association between early intervention and better outcomes but late intervention is better than no intervention at all.
- There is an association between parental health difficulties and children's safety, health and wellbeing, but the exact mechanisms involved are only partially understood. As causal relationships are difficult to establish, it cannot be said that negative outcomes are inevitable and care needs to be taken in assessing the impact on children of parental health difficulties. Both the characteristics of the parents/carers **and** the characteristics of children/young people themselves can play a role in determining outcomes. Resilience in children has been identified as a key factor in mediating poor outcomes for them even in what might appear to be adverse circumstances.
- Positive outcomes for parents with the spectrum of needs covered by this review include: physical and psychological wellbeing; self-esteem; cultural and ethnic identity; improved adult/child and partner relationships; and improvement in parenting competence.
- The Think Family Pathfinders and the related Family Intervention Projects have begun to show some encouraging results. The flexible personalised way in which they respond to both children's and adults' needs is viewed extremely positively by families and the professionals working with them. Evaluations of the programmes stress the value of flexible working from adult services, information sharing and joint commissioning in delivering a more cohesive service for vulnerable families.
- An evaluation of Family Action projects – which offer a mixture of practical, therapeutic and emotional support to families – has identified some very encouraging results in terms of outcomes. The quality of the relationship between professionals and the families they supported was found to be a crucial lever for change.

Who are the key stakeholders?

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

Their contributions are valuable in the process of improvement

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

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

As children and young people will be prime beneficiaries of improvements in services, it is important that they are encouraged to feel a key sense of interest in, engagement with, and entitlement to, services on offer. All conventional strategies have a part to play as does publicity linked to the UN Convention on the Rights of the Child, which includes, of course, the right to family life.

Those with responsibility for designing/commissioning services

The challenge facing those designing services at both the national and local level is the need to create a system that can respond to the needs of the whole family, simultaneously addressing the needs of both children and parents and carers with additional difficulties, and the stresses in their lives. This, in particular, requires recognition of the need to build bridges between the different levels of need and to improve the cohesion between adults' and children's services. It may well not be either desirable or realistic to create new

organisational structures, but barriers to partnership working across children's and adults services need to be addressed.

Those who work in children's social care services

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

Those who work in education services

It is clear from this review that our knowledge of many parents with health difficulties is only very partial. Therefore there will be a significant number of children living with parents with health difficulties who are living with little or no support. While teachers and other support staff will need training and support in order to assist families, schools nevertheless play a vital role in identifying those children whose families are under stress. In some cases it may simply be necessary to be sensitive to these children's needs. However, for those children who are experiencing greater difficulties, eliciting further support through the use of the Common Assessment Framework and making other referrals will be crucial.

Those who work in adult services

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

Those who deliver services in the adult/youth justice system

In some of the instances where problems – particularly those related to substance misuse – are more entrenched, parents may come into contact with the youth justice system. Also, there is a correlation between problematic substance misuse, mental health difficulties and domestic abuse. Workers in these services therefore need high-quality training and the services need effective protocols so that practitioners can be sensitive to the impact of such problems on children but also know how to act decisively when they have concerns.

Those who work in health services

There will be many practitioners working across the health system who will have a key role in meeting the needs of children and their parents who have health problems. Like colleagues in schools, practitioners – such as GPs and health visitors – in primary healthcare settings will be crucial in identifying those parents who need extra support. At the more specialist level, like workers in other adult services, they need to be aware of those patients who are also parents. Health workers focused on children need to be aware

that some childhood problems, such as those related to behaviours, may be symptomatic of parental stress caused by health problems.

What data is available to inform the way forward?

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

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

The evidence base

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

Research review methods

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

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

Next steps

An updated version of this review is due to be published in Spring 2011. This will include validated practice examples and views from children, young people, parents, carers and service providers.

C4EO reviews on improving children's outcomes by supporting parental and carer couple relationships and reducing conflict within families, including domestic violence; and improving children's and young people's achievement, behavioural and emotional outcomes through effective support and intervention with mothers, fathers and carers of 17- to 19-year-olds are also available on the C4EO website. Local decision-makers and commissioners working in local authorities and children's services may also find it helpful to read the Families, Parents and Carers Directors' Summary, which presents the key messages from all three reviews.

C4EO is using the main messages from the three Families, Parents and Carers reviews to underpin its knowledge sharing and capacity building work with children's services, and through them the full range of professions and agencies working with children and their families.

1. Introduction

This review aims to draw out the key ‘what works?’ messages on improving the safety, health and wellbeing of children through improving the physical and mental health of mothers, fathers and carers. It addresses three questions that were set by the C4EO Theme Advisory Group (TAG), a group of experts in families, parents and carers’ policy, research and practice. These questions are:

- What proportion of mothers, fathers and carers experience mental and/or physical health problems and what are their characteristics?
- What is the relationship between mothers’, fathers’ and carers’ mental and physical health and their children’s safety, health and wellbeing?
- What interventions and support mechanisms are most effective in increasing children’s safety, health and wellbeing through improving mothers’, fathers’ and carers’ a) physical and b) mental health?

Reviews on improving children’s outcomes by supporting parental and carer couple relationships and reducing conflict within families, including domestic violence; and improving children’s and young people’s achievement, behavioural and emotional outcomes through effective support and intervention with mothers, fathers and carers of 17- to 19-year-olds are also available on the C4EO website.

The reviews are based on:

- the best research evidence from the UK – and where relevant from abroad – on what works in improving services and outcomes for children and young people
- the best quantitative data with which to establish baselines and assess progress in improving outcomes.

C4EO will use this review to underpin the support it provides to professionals working in children’s services to help them improve service delivery and, ultimately, outcomes for children and young people. It will be followed by a knowledge review, which will update the research evidence and also incorporate:

- the best validated local experience and practice on the strategies and interventions that have already proved to be the most powerful in helping services improve outcomes, and why this is so
- stakeholder and client views on ‘what works?’ in improving services.

Definitions of key terms

The TAG provided the following definitions:

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

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

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

Methods

The research included in the review was either cited in the scoping study 'Improving the safety, health and wellbeing of children through improving the physical and mental health of mothers, fathers and carers' (Twist *et al* 2009) or was cited within the research items identified. The research team ruled out obviously irrelevant research studies by screening study titles. Remaining research studies were then coded on the basis of their abstracts. Coding took account of each study's features – including research design, relevance to the scoping review questions and country of origin – to identify the key items to be included in the forthcoming main review. The review team have appraised these key items to ensure that the evidence presented is the most robust available. For further details of the review method adopted, see Appendix 1.

The aim of the method was twofold:

- To conduct the review thematically, rather than to describe each study in turn, in order to maximise learning from the knowledge base.
- To ensure consistency in the quality of the review process. Therefore, in order to check for consistency, at the start of the project all team members read the same four pieces of evidence and completed the template. We then reviewed the completed templates to ensure that all members of the team had a shared approach to the issues involved, and to identifying appropriate key points.

Strengths and limitations of the review

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

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

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

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

2. Context

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

- parents, not governments, bring up children
- parents need help and support to do their job
- all children have the potential to succeed and should go as far as their talents can take them
- children and young people need to be safe, healthy and enjoy their childhood, as well needing to grow up prepared for adult life.

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

The Every Child Matters change agenda (HM Government 2004) was informed by the recommendations of the Laming Inquiry into the death of Victoria Climbié. The Laming Inquiry (Laming 2003) painted a picture of dangerous fragmentation between the key agencies at local level, such as health, education, police and social services. The creation of children's trusts partnerships at local level sought to improve communication between agencies working with children and young people, particularly health education and social care. In most areas, this led to separate divisions or directorates within local authorities for adult and children's services. In recent years, the previous government was aware of the need for adult and children's services to work more closely together – particularly with the most vulnerable families – and launched the Think Family Pathfinders projects, with a view to promoting cohesive whole family approaches (DCSF 2010b). The recent change of government in the UK will inevitably lead to some changes of direction in child welfare policy and the introduction of some new initiatives, particularly as children's services adapt and respond to the challenging economic circumstances.

In the UK, building on the 'prevention typology' concept, developed primarily in public health services, the delivery of agency services for children and their families is organised across the operational concept of 'the four Tiers':

Tier 1 services are universal services (whether free at the point of delivery or publicly subsidised) provided to all citizens who choose to use them (for example, GP services, public libraries) or available to all in a particular age group (for example, schools for those

of compulsory school age) or in a particular need group (midwifery services for expectant mothers, job centres for those seeking employment, for example).

Tier 2 services are targeted at groups or communities where research indicates that there is an additional level of need or vulnerability, but where the choice to use the service remains with the family. For example Sure Start projects; open access community-based services for refugee families, or families with disabled children.

Tier 3 services (sometimes referred to as 'targeted' or 'referral based') are 'targeted' at identified families known to be vulnerable, who may refer themselves – or be referred by a worker within a universal service such as a teacher or GP – for a more specialist service. There is usually a needs 'threshold' (legally or administratively established) for access to these services. They aim to prevent identified problems from causing harm to parents or children, but may involve therapy for established difficulties.

Tier 4 services are 'remedial' or 'rehabilitative' 'heavy end' support and/or therapy services for referred families, and sometimes involve court orders or an element of coercion (such as a child protection inquiry; a young person convicted of an offence being placed in a treatment foster family; a health service placement in an addiction treatment unit; or a residential unit for a family evicted as a consequence of anti-social behaviour).

Over the last twenty years, a key policy goal has been to support **all parents**, especially in the context of growing awareness of the needs and rights of disabled people generally, and of disabled parents in particular. This was reflected in disability discrimination legislation of 1995 and the *Human Rights Act 1998* (GB Statutes 1998).

Valuing people (DH 2001) marked a new phase in responding to the needs and aspirations of people with learning disabilities and its ethos of person-centred planning has remained a recurring theme that is reinforced through personalisation. However, the policy review *Valuing people now* (DH 2009) and the Department of Health guidance (DH 2007a) on working with parents with learning disability makes it clear that this aspiration has not yet been realised in many areas. Nevertheless, it is obvious that since the community care initiatives of the 1980s onwards, there has been a major shift in the way that the welfare state responds to disabled people. Far more physically and learning disabled adults are now able to live in the community and have a family life. While the ongoing issues of stigma and social exclusion should not be underestimated, these changes have, nevertheless, demanded new approaches to this group of families. These are reflected, implicitly or explicitly in the discussion of both the extent of use and nature of outcomes for the initiatives described in the overview of interventions.

3. The evidence base

The evidence base addressed in this overview inevitably reflects the different research traditions within the disciplines of health, social care and education, all of whose service provision plays a key role in meeting the needs of vulnerable parents and carers and children. For example, health researchers have tended to attach more weight to the findings of research studies that have been based on methodologies such as random controlled trials. In social care/family support research, fewer studies have relied solely on this particular approach and have valued a wide range of qualitative methods, including surveys, interviews and case studies to capture outcome data (SCIE 2005; Asmussen and Weizel 2009).

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

- administrative data sources
- national/cross national surveys that address service access
- summative data using experimental methodologies including randomised controlled trials
- process and outcome evaluation studies
- client data mining activities
- qualitative methods.

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

Accordingly, we drew extensively on the initial scoping document (Twist *et al* 2009), whose authors had reviewed a total of 671 sources and selected 252 sources as relevant (based on information available in the abstracts), finally selecting 54 items as key items for the review. These comprise literature reviews/evidence syntheses or empirical research, as well as a small number of practice guides. Over half of the key items are from England or Australia. The table below shows the number of relevant items by Review Question number – highlighting the fact that more evidence was available for Review Questions 2 and 3 than for Review Question 1. (The review questions are presented in full in Section 1 of this report).

Review question	Number of key items
Review Question 1	16
Review Question 2	32
Review Question 3	30

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

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

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

- In order to minimise the negative impact of variations in the respective **depth** of research literature relating to specific areas, we ‘mined’ the ‘relevant’ articles and reviews. Some additional references have been selected on this basis which were not flagged up in the initial evidence base identified (this process is often know as ‘reference harvesting’).
- Mindful of the end target that this review be capable of informing both local agency **policy implementation** and **individual day-to-day practice**, we included a number of key government generated sources. Two main types of literature fell into this category: first, published government commissioned research overviews, not already identified in the original search, for example Quinton’s (2004) analysis of fourteen research studies of various aspects of family support; second, and bearing in mind the **on-going/on the ground** implementation of a number of practice strategies, such as the *Framework for the assessment of children’s needs* (DH 2000), empirical sources for practitioners that have already been widely disseminated by central government. References that fall into this category include Ward and Rose (2001) and Aldgate *et al* (2006).

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

Key findings

- While there is no single source of purposely collected national data for identifying parents with either physical or mental health conditions, data collected in the context of government labour surveys suggest that 1.7 million (12 per cent) parents in the UK have a disability as defined under the *Disability Discrimination Act 1995* (GB Statutes 1995). (For a definition, see Data annexe).
- Of that 1.7 million, a total of at least 64 per cent, have a disability related to a physical condition.
- Obesity levels for both genders are approximately 25 per cent of the population.
- Estimates vary but the labour surveys suggest 26 per cent of disabled parents have a disability by virtue of a mental health condition.
- There are estimated to be 150,000 young carers in the UK, 30 per cent of whom are believed to be caring for adults with mental health needs.
- In the UK, 2.2 per cent of the population are identified as having a significant learning disability with a further 6.7 per cent recognised as having mild and borderline learning disability.
- Approximately, 9 to 10 per cent of women and 5 to 6 per cent of men in the UK are suffering from **diagnosed** mental health difficulties at any one time. Given the intermittent nature of many such difficulties this means a considerably wide spectrum of the UK population experiences mental health difficulties at some point in their lives. Most of these difficulties are mild in nature with only a small minority experiencing serious mental health illness.
- It is estimated that 200,000 to 300,000 children and young people are living with a parent whose drug use is problematic.
- An estimated 3.3 million children live with at least one parent who binge drinks.
- Some black and minority ethnic (BME) groups are over represented in diagnostic terms in the mental health system, in particular African and African Caribbean men are twice as likely to be diagnosed as suffering from schizophrenia as their white UK counterparts, while only half as likely to be diagnosed with depression.

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

- physical health and disability
- learning disability
- mental health
- substance misuse.

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

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

Physical health difficulties and physical disability

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

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

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

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

Learning disability

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

Mental health difficulties

More data on parents with mental health difficulties was captured during the scoping phase of this review. In a major review for SCIE, Parker *et al* (2008) report that much of the data is variable in quality. They also argue that many practitioners in different agencies are not well attuned to identifying parental mental health difficulties among those who use their services. Therefore, as is the case with learning disability, while they may well work with parents with mental health difficulties they would not recognise them as such. What emerges from across the different sources is that mental health, like other health issues, needs to be understood on a continuum. Nevertheless, large-scale high-quality surveys conclude that in the non-elderly population in the UK, 9 to 10 per cent of women and 5 to 6 per cent of men may be experiencing mental health difficulties (Parker *et al* 2008). However, given the episodic nature of mental health difficulties, a much greater population of the UK population will experience mental health problems at some point in their lives.

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

engage with these parents rather than indicating that these problems are in any sense trivial. More serious mental health difficulties, and in particular psychotic illness, are much rarer with only 2.5 per cent of parents experiencing such problems. Morris and Wates (2006) reported that 26 per cent of parents in the UK recognised as having a disability or long-term health problem have some sort of mental illness. Of the 150,000 to 175,000 young people identified in the 2001 census as possible young carers, 30 per cent (or up to 50,000) were caring for parents with mental health difficulties (SCIE 2009). Morris and Wates (2006) reported that between 33 per cent and 50 per cent of children who use young carers' projects do so on the basis that their parents have mental health problems.

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

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

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

In terms of gender there is a consistent finding that mental health difficulties are more prevalent among mothers than fathers (Smith 2004; Tunnard 2004; Maybery *et al* 2009b; Tobias *et al* 2009). For some time, there has been recognition of the significant number of women who experience post-natal depression. Goodman (2004) reports that 13 per cent of women suffer from this condition. However, she cites other literature, which suggests considerable variation in the estimates of researchers. Some community-based studies report the incidence of maternal depression to be 1.2 per cent in the first year after birth, while others estimate this figure to be as high as 25 per cent. Some researchers whose work Goodman reviewed, estimate the incidence of post-birth **paternal** depression, for

men whose partners were suffering post-natal depression, as being as high as 50 per cent.

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

Ethnicity

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

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

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

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

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

Substance misuse

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

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

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

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

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

Key findings

- There is an association between parental health difficulties and children's safety, health and wellbeing, but the exact mechanisms involved are only partially understood.
- Understanding this inter-relationship is complicated by the relative absence of knowledge available around the impact on child wellbeing and of the needs of those parents whose assessed needs fail to meet the **thresholds** for services.
- Research suggests that both the characteristics of the parents/carers **and** the characteristics of children/young people themselves can play a role in determining outcomes.
- Resilience has been identified as a key factor in mitigating adverse outcomes for children even in what might appear to be adverse circumstances.
- Children who have provided a significant amount of care to parents while growing up may be more vulnerable in adulthood to unemployment, poverty and isolation.
- Poorer outcomes have been identified across a range of research for children growing up in circumstances where there are:
 - poor parenting skills
 - parental mental health problems
 - parental substance use
 - violence between adult family members
 - parents who were themselves abused or neglected as children
 - social isolation.

The inter-relationship between children's and young people's needs, their chances of achieving optimum outcomes, and the physical, emotional and social characteristics and circumstances of their parents' and carers has been widely and consistently acknowledged and highlighted by researchers over a long period (Horwath 2001; Quinton 2004). Intuitively, many of those working in the child welfare field recognise that living with parents with significant health difficulties can cause difficulties for children and young people in both the short and long term. In 2000, findings from a range of studies were distilled to design a framework for helping practitioners better understand the interventions and supports that may be helpful for parents in maximising child outcomes (DH *et al* 2000). This research-based framework, designed to be applicable to all parents and carers, identifies six dimensions to the task of parenting:

- basic care

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

However, our understanding of the process whereby the successful undertaking of these tasks by parents can be hindered or supported is still partial. For example, questions remain as to how individual parental and child characteristics interact (Aldgate *et al* 2006; Beresford *et al* 2008). In particular, research studies from a range of disciplines have continued to explore the exact nature of the relationship between children's and young people's safety, health and wellbeing and their mothers', fathers' and carers' mental and physical health, including substance abuse. It should also be noted that there are imbalances in the literature, so, for example, we have more knowledge about the impact of parents and carers' mental health on their children's wellbeing, than on parental physical health. We do know that children who have provided a significant amount of care to parents while growing up may be more vulnerable in adulthood to unemployment, poverty and isolation (Aldridge and Becker 2003; Finkelstein *et al* 2005; Gorin 2004).

We also know that parental characteristics and circumstances can impact – for better or worse – on the ability of parents to respond to the needs of children and young people for whom they have responsibility, and both policy and practice literature addresses this topic (Cowling 2004; Tunnard 2004; Beresford *et al* 2008). This knowledge has been central to the design of both policy and practice. Of particular relevance to parents and children with health problems are the Family Intervention Projects (FIPs) which are currently being evaluated (National Centre for Social Research).¹ Evidence for the first 1,000 families to receive interventions shows that there have been significant improvements in a range of areas including reductions in mental health problems and drug and alcohol misuse. Central to their way of working is a 'team around the family', led by a lead key worker for the whole family:

The primary responsibility for a family's welfare will always rest with parents. The task of public services is to provide the best possible support to enable parents to fulfil that responsibility.

(Social Exclusion Task Force 2008 p 4)

Parents may be experiencing their own problems which may have an impact through their behaviour on their capacity to respond to their child's need.

(DH *et al* 2000 p 25)

A parent's mental ill-health can have an effect on the mental health and development of their child.

(DCSF 2006 p 76)

1. There will be a fuller account of the FIPs, once they are more advanced in their implementation, in the knowledge review, to be published in 2011.

Despite these aspirations in policy to support parents in order to facilitate better outcomes for children, the ‘definitive understanding’ of the nature of any relationship between children’s safety, health and wellbeing, and their mothers’, fathers’ and carers’ physical and mental health remains elusive. Even if we can identify the crucial **range** of adverse circumstances (Tunnard 2004; Gorin 2004, we still lack the ability to conclude **categorically** whether the association between the two is **causal** or merely a **risk marker** (Darlington *et al* 2005; Finkelstein *et al* 2005). In particular, there are gaps in knowledge about the factors that can mediate, even in adverse circumstances, against damage to the outcomes for children and young people. The way in which practitioners handle this tension lies at the heart of good practice.

What are the key factors that impact on outcomes?

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

- conception and pregnancy
- parenting
- the wider family and environment.

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

- poor parenting skills
- parental mental health problems
- parental substance use
- violence between adult family members
- parents who were themselves abused or neglected as children
- social isolation.

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

- no parent in family in work
- family living in poor or overcrowded accommodation
- no parent has any qualifications

- mother has mental health problems
- at least one parent has a longstanding limiting illness
- disability or infirmity
- family has low income (below 60 per cent of the median or cannot afford a number of food and clothing items).

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

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

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

With a minority of exceptions, authors across all the studies reviewed sound a three-note health warning in respect of adopting a simplistic application of research findings to practice.

First, there are no crude formulae available for calculating the impact on outcomes for children in families where there are parental problems such as substance misuse and mental disorder. The most rigorous research cannot be guaranteed to supply a simple answer. Even what may be viewed as a **discrete phenomenon**, such as the impact of post-natal depression, has been found to have an impact on a child’s risk of displaying violent behaviour:

What is clear... is that the mother’s mental health state after childbirth is an easily identifiable risk factor for her child’s intellectual and social development... what is not clear is the mechanism whereby this risk factor exerts its influence.

(Hay *et al* 2008 p 1092)

However, although exposure to maternal depression had an effect on adolescent IQ, especially for boys, it did not predict emotional and behavioural difficulties (Hay *et al*

2003). In addition, postnatal depression in women can have an effect on fathers too, and has been found to have important implications for overall family health and wellbeing (Goodman 2004).

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

Second, we cannot infer simplistic causal relationships – a number of authors (for example, Powdthavee and Vignoles 2008; Pretis and Dimova 2008; Scaife 2008) caution against this temptation. This caveat applies across parental characteristics, including parental disability such as mental illness, as well as maternal and paternal drug misuse:

It cannot be assumed that parental drug misuse automatically leads to poor outcomes for children...

(Scaife 2008 p 55)

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

(Pretis and Dimova 2008 p 152)

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

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

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

Whilst early childhood mental health is significantly affected by prenatal events in addition to the child's later environment... (but) interventions targeting adverse

prenatal, prenatal and postnatal influences can be expected to improve mental health outcomes for children in the early years...

(Robinson *et al* 2008 p 1118)

What may be the possible pathways?

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

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

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

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

Given the range of adverse outcomes for children that have been identified, inevitably the relationship between some will be easier to understand than others. For example, physical health problems sometimes arise directly from injuries received as a result of abuse. Neglect can also result in immediate physical health problems. However, there are more subtle impacts where the links will be less immediately obvious, such as: poor educational performance; offending; substance use; or impaired physical health (Clark *et al* 2004). Mental health problems – including anxiety, depression, disorder and conduct disorders – can reflect problems such as parental mental health and substance use problems (Marmorstein *et al* 2009).

Resilience

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

It emerges as a crucial tool for navigating a route through adversity in many of the studies reviewed or by policy-makers and practitioners:

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

In other words, children’s safety, health and wellbeing is not just determined by whether their parents have mental or physical health problems; they are active agents in determining their own life courses. This should not be confused with children displaying artificial levels of social maturity that in effect are masking a lack of parenting and neglect. Rather, as the literature around young carers in particular illustrates (SCIE 2009), children are not simply the passive recipients of the circumstances in which they find themselves. In some, albeit not all, situations the sense of self-efficacy that results from coping with adversity will promote their resilience. The adaptation of individuals to adversity, including maltreatment, results from interactive processes among the resilience factors located within the child, family and community. While resilience has increasingly been seen as important to understanding the relationship between parental difficulties and child outcomes, it is important to recognise that it is an area that is not yet fully understood. Nevertheless, while the mechanisms might not be understood, it does appear that resilience can help maximise children’s outcomes by providing a more positive family or wider environment. Resilience and better child outcomes, however, can also be related to certain characteristics of the individual child.

In summary, the research studies reviewed provide a consistent picture of the challenges posed by a range of diverse circumstances, which undermine the ability of parents and carers to meet the needs of children and young people. These circumstances include physical and mental health problems, as well as substance abuse. In some cases, as a result of the impact of these issues, the development of children will be affected. In others there appear to be family and individual child-level factors which mean this harm is avoided, a relationship that is still insufficiently understood. However, the variation in adverse circumstances and the differences between individual child and parent

characteristics is likely to require a similar diversity across services designed to support parents in their parenting roles.

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

Key findings

- Measuring the effectiveness of interventions is a complex task which involves outcomes at three levels: family level; parent/carer level; and child level.
- Key outcomes of effective support interventions for each of the three groups (parental physical health, mental health and substance misuse problems) include: physical and psychological wellbeing; self-esteem; cultural and ethnic identity; improved adult/child and partner relationships; improvement in parenting competence.
- Service usage is likely to be influenced by the characteristics of the services, notably whether they are seen as stigmatising or not, a hazard which particularly relates to involuntary rather than voluntary service use.
- Services across the spectrum of need must be sensitive to the circumstances of the children and families using them especially with regard to poverty, ethnicity and disability.
- It is essential that services are provided at each of the tiers of need and that bridges to access are constructed both between the levels of need and between the different professional groups and systems.
- There is a positive association between early intervention and better outcomes, but late intervention is better than no intervention at all.
- The Think Family Pathfinders and the related Family Intervention projects have begun to show some encouraging results. The flexible personalised way in which they respond to both children's and adults' needs is viewed extremely positively by families and the professionals working with them. Evaluations of the programmes stress the value of flexible working from adult services, information sharing and joint commissioning in delivering a more cohesive service for vulnerable families.
- An evaluation of Family Action projects, which offer a mixture of practical, therapeutic and emotional support to families, has identified some very encouraging results in terms of outcomes. The quality of the relationship between professionals and the families they supported was found to be a crucial lever for change.

As we highlighted in Section 5, because there is no straightforward association between parental wellbeing and child wellbeing, measuring the effectiveness of interventions is by definition a challenging task. In order to capture the most helpful messages for practice we

have drawn on evidence collected from a range of research methods, including explorations of the views of those who use services.

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

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

The four tiers: implications for understanding service efficacy

The 'four tier' framework (see Section 2 above) can facilitate understanding of the relationship between 'severity of problem' at the point of referral and 'measurable outcomes of services' at the point of delivery.

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

We know rather less about the effectiveness of services at Tiers 3 and 4; in large part because the complexity of issues which 'referred' families face almost invariably means that several services are provided consecutively or concurrently. Deciding whether a particular service or therapeutic method has led to a particular outcome is a major difficulty for summative research (-; Thoburn 2009). For some, a high-intensity multi-method approach will help. The model of home visiting, developed by Olds in the US, looking at the intensive individualised support provided by trained nurses to teenagers through

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

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

What do we know about Tier 1 interventions?

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

What do we know about Tier 2 interventions?

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

Home visiting

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

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

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

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

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

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

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

Parenting skills programmes

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

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

Evaluations have shown that these interventions lead to:

- reductions in harsh, negative, inconsistent and ineffective parenting and increases in supportive and positive parenting (Webster-Stratton)
- reductions in ineffective commands by parents (Webster-Stratton)
- improvements in parents' self-esteem (Parenting Matters; Mellow Parenting)
- improvements in parent–child relationships (Mellow Parenting, Parenting Matters, Triple P)
- reductions in parental anger and blame of children (Triple P).

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

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

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

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

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

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

In terms of interventions at Tier 3, Tunstill *et al* (2007) note that a particular advantage of neighbourhood family centres is that families can enter and leave the service as stresses in the family become manageable or escalate. Being able to access services at different points in time over a sustained period is viewed by parents as very helpful in their parenting tasks. A key issue for commissioners in the coming period of contracting budgets will be targeting children's centre provision in such a way that it is able to respond to families with this level of need. The potential of this model of working is reinforced by Morris (2007) in an evaluation of Family Action projects that were designed to meet the needs of families where parents had mental health difficulties. Morris reports that the development of these services was to a large extent a response to the disparity in thresholds between adult mental health services and children services. The largest number of referrals (29 per cent) came from children's social care, who identified a group of families that needed support because of the adult's mental health needs. However, these health needs were not serious enough to trigger intensive input from adult mental health services (and only 11 per cent of referrals came from adult mental health services). Child care practitioners were therefore faced with children who were clearly in need of additional services and, indeed, some were in need of protection, but with no service directly that could meet the parental health difficulties that underpinned this need. The projects offered a package of services, some of which were focused on working with the parent, some on supporting the child and some family work. They offered a mixture of practical, therapeutic and emotional support. The projects attempted to use a number of standardised intervention tools and, while Morris noted the merits of the aspiration of such an 'evidence based' approach, she nevertheless questioned the practicality in terms of capacity (of parents and support workers) in using such methods. While a relatively small-scale evaluation, Morris nevertheless did identify some very encouraging results in terms of outcomes. The quality of the relationship as a lever for change was crucial:

‘The overwhelming message from parents was their appreciation of practical support, support to their children, and in particular the warmth and understanding of Family Support projects.’

(Morris 2007 p 20)

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

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

In terms of services at this tier for parental substance misuse, similar messages emerge. The *Hidden Harm* report (Advisory Council on the Misuse of Drugs 2003) emphasised that if the potential damage of parental drug misuse is to be minimised then effective treatment for the parent is the key. Cognitive behavioural approaches have been identified as an effective intervention for many who misuse drugs and alcohol as well as increasingly the use of motivational interviewing (Forrester *et al* 2008). Nevertheless, in terms of meeting the needs of the child, relying solely on treatment is insufficient and a similar multi-agency package of services is required. A recent review by Asmussen and Weizel (2009) into ‘what works’ in supporting parents who misuse drugs and alcohol again emphasises the importance of a package of services focused on the whole family. Also they recognised similar issues in terms of thresholds for treatment (as with those that impede access to parents in need of mental health services) and argued that early access for patients who are **parents** should be facilitated.

Tier 4 services are ‘remedial’ or ‘rehabilitative’ support and/or therapy services for referred families, and sometimes involve court orders or an element of compulsion (such as a child protection inquiry; a young person convicted of an offence being placed in a treatment foster family; a health service placement in an addiction treatment unit, or a residential unit for a family evicted as a consequence of anti-social behaviour).² Many of the children who require services at this level do so because of parental mental health difficulties and/or parental substance misuse difficulties. Brandon *et al* (2009) in a review of serious case reviews noted the co-morbidity of parental mental health and substance misuse problems,

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

alongside domestic abuse. However, she also warned against a mechanistic, overly deterministic approach. Forrester and Harwin (2008) also noted that in 62 per cent of cases which progressed to care proceedings, parental substance misuse was a factor.

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

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

Role of adult services

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

A recurring theme that emerges throughout the literature in terms of intervening effectively across the range of health difficulties that parents face is the importance of coordinated approaches from adult and children's services. *Think Family* (Social Exclusion Task Force 2008) was a direct response from the former government to this and attempted to promote a holistic understanding of families' needs in the context of the trajectory of welfare policy in adult and children's services moving them in different directions. Research carried out in all areas of parenting difficulty (Olsen and Clarke 2003; Moran *et al* 2004; Asmussen and Weizel 2009; SCIE 2009) warn both adult and children's services against the dangers of

not working together in a coordinated way to meet the family's needs and also cite the positive impact of such collaboration.

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

Overall characteristic of services that parents value

Much of this discussion relating to interventions with parenting with health difficulties has focused upon the continuum of mental health difficulties including substance misuse and, to a lesser extent, learning disability. However, in terms of the feedback from the users of services it is perhaps unsurprising that much of the literature relates to parents with physical health difficulties and disabilities. Olsen and Tyers (2004) articulate from a perspective that reflects a social model of disability, a view of services which is congruent with much of what has been written in relation to *Think Family*. That is, that all too often there has been a one size fits all approach to service design and delivery, and the aspirations of disabled parents very much reflects the personalisation agenda that is transforming adult services. This vision is one of a responsive individualised package of culturally sensitive support that is developed on the basis of the strengths and the resources they offer their children, rather than simply a source of unmet needs. A positive development has been that as part of the previous government's *Aiming higher for disabled children*, parental satisfaction with services is now recognised as an important performance indicator.

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

approach, addressing the difficulties they face across the different areas of their lives (Morris and Wates 2006).

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

7. Conclusions and main messages

Having undertaken this review we have identified six key themes that emerge across the extensive research and practice literature in respect of the relationship between the safety, health and wellbeing of children and improvements in the physical and mental health of mothers, fathers and carers. We have redefined these six themes as broad questions. They are deliberately broad in scope and are relevant, in different respects, to all the stakeholders who are addressed in this review. We believe that they can throw some light on the challenges that currently exist and, perhaps, optimistically, that they **can** point to solutions in the future for mitigating the most obvious impediments to better child outcomes.

- What are the key structural obstacles?
- How can we improve the scope and relevance of nature of the knowledge base?
- How can professional collaboration be facilitated and improved?
- Can we begin to build better bridges across and between services?
- How can we apply the concept of resilience to understanding outcomes for children and young people?
- How can the deterrent impact of stigma be reduced?

What are the key structural obstacles?

The guarantee of access to services at the right time and for the right family member is made less likely by the current organisational configuration of adult and children's services. Children's services departments, introduced as one of the Every Child Matters (ECM) reforms, have sought, it might be argued with some success, to create better 'joined up' services between social care and education. However, this has been at the cost of introducing a new potential divide between adult services and children's services. Given that all stakeholders are in agreement that the key influence on, and inputs into children's lives will, in almost every case, be exerted by their parents and carers, this new division is far from helpful. This is because it can exacerbate the already well-documented reluctance of adult service providers to recognise adults as parents. This failure can potentially lead to all or many of their adult/parent needs being unmet. In addition, it can also fail to identify children's needs if they fall below a child protection threshold. Indeed there is an exciting potential for cross-service learning. Adult services can and do provide valuable examples of providing a personalised approach to problems in order to produce personalised outcomes, so that targeted support will not be seen as stigmatising by parents, children and young people.

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

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

questionable, given that much of the health agency collected data fails to identify patients as parents.

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

How can professional collaboration be facilitated and improved?

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

Can we begin to build better bridges across and between services?

The literature reviewed, while highlighting promising lines of intervention, fails to identify any one service which could be seen to constitute a 'silver bullet' in its own right, and if delivered in isolation from other services and supports.

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

access to services at different points in time over a sustained period in order to facilitate early access at whatever stage of the problem.

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

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

It is equally important that service commissioners do not restrict the menu of services on offer locally to these sorts of approaches, as we know from other aspects of the research literature that variables such as **child resilience** play a large part in the emergence at a later stage in life of positive overall outcomes. However, less is known about the nature of the associations between resilience and family/community/individual characteristics. There is some indication in the literature that supports in the wider community underpin resilience. These may include access to supportive adults in the wider community/kinship network, or more purposively designed input through, for example, school support workers.

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

How can the deterrent impact of stigma be reduced?

Many of the parents and carers covered in this review face significant levels of social exclusion and discrimination in their lives. This can be exacerbated by the stigma they feel in relation to services. However, a further dividend of taking a more integrated whole family approach is that it can address the barrier of stigma that has been identified as a significant impediment to parents and carers accessing the services that can improve outcomes for both them and their children. Parents and carers positively reported that services which met their needs beyond a narrow definition of 'parenting support' made a difference to their lives. Such an approach can support both a strength-based perspective and resilience. This approach can also be applied in different ways at each of the tiers of need.

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

This research review has covered a wide range of the challenges that face parents with health difficulties. It reinforces both the wide and specific definition of key terms in relation to 'in need' in the *Children Act 1989*. For example, Section 17(11) requires that in Part 3 of the Act 'development means physical, intellectual, emotional, social or behavioural development, health means physical or mental'. For these aspirations to be achieved in respect of children and young people, parallel account must be taken of the equivalent needs of parents. The findings of the review highlight that there are areas of parental health where the data is much stronger than others but that overall there is no proven causal link between parental difficulties and outcomes for children and young people. Faced with such a diversity of need both in its nature and degree, it is clear that commissioners of services and practitioners need to respond with a range of services and interventions that are located across the continuum of need. In particular, there needs to be an emphasis within services on a strength-based approach that builds child and parental resilience.

Data annexe

Key messages

- There is much data available on adults' and children's physical and mental health and the characteristics of those who are affected by these issues. Most of these data sources, however, do not identify whether adults are parents or carers or link parents' health to their children's outcomes.
- Many of these data sources can be used by local authorities and primary care trusts to inform their Joint Strategic Needs Assessments of adults' and children's health needs in their area and to plan their future priorities and interventions.
- The data available shows that both adult and child obesity have increased over time, although obesity among children has levelled off over the past few years. Generally, adults living in lower-income households were the most affected by poorer health. Drug and alcohol dependency were more prevalent among men than women, while a greater proportion of women than men had poorer mental health.
- Children's mental health and physical health were linked to their family backgrounds and their parents' health. In particular, mental health disorders were more prevalent among children living in families that had experienced marital breakdown.

Introduction and availability of data

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

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

- a summary of the search strategy for identifying data
- an overview of the nature and scope of the data that was found, with a brief commentary on the quality of this data, and any gaps that have been identified
- charts on the prevalence of mental and physical health problems among adults and children, including obesity, mental health disorders and alcohol and drug dependency,

produced from selected publicly available data, along with a brief commentary on these.

A summary table of the data sources of readily available, published data relating to the health, safety and wellbeing of adults and children and young people at a national, regional and/or local authority level is presented in Appendix 4. Some of the data refers to disability. The definition of disability under the *Disability Discrimination Act 1995* (GB Statutes 1995) is as follows:

The Disability Discrimination Act (DDA) defines a disabled person as someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.

Data search strategy

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

Data for this annexe was obtained by a combination of search methods including obtaining online access to known government publications (such as the Statistical First Releases from the Department for Education; DfE³); access to data published by the Office for National Statistics, the Department of Health and other government departments; data published by the National Health Service and other national, regional and local bodies; and online searches following leads emerging from these publications, research funding council summaries and other literature searches. It should be noted that links to statistical sources that were live at the time of searching may not remain live after publication.

Nature and scope of the data

There are a number of data sources that provide information about the proportion of adults in England who experience mental and physical health issues. This data, however, usually does not identify whether adults are parents or carers. Furthermore, most of the data on children's outcomes at local level does not link these to their parents' characteristics or health, although some data available at the national level offers insight into how children's family backgrounds and their parents' health behaviours are associated with their own health. The data available does, however, enable local authorities and primary care trusts to identify where and to whom intervention might be targeted to improve health and can be used to inform their Joint Strategic Needs Assessments (JSNA) of the needs in their areas

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

to plan their future priorities, as they are now required to do as part of the *Local Government and Public Involvement in Health Act 2007* (DH 2007b). Data that can be used for this can be accessed on C4EO's [interactive data site](#). The Association for Public Health Observatories (2008) has also compiled a list of the data sources that can be used to measure national indicators and Vital Signs (the NHS version of national indicators) in *The JSNA core dataset*.

For this review, the term 'wellbeing' incorporates a diverse range of children's outcomes, including their emotional and behavioural health, economic wellbeing, physical health and educational achievement. There are a large range of datasets available that local authorities can use to assess their progress towards improving children's wellbeing in their area, including progress towards public service agreement (PSA) 12 'improve the health and wellbeing of children and young people', PSA 13 'improve child and young people's safety', and PSA 10 'raise the educational achievement of all children and young people'. The DfE⁴, for instance, publishes a wide range of statistics about children's educational achievement based on data collected through the School Census. It also collates data on the number of children and young people who have been referred to social services and who have been subject to child protection plans from Child Protection and Referrals 3 (CPR 3) statistical returns. Further data on children's safety is also available from the Hospital Episode Statistics warehouse⁵, which records information about all hospital admissions in England. The latter is the official measure of local authorities' progress towards national indicator 70, regarding hospital admissions caused by unintentional and deliberate injuries to children and young people.

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

Data on the prevalence of obesity among children is collected by the National Child Measurement Programme (NHS Information Centre 2009) and this is also the formal measure of local authorities' progress towards national indicators 55 and 56 regarding reducing the proportion of primary school children who are obese. Weight and height measurements of children are collected by trained staff in schools which enables a robust measure of obesity in terms of body mass index (BMI) to be calculated. Data has been collected since 2006/07, so there is currently only limited trend data available. The Health Survey for England (Craig *et al* 2009), however, has been collecting data over a longer period and provides a good overview of national trends over time.

The TellUs survey (Chamberlain *et al* 2010; DCSF 2010a) measures local authority progress towards national indicator 50 regarding the emotional wellbeing of children and young people. Apart from this, there is little data at a local level about children's mental wellbeing. Although useful, some caution should be exercised when interpreting the TellUs

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

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

national indicator data, as its measurement is limited to children and young people's perceptions of whether they have good friends and whether they can talk to people about their worries. It does not take into account other factors that can also influence wellbeing, such as positive affect or self-esteem. More comprehensive data on children and young people's mental health, at a national and government office region level, is available in the The Mental Health of Children and Young People in Great Britain survey (Green *et al* 2005). This source provides information on the prevalence of mental disorders among children aged five to 16 in 2004. The classification of mental disorders used is based on the ICD-10 diagnostic criteria and so the statistics on the prevalence of each disorder reflect cases where symptoms reach a clinical level of distress or dysfunction.

There is also a wide range of data on aspects of adults' physical and mental health. In this annexe, we have focused on data about the prevalence of obesity, alcohol and drug dependency and mental health disorders among adults, and the characteristics of adults who are particularly vulnerable to these issues. Data on the prevalence of adult mental health problems, both common mental disorders such as depression and anxiety and more severe disorders, at a national and government office region level is available in the Adult Psychiatric Morbidity in England, 2007 survey (McManus *et al* 2009). Detailed data at local level is currently sparser. The MINI, MINI2000 and National Psychiatric Morbidity Survey (NPMS) indices⁶ record hospital admissions due to severe disorders and the proportion of people predicted to have a common mental disorder in an area. We have drawn on data from the Health Survey for England (Craig *et al* 2009) to look at adult obesity and trends in the prevalence of this over time, but local authorities can access data at a local level on obesity rates from *Healthy lifestyle behaviours* (Scholes *et al* 2007) published by the Information Centre for Health and Social Care. Data collected through the Quality and Outcomes Framework (DH 2010) is also available at primary care trust level, but due to methodological limitations the Association for Public Health Observatories and Department of Health (2008) recommends that this data is not used to assess the prevalence of obesity.

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

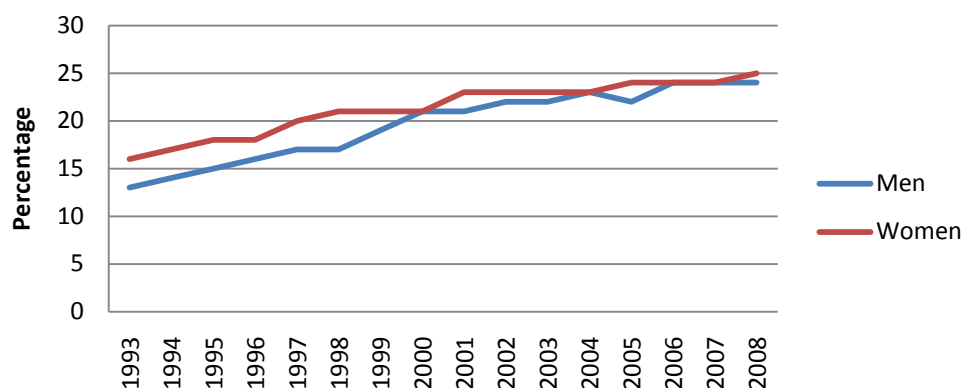
This section contains information about the prevalence of obesity and mental health disorders among adults and children, as well as alcohol and drug dependency among adults, and the characteristics of those affected by these issues.

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

Adult obesity

The rise in both adult and child obesity in the UK has been a topic of much discourse in the media over the past few years. The data presented here refers to general obesity which is, in itself, an important public health issue. Nevertheless, it is important to recognise that in terms of the extent to which obesity can be considered a disability, or significantly impacts on parenting, it is severe or morbid obesity that is of greatest relevance. Data from the Health Survey for England (Craig *et al* 2009) shows that in 2008 around a quarter of adults in England (24 per cent for men and 25 per cent for women) were classed as obese, based on their BMI measurement⁷ (see Figure 1). The proportion of adults in this category increased steadily between 1993 and 2008 by 9 per cent for women and 11 per cent for men. Over this period, generally a greater proportion of women than men were classed as obese, but by 2008 the proportion of men and women who were obese was similar.

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

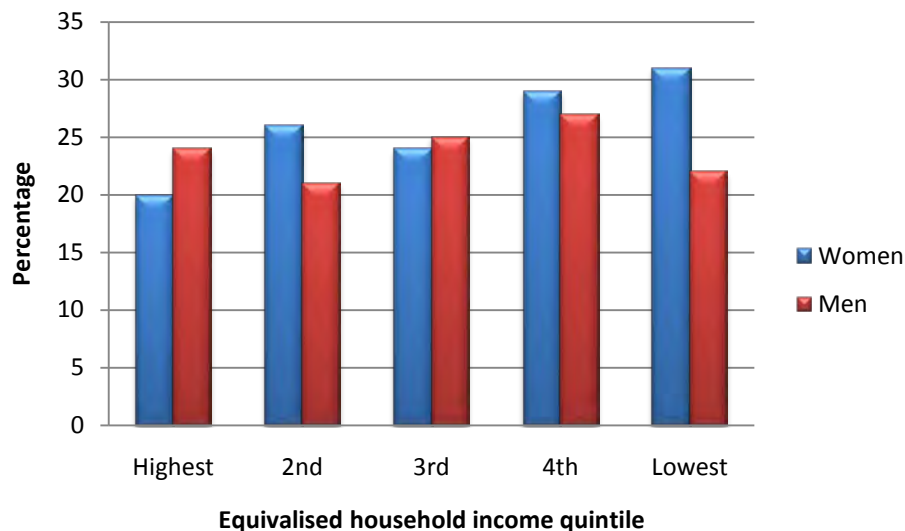


Source: Craig *et al* 2009

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

7. BMI is a measure of whether or not a person's weight is ideal according to their height. It is calculated by dividing a person's weight in kilograms (kg) by their height in metres squared (m²). In the Health Survey for England, people were classed as obese if their BMI was 30kg/m² or more.

Figure 2: Prevalence of obesity among adults in 2008: by household income and gender



Source: Craig *et al* 2009

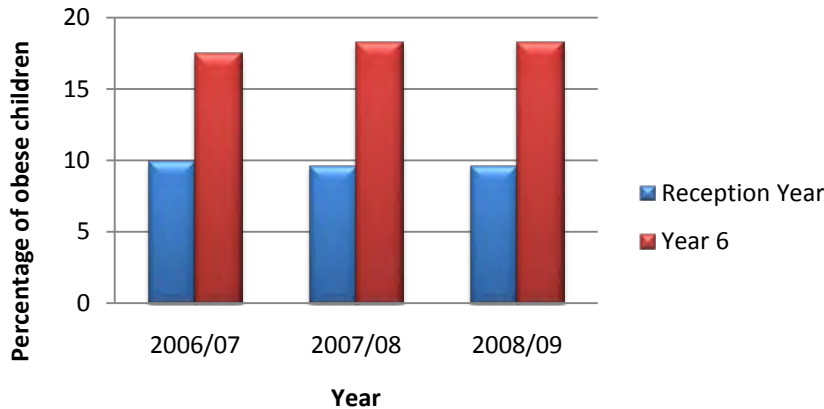
Obesity among children and young people

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

Data on children’s obesity has been collected for a longer period by the Health Survey for England (Aresu *et al* 2009). This shows that, in line with the increase in adult obesity, the proportion of obese children in England increased between 1995 and 2008 (see Figure 4). Obesity rates for boys and girls peaked at around 2005 when about one in five boys (18 per cent) and girls (19 per cent) aged two to 15 was classed as obese. Between 2005 and 2008, the proportion of girls who were obese reduced slightly by 4 per cent, while among boys it only decreased by 1 per cent. It is not possible to say why this may be the case from this data, but national efforts to improve the health of children and young people, such as improvements to school dinners, may have had more impact on outcomes for girls. Indeed, the most recent evaluation of the School Fruit and Vegetable Scheme⁸ in primary schools in England (Teeman *et al* 2010) found evidence that this initiative may have had more effect on improving the diets of girls than those of boys.

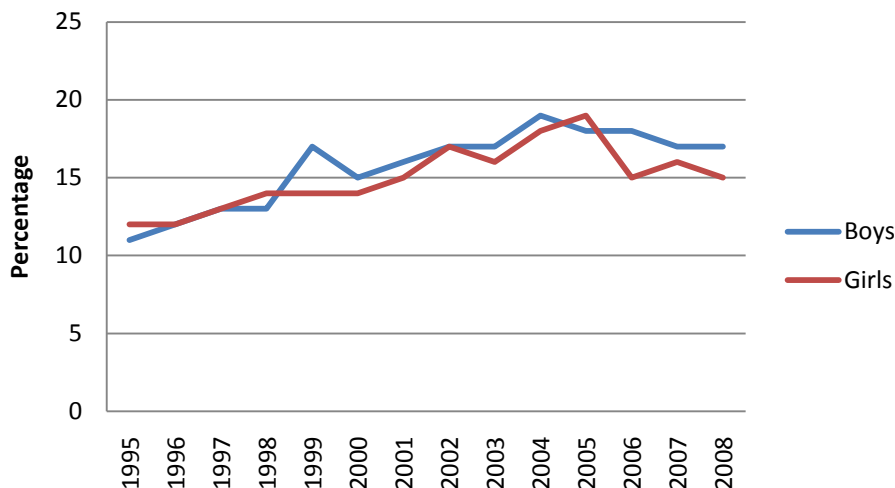
8. This is a national scheme in which children in Year 1 and 2 in primary school are given a free piece of fruit or vegetable to eat at break time every school day.

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



Source: The NHS Information Centre 2009

Figure 4: Trends in proportion of children aged 2 to 15 years who were obese between 1995 and 2008: by gender

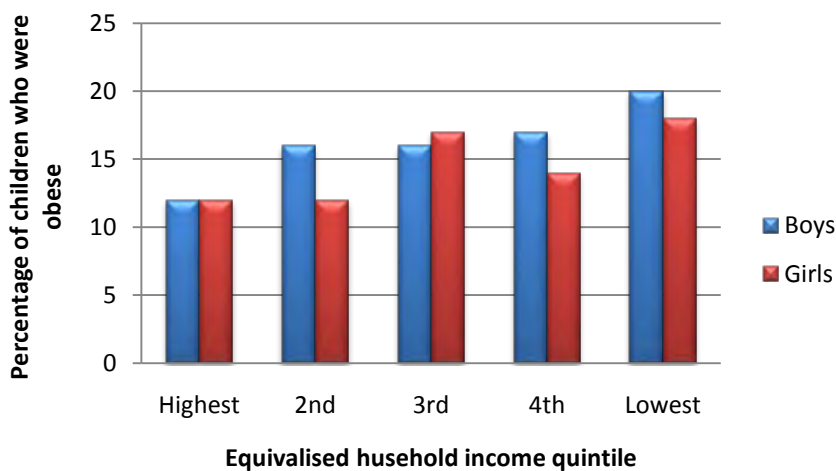


Source: Craig *et al* 2009

Data from the Health Survey for England (Craig *et al* 2009) offers some insight into how children and young people’s families and their backgrounds are associated with their weight. In line with the prevalence of obesity among adult women, a greater proportion of children and young people in the lowest income households were obese than those in the highest income households (see Figure 5). Furthermore, Figure 6 shows that parents’ weight was associated with whether or not their child was obese, especially for girls. Around two in five girls (37 per cent) who lived in households where both parents were obese were also obese compared with only 16 per cent of girls living with parents who

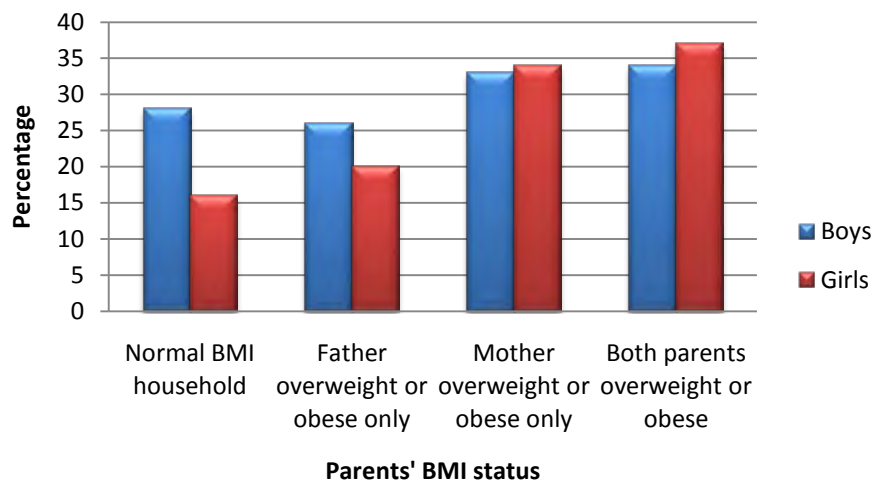
were both of normal weight. Among girls, their mother’s weight seemed to be more associated with whether or not they were obese than their father’s weight. A third of girls (33 per cent) living with obese mothers were also obese compared with a fifth or girls (20 per cent) living with obese fathers. This suggests that interventions which aim to improve physical health of children might improve obesity outcomes for girls by including a component that also improves mothers’ weight.

Figure 5: Proportion of children aged 2 to 15 years who were obese in 2008: by household income and gender



Source: Craig *et al* 2009

Figure 6: Proportion of children aged 2 to 15 years who were overweight or obese in 2006: by parental BMI

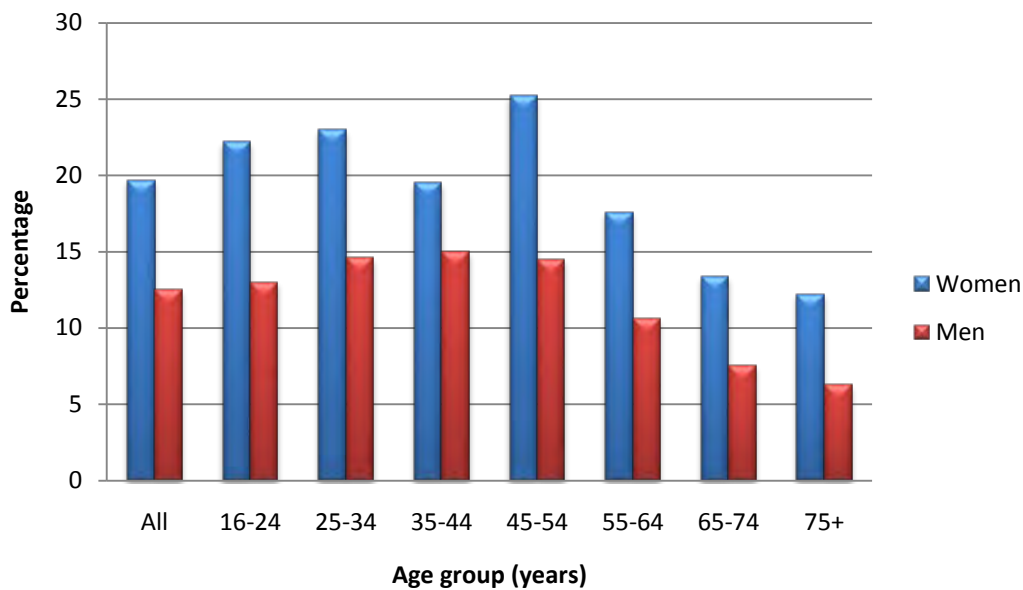


Source: Craig and Mindell 2008

Adult mental health

In 2007 just under one in five (18 per cent) adults reported experiencing symptoms of a common mental disorder (CMD)⁹, such as depression or anxiety, over the past week (see Figure 7). Women were at greater risk of experiencing a CMD than men, with one in five women (20 per cent) showing signs of having a CMD compared with around one in 10 men (13 per cent). CMDs were especially prevalent among men and women in age groups where adults are particularly likely to be caring for a child (aged 16 to 54), with comparatively fewer older adults aged 55 years or over experiencing a CMD. Figure 8 shows that the proportion of adults experiencing a CMD increased slightly between 1993 and 2007, by about 2 per cent for both genders.

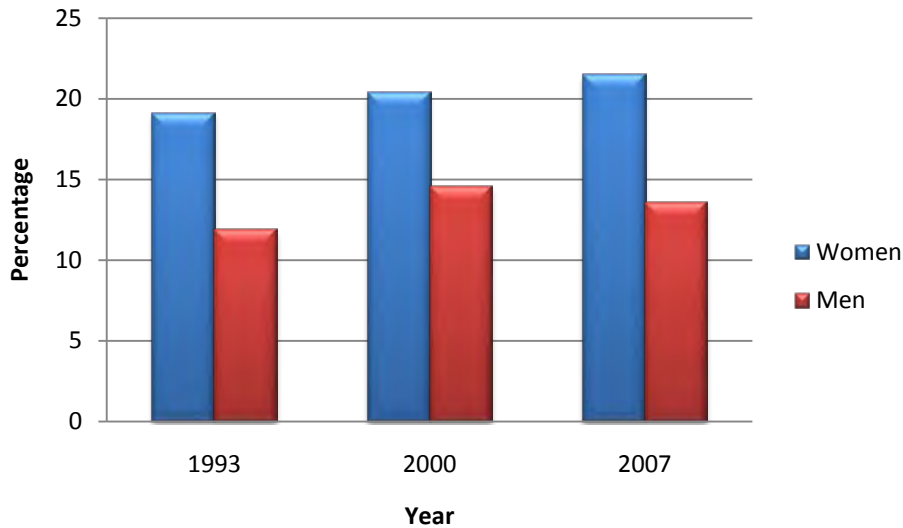
Figure 7: Proportion of adults who had experienced symptoms of a common mental disorder in the past week in 2007: by gender and age



Source: McManus *et al* 2009

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

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

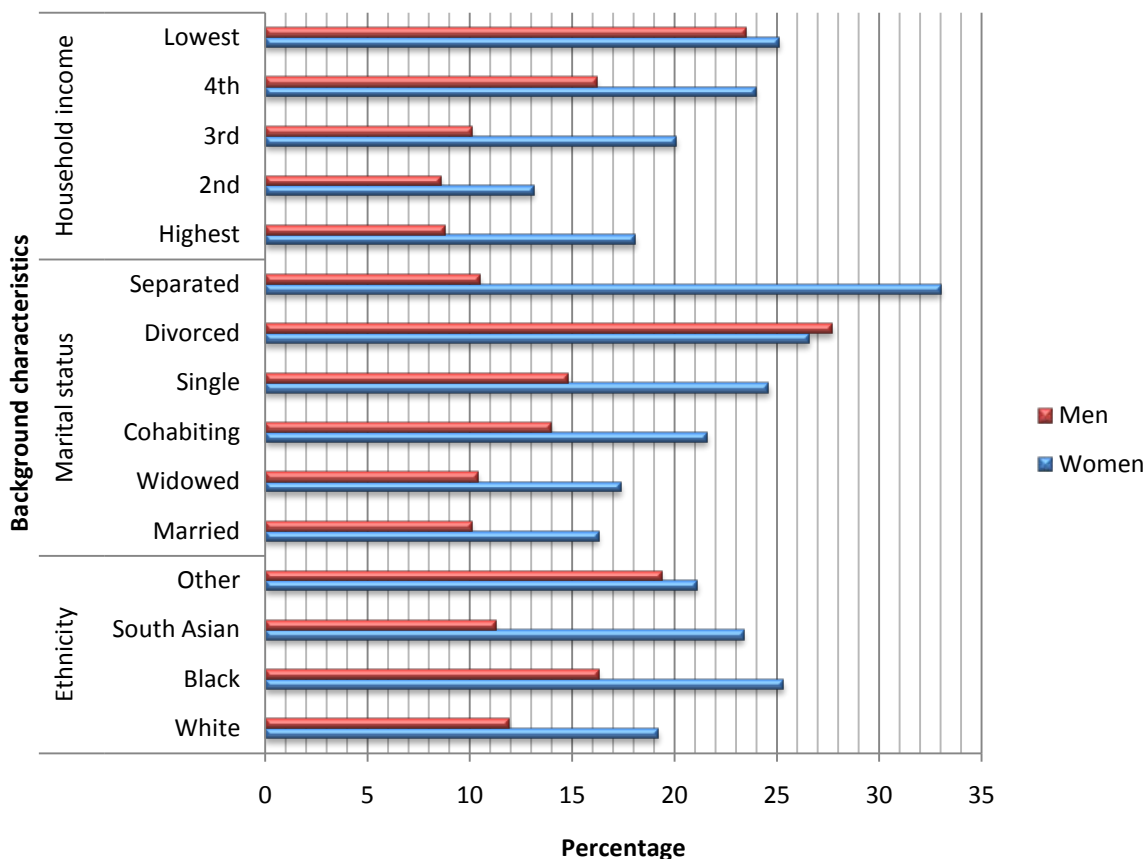


Source: McManus *et al* 2009

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

- A slightly greater proportion of women from a black ethnic minority background had experienced symptoms of a CMD in the past week than women from other ethnic backgrounds.
- A greater proportion of adults in households with a lower income experienced a CMD than those in higher income groups, and this was especially marked among men.
- Mental health difficulties were the least prevalent among people who were married, while those who were divorced or separated had the greatest prevalence of difficulties, especially separated women.
- Although we cannot tell from this data whether these individuals were parents or carers, this suggests that marital breakdown may be a particular risk factor for emotional difficulties and that mental health problems may be more prevalent among parents in families that have experienced marital breakdown.

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



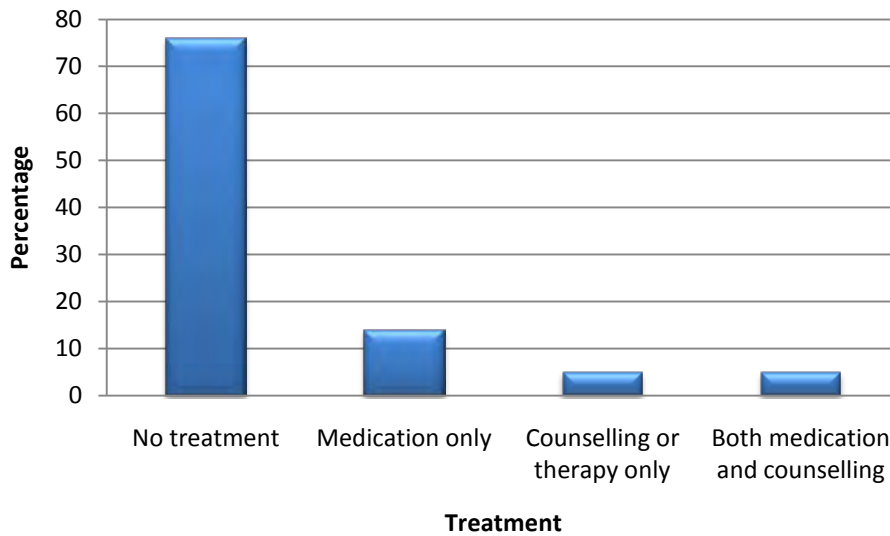
Source: McManus *et al* 2009

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

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

the highest income group (0.1 per cent). Also in line with the prevalence of CMD, proportionally more adults who were divorced (0.9 per cent) had experienced a psychotic disorder than those who were married (0.2 per cent).

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

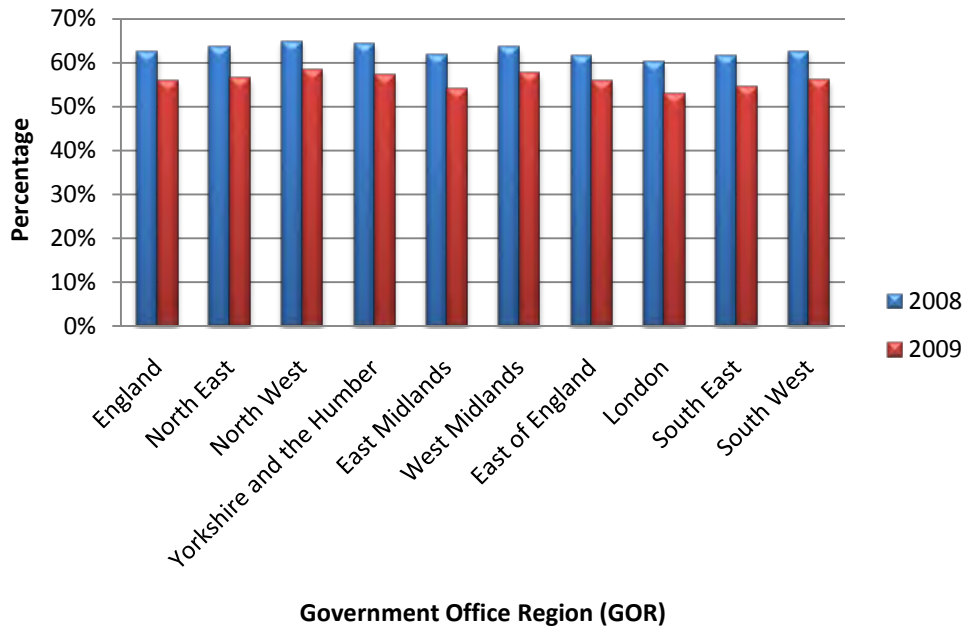


Source: McManus *et al* 2009

Children and young people’s emotional wellbeing

Data on national indicator 50, the emotional health of children, is assessed by the TellUs survey (DCSF 2010a). The data shows that the proportion of children and young people showing ‘good’ emotional wellbeing reduced across England and all government office regions in between 2008 and 2009 (see Figure 11). According to the TellUs report, this was mainly due to a reduction in the number of children and young people who felt that they could talk to an adult other than their parents about their problems.

Figure 11: Proportion of children and young people aged 10 to 15 years who showed good emotional wellbeing, 2008 and 2009 (national indicator 50)



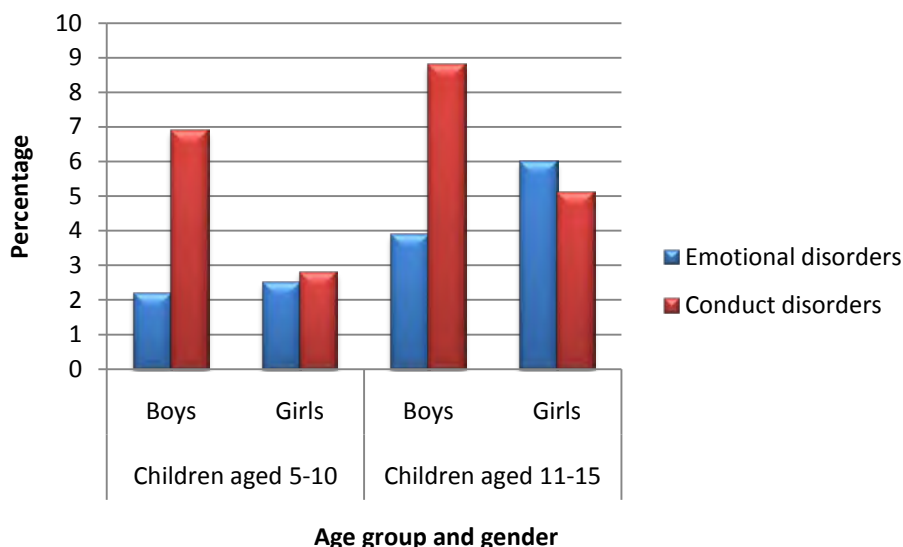
Source: DCSF 2010a

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

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

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

Figure 12: Proportion of children and young people who experienced a mental disorder in 2004: by age and gender



Source: Green *et al* 2005

In line with obesity outcomes, children’s mental health was related to their family backgrounds and their parents’ own mental wellbeing. A higher proportion of families with children with emotional disorders were assessed as having unhealthy functioning¹¹ in comparison with families where no child had an emotional disorder (see Figure 13). This was especially the case for families with a child who had depression. Furthermore, over half of the parents (50 per cent) who had children with an emotional disorder, except for children with a specific phobia, were identified as having poorer mental health¹² themselves (see Figure 14). Again, mental health was especially poorer among parents of children with depression.

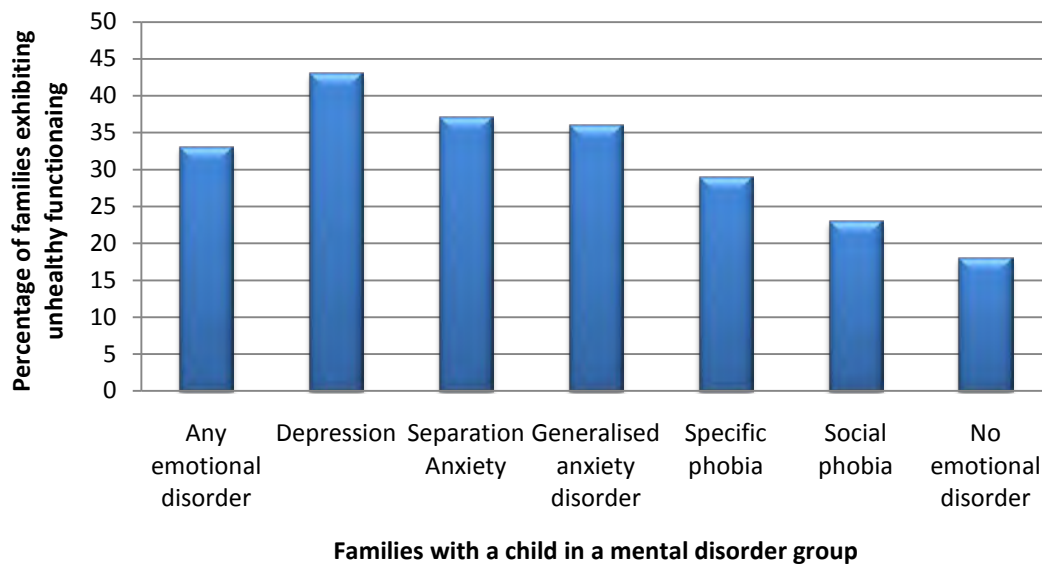
In line with the relationship between adult mental health and marital status, children and young people from families with married parents were the least likely to have a mental disorder (see Figure 15). Twice the proportion of children and young people living in lone parent families (16 per cent) as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

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

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

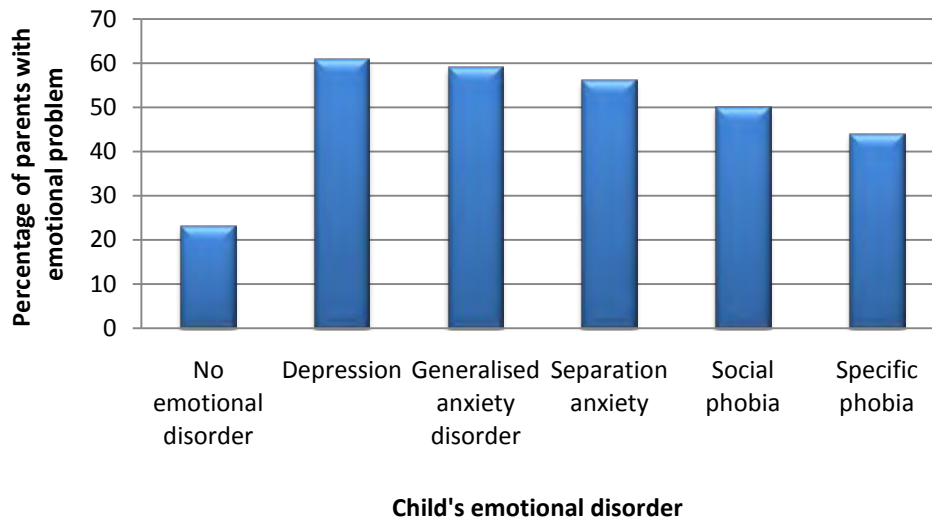
along with data on adult mental health above, that marital breakdown may be a risk factor for poorer mental health among both parents and their children.

Figure 13: Proportion of families with a child with a mental disorder who were assessed as having unhealthy functioning, 2007



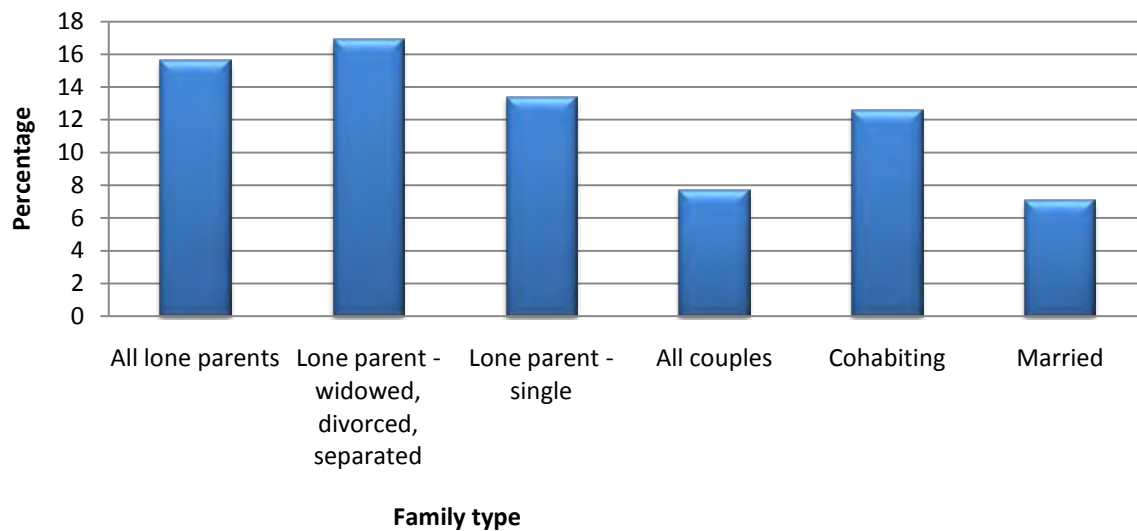
Source: Green *et al* 2005

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



Source: Green *et al* 2005

Figure 15: Proportion of children and young people who experienced a mental disorder in 2004: by family type

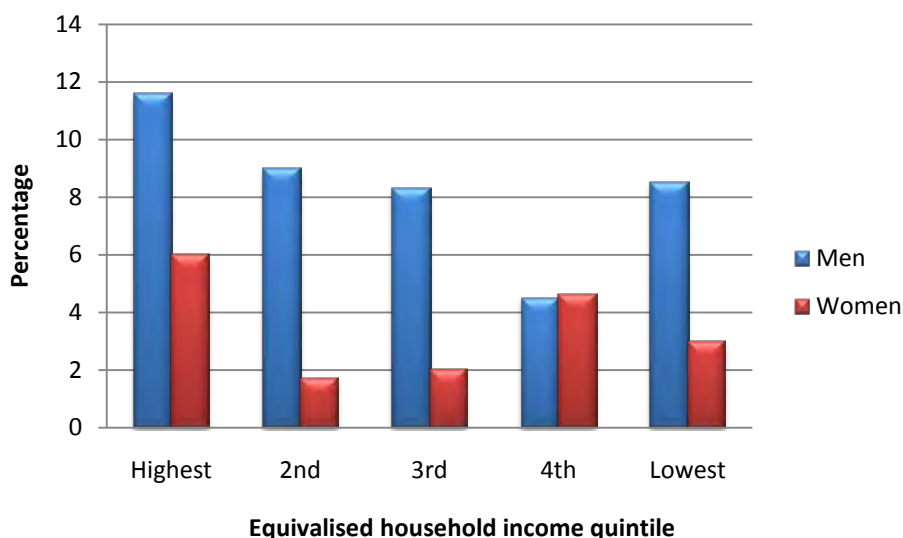


Source: Green *et al* 2005

Alcohol and dependency among adults

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

Figure 16: Proportion of adults who were dependent on alcohol in 2007: by household income and gender

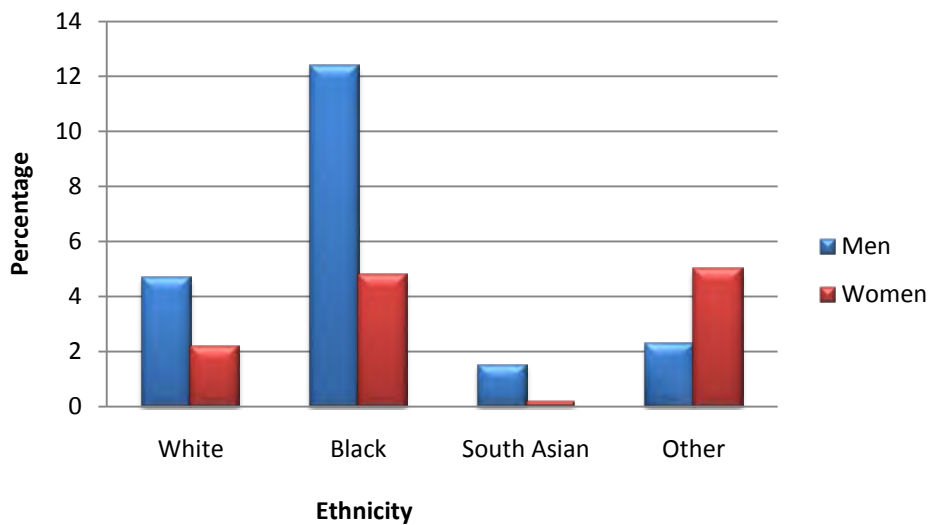


Source: McManus *et al* 2009

Dependency on drugs was rarer than on alcohol, with only 3 per cent of all adults showing signs of drug dependency (McManus *et al* 2009). Most commonly, adults showed signs of dependency on cannabis rather than higher class drugs. Similarly to alcohol misuse, drug dependency was more prevalent among men (5 per cent) than women (2 per cent). In contrast to alcohol dependency, though, which was most prevalent among white males, males from a black ethnic minority background were most likely to show signs of drug dependency: 12 per cent of black males showed signs of drug dependency in comparison to 5 per cent of white males and 2 per cent of South Asian males (see Figure 17). It was also particularly prevalent among men in the lowest income category (see Figure 18).

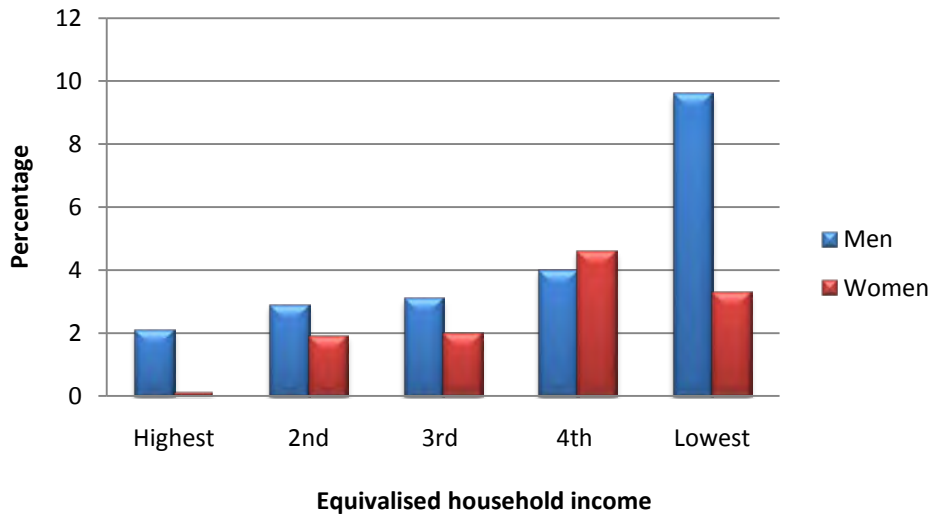
Although we cannot relate this data to whether or not these respondents were a parent or carer, this suggests that children in low-income families or from a black ethnic minority background may be particularly likely to be exposed to parents, and perhaps especially fathers, experiencing drug dependency.

Figure 17: Proportion of adults who showed signs of dependency on drugs in 2007: by ethnicity and gender



Source: McManus *et al* (2009)

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



Source: McManus *et al* 2009

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Appendix 1: Research review methods

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

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

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

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

There were six phases in the review method undertaken:

1. The research team undertook an initial review of the study titles of items of literature cited in the scoping study 'Improving the safety, health and wellbeing of children through improving the physical and mental health of mothers, fathers and carers' (Twist *et al* 2009). They then, following face-to-face discussion, taking the review title as parameters for this discussion, eliminated all but those which were most obviously relevant, on the basis of study title/publication abstract.
2. The remaining publications were then subjected to a second phase of coding on the basis of their abstracts. Coding at this stage took account of key study features – including research design, relevance to the scoping review questions and country of origin – to identify the key items to be included in the forthcoming main review. Subject topics were identified as relevant for inclusion in the design of the template.

3. A draft template was designed and circulated by the lead author, which was designed to record data on all or most of the following:
 - Appropriateness of the methodology in answering this question, and judgement as to the weight of evidence provided by the item in respect to the review questions.
 - Evidence on prevalence of problems such as mental and physical illness; incidence of child-level problems; and data on the outcomes of interventions.
4. In order to check for consistency, at the start of the project all team members read the same four pieces of evidence and then completed the template for each. This enabled us to check for consistency of approach across all team members.
5. A draft overview was produced on each of the sections, by the allocated researcher.
6. Completed review templates were collated and analysed thematically, so that writing could begin.

Appendix 2: Scoping study process

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

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

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

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

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

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

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

Table A2.1. Overview of searches

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

Search strategy

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

Applied Social Sciences Index and Abstracts (ASSIA)

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

Families/parents/carers

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

Mental health

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

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

Physical health

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

Substance abuse

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

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

Wellbeing

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

Interventions

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

Australian Education Index (AEI)

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

Families/parents/carers

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

Mental health

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

Physical health

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

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

Substance abuse

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

Wellbeing

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

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

Interventions

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

British Education Index (BEI)

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

Families/parents/carers

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

Mental health

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

Physical health

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

Substance abuse

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

Wellbeing

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

Interventions

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

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

British Education Index Free Collections

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

Families/parents/carers

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

Mental and physical health

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

Substance abuse

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

CERUK*plus*

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

Freetext search

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

Educational Evidence Portal (EEP)

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

Freetext search

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

#17 Drug use

Education Resources Information Center (ERIC)

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

Families/parents/carers

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

Mental health

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

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

Physical health

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

Substance abuse

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

Wellbeing

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

Interventions

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

PsycINFO

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

Families/parents/carers

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

Mental health

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

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

Physical health

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

Substance abuse

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

Wellbeing

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

Interventions

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

Research in Practice

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

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

- #6 Parenting
- #7 Substance misuse

Research Register for Social Care (RRSC)

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

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

Social Care Online

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

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

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

Social Policy and Practice

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

Families/parents/carers

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

Mental health

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

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

Physical health

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

Substance abuse

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

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

Wellbeing

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

Interventions

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

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

Appendix 3: Parameters document

1. C4EO Theme: Families, Parents and Carers

2. Priority 1

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

3. Context for this priority

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

4. Main review questions¹³ to be addressed in this scoping study (no more than five; preferably fewer)

- 1) What proportion of mothers, fathers and carers experience mental and/or physical health problems and what are their characteristics?
 - Include consideration of substance abuse as a contributory factor to mothers', fathers' and carers' health.
- 2) What is the relationship between children's safety, health and wellbeing and their mothers', fathers' and carers' a) mental and b) physical health?
 - Include consideration of substance abuse as a contributory factor to mothers', fathers' and carers' health.

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

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

- Include consideration of substance abuse interventions where they aim to improve parents' and carers' mental and/or physical health.
- Include consideration of parental outcomes (in parenting role) as well as children's outcomes, though the latter are the main focus.
- Include consideration of barriers and how they are overcome.
- Include consideration of value for money.

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

Child poverty, Workforce development, Equality and diversity, Disability

6. Definitions for any terms used in the review questions

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

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

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

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

7. What will be the likely geographical scope of the searches?

(Work conducted in/including the following countries)

English-speaking countries.

8. Age range for CYP:

0-19

9. Literature search dates

Start year

2003

10. Suggestions for key words to be used for searching the literature.

alcohol dependency, drug misuse, substance abuse, anxiety, depression, mental illness, personality disorder, parental disability, young carers, child carers, antenatal and postnatal mental health, substance misuse, obesity, hazardous drinking, harmful drinking, criminality, parents in prison, child accidents

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

Think Family programme -

www.dcsf.gov.uk/everychildmatters/strategy/parents/ID91askclient/thinkfamily/tf/

DCSF Family Pathfinders programme

Parental Mental Health and Child Welfare Network

www.pmhcnw.org.uk/resources_index.asp

Department of Health

SCIE/Social Care Online

DCSF

National Academy of Parenting Practitioners

Joseph Rowntree Foundation

NICE

Child and Maternal Health Observatory

National Treatment Agency, NTA

Home Office

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

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

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

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

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

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

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

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

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

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

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

13. Anything else that should be included or taken into account?

Review to identify issues around diversity and parental health, for example, age, gender, ethnicity, social class.

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

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

Note on setting review questions

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

1. What is the evidence of different outcomes (in relation to ECM outcomes) for children and young people from diverse backgrounds and with different characteristics?
2. What do we know about the causes and correlates of these outcomes?
3. What works – what do we know about specific strategies, approaches and systems that helps all children and young people to achieve good outcomes?

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

Appendix 4: National indicators and key data sources

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

National indicator (NI) number	NI detail	Source (published information)	Scale	Frequency of data collection	Latest data collection	First data collection	Link
Be healthy							
NI 50	Emotional health and wellbeing – children and young people user perception	DCSF: Local authority measures for national indicators supported by the Tellus4 Survey 2009–10	National, regional and local authority	Annual	2009	2007	www.dcsf.gov.uk/rsgateway/DB/STR/d000908/index.shtml
NI 50	Emotional health and wellbeing – children and young people user perception	Mental health of children and young people in Great Britain	National	Ad hoc (1999, 2004 and 2007)	2007	1999	www.statistics.gov.uk/downloads/theme_health/GB2004.pdf www.statistics.gov.uk/articles/nojournal/child_development_mental_health.pdf

Improving the safety, health and wellbeing of children

National indicator (NI) number	NI detail	Source (published information)	Scale	Frequency of data collection	Latest data collection	First data collection	Link
NI 51	Effectiveness of child and adolescent mental health (CAMHS) services	DCSF: Effectiveness of CAMHS as at December 2009	National, government office region and local authority	Annual	2009	2008	www.dcsf.gov.uk/rsgateway/DB/STR/d000932/index.shtml
NI 55/56	Obesity among primary school age children in Reception Year/Year 6	The Health Survey for England – 2008: Physical Activity and Fitness	National and strategic health authority	Annual	2008	1994	www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/health-survey-for-england/health-survey-for-england--2008-physical-activity-and-fitness
NI 55/56	Obesity among primary school age children in Reception Year / Year 6	Health Survey for England 2006. Volume 2. Obesity and Other Risk Factors in Children	National, government office region and strategic health authority	Annual	2006	1994	www.ic.nhs.uk/webfiles/publications/HSE06/HSE06_VOL2.pdf

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

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

National indicator (NI) number	NI detail	Source (published information)	Scale	Frequency of data collection	Latest data collection	First data collection	Link
							la-level-2003-05
Additional indicators	Adult obesity	Statistical Release. Smoking at Delivery, GP Recorded Smoking and GP Recorded Obesity (BMI), Quarter 4, 2009/10	National, strategic health authority and primary care trust	Quarterly	2009/10	2005/06	www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_116059
Additional indicators	Live and still births	Birth Statistics: Births and Patterns of Family Building in England and Wales	National, government office region and unitary authorities	Annual	2008	1998	www.statistics.gov.uk/statbase/Product.asp?vlnk=5768
Additional indicators	Adult health	General LiFestyle Survey (formerly the General Household Survey)	National and government office region	Annual	2008	1971	www.statistics.gov.uk/STATBASE/Product.asp?vlnk=5756
Additional indicators	Proportion of adults with a disability	DWP: Family Resources Survey 2008/09	National and government office region	Annual	2008/09	1992	http://research.dwp.gov.uk/asd/frs/

National indicator (NI) number	National indicator (NI) detail	Source (published information)	Scale	Frequency of data collection	Latest data collection	First data collection	Link
Additional indicators	Characteristics of Sure Start Local Programme areas between 2000/01 and 2004/05	National Evaluation of Sure Start	England and Sure Start Areas	Annual from 2000 to 2005	2005	2000	www.dcsf.gov.uk/everychildmatters/publications/0/1908/
Enjoy and achieve							
NI 73/74	Proportion of pupils achieving Level 4 or above in both English and maths at each of Key Stages 2 and 3	DCSF: Key Stage 2 Attainment by Pupil Characteristics, in England 2008/09	National, regional and local authority	Annual	2009	Trend data from 2006 onwards available	www.dcsf.gov.uk/rsgateway/DB/SFR/s000889/index.shtml
NI 75	Proportion of pupils achieving 5 or more A*-C GCSEs (or equivalent) including English and maths	DCSF: GCSE Attainment by Pupil Characteristics, in England 2008/09	National, regional and local authority	Annual	2009	Trend data from 2006 onwards available	www.dcsf.gov.uk/rsgateway/DB/SFR/s000900/index.shtml

National indicator (NI) number	National indicator (NI) detail	Source (published information)	Scale	Frequency of data collection	Latest data collection	First data collection	Link
Staying safe							
NI 59	Percentage of initial assessments for children's social care carried out within seven working days of referral	DCSF: Referrals, Assessments and Children and Young People who are the subject of a Child Protection Plan, England	National, government office region and local authority	Annual until 2009. Data from April 2009 onwards will be published in the Children in Need (CIN) census	2008/09	Trend data available for past 10 years	www.dcsf.gov.uk/rsgateway/DB/SFR/s000873/index.shtml
NI 70	Hospital admissions caused by unintentional and deliberate injuries to children and young people	Hospital Episode Statistics	National and primary care trust/NHS Foundation Trust	Monthly	January 2010	1989/90	www.hesonline.nhs.uk/Ease/servlet/ContentServlet?siteID=1937
Additional indicators	Infant mortality	Unexplained deaths in infancy, England and Wales, 2007	National and government office region	Annual	2007	Unknown	www.statistics.gov.uk/StatBase/Product.asp?vlnk=14127

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

OCTOBER 2010

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

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

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