East Sussex
County Council

Safe, resilient and secure parenting for all children and young people

Foreword

The first of April 2013 saw the successful completion of the transfer of Public Health Services from the Primary Care Trusts to the County Council, and the Health and Wellbeing Board, established in shadow form in 2011, take on its full statutory powers and duties.

The Health and Wellbeing Board has developed its first Health and Wellbeing Strategy – *Healthy Lives, Healthy People, The East Sussex Health and Wellbeing Strategy 2013-2016* – which aims to protect and improve people's health and wellbeing and reduce inequalities. The Strategy sets out the seven key priorities for improvement over the next three years:

1. The best possible start for all babies and young children
2. Safe, resilient and secure parenting for all children and young people
3. Enabling people of all ages to live healthy lives and have healthy lifestyles
4. Preventing and reducing falls, accidents and injuries
5. Enabling people to manage and maintain their mental health and wellbeing
6. Supporting those with special educational needs, disabilities and long term conditions
7. High quality and choice of end of life care

These priorities are areas where the Board can make a real difference and the strategy sets out how this will be achieved through the commissioning of services, joint working and collective action.

The Annual Report of the Director of Public Health 2013/14 was produced to inform delivery of the Health and Wellbeing Strategy. Whilst the full Annual Report covers all seven priority areas, a series of booklets have also been produced which focus on each of the priority areas in turn. Each booklet reproduces what is contained in the Annual Report for that area.

This booklet presents the results for priority 2: Safe, resilient and secure parenting for all children and young people.

Acknowledgements

Lesley Allen
Jenny Broome-Smith
Sharon Burns
Philippa Carr
Anita Counsell
Anna Czepil
Graham Evans
Helen Foreman
Clare Harmer
Adam Horvath
Rachael Hornigold
Sandra Jay
Steve Jarvis
Jane Mackney
Louise MacQuire-Plows
Martina Pickin
Peter Questor
Phillip Rowcliffe
Miranda Scambler
Alison Smith
Becky Surman
Jane Thomas
Claire Turner
Anthony Wakhisi
Rachel West
David Wolfe

Cynthia Lyons
Acting Director of Public Health
East Sussex County Council

Chapter 1: Introduction

The Director of Public Health is required by statute to prepare and publish an annual report. This year's report provides the evidence to help commissioners identify the interventions that will deliver the priorities which have been agreed in the East Sussex Health and Wellbeing Board's Health and Wellbeing Strategy for 2013-2016 "Healthy Lives, Healthy People".

The report presents the results from a series of rapid evidence and literature reviews aligned to the seven priority areas identified in Healthy Lives, Healthy People and the recommendations will help service commissioners to ensure that they make the best investment of the resources they have available and to weigh the return on that investment against other competing priorities.

For each of the seven priority areas, sub-topics have been identified which are important for delivery. Recommendations from the evidence reviews have been included in the appendices, and the full evidence review reports are included on the East Sussex Joint Strategic Needs Assessment website **www.eastsussexjsna.org.uk.**

To make the recommendations more easily accessible a series of booklets have been produced. Each booklet focuses on one of the priority areas in Healthy Lives, Healthy People, and reproduces what is contained in the full annual report for that area, including all the recommendations contained in the appropriate appendix.

Booklet 1:	The best possible start for all babies and young children
Booklet 2:	Safe, resilient and secure parenting for all children and young people
Booklet 3:	Enabling people of all ages to live healthy lives and have healthy lifestyles
Booklet 4:	Preventing and reducing falls, accidents and injuries
Booklet 5:	Enabling people to manage and maintain their mental health and wellbeing

Booklet 6: Supporting those with special educational needs, disabilities and long term conditions
Booklet 7: High quality and choice of end of life care

Commissioners can use the booklets to prioritise the key recommendations for implementation. Recommendations should be prioritised where they:

- are not part of current practice;
- highlight the need for practice to change;
- require retraining or the development of new skills;
- require implementation by a broad range of agencies or across a range of settings
- may be viewed as potentially contentious or difficult to implement for other reasons.

The Health and Wellbeing Strategy Action Plan

Healthy Lives, Health People is supported by an action plan setting out high level actions, outcomes, indicators and targets including those aimed at 'narrowing the gap' between the best and worst performing areas in the county. Table 1.1 presents the targets and indicators for priority area 2: Safe, resilient and secure parenting for all children and young people.

The Structure of this Booklet

This booklet outlines the approach taken to review the literature and evidence, identifies the sub-topics that are important for delivery, presents some of the key facts and figures for and then identifies evidence based recommendations for implementation.

The full evidence review report for this priority area is included on the East Sussex Joint Strategic Needs Assessment website **www.eastsussexjsna.org.uk.**

Table 1.1 The Health and Wellbeing Strategy Action Plan: Priority Area 2 – Safe, resilient and secure parenting for all children and young people

OUTCOMES	ACTIONS AND OUTPUTS	OBJECTIVES
Priority 2: Safe, resilient and secure parenting for all children an		
Parents are confident, able and supported to nurture their child's development.	• Enhance the capacity and leadership of targeted early help services for parents who are struggling. • Ensure quick decisions and actions are taken where it is clear that parents do not have, and cannot develop, the capacity to provide good enough care for their children. • Invest in high quality training for all those who work with vulnerable families and ensure that support is streamlined and coordinated.	• More familie help suppor • Improved ra and vaccina • Reduce the referrals to c

	STRATEGIC OUTCOME INDICATORS
d young people	
es given targeted early rt. tes of immunisation tion. rate of inappropriate children's social care.	2.1 Fewer children who need a Child Protection Plan (CPP). Indicator definition: Rate per 10,000 (of 0-17 population) of children with a CPP. Baselines: (2011/12) England = 37.8; East Sussex = 65 2012/13 outturn to be confirmed. Target by 2016: To reduce the East Sussex rate to 2013/14 = 49.9; 2014/15 = 48.3; 2015/16 = 47.9 2.2 Reduce the number of young people entering the criminal justice system. Indicator definition: The rate of first time entrants to the criminal justice system per 100,000, where first time entrants are defined as young people (aged 10 – 17) who receive their first substantive outcome (relating to a reprimand, a final warning with or without an intervention, or a court disposal for those who go directly to court without a reprimand or final warning). Baselines: (2011/12) England 712; East Sussex 423 Target by 2016: 2013/14 (381 countywide) = 10% reduction on the 2011/12 East Sussex outturn; 2015/16 = 5% reduction on the 2013/14 East Sussex outturn.

Chapter 2: Evidence based commissioning

2.1 The approach – identifying the evidence

Within each of the seven priority areas of the Health and Wellbeing Strategy several sub-topics were identified as important for delivery. These were reviewed for evidence to support health and social care interventions and services.

The reviews focused on systematic reviews and meta-analyses, but where there was a lack of evidence, randomised controlled trials were also included. Each review aimed to identify the most important and relevant message supported by the scientific literature. They deliver a summary of clear and concise evidence statements based on the 5-10 most recent and relevant systematic reviews or meta-analyses.

Table 2.1: Sub-topics for the overall literature review of priority area 2: Safe, resilient and secure parenting for all children and young people

Priority area	Sub-topic
Safe, resilient and secure parenting for all children and young people	a. Interventions to support parents who are struggling
	b. Quality training as an intervention for those who work with vulnerable families
	c. Effective parenting interventions to support children/young people
	d. Interventions to reduce the number of young people entering the criminal justice system
	e. Interventions to improve outcomes for children in families supported by social care services

Evidence was classified based on the Scottish Intercollegiate Guidelines Network (SIGN) methodology. These reviews did not include a full systematic assessment of study quality, perceived levels of bias and probabilities of causal relationships were scored based on an assessment of each source's methodology. Scorings were indicative rather than definitive.

Table 2.2: Study Quality Classification

1++	High quality meta-analyses, systematic reviews of Randomised Controlled Trials, or RCTs with a very low risk of bias.
1+	Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias.
1-	Meta-analyses, systematic reviews, or RCTs with a high risk of bias.
2++	High quality systematic reviews of case control or cohort or studies. High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal.
2+	Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal.
2-	Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal.
3	Non-analytic studies, e.g. case reports, case series.
4	Expert opinion.

The recommendations for each topic were classified using a system based on the overall quality of the evidence. Recommendations graded 'A' are based on the highest quality evidence and those graded 'D' the lowest.

Table 2.3: Recommendation Strength Classification

A	At least one meta-analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results.
B	A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 1++ or 1+.
C	A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 2++.
D	Evidence level 3 or 4; or extrapolated evidence from studies rated as 2+.

2.2 Commissioning prioritisation

This booklet aims to provide commissioners and multi-agency partnerships with a checklist against which commissioning plans and strategies can be compared to ensure they are based on current best evidence.

The evidence review includes some interventions that are well established within local services. However, it is recommended that commissioners and multi-agency partnerships review the full list of recommendations against strategies.

A process of prioritisation and building recommendations into work plans is recommended using the following criteria to identify interventions which:

- are not part of current practice;
- highlight the need for practice to change;
- require retraining or the development of new skills;
- require implementation by a broad range of agencies or across a range of settings; and
- may be viewed as potentially contentious or difficult to implement for other reasons.

Chapter 3: Safe, resilient and secure parenting for all children and young people

Focus on

3.1 Interventions to support parents who are struggling

3.2 Quality training as an intervention for those who work with vulnerable families

3.3 Effective parenting interventions to support children/young people

3.4 Interventions to reduce the number of young people entering the criminal justice system

3.5 Interventions to improve outcomes for children in families supported by social care services

Public Health Outcome Framework indicators relevant to this key area and their East Sussex rating in comparison to the England Average, November 2013.

Public Health Outcome Indicator	Comparison to England
1.01 Children in poverty	Significantly better
1.03 Pupil absence	Significantly worse
1.04 First time entrants to the youth justice system	Significantly better
1.05 16-18 year olds not in education employment or training	Significantly worse
2.04 Under 18 conceptions	Worse

3.1 Key facts and figures: supporting parents

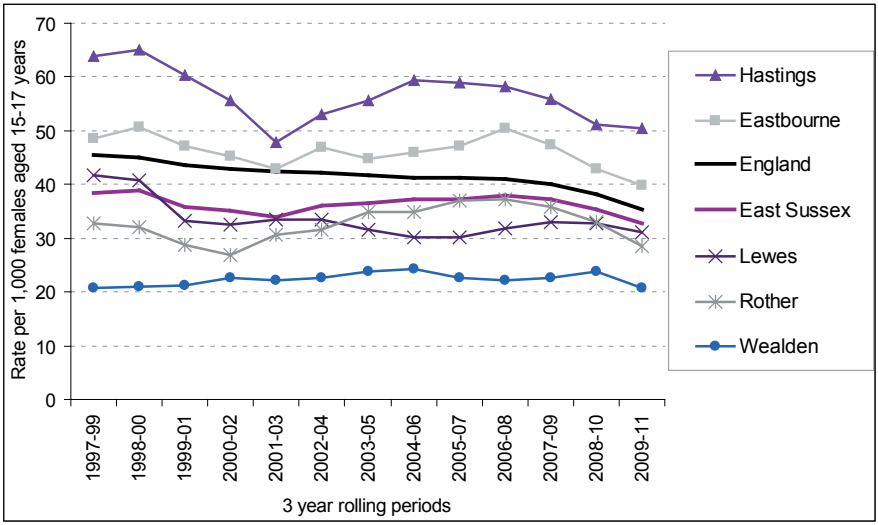
Many families are struggling to bring up their children in difficult personal and life circumstances.

Families with low incomes are more likely to live in deprived neighbourhoods with poorer housing, higher rates of crime, poorer air quality, lack of green spaces for children to play and more risks to safety from traffic all of which impact on their health.

Around one in five (18.7%) children in East Sussex are living in poverty with almost a six fold difference in the number of children in urban areas compared with rural areas. The wards with the highest numbers are Hampden Park and Langney. The ward with the highest percentage of children living in poverty is in Central St Leonards (50%).

Teenage pregnancy and early motherhood are associated with poorer health and social outcomes both for mothers and children. Socio-economic disadvantage can also be a cause of teenage parenthood as well as a consequence.

Figure 3.1: Under 18 conceptions for East Sussex local authorities, rate per 1,000, 1997 to 2011



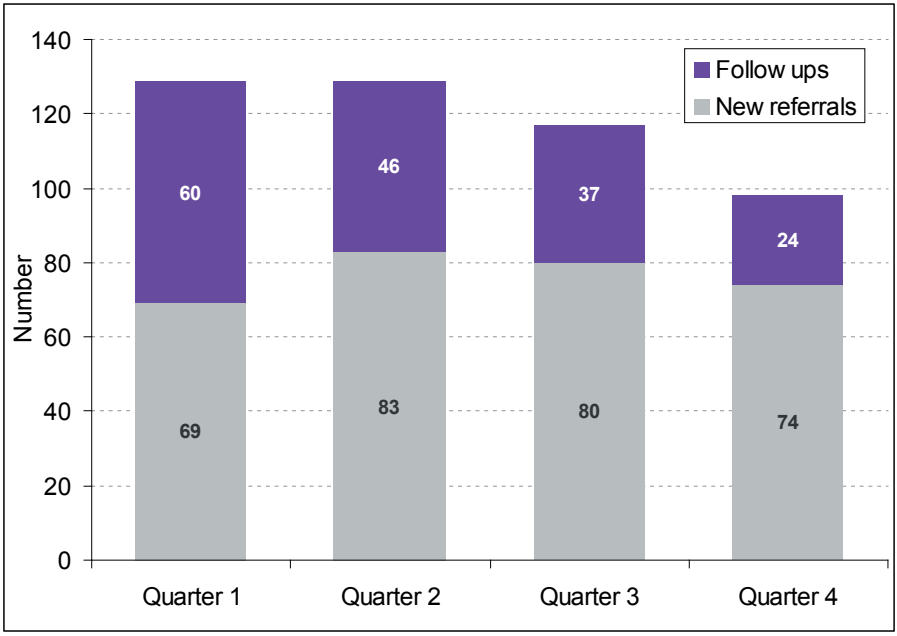
Source: Office for National Statistics

The teenage pregnancy rate in East Sussex is generally declining and is lower than the England average. Rates are highest in Hastings and Eastbourne and lowest in Wealden.

There is good evidence that postnatal depression affects the mother-infant relationship and children's cognitive and emotional development. Depression and anxiety are the most common mental health problems in pregnancy affecting 10-15 in every 100 women, although women also experience a range of other mental health problems during pregnancy. In 2012 there were 5,422 births to East Sussex women, around 550-800 of whom will have developed postnatal depression.

The East Sussex perinatal mental health service provides a service to women who develop mental health problems related to pregnancy, those with postnatal mental illness and those with pre existing psychiatric disorder. Provision continues until the first year of the baby's life. As well as taking referrals for women with moderate to severe mental health problems, the service provides advice and information, training and signposting for health professionals working with women with less severe presentation. The aim is to improve outcomes for women and prevent future crises which may affect parenting and have long term effects on their children.

Figure 3.2: Referral to East Sussex specialist perinatal mental health service 2012/13 by quarter



Source: East Sussex Healthcare NHS Trust

Figure 3.2 shows that in 2012/13 there were a total of 473 referrals to the perinatal mental health service, of which 306 were new referrals and 167 follow-up visits. The majority of new referrals are for depression and anxiety, with midwives and GPs being the main sources of referrals.

Those with less severe mental health problems are cared for by the Health Visiting Service or referred for community-based counselling. It is estimated that the latter service receives around 120 referrals per annum and provides both individual and group sessions.

3.2 Key facts and figures: working with vulnerable families

The Government's three-year Troubled Families Programme offers incentives to encourage local authorities, and their partners, to 'turn around' (achieve lasting change with) troubled families. Troubled families are characterised by there being no adult in the family working, children not being in school and family members being involved in crime and anti-social behaviour.

The national Troubled Families Programme rated East Sussex County Council 'green' at the end of the first year having already achieved 90% of its three year target for identification of troubled families and 83% of its target for engaging with troubled families. At the time of assessment 17 services/school clusters were offering Keywork to families and new services have since joined the programme. Keyworkers are now being introduced more widely into Early Help services as part of the THRIVE programme.

East Sussex County Council has a clear commitment to invest in the Children's Workforce through comprehensive training and other development opportunities, supporting staff to change the way they work, achieve greater confidence in keeping children safe and intervene with families more effectively.

3.3 Key facts and figures: effective parenting

The Health Visitor Implementation Plan sets out the need for both universal provision and targeted help and support. In East Sussex around 1,450 families and 2,400 children were in receipt of targeted early help from the Health Visiting Service in each quarter of 2012/13. Of these, around 850 families and 1,000 children received Universal Plus provision and 600 families and 1,400 children received Universal Partnership Plus provision.

Under Universal Plus, health visitors provide a rapid response to families when there is a need for specific expert help, for example with postnatal depression, a sleepless baby, weaning or answering any concerns about parenting

Under Universal Partnership Plus, health visitors provide families and children with ongoing support and access to a range of local services to help them deal with more complex issues over a period of time. These include services from Sure Start Children's Centres, other community services including charities and, where appropriate, the Family Nurse Partnership.

The Family Nurse Partnership is an evidence-based preventive programme for vulnerable young first time mothers and their families offering intensive and structured home visiting from early pregnancy until the child is 2 years old.

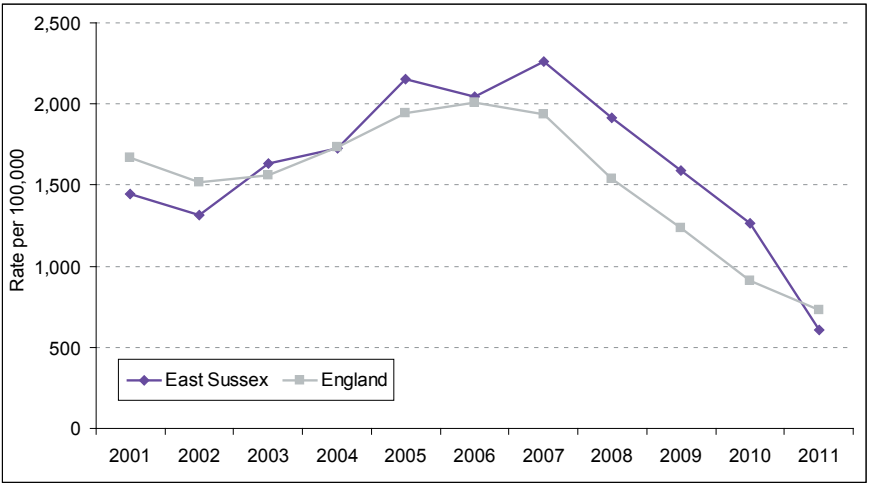
All first time mothers who are 19 years old and younger at conception are eligible for the East Sussex Family Nurse Partnership Programme. The programme has a caseload capacity of 266 clients: 123 for the East and 143 for the West of the county. At the end of June 2013 the programme was at 76% capacity in the East and 84% capacity in the West.

Research shows that good-quality early years education benefits children in the long term, particularly the most disadvantaged. It enhances children's all round cognitive, language and social development. In East Sussex 96% of 3 year olds and 98% of 4 year olds take up Early Years Educational Entitlement, similar to England.

3.4 Key facts and figures: young people entering the criminal justice system

The main aim of the youth justice system is to prevent youth offending. The effectiveness of the criminal justice system is therefore partly judged on its progress in reducing the number of young people entering the system for the first time. Justice agencies have worked to reduce the numbers through voluntary interventions targeted at those considered to be at risk of offending, and also by responding to minor offending in a more informal way. Figure 4.3 shows there have been substantial reductions in the number of first-time entrants in East Sussex since 2007, which is in line with the national picture.

Figure 3.3: Juveniles (10-17 year olds) receiving their first reprimand, warning or conviction, rate per 100,000 population, 2001 to 2011



Source: Ministry of Justice and Office for National Statistics

3.5 Key facts and figures: children in families supported by social care service

Generally children in care have poorer outcomes than the wider population particularly in relation to educational achievement, homelessness and mental health.

Looked after children are over-represented within the youth criminal justice system. Recent analysis of the experiences of 15–18-year-olds in prison found that around a third of the young people surveyed (30%) said they had been looked after by a local authority at some point.[1]

At the end of March 2013 there were 596 looked after children in East Sussex - a reduction on the previous year's 618 - of which 71% were placed with foster carers.

The ESCC THRIVE programme focuses on improving early help and prevention services, as well as social work practice and systems, to achieve better outcomes for children and families. It was introduced in response to the rising demand and cost of children's social care services and has involved a major change in the way children's services are delivered. Early indications suggest that the investment in early help is reducing the demand for social care intervention, and more purposeful work from social workers is impacting positively on social care spend across a number of budgets. The first year saw a 21% increase in the number of families offered a targeted preventative family support service, a 45% reduction in referrals to Children's Social Care services, and 100 fewer children and young people requiring statutory Child Protection Plans.

Recommendation: commissioners and multi-agency partnerships delivering in this area should review current commissioning plans and strategies against evidence recommendations laid out in Chapter 4. Where gaps or weaknesses are identified interventions for implementation should be prioritised using criteria outlined in Chapter 2.

1. References

Murray R. Children and Young People in custody 2011-12. HM Inspector of Prisons/Youth Justice Board. http://www.justice.gov.uk/news/press-releases/hmi-prisons/children-and-young-people-in-custody-a-fall-in-numbers,-but-little-change-otherwise

Chapter 4: Evidence based recommendations for priority area 2

The objective of this section is to make evidenced based recommendations that support commissioners with a robust basis for decision making.

Recommendations are based on evidence from systematic reviews and meta-analyses. Scoring of recommendations is based on the SIGN methodology as set out in Chapter 2. Recommendations graded 'A' are based on the highest quality evidence and those graded 'D' the lowest. These reviews were carried out at a specific point in time and we acknowledge there are further caveats commissioners must take into consideration:

- NICE guidance is being updated on a continuous cycle, and some of the evidence presented here may not have been reviewed by NICE at this time. Commissioners need to ensure interventions do not conflict with current NICE guidance.
- East Sussex CCGs operate a 'Low Priorities Procedures' process whereby some procedures are not ordinarily commissioned and requests for treatment are referred to an 'individual treatment panel'. It is important to recognise that the agreed processes should be followed for these interventions.
- Locally, new pathways to treatment for patients for a wide range of conditions are being developed by GPs, commissioners and secondary care clinicians. It is important to ensure agreed treatment pathways are followed.

It is recommended that commissioners review the entire evidence base set out in the evidence review for this priority area, but that service planning focuses on those issues highlighted in this recommendations section.

RECOMMENDATION NUMBERS LISTED ARE THOSE FROM THE FULL EVIDENCE REVIEW FOR THIS PRIORITY AREA. FULL EVIDENCE REVIEWS ARE AVAILABLE ON THE EAST SUSSEX JOINT STRATEGIC NEEDS ASSESSMENT WEBSITE WWW.EASTSUSSEXJSNA.ORG.UK

2.2 Recommendations for interventions to support parents who are strugglin

This evidence review recommends:

Intervention
Commissioners and planners
2.2.1 Ensure commissioners and planners target vulnerable children aged less than 5 years
Health and Early Years Professionals
Ensure:
2.2.2 health and Early Years professionals develop trusting relationships with vulnerable fa needs.
2.2.3 health professionals in antenatal and postnatal services identify factors that may pos
Home visits
2.2.4 Ensure an appropriately trained health visitor or midwife offers a series of intensive h sustained period of time (sufficient to establish trust and help make positive changes
2.2.5 Promote a set curriculum for home visits which aims to achieve specified goals in rela
• maternal sensitivity (how sensitive the mother is to her child's needs);
• the mother–child relationship;
• home learning (including speech, language and communication skills);
• parenting skills and practice.
2.2.6 Ensure health visitors or midwives regularly check the parents' level of involvement ir
2.2.7 Ensure health visitors or midwives explain to parents that home visits aim to promote

g

	Grade
s and their parents to address health inequalities.	A
amilies and adopt a non-judgmental approach, while focusing on the child's	A
e a risk to a child's social and emotional wellbeing.	A
ome visits to parents assessed to be in need of additional support over a). It should be ensured both parents can fully participate in home visits.	A
tion to:	A
n the intensive home visiting programme.	A
e the healthy development of the child.	A

Intervention
Interventions that improve parenting and the mental health and well-being of children
Promote:
2.2.8 the following low cost universal programmes to improve parenting and the mental hea abdominal massage in pregnancy, media-based parenting programmes.
2.2.10 slightly higher cost universal programmes to improve parenting and the mental healt infant massage.
2.2.13 problem solving therapy delivered to parents to improve parent problem solving skill
2.2.12 Ensure health visitors and midwives consider evidence-based interventions, such as and mother–infant attachment.

High-risk groups
2.2.14 Promote the following targeted programmes for high-risk groups to improve parentin
• Psychosocial interventions offering emotional and practical support for the preven
• Treatment for post-natal depression using cognitive behavioural approaches, inter
• Long-term multicomponent home visiting programmes starting antenatally, offerin parents.
• Short-sensitivity focused interventions including parent–infant interaction guidan
• Manualized group based and one-to-one parenting programmes addressing behav

	Grade
alth and well-being of children: skin-to-skin contact at birth, Kangaroo care,	A
th and well-being of children: developmental guidance, anticipatory guidance,	A
s and parent mental health.	A
baby massage and video interaction guidance, to improve maternal sensitivity	A
g and the mental health and well-being of children:	A
tion of post-natal depression.	
personal therapy or non-directive counselling.	
g both support for parenting and support for parents particularly for teenage	
ce training for high-risk infants.	
viour management and parent–child relationships.	

Intervention
Parents of children with developmental disabilities
2.2.15 Promote multiple component interventions addressing both parent well-being and b parent training or cognitive behavioural training alone for parents of children with d
Father and other family members
Ensure:
2.2.16 that a nurse, where possible, focuses on developing the father–child relationship as father involved in any curriculum activities.
2.2.17 health visitors or midwives try to involve other family members, if appropriate and ac
2.2.18 Promote parenting and stress management interventions for fathers, for parents of c
Group based
2.2.19 Promote group-based parenting programmes to improve the short-term psychosocia
Psychological therapies
2.2.20 Promote the inclusion of parents in psychological therapies that reduce pain in child

	Grade
ehavioural parent training over interventions that offer either behavioural levelopmental disabilities.	B
s part of an approach that involves the whole family. This includes getting the	A
cceptable to the parents.	A
hildren with developmental disabilities	B
l wellbeing of parents.	A
dren with painful conditions.	A

Intervention
Other support services
Ensure:
2.2.21 health and early years practitioners use outreach methods to maintain or improve th activities.
2.2.22 health visitors and midwives encourage parents to participate in other services deliv
2.2.23 health and Early Years practitioners are systematic and persistent in their efforts to e
• targeted publicity campaigns;
• making contact by using key workers and referral partners;
• encouraging other parents to help get them involved;
• sending out repeat invitations;
• using local community venues, such as places of worship and play centres to enc
• addressing any concerns about discrimination and stigma home visits by family s
2.2.24 health visitors and midwives work in partnership with other Early Years practitioners
2.2.25 health and Early Years practitioners are clear about their responsibility for improving
2.2.26 health and Early Years practitioners work with community and voluntary organisatio years services.

Reviewing and improving
Ensure:
2.2.27 health and Early Years providers have a process in place to systematically involve pa improved. Vulnerable parents and families should be asked about their needs and
2.2.28 managers of intensive home-visiting programmes conduct regular audits to provide

	Grade
e participation of vulnerable parents and children in programmes and	A
vered by children's centres and as part of the Healthy Child programme.	A
encourage vulnerable parents to use early year's services through:	A
ourage them to participate;	
support worker;.	
s to coordinated family support.	A
g the social and emotional wellbeing of vulnerable children and their families.	A
ns to help vulnerable parents who may find it difficult to use health and early	A

rents and families in reviewing services and suggesting how they can be concerns and experiences.	A
consistency and quality of delivery.	A

2.3 Recommendations for quality training as an intervention for those who wo

This evidence review recommends:

Intervention
Work force training focused on delivering effective programmes and interventions to su
Promote evidence based programmes that include:
2.3.4 skin-to-skin contact at birth; kangaroo care; abdominal massage in pregnancy and me
2.3.5 developmental guidance, anticipatory guidance and infant massage.
Promote targeted programmes:
2.3.6 to improve parenting and the mental health and well-being of children to high risk gro support for the prevention of post-natal depression.
2.3.7 for high risk women to treat post-natal depression that include CBT, interpersonal the
2.3.8 with long-term multicomponent home visiting programmes for high risk groups startin particularly for teenage parents.
2.3.9 targeted short-sensitivity focused interventions including parent–infant interaction gu
2.3.10 with manualized group based and one-to-one parenting programmes, high risk grou
Ensure:
2.3.1 a skilled workforce is established to deliver evidence based interventions to improve p
2.3.2 the relevant workforce is trained to support disabled parents and parents with additio
2.3.11 disabled parents and parents with additional support needs, including those who ar training, and in the monitoring of their implementation.
2.3.3 Support policies and programmes that promote parenting for improving mental health

rk with vulnerable families

	Grade
pport vulnerable families	
edia-based parenting programmes	A
	A
oups that include psychosocial interventions offering emotional and practical	A
rapy or non-directive counselling.	A
ng antenatally, offering both support for parenting and support for parents,	A
uidance training for high-risk infants.	A
ps addressing behaviour management and parent–child relationships.	A
parenting and the mental health and well-being of children.	A
onal support needs.	B
e currently using services, are involved in the development of protocols, in	B
n.	A

Intervention
Quality staff training to deliver effective integrated support to vulnerable families
Promote staff training:
2.3.12 to support disabled parents across all levels of personnel in relevant agencies to mai
2.3.13 supporting integrated services and ensuring effective communication between profes
2.3.14 on role awareness to support integrated services.
2.3.15 including partnership working and interprofessional working to support integrated se
Quality staff training to support and train parents of children with complex health needs
Ensure:
2.3.16 that parents of children with complex health care needs are appropriately trained by be undertaking; parental competence in these tasks must be assessed prior to hosp
2.3.17 parents of children with complex health care needs receive training given by nursing procedures involved.
Training school staff and carers caring for children with complex health care needs
Local authorities need to ensure that:
2.3.18 staff of schools offering specialist child care for children with complex needs receive
2.3.19 carers who offer short-break to children with complex needs receive quality training,
Quality staff training interventions to support disabled parents and parents with additio
Ensure:
2.3.20 mainstream services and specialist adults' and children's services specifically addre needs associated with illness or substance misuse.
2.3.21 disabled parents with learning difficulties receive practical services that are supporti and counselling.

	Grade
intain sustainable, good practice	B
ssional groups within teams.	B
	B
ervices.	B
s	
nursing or medical staff to undertake the specialist care giving tasks they will pital discharge to ensure the child's health is not placed at risk.	B
or medical staff that addresses the socio-emotional effects as well as medical	B
quality training, policies, support and supervision.	B
policies, support and supervision.	B
onal support needs	
ess the needs of families where a parent is disabled or has additional support	B
ive, respectful and considerate, and include information, advice and advocacy,	B

Intervention
Quality staff training to deliver effective evidence based practice to vulnerable families
2.3.23 Promote continual professional development to a postgraduate level to support the u promoting a research culture.
Ensure:
2.3.22 evidence based research for the social care workforce is available to support evidenc
2.3.24 the teaching of evidence-based practice skills includes practical application and crit
2.3.25 gaps in the skills of applying evidence-based knowledge are addressed.
2.3.26 gaps in knowledge and skills for evidence-based practice are clearly identified and a

Intervention
Quality staff training to deliver effective support to socially disadvantaged people with l
2.3.27 Promote education interventions to improve diabetes care in socially disadvantaged interventions and community educators leading the intervention.

This evidence review does not recommend:

Intervention
2.3.28 Psychological debriefing after birth and universal approaches to prevention of postn

	Grade
use and production of evidence in the social care workforce, as well as	C
ce-informed practice.	B
ical reflection in order for clinical decision-making to be fully contextualised.	C
	C
rolling programme for addressing these is developed in the workplace.	B

ong term conditions, e.g. diabetes.	
populations that include the cultural tailoring of the interventions, one-on-one	B

	Grade
atal depression.	B

2.4 Recommendations for for effective parenting interventions to support chi

This evidence review recommends:

Intervention
Parenting interventions to support children/ young people
Promote:
2.4.1 parenting interventions within the home as part of a multi-faceted intervention to imp
2.4.2 the following programmes to improve parenting and the mental health and well-being
• Low cost universal: skin-to-skin contact at birth, kangaroo care, abdominal massag
• Slightly higher cost universal: developmental guidance, anticipatory guidance, infa
2.4.3 further research into the following promising interventions to improve parenting and t
• Antenatal education focusing on transition to parenthood and emotional and attac
• In families experiencing attachment difficulties and where there is a risk of abuse:
• In families which physical abuse has occurred—intensive, multicomponent, multi- parenting programmes.
• In which emotional abuse has occurred—parent–infant psychotherapy; and where training with additional anger management components.
• Where sexual abuse has occurred—CBT for the non-abusing parents; abused child
• Where parents abuse drugs: multicomponent programmes targeting affect regulati delivered on a one to one basis.
2.4.4 Increasing positive parent-child interactions and emotional communication skills; tea requiring parents to practice new skills with their children during parent training sess
2.4.5 Ensure the following key factors are taken into consideration when attempting to posit
• Parents to acknowledge that there is a problem.
• The seriousness of the consequences of conduct disorder to be understood.
• Knowledge and skills related to handling children's behaviour to be gained.

ldren/young people

	Grade
rove a range of child (and often maternal health) outcomes.	A
of children:	A
ge in pregnancy, media-based parenting programmes.	
ant massage.	
he mental health and well-being of children in families:	B
chment issues and programmes to support parenting of fathers.	
parent–infant psychotherapy and infant led psychotherapy.	
systemic family support approaches and cognitive behavioural-based	
anger management is also an issue— group-based behavioural parent	
ren can also benefit.	
ion, parental mood and views of self as a parent, drug use and parenting skills	
ching parents to use time out and the importance of parenting consistency; ions.	B
tively engage parents in parenting programmes:	B

Intervention
• Control and confidence in one's ability to parent effectively to be acquired.
• Parents need to receive non-judgemental support from professionals in the proces implementing parenting skills; parents need peer support.
• Parents need for their own needs to be recognized.
• Mothers need for support from their spouse/partner.

Teenage parenting interventions
2.4.6 Promote parenting programmes for teenage parents to improve a number of aspects o

Self-help parenting interventions
Promote self-help:
2.4.7 parenting intervention programmes in improving child behaviour, over the short and l
2.4.8 delivery of self-help parenting intervention programmes via bibliotherapy and multim
2.4.10 within primary healthcare settings via community nurses and health visitors, for use
2.4.11 as part of a stepped-care approach to treatment, where it may be used as the most b specialist clinical services.

Group based interventions
Promote:
2.4.13 group based parenting programmes to allow parents to gain acceptance and support
2.4.14 cognitive-behavioural group-based parenting.

	Grade
s of gaining new knowledge, skills and understanding, and help with	

f parent-child interaction both in the short- and long-term.	B

onger term.	A
edia	B
with children with early-onset conduct problems.	B
asic and least intrusive level of intervention for families on waiting lists within	B

from other parents in the group	B
	B

Intervention
Intervention for parents in transition to parenthood
Promote:
2.4.16 parenting-focused interventions for expectant and new parents.
2.4.17 interventions lasting 3 to 6 months to promote positive parenting and social develop
2.4.18 interventions encouraging effective parenting in the transition to parenthood with ar

Booster interventions
2.4.19 Promote booster interventions compared to initial intervention only.

Father involvement
Ensure:
2.4.20 fathers participate in parenting programmes by taking the following barriers into acc of organisational support and concerns over programme content.
2.4.21 participation in parenting programmes by actively promoting services to fathers rath organisations and take different cultural and ethnic perspectives into account.

Health and social care provider's interventions
2.4.22 Ensure there is a skilled workforce.
2.4.23 Promote interventions delivered person-to-person and designed to modify parenting

	Grade
	B
ment of the child.	B
after-birth component to aid cognitive development.	B
	B
count: lack of awareness, work commitments, female-orientated services, lack	B
er than parents, offering alternative forms of provision, prioritise fathers within	B
	A
skills by targeting parents and other caregivers.	B

Intervention
High risk groups
Promote:
2.4.24 the following targeted programmes for high-risk groups to improve parenting and the
• Psychosocial interventions offering emotional and practical support for the preven
• Treatment for post-natal depression using cognitive behavioural approaches, inter
• Long-term multicomponent home visiting programmes starting antenatally, offerin parents.
• Short-sensitivity focused interventions including parent–infant interaction guidan
• Manualized group based and one-to-one parenting programmes addressing behav
2.4.25 health and social care provider home visiting programmes to 'at risk' families.

Long term benefits
2.4.26 Promote parenting programmes that share an emphasis on active parental involvem parenting to help prevent substance misuse in children <18 years.

This evidence review does not recommend:

Intervention
2.4.27 the role of parenting programmes in the primary prevention of mental health problem
2.4.28 self-help for families that have additional risk factors, such as single parenthood, lo
2.4.29 interventions promoting effective parenting in the transition to parenthood.
2.4.30 teaching parents problem solving; teaching parents to promote children's cognitive,
2.4.31 psychological debriefing after birth and universal approaches to prevention of postna

	Grade
e mental health and well-being of children:	A
tion of post-natal depression.	
personal therapy or non-directive counselling.	
g both support for parenting and support for parents particularly for teenage	
ce training for high-risk infants.	
viour management and parent–child relationships.	
	B

nent and on developing skills in social competence, self-regulation and	B

	Grade
ms (there is currently insufficient evidence to reach any firm conclusions).	C
w income and maternal depression.	C
	B
academic, or social skills; and providing other additional services.	B
atal depression.	B

2.6 Recommendations for interventions to reduce the number of young peopl

This evidence review recommends:

Intervention
Parent-training or education
Promote:
2.6.1 group-based parent-training/education programmes in the management of children w
2.6.3 behavioural and cognitive-behavioural group-based parenting interventions to improv short term (effective and cost-effective).
2.6.2 Ensure that all parent-training/education programmes
• are structured and have a curriculum informed by principles of social- learning the
• include relationship-enhancing strategies;
• offer a sufficient number of sessions, with an optimum of 8–12;
• enable parents to identify their own parenting objectives;
• incorporate role-play during sessions, as well as homework to be undertaken betw home situation;
• are delivered by appropriately trained and skilled facilitators who are supervised, engage in a productive therapeutic alliance with parents;
• adhere to the programme developer's manual and employ all of the necessary mat

e entering the criminal justice system

	Grade
ith conduct disorders.	A
e child conduct problems, parental mental health and parenting skills in the	A
	A
ory;	
een sessions, to achieve generalisation of newly rehearsed behaviours to the	
have access to necessary ongoing professional development, and are able to	
terials.	

Intervention
Working with people with antisocial personality disorder
Ensure:
2.6.4 that when a diagnosis of antisocial personality disorder is made, the implications of i relevant staff.
• Acknowledge the issues around stigma and exclusion.
• Emphasise that the diagnosis does not limit access to a range of appropriate treat
• Provide information on and clarify the respective roles of the healthcare, social car
• Consider consulting with a relevant specialist.
• Motivate them to attend and engage with treatment.
• Establish regular one-to-one meetings to review progress.
2.6.5 all staff working with people with antisocial personality disorder are familiar with the health practice' and have a knowledge and awareness of antisocial personality disord colleagues.
2.6.6 all staff have skills appropriate to the nature and level of contact with service users.
2.6.7 staff providing psychosocial or pharmacological interventions for the treatment or pre and supervised, and that they adhere closely to the structure and duration of the inte
2.6.8 staff supervision is built into the routine working of the service.

Continuity of health and social care
Ensure:
2.6.9 the disruption to therapeutic interventions is minimised for people with antisocial pe
• initial planning and delivery of treatment, transfers from institutional to communit
• avoiding unnecessary transfer of care between institutions whenever possible duri
2.6.10 people with antisocial personality disorder are not excluded from any health or socia behaviour.
2.6.11 people with antisocial personality disorder are offered treatment for any comorbid di where available.

	Grade
t is discussed with the person, the family or carers where appropriate, and	A
ments for comorbid mental health disorders.	
e and criminal justice services.	
'Ten essential shared capabilities: a framework for the whole of the mental ler that facilitates effective working with service users, families or carers, and	A
	A
vention of antisocial personality disorder are competent and properly qualified rventions as set out in the relevant treatment manuals.	A
	A

rsonality disorder by:	A
y settings take into account the need to continue treatment;	
ing an intervention.	
l care service because of their diagnosis or history of antisocial or offending	A
sorders in line with recommendations in the relevant NICE clinical guideline,	A

Intervention
Family involvement interventions
Ensure the person with antisocial personality disorder are asked directly if they want their f consent and rights to confidentiality by:
• encouraging families or carers to be involved;
• ensuring that the involvement of families or carers does not lead to a withdrawal o
• informing families or carers about local support groups for families or carers.
2.6.12 Ensure that when identifying vulnerable parents, care is taken not to intensify stigma them as antisocial or problematic.
Working with people with conduct problems
2.6.13 Promote cognitive problem-solving skills training for children aged 8 years and older
• the child's family is unwilling or unable to engage with a parent-training programm
• additional factors, such as callous and unemotional traits in the child, may reduce
2.6.14 Ensure social problem-solving skills training is conducted in groups over a period of to:
• modify and expand their interpersonal appraisal processes;
• develop a more sophisticated understanding of beliefs and desires in others;
• improve their capacity to regulate their emotional responses.
Child and adolescent mental health services
2.6.15 Ensure child and adolescent mental health services establish robust methods to iden with the established local assessment system. These should focus on identifying vu
• parents with other mental health problems, or with significant drug or alcohol prob
• mothers younger than 18 years, particularly those with a history of maltreatment in
• parents with a history of residential care;
• parents with significant previous or current contact with the criminal justice systen

	Grade
amily or carers to be involved in their care, and, subject to the person's	A
f, or lack of access to, services;	
a associated with the intervention or increase the child's problems by labelling	A

with conduct problems if:	A
ne;	
the likelihood of the child benefiting from parent-training programmes alone.	
10–16 weeks. Training should focus typically on strategies to enable the child	A

ntify children at risk of developing conduct problems, integrated when possible lnerable parents including:	A
blems;	
n childhood;	
n.	

Intervention
Primary and secondary care services
2.6.16 Ensure staff involved in the assessment of antisocial personality disorder in seconda possible to increase the validity of the assessment.
2.6.17 Promote tertiary-level interventions over primary- or secondary-level interventions to

Risk management strategy
Ensure:
2.6.18 when staff assess the risk of violence they take a detailed history of violence
2.6.19 staff consider a referral to forensic services where there is:
• current violence or threat that suggests immediate risk or disruption to the operati
• a history of serious violence, including predatory offending or targeting of children
2.6.20 healthcare professionals in forensic or specialist personality disorder services consi measure of the severity of antisocial personality disorder and a formal assessment
2.6.21 Probation services develop a comprehensive multi-agency risk management plan for risk.

Interventions to support individuals with psychopathy or dangerous and severe persona
2.6.22 Consider cognitive and behavioural interventions to support individuals with psycho

Psychological interventions
2.6.23 Support the provision of the following psychosocial Interventions for maladaptive ag
• Provide or assist the family in obtaining evidence-based parent and child skills tra
• Engage the child and family in taking an active role in implementing psychosocial
• Initial medication treatment should target the underlying disorder(s).
• When available, follow evidence-based guidelines for the primary disorder.

	Grade
ary and specialist services use structured assessment methods whenever	A
prevent youth violence.	B

	A
	A
on of the service;	
or other vulnerable people.	
der, as part of a structured clinical assessment, routine use of a standardised tool to develop a risk management strategy.	A
people with antisocial personality disorder who are considered to be of high	A

lity disorder	
pathy or dangerous and severe personality disorder.	A

gression in youth:	A
ining during all phases of care.	
strategies and help them to maintain consistency.	

Intervention
Cognitive and behavioural interventions
2.6.24 For individuals with antisocial personality disorder, including those with substance group-based cognitive and behavioural interventions, to address impulsivity proble
2.6.25 For young offenders aged 17 years or younger with a history of offending behaviour w interventions aimed at young offenders and that are focused on reducing offending
School-based interventions
2.6.26 Promote universal school-based programs to prevent or reduce violent behaviour.
Inter-agency working
2.6.27 Ensure that there are clear pathways for people with antisocial personality disorder.
2.6.28 Establish antisocial personality disorder networks, where possible linked to other pe
Nurse practitioner interventions
2.6.29 Promote strategies already employed by nurse practitioners to promote the develop of youth violence.
Multidimensional treatment foster care
2.6.30 Promote multidimensional treatment foster care for young people aged between 12 a home care.

This evidence review does not recommend:

Intervention
2.6.31 individual-based parent-training/education programmes in the management of child younger) with conduct disorders.
2.6.32 additional interventions targeted specifically at the parents of children with conduct problems) alongside parent-training programmes.

	Grade
misuse problems, in community and mental health services, consider offering ems, interpersonal difficulties and antisocial behaviour.	A
ho are in institutional care, offer group-based cognitive and behavioural and other antisocial behaviour.	A
	A
	A
ersonality disorder networks.	A
ment of healthy families which can contribute greatly to reducing the problem	B
and 17 years with conduct problems at risk of being placed in long-term out-of-	A

	Grade
lren (aged 12 years or younger or with a developmental age of 12 years or	A
problems (such as interventions for parental, marital or interpersonal	A

2.7 Recommendations for interventions to improve outcomes for children in fa

This evidence review recommends:

Intervention
Leadership and partnership
2.7.1 Create strong leadership and strategic partnerships to develop a vision and a corporat working
Ensure:
2.7.2 senior managers in partner agencies provide strong, visible leadership to raise aspira
2.7.4 local strategic plans adhere to national guidance.
2.7.5 the joint strategic needs assessment process is a central component in assessing the

Plans and strategies
2.7.6 Prioritise the needs of looked after children.
2.7.7 Create strong leadership and strategic partnerships to develop a vision and a corporat looked-after children and young people.
2.7.8 Ensure local plans and strategies for children and young people's health and wellbein leavers.

milies supported by social care services

	Grade
e parenting strategy that focuses on effective partnership and multi-agency	A
tions and attainment, and promote joint working.	A
	A
needs of looked-after children and young people.	A

	A
te parenting strategy that addresses health and educational inequalities for	A
g fully reflect the needs of looked-after children, young people and care	A

Intervention
Commissioners
2.7.9 Encourage authorities to work together in local partnerships when commissioning ser
2.7.10 Commission services that enhance the quality of life of the child or young person by p
2.7.12 Jointly commission services dedicated to promoting the mental health and emotional independent living.
Ensure services:
2.7.11 dedicated to looked-after children and young people are integrated, preferably on the health needs.
2.7.13 commissioned for looked-after children and young people are informed by: the views data; the local corporate parenting strategy; local knowledge and experts; local auc children and young people's health and wellbeing.
Regulation of services caring for children in families supported by social care services
2.7.14 Regulate services by auditing, monitoring and inspecting local authorities, providers effectively with one another.
2.7.15 Inspect services for care leavers and adopt the standards developed by the National
Needs of children in families supported by social care services
2.7.16 Support professional collaboration on complex casework including multi-agency tean
2.7.17 Ensure services have local authority children's specialists, dedicated health and men practitioners who are trained and supported to work with multi-agency networks on

	Grade
vices to offer greater choice and quality of services.	A
promoting and supporting their relationships with others.	A
wellbeing of children and young people who are looked after or are moving to	A
e same site, and have expert resources to address physical and emotional	A
of children and young people; national evidence, guidance and performance dits; the joint strategic needs assessment; local plans and strategies for	A

of health services and key partners to ensure local partnerships communicate	A
Leaving Care Advisory Service.	A

n working.	A
ntal health professionals, and education specialists including experienced n complex casework.	A

Intervention
Needs of children and young people entering secure accommodation or custody
Ensure:
2.7.18 looked-after children and young people entering secure accommodation or custody h paediatrician, or suitably qualified professional with input from the dedicated mult
2.7.19 recommendations from assessments are included in the care plan or pathway plan.

Placing children
2.7.20 Develop a strategy to identify suitable placements and interventions for looked-after
2.7.21 Use current information to make decisions about placement changes.

Needs of babies and young children from families supported by social care services whe
Ensure:
2.7.22 there are specialist services for babies and young children.
2.7.23 comprehensive and sensitive assessment processes and access to services are in pla

Information
2.7.24 Assess the health needs of looked-after children and young people.
2.7.25 Introduce protocols that address information-sharing processes that include legal an social care.
2.7.26 Ensure that policies and activities are in place to allow each child or young person to
2.7.27 Promote continued contact with former carers, siblings or family members personally interests.

	Grade
ave their physical, developmental and mental health needs assessed by a i-agency mental health service.	A
	A
children and young people.	A
	A
n making placements	
	A
ace to identify the needs of babies and young children as early as possible.	A
	A
d confidentiality issues, to assist health information flows between health and	A
explore their personal identity, including their life story.	A
valued by the child or young person where this is felt to be in their best	A

Intervention
Diversity
2.7.28 Appoint a diversity champion and ensure everyone understands diversity issues. Pro access to expertise.
2.7.29 Network and share good practice with other local authorities with a similar profile of

Needs of asylum-seeking children and young people who are looked after
Provide:
2.7.30 expertise relating to unaccompanied asylum-seeking children and young people who
2.7.31 support and training to foster parents and residential staff to ensure they have a goo seeking children and young people who are looked after.

Ensure staff receive high-quality, core training from trainers with specialist knowledge a
2.7.32 Ensure foster and residential carers receive high-quality, core training from trainers w
2.7.33 Ensure foster carers and their families, including carers who are family or friends, rec set out in the core training recommendation.

Looked-after children and young people who are in further and higher education.
2.7.34 Support looked-after young people in further and higher education.
2.7.35 Involve designated teachers for looked-after children and young people.

Independent living
2.7.36 Provide leaving-care services; supporting the preparation for the transition to adulth

	Grade
vide all professionals and managers with specialist training, resources and	A
looked-after children and young people.	A
are looked after.	A
d understanding of the particular issues affecting unaccompanied asylum-	A
and expertise about the complex needs of children	
with specialist knowledge and expertise. Adapt the training to local needs.	A
ceive high quality ongoing support packages that are based on the approach	A
	A
	A
ood and moving to independent living.	A

Intervention
Kinship care for children and young people
2.7.37 Support the practice of treating kinship care as a viable out-of-home placement optio
Interventions to improve outcomes for visually impaired children
2.7.38 Support families of newly diagnosed children with information, especially about edu informal and formal social networks, and support groups.
Pharmacotherapy interventions
2.7.39 Support the best practice training guidelines for mental health in child welfare relati
2.7.40 Provide youth and families with ongoing information on the diagnosed mental health
Nurse family partnership interventions
2.7.41 Consider promoting the Family Nurse Partnership.
Early prevention interventions
2.7.42 Promote early prevention programs for families with young children at risk for physica
Multicomponent parenting interventions
2.7.43 Target parents and the parent-child interaction context in home-based settings durin

	Grade
on for children removed from the home for maltreatment.	B
cational and social services, and emotional support from professionals,	B
ng to pharmacotherapy.	B
n disorder, effective treatment options, and managing life with the condition.	B
	C
al child abuse and neglect.	C
g early childhood. Target families of higher risk children.	C

Getting more copies of this leaflet
You can get all our booklets in large print, easy read format, in Braille, on audio tape or CD, or in other languages. They are also available in PDF form, which you can download from our website at www.eastsussexjsna.org.uk

East Sussex County Council
County Hall
St Anne's Crescent
Lewes BN7 1UE
Phone: 0345 60 80 190
Fax: 01273 481261
Website: eastsussex.gov.uk/contactus

December 2013 • 13-14 138