NSPCC
Cruelty to children must stop. FULL STOP.

NSPCC's Response to the *Social Exclusion Task Force Families At-Risk Review*

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Introduction
The National Society for the Prevention of Cruelty to Children (NSPCC) is the UK's leading charity specialising in child protection and the prevention of cruelty to children. The NSPCC aims to end cruelty to children by seeking to influence legislation, policy, practice, attitudes and behaviours for the benefit of children and young people. This is achieved through a combination of service provision, lobbying, campaigning and public education.

The NSPCC believes that, given the will, most cruelty can be prevented. In order to achieve this, it is vital that all children, whatever their needs, have a range of services that are flexible and offer them support and protection. The NSPCC has more than 180 services in the UK and the Channel Islands. These services aim to:

- Prevent children being abused by working with parents and carers in vulnerable families to improve their knowledge and skills in safeguarding, and giving children and young people someone to turn to through the provision of our Listening Services.

- Protect vulnerable children and young people from abuse by providing direct services in a number of settings, including schools and young people's centres. We also protect them by providing Listening Services for adults to ensure they have someone to turn to with their concerns; by ensuring that abused children and young people are identified and effective action is taken to protect them, and by working with young people and adults who pose a risk to children and young people to reduce the risk of abuse.

- Help children and young people who have been abused overcome the effects of abuse and achieve their potential.

The NSPCC's comments on this consultation document are based on our expertise in safeguarding children and promoting their welfare. In particular, we have drawn on our practice experience of work with families who have multiple complex needs, and where our services work with all members of a family to ensure risks to children are reduced.

Section A: 'Whole Family' approaches to delivery of services for at-risk families

We are interested in exploring your views about the potential of 'Whole Family' approaches to improve outcomes for families with additional or complex needs. For example, services and practitioners who take a whole family approach might:

- *consider their clients within their family context, identifying and assessing the needs of all family members;*
- *share information with other professionals in the interests of providing the best possible services for the family;*
- *configure support around the needs of the whole family;*
- *recognise and respond to diverse family circumstances.*

We would like you to answer the following questions thinking about your general experiences of providing, researching and managing services for at-risk families. All the sections may not apply to you so please skip questions that are not appropriate.

What do you see as the main advantages of such a 'Whole Families' approach – especially for clients with additional or complex needs?

This response draws on the practice experience of the NSPCC and on a recent research project that the NSPCC has been involved in. The research, *Living with hardship 24/7: The diverse experiences of families living in poverty in England*[1], was developed in partnership with the Frank Buttle Trust and the University of York Department of Social Policy and Social Work. The research design involved 70 low income households, 38 living in relatively affluent areas, 32 in areas with high levels of deprivation. Interviews were carried out with 82 adults (67 women, 15 men) and 59 children (34 girls, 25 boys). Two thirds of the households were lone parent households. In the affluent areas, the sample was almost entirely white British. In the deprived areas, 32% of the adults and 21% of the children were Bangladeshi, and 23% of the adults and 25% of the children were Black African or Black Caribbean. Participants were recruited through Social Services Departments (including some who had children on the child protection register and receiving family support), voluntary organisations and schools. Focus groups were also held with professionals to explore their perspectives on the relationship between low income families and services.

The *Living with hardship 24/7*[2] research shows that more services are needed that go into people's homes to reach the most vulnerable parents in need of support, and/or to develop creative ways of engaging parents. This is especially important for

[1] Hooper, C. A., Gorin, S., Cabral, C., Dyson, C., *Living with hardship 24/: The diverse experiences of families living in poverty in England.* (Publication expected July 2007). The Frank Buttle Trust; University of York Department of Social Policy & Social Work; NSPCC Research Department.

[2] Ibid.

parents with mental health problems who may lack the energy, motivation or confidence to approach services themselves.

A more holistic approach is needed for professionals working with families. Both anti-oppressive practice and the 'ecological framework'[3] require social workers to have a fuller appreciation of the many ways poverty impacts on family life. Many parents also have histories of and/ or ongoing abuse, violence and trauma in their own lives, and need support for their own needs alongside intervention on their children's behalf. More recognition is also needed of the impact of children with serious social, emotional and behaviour difficulties on their parents and siblings, and appropriate help offered to manage and reduce it. In line with this finding, resources for health visiting need to be increased, and training for health visitors must be provided to enable them to help parents whose children have developed behaviour problems.

The *Living with hardship 24/7*[4] research also shows that all organisations providing training for professionals working with parents, particularly social workers and health visitors, need to pay more attention to the many and complex ways in which poverty impacts on family life; appreciation of these issues is essential if practitioners are to engage families on low incomes in service provision and alleviate rather than increase social exclusion. The National Academy for Parenting Professionals may have a significant role to play here.

Initial and ongoing training for professionals who work with children must ensure that they have the skills to engage with young children and listen to their views, both in the context of safeguarding them and in their work with family courts. The tendency to regard 12 as the age at which children are able to judge their own interests may leave younger children at significant risk of harm.

The NSPCC's Parkside mental health service is an example of a very effective partnership between adult mental health services and children's services, and more details are provided below of this service. Our own practice indicates that it is important that adult mental health services should determine whether the children of their adult clients require a particular care plan and should ensure that this is put in place.

Are there specific circumstances in which a 'Whole Families' approach might be inappropriate or undesirable for service users?

- ***<u>Yes</u>***
- *No*

If yes, why.

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[3] This framework is the mechanism used to determine whether a child is 'in need' as per s.17 of the Children Act 1989, and explained more fully in *The Framework for Assessment of Children in Need and their Families* (Department of Health, Department of Education and Employment, Home Office, 2000).
[4] Hooper, C. A., Gorin, S., Cabral, C., Dyson, C., (2007) Op.Cit.

The specific circumstances are where a child is involved in a s.47[5] inquiry and it is established that the individual causing significant harm is a member of that child's family, or if it is established that a family member is colluding in causing that child significant harm. S.47 states if:

> "the local authority has reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare"

In general, do you think that adults', children's and community services currently work together well on the ground to achieve positive outcomes for families with additional or complex needs? Please say why and provide any specific examples.

- *In general 'yes'*
- ***In general 'no'***

Please provide any specific examples:

A more holistic service response is needed which addresses the multiple forms of violence and abuse that often coexist in some families. A good example here is the Scottish system, where child protection and youth justice issues are dealt with together; this is also the case in many other European countries. The proposed Machinery of Government Changes will lead to the development of a new Department of Justice, which may go some way towards this as Family Proceedings Courts will probably be within the same department as Youth Courts, although we are concerned that anti-social behaviour will still be in a different Government department. At present families often receive a service based on a partial understanding of their lives and needs, usually in response to crisis or anti-social behaviours, and this can lead to different and sometimes contradictory responses from different agencies. In our view a holistic and coordinated response is only possible if youth justice is integrated into children's services and other services dealing with children and families at a local level.

Children who have aggressive and violent behaviour often exhibit these behaviours because of maltreatment, but there is growing evidence that there is a hereditary component to such behaviours, as well as links to early attachment disorder, which may be a consequence of the mother or father having inadequate parenting skills or emotional and behavioural difficulties of their own. In cases such as this, it is necessary to provide interventions for the parents and the child, as a multi-systemic

[5] This refers to section 47 of the Children Act 1989, which can be found at the following link: http://www.opsi.gov.uk/acts/acts1989/Ukpga_19890041_en_6.htm#mdiv47

intervention. Where children under 10 are exhibiting these behaviours, intervention at the earliest possible opportunity will have an impact on such behaviours becoming anti-social and possibly criminal. There is much evidence that indicates that child maltreatment (and early child maltreatment in particular) should be regarded as a critical and primary pre-disposing risk factor in relation to anti-social and offending behaviour[6] [7] [8] [9] [10] [11] [12] [13] [14], so a multi-agency early intervention system needs to be developed that responds to children and families in a comprehensive way. Such interventions can be provided by social services, by mental health services, by school-based counselling and therapy professionals, and by youth offending teams.

More resources need to be made available to make the government's stated commitment to prevention real, without a reduction in levels of service for early intervention and longer-term treatments. It is not enough simply to identify risk or need; services must have the capacity to respond where such needs are identified, in particular where it is established that a child has suffered significant harm, and needs intervention to enable them to overcome the harm they have suffered. Families who are assessed and then offered no service, or a service only after a long wait, may be left further alienated and disempowered, and without therapeutic interventions children are likely to suffer in all areas of their development.

The *Living with hardship 24/7*[15] research shows that all organisations providing training for professionals working with families, particularly social workers and health visitors, need to pay more attention to the many and complex ways in which poverty impacts on family life. Appreciation of these issues is essential if practitioners are to engage families on low incomes in service provision and alleviate rather than increase social exclusion. The National Academy for Parenting Professionals may have a significant role to play here.

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[6] Boswell, G. (1996). *The prevalence of abuse and loss in the lives of Section 53 offenders.* Young and Dangerous – the background and careers of Section 53 Offenders. Avebury.

[7] Hawkes, C., Jenkins, J.A. and Vizard, E. *Roots of Sexual Violence in Children and Adolescents* in Ved Varma (Ed) 1997. Violence in Children and Adolescents. Jessica Kingsley Publishers. London.

[8] Hamilton, C. E., Falshaw, L. and Browne, K. D. (2002). *The Link between recurrent maltreatment and offending behaviour.* International Journal of Offender Therapy and Comparative Criminology. 46(1) pg75-94.

[9] Lader, D, Singleton, N and Meltzer, H. (2000). *Psychiatric morbidity among young offenders in England and Wales.* London Office for National Statistics, London.

[10] Weeks, R and Widom, C.S. (1998). *Self-reports of early childhood victimization among incarcerated male felons*, Journal of Interpersonal Violence, Vol 13. No. 3, pp346-61.

[11] Fergusson, D.M. and Lynskey, M. (1997) *Physical punishment/ maltreatment during childhood and adjustment in young adulthood*, Child Abuse and Neglect, Vol. 21, No. 7, pp. 617–30.

[12] Shields, A.M., Cicchetti, D. and Ryan, R.M. (1994) *The development of emotional and behavioural self-regulation and social competence among maltreated school-age children*, Development and Psychopathology, Vol. 6, pp. 5–75.

[13] Widom, C.S. (1989*) Child abuse, neglect, and adult behaviour: research design and findings on criminality, violence, and child abuse*, American Journal of Orthopsychiatry, Vol. 59, No. 3, pp. 355–67.

[14] Jonson-Reid, M. and Way, I. (2001) *Adolescent sexual offenders: incidence of childhood maltreatment, serious emotional disturbance and prior offences*", American Journal of Orthopsychiatry, Vol. 71, No. 1, pp. 120–30.

[15] Hooper, C. A., Gorin, S., Cabral, C., Dyson, C., (2007) Op.Cit.

Section B: Specialist areas of adults' services expertise

Some of the questions that now follow relate to specialist areas of service provision for adults.

First, could you select one of the following options to indicate your primary area of expertise – the main area that your work focuses on, and about which you will be asked further questions:

- *None of the specialist topics below*
- *Family poverty and debt*
- *Adults with poor basic skills*
- *Worklessness (and poor quality jobs)*
- *Adult mental health*
- *Adult disability and poor health*
- *Relationship conflict and breakdown*
- *Adults who misuse illicit drugs*
- *Adults who misuse alcohol*
- *Domestic violence*
- *Poor housing and homelessness*
- *Adults who are offenders or exhibit antisocial behaviour*

And which, if any, would you say is your secondary area of expertise? If you only wish to answer questions about one area, please choose the first option from the following list. Otherwise you will be asked questions about both your primary and secondary areas of expert knowledge.

- *No further areas of expertise*
- *Family poverty and debt*
- *Adults with poor basic skills*
- *Worklessness (and poor quality jobs)*
- *Adult mental health*
- *Adult disability and poor health*
- *Relationship conflict and breakdown*
- *Adults who misuse illicit drugs*
- *Adults who misuse alcohol*
- *Domestic violence*
- *Poor housing and homelessness*
- *Adults who are offenders or exhibit antisocial behaviour*
- *Only wish to answer questions about one area*

The NSPCC works with families which experience all of these issues. Hence we are unable to answer these question in the format suggested. Below are examples of work with some of the groups mentioned above, highlighting good practice issues.

Work with adults with mental health needs
The Parkside Assessment Project, based in North Kensington, works in partnership with the Central and North West London Mental Health Trust, using a range of models including psychodynamic and systematic family therapy models of work. All work carried out is based on knowledge of normal child development and the impact that abuse, neglect and trauma can have on children. Specialist multi-disciplinary family and parenting assessments are provided, where there are court proceedings or decisions need to be made about a child's care, ie, in cases where the child's welfare and safety are of serious concern. Reports are produced for the court, which include overall assessment of the family and parenting, as well as individual needs assessment for each child. The project also offers consultation where there are complex abuse and neglect issues affecting the child, family and professional system.

As Parkside is a Specialist Service its practitioners act as expert witnesses in complex court proceedings. The team is commissioned to assess families where children have been abused or neglected at home over a long period. Many parents in these circumstances have their own experiences of abuse and often additional difficulties of substance misuse or mental health problems. The team are asked to think about the impact of their family lives on their development, their parents' capacity to change and what should happen to the children in the future. This help is often sought because the NSPCC is independent but also because the emphasis is always on children's needs. A fee is charged for this service and the NSPCC also part-subsidises this service.

Also based at Parkside, the Parental Mental Health Service is local to north Kensington. This service has built bridges with the adult mental health teams encouraging them to think about their patients as parents as well as adults, to improve the assessment of families' needs so that children's lives are clearer and their need for support and help is thought about more and families are better supported. Following on from the awards the service won in 2004, a short film was made in 2005[16] to share with other services to help them think about how they might develop their mental health services to take more account of children as carers in need of support.

Work with men who are perpetrators of domestic violence
Of several NSPCC projects that work with perpetrators, the work of the Caring Dads pilot, based in Cardiff, and the Merseyside No Xcuses programme is of particular relevance here. Both projects have moved from work that focuses on the behaviour of men towards their partners to a focus upon the men's relationship with their children. Both projects also work with women and children and it is around the integration of this that some of the learning has taken place. They have each been recently evaluated and there are elements of commonality in the findings.

[16] *Still Waiting for an Answer.* The Parental Mental Health Service, Central and North West London Mental Health NHS Trust, NSPCC, 2005.

Though the numbers involved are small, there are positive indications which suggest that a focus on their role as dads may be a more effective lever for change for abusive men. This is particularly exciting given the importance of their role and the increasing awareness of the need for some men to be helped in taking responsibility for parenting. The Caring Dads group showed improvements in their parental disciplinary style and in fathers' and their partner's perception of how they worked together as parents. It also showed a self assessed reduction in aggressive behaviour.

An important finding common to both was the need for a clear focus on the women and children throughout the programme. The Caring Dads evaluation recommended further consideration of ensuring child safety where other agencies were not involved. In the No Xcuses work with perpetrators, the partners had separate female workers. It was recommended that work with children on a larger scale be developed alongside this.

The evaluation of both projects recommended that the work continue and that there be continued evaluation in order to build upon this early evidence. The evaluations also contributed useful learning about the best methods of evaluation. The Caring Dads evaluation recommended that the use of evaluation tools be reviewed and the No Xcuses evaluation that the assessment tool be improved and also used to review progress.

Work with ethnic minority families

The *Living with hardship 24/7*[17] research demonstrates that GPs need to have access to information about local support services that they can recommend and refer families to. This is particularly important for those families with mental health problems and minority ethnic families who may only ever visit the GP.

The research also indicates that public education around mental health should seek particularly to address the stigma attached to mental health problems in minority ethnic communities, such as those in the Bangladeshi community who have recently arrived in the UK. Also interpretation services should be widely available, as should information for families in all languages in all services.

Communities which are relatively new to the UK, such as those from the Democratic Republic of Congo and Angola, can be suspicious of authority. If they become worried about their immigration application if they are seeking asylum in the UK they might be deterred from contacting statutory agencies.

Professionals, local agencies and institutions should, as a matter of good practice, improve their knowledge about families and learn to identify beliefs that may lead to harmful behaviour towards children.

[17] Hooper, C. A., Gorin, S., Cabral, C., Dyson, C., (2007) Op.Cit.

Work with families with alcohol abuse
The following is a summary of an evaluation of a service provided by the NSPCC and the Alcohol Recovery Project (ARP) called the Family Alcohol Service, based in Camden, London[18].

The Family Alcohol Service provides therapeutic and family support services to families in Camden and Islington where there are parental alcohol problems. The project aims to bridge the gap between adult and children's services by offering support to the whole family through one service, using a solution focussed approach which emphasises the values and strengths of family members, looking at their motivation to change their behaviour to concentrate on the needs of their children. The aim is to increase children's resilience to cope with their situation, as well as helping parents to see the impact their drinking has on their children and make positive changes to benefit them. Referrals mostly come from Social Services but the project also works with other alcohol agencies as well as health services. Self-referrals are also encouraged and often these are more motivated to attend and make positive changes.

The initial stage of the intervention is about gathering information from the whole family about all aspects of their life, with the emphasis on what the family does well and on 'positive reframing'. Following on from this initial stage, the work involves any or a combination of family sessions, individual sessions or couple work. There is an underlying family systems view of the work, that a positive change in one family member will engender change in others.

The Family Alcohol Service was evaluated to determine the outcomes of its work, focusing on parenting and family functioning, improving parent-child communication, and on keeping children safe.

Some of the outcomes from the evaluation report include:

- Referring agencies and staff of the project have reported significant success in engaging difficult-to-treat families in the recovery process.
- Family functioning has improved, with better communication, and more joint parent-child activities.
- Children's coping responses have improved, as has school attendance and achievement. Children have demonstrated an improvement in resilience characteristics, and changes have been made to Care and Supervision orders and Child Protection Registration figures.
- Parents have reported major improvements in functioning which they attribute to the service, including coping skills, recognising the impact their drinking has on children, an enhanced commitment to ensuring this impact is reduced, and reported improvements in self-esteem.
- Two thirds of problem-drinking parents who engaged for two or more sessions either sustained abstinence or reverted to abstinence.

[18] Velleman, R., Templeton, L., Taylor, A., Toner, P. (2003). *The Family Alcohol Service: Evaluation of a Pilot.* Mental Health Research and Development Unit, University of Bath..

- The evaluation team attempted to follow up families who did not remain engaged with the project. In many cases families have experienced a variety of problems, many of which are known to undermine parenting capacity and adversely affect child development. Some work was achieved by the project with this group of families, but the non-engagement of parents or carers remains a key issue and limited the opportunities for face-to-face work with children.

There are a number of good practice points which are important to highlight:

- There are significant benefits from having staff from varied backgrounds and the utilisation of a multi-disciplinary team with co-working, peer support and high quality supervision from a team manager.
- The process of obtaining a holistic view of what is going on in a family is very helpful, according to staff and parents. The approach is about seeing the problems as more than to do with problematic drinking, and being inclusive of children as integral to family life and the part drinking may play in it.
- The study determined that when working with children in such situations it is vital to be aware of the child's development and coping mechanisms, and the way parental drinking may have affected their behaviours and broader development.
- In families where engagement has proved most problematic, it has been suggested that more joint work, earlier and more detailed consultations about disengagement, and increased use of a multi-agency, multi-disciplinary project such as the Family Alcohol Service, might lead to more effective and long-term engagement.

Work with adults who are sex offenders

The Hinton House Adult Sex Offender Service in Middlesbrough works together with health, police, probation, the prison service and local authorities to develop multi-agency practice in assessment, treatment and management of sexual abusers in the Tees Valley area, as well as protocols on issues such as information sharing, training, consultation and child clearance procedures.

This last year has seen the development of the Multi-Agency Public Protection Panel (MAPPP) Steering Group, its terms of reference and work programme. The MAPPP Steering Group has clear links to the three Local Children's Safeguarding Boards within its area. The service is still developing within the child protection, criminal justice, public health and community safety systems. The direct service, which commenced in February 2001, is a holistic service for the assessment of sexual abusers and their families, combining actuarial data and clinical judgement for informed assessment. The needs of the whole family are considered when assessing family relationships and the service offers counselling to the non-abusing parent.

The service accepts referrals of:

- Convicted sexual abusers in the community, including sexual abusers not currently in the criminal justice system, but identified as having contact with children;

- Those with suspected sexual abusive behaviours which have not resulted in convictions; and
- Those who have asked for help with behaviours or thought patterns which they feel may lead them to abuse;

The service also provides

- Counselling for partners to explore their feelings denial, loss, betrayal, and confusion;
- Assessment of the non-abusing partner's ability to protect; and
- Discussion of the wishes and feelings of children as part of the overall assessment when family reconstruction is being considered.

Section C: Details of research and good practice

The final couple of questions ask you to provide details of any research and practice that you think will be helpful to this review.

Do you know of any current examples where a 'Whole Families' approach with excluded families is working well?

- ***Yes***
- *No*

Please provide a brief description of the example, contact details for key people involved and any references to reports or published information on the example.

The NSPCC's focus is on preventing cruelty to children, and ensuring that children grow up in a loving, caring environment that enables children to reach their full potential. The projects outlined above all work within a 'whole families' approach, as we are very clear that it is necessary to change the behaviour of adults towards children where they are causing harm, as well as provide therapeutic interventions for children if they have been harmed. If it is not possible to change the behaviour of adults towards children it may then be necessary to remove the child from the adult causing them harm, but this is very much a measure of last resort. Further details of the location of these projects and more detailed reports, particularly of the Family Alcohol Service evaluation, referenced above, can be provided on request. The research report mentioned above, *Living with Hardship 24/7*, will be published in July 2007.

Finally, do you know of any other research (including papers, reports, cost effectiveness data, case studies etc.) which you think will be particularly relevant for us to consider in relation to any of the questions raised in this questionnaire?

- ***Yes***
- *No*

Case Studies

Tom

Tom was only seven when his uncle began sexually abusing him. At first he didn't dare tell anyone because his uncle told him that he'd get him if he did. It took six months before Tom found the courage to tell his mum. It was incredibly hard for her to accept but when she saw that he was genuinely frightened she called social services. After Tom's social worker assessed the situation he referred him to the local NSPCC Therapeutic Project. As a result of his abuse Tom was suffering from frequent nightmares, experiencing feelings of self blame, betrayal, and guilt. He was underperforming at school, had a negative body image and a constant, intense fear that his uncle would find him and punish him for telling

In the first six months of Tom's work with Jeanette his drawings were very dark. He often drew himself being eaten by a monster with giant claws. He also wrote down what the monster was saying: "You can't get away, no-one will ever believe you", "Just be a good boy", "If you ever tell, I'll get you".

After twelve months progress had been made, and although there were still some problems, such as Tom not sleeping well, these were much reduced. Importantly Tom had come to understand that the abuse was not his fault and he had managed to build a supportive, honest and trusting relationship with his mum. His performance at school had also improved and, as a result of growing self esteem, he had begun to make new friends. After fifteen months Tom's life had changed beyond recognition, he was no longer the frightened, withdrawn child he had been. Jeanette decided it was time to start talking about saying goodbye. Finally, after eighteen months of attending Tom said "Thank you for helping me from getting sad and angry, I feel much better now you have helped me, I can go out all by myself now and play with my friends"

Family with Susan, mother and three children, Emma, 10 years, Jason, eight years and Tyler, three years

Jason is the middle child of a White British family living in West Sussex. Along with his siblings, Emma 10 years and Tyler 3 years, he had witnessed severe physical and emotional abuse of his mother by his father and also cruelty by his father towards the family dog. On one occasion, his father stabbed the dog which then disappeared from the home.

Jason's mother, Susan, managed to get away from this violent and abusive relationship, taking the children with her and they moved to temporary accommodation in a local refuge. Susan was assisted to get legal advice and obtained an Ouster Order which enabled her and the children to return to their home. Following their return, they were subjected to ongoing harassment from the extended family on the father's side.

A referral was made to the Project and an assessment of the needs of the family and each individual was undertaken. Following this work, Susan attended one of the group work programmes and her youngest child who was aged three attended a crèche in order that she could fully participate in the sessions. The oldest daughter, Emma who was 10 years old, attended a group for children.

Jason's behaviour was very troubled and explosive, particularly in school, which resulted in his exclusion. The Behaviour Support Team were involved in work with Jason and supported his reintegration into education. Due to Jason's behaviour and extensive needs, he was offered individual work to help him make sense of what had happened to him and his family and also to have time to explore and make sense of

his feelings. This was done by using therapeutic stories, games, and feelings charts, which he especially liked. Jason saw his NSPCC worker on a weekly basis and they started by talking about what Jason wanted help with and how they would do this work. They identified the best times and place to meet and what would happen to the information that Jason might tell his worker. Although he was eight years old, Jason was well able to engage in drawing up an agreement, which included what would be kept confidential between himself and his NSPCC worker and what, if anything would be shared with others and the reasons for this.

Gradually, Jason was able to express his anger about what had happened in his family, his anger at losing his dad and his wish to control his angry feelings. His sadness and anger at the hurt inflicted on the family's dog remains a constant feeling for Jason. He is able to identify that the dog did not deliberately do things to annoy his father and was not responsible for his father's anger and violence. He was able to draw similarities about how he as a child could not be responsible for it either, although he had constantly been told it was due to his behaviour that his father was violent.

Over a period of ten months and with support from his mother, his class teacher and an education support worker, and working with the NSPCC worker, Jason gradually returned to school. There were times when he still exploded in some situations, but he was learning to identify what he felt before he exploded and worked out some strategies to take himself away from those situations. He was also able to use these strategies at home when he got into conflict with his sister and younger brother.

In the mother's group, Susan was able to think about domestic violence and the impact it has on all family members. Issues explored included power and control in relationships; separation and loss; the impact on children of domestic violence; making sense of children's behaviours; helpful relationships; being assertive; feeling positive about oneself and moving on. This was achieved through different methods, which included sharing experiences with other women in the group and discussing case examples. In the children's group, Emma was given the opportunity to think about similar issues but, in a way which was appropriate to her age and developmental understanding. After the groups had finished, Susan and Emma said that it had been helpful to receive support from others who had been through similar experiences.

By providing help which met the needs of three members of the family, each person was individually helped to make sense of what had happened and to start moving forward. The result was that Susan had a better understanding of the impact of domestic violence on her children and that some of their behaviours could be attributed to this. Susan also came to realise that she was not a 'bad mother' and her children would not be 'taken away from her' - during the years she lived with her former partner she had been told this repeatedly which had made it difficult for her to leave.

Other research and practice issues of relevance to this review.

The need for Therapeutic Services for Maltreated Children

Research into the effects of abuse consistently shows serious and lasting damage to children. For them the long-term effects of abuse does not stop when the abuse stops; it continues into adulthood and will often mean they find it difficult to trust others and to form close relationships. Adults being treated for mental health problems, for example, often identify child harm as an influence.

Anxiety and depression, anger and guilt, poor self-image, difficulties in functioning at school and later at work, problems with personal relationships and parenting, sexual problems and physical effects are increasingly recognised as the long-term consequences of child sexual abuse[19]. Abused children can suffer post traumatic stress disorder (PTSD), a condition also commonly associated with major accident victims or battlefield veterans.[20] More generally, maltreated children are at risk of a range of psychiatric conditions which may contribute to their reduced ability to function successfully. These include cognitive distortions; depression and anxiety; dissociation; a decreased sense of self and others; low self-esteem; and altered/ confused sexuality.[21] They are at greater risk of becoming alcohol and drug abusers and of engaging in tension-reducing behaviours, such as self-mutilation, compulsive sexual behaviour and eating disorders. They are also at greater risk of suicide. As mentioned above, maltreatment can result in disturbed or antisocial behaviour and can also result in offending.

One detailed study of the provision of therapeutic services for sexually abused children estimated that 90 per cent of children who have experienced sexual abuse receive no substantial support.[22] According to the authors, the responses received from the social services departments involved in the study, while not claiming to be nationally representative, do "match the anecdotal comments received from around the four countries [of the UK]". A Department of Health study found that three months after referral, therapeutic work had happened or was planned in less than a quarter of cases of children who had been sexually abused. After a year, only 29% of children who had been sexually abused had received any kind of therapeutic intervention.[23] Of those children who do receive a service, many children who talk about their abuse regret having done so because of the way their cases are handled by adults. Young people who have experienced sexual abuse may have particular difficulties in seeking help, support and counselling. Often they do not come forward or do so only after many years.

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[19] Baginsky, M. (eds) (2001), *Counselling and support services for young people aged 12-16 who have experienced sexual abuse: a study of the provision in Italy, the Netherlands and the UK*, NSPCC, London.
[20] Famularo, R., Fenton, T., Augustyn, M., and Zuckerman, B. (1996*) Persistence of pediatric Post Traumatic Stress Disorder after 2 years*, Child Abuse and Neglect, Vol. 20, No. 12, pp. 1245–48.
[21] Briere, J.N. (1992) *Child Abuse Trauma*, Newbury Park, CA, Sage.
[22] Baginsky, M. (eds) (2001), Op. Cit.

[23] Sharland et al. (1996) *Professional intervention in child sexual abuse*. HMSO, pp.108-109.

Research shows that children benefit from therapy. McCrone et al (2005) report substantial improvements from psychotherapy in a group of severely affected girls (73% Post Traumatic Stress Disorder and 57% Major Depressive Disorder at baseline).[24] There is research[25] that "talking therapy" (particularly cognitive behavioural therapy provided by a psychologist) is both cheaper and more effective than anti-depressants (Selective Serotonin Re-uptake Inhibitors, or SSRIs), which are increasingly contra-indicated for children and young people. Group therapy is as effective as individual therapy and is significantly cheaper.[26]

In summary, without adequate post-disclosure therapeutic services children and young people are at risk of developing life-time dysfunctional consequences which incur very substantial costs; they may be deterred from reporting sexual abuse, and many children and young people will continue to experience unnecessarily the pain and distress of their abuse in the longer term. But when they do receive help it can make a real difference:-

Recommendations

The following recommendations being made by the NSPCC would help to fulfil the Children and Young People's NSF standards for both child protection and for mental health as they relate to therapeutic services:

- Ensuring all abused children receive therapy. The majority of children who are deeply traumatised by abuse currently receive little or no help to deal with the serious and lasting damage it can cause, and its effects can last well into adulthood. Every child who experiences sexual abuse should be given the therapeutic services they need.
- The Department of Health should commission a detailed analysis of the shortfall in current provision including examining which children are not receiving services either through CAMHS or other provision and identify the reasons why.
- The Government should establish a fully funded delivery plan at national and local levels to ensure that children who are abused receive child-centred therapeutic services. There should be comprehensive access to therapeutic services in all areas. To achieve this, the children and young people's plan must ensure that CAMHS/therapeutic services are commissioned in such a way to ensure that, at a minimum, there should be at least one such service in every children's trust. To support this, the Department of Health should review CAMHS services, and the extent and type of services they provide, with a view to modifying them so that they can undertake the type of child-centred therapeutic work that is needed to help children overcome the effects of abuse.

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[24] McCrone et al. (2005) *Cost-effectiveness of Individual versus group Psychotherapy for Sexually Abused Girls.* Child and Adolescent Mental Health Vol. 10, No 1.

[25] Haby, MM et al. (2004) *Cost-effectiveness of cognitive behavioural therapy and selective serotonin reuptake inhibitors for major depression in children and adolescent'*. Australian and New Zealand Journal of Psychiatry, 38: 579-591.

[26] McCrone et al. (2005) Op. Cit.

- In addition, any or all of the relevant government departments, including the Department of Health, the Home Office, the Department for Education and Skills and the Department for Constitutional Affairs, should consider funding a new delivery model for providing therapeutic services through the voluntary sector in a similar way to the funding arrangements for victim support schemes. As part of this work, they should examine the potential of Sexual Assault Referral Centres (SARCs) for children and young people.

Listening Services

Child-centred practice is most effective when it takes account of the needs of the community of children and young people as well as the particular circumstances of each child. This includes listening to children in a way that they like and will use, and finding ways to provide advice and support that seek to overcome the barriers that we know prevent many children from seeking help. It also includes ensuring that they have access to such support and advice when they want it and need it. It is important for there to be a range of methods by which they can do this, and new technology, such as computers and mobile phones, can provide new solutions and opportunities, particularly for children and young people. NSPCC research[27] found that only a quarter of people who had experienced sexual abuse as a child told anyone at the time it occurred. A quarter told someone later, but 31 per cent had never told anyone by their early adulthood.

Helplines present a unique opportunity to tap into all those children and young people who currently do not access help. Developing technology has expanded this opportunity enormously. The NSPCC would like to see the establishment of one definitive UK wide online counselling and support service from which other sites can be accessed. We would also like to see the extension of telephone helplines to be able to effectively respond to those children to whom we cannot provide a full service at present.

Evidence of the effectiveness of telephone helplines, online services and SMS texting is discussed below.

Telephone Helplines

ChildLine is the UK's free, 24-hour helpline for children in distress or danger. It was established in 1986, initially with a key focus on responding to children who had been sexually abused, though children call the helpline about a whole range of issues. Trained volunteer counsellors comfort, advice and protect children and young people who may feel they have nowhere else to turn. Almost 1,400 volunteers provide a counselling service, supervised by a team of professional supervisors and managers. ChildLine merged with the NSPCC in February 2006.

Every day around 4,500 children call ChildLine, but at present we can only talk to 2,500 of them. About one third of callers need in-depth help, sometimes over a

[27] Cawson et al., *Child maltreatment in the United Kingdom* (2000) London, NSPCC; Cawson, P., (2002) *Child maltreatment in the family: the experience of a national sample of young people*, London, NSPCC

number of sessions. Between April 2005 and March 2006, ChildLine counselled 157,409 children. Children call ChildLine about a wide range of problems, but the most common problems are abuse (both sexual and physical), bullying, serious family tensions, worries about friends' welfare, emotional and physical health and teenage pregnancy.

ChildLine operates out of 11 counselling centres around the UK: Belfast, Glasgow, Aberdeen, Leeds, London, Nottingham, Manchester, Swansea, Rhyl, Birmingham and Newton Abbot. The London centre operates a 24-hour service, but during peak hours when the other centres are open, children's calls go through to the nearest centre with an available counsellor.

Since it was launched, ChildLine has saved children's lives, found refuges for children in danger on the streets, and given hope to thousands of children who believed no one else cared for them. ChildLine has now counselled well over one million children and young people.

As Mary MacLeod, former policy director of ChildLine has commented: "To increase children's access to protection from assault requires a transformation of the way we think of children and conceive of them as users of help. Helplines have made a start here. Their existence has changed the relationship between children and help from passive recipients of services, responded to only when adults see something amiss, to active seekers of help"[28]. Macleod also states, "Helplines have now become so much a part of society's response to child assaults that they are recommended in the Implementation Handbook for the Rights of the Child (Hodgkin and Newell, 1998) by the Utting report (1997) and required in Department of Health and Department for Education and Skills guidance to residential homes and boarding schools. They have sprung up across the world"[29].

Online Services

There4me.com is an NSPCC service that offers information and advice to young people aged 12 -16 who have been or are at risk of being abused. Its target audience is the two-thirds of young people who have been abused but do not take advantage of traditional services to speak about their abuse and have no one to turn to. They come from all backgrounds and live in rural and urban areas. The service provides a wealth of information including an Agony Aunt page, where young people can send or read e-letters, a Message Board and an interactive feature called 'Got a Problem?' The live one-to-one service allows young people to communicate with an on-line adviser in real time. The topics that young people ask for help with most are relationships, sex, abuse and self-harm.

[28] MacLoed, M. (1999) *"Don't Just Do It": Children's Access to Help and Protection'.* In: Parton, N., and Wattam, C., (eds.) Child sexual abuse: responding to the experiences of children. Wiley series in child protection and policy Chichester, West Sussex: Wiley.
[29] Ibid.

Communication via the telephone or the internet is limited to voice or text, a limitation which can offer great appeal to children, not least because it offers them freedom from the usual constraints and requirements of physically seeking someone out for help and the difficulty or embarrassment that can be involved in talking about something very private with someone face to face, or talking to someone they know. MacLeod states "They are (also) safe from physical abuse or interference from the adult with whom they talk."[30] Between May 2002 and July 2004 the University of Southampton undertook an evaluative study of There4me.com.[31] This highlighted the value to young people of being able to seek advice in this way:

"It felt ok talking to a computer 'cos after a bit I got to know him and it didn't feel like talking to a computer also it was better than talking to someone who was really there 'cos I don't think I would have been able to say a lot of the things I told him out loud". "I didn't want someone to see me cry or try and hug me or something. I felt much more in control this way. I could just close the screen if I had had enough".

Young people also said they could trust the advisers and that they were not patronised. The advisers helped them to see their options and gave them practical advice rather than telling them what to do:

"At first I was very cautious and didn't know whether to trust them, but they make it easy and [I was] less nervous. They don't judge you or make you feel bad, which is a big help. They gave me loads of advice and I wanted to use it".

Some young people talked about how the advice and information they had received from using the There4me.com had helped them make changes to their lives and helped them solve their problems:

"I told my teacher, now the kids have been excluded and everything is fine. If it wasn't for There4me I would never of done it and today I would still been [have] bullied."

It is clear from the NSPCC's experience that it is important to establish a definitive web-based support service as part of providing a range of safe and trusted spaces that children and young people will be comfortable using to share and find solutions to their worries, concerns and fears.

SMS texting

From June to September 2006 the NSPCC's for the first time piloted an SMS text advice service for children and young people. This tested a service developed for young people at risk from abuse to enable them to access information, support and advice through SMS text. The pilot also sought to assess the extent to which SMS

[30] Ibid.

[31] Waldman, J., et al (2004). *There4me.com Evaluation.* University of Southampton, available online at: http://www.sws.soton.ac.uk/t4mstudy.

text is a viable and effective new way for children and young people to access the NSPCC's There4me.com service.

In particular, the NSPCC was concerned to find a new way to reach out to the most vulnerable children and young people. Recent research[32] found that only 61 per cent of children in lower socio-economic groups have accessed the internet at home, compared with 88% of children from in higher socio-economic groups.

In contrast, a MORI poll in 2004[33] showed that 97 per cent of females and 92 per cent of males aged 11- 21 have access to a mobile phone. Texting is the most frequent form of communicating: nine out of 10 text at least daily, and 54 per cent do so more than five times a day.

In autumn 2005, the NSPCC therefore conducted research to inform the development of the SMS Text pilot and promotion. This included researching potential areas for promotion, via consultations with local schools, exploring local websites, consulting with community groups, researching SMS technology and consulting with ChildLine in Eire (part of the Irish Society for the Prevention of Cruelty to Children).

Young people were also consulted through the There4me.com advisory group, ChildLine Saturday CHAT advisory group, the NSPCC Trustees advisory group of young people and users of There4me.com

The pilot showed that demand for this service was extremely high:

- 1.5% of all 11-16 year olds in the test area used the SMS text ser that there are potentially hundreds of thousands of young people se a national service;
- 20% of users wanted general information, 63% more specific advice and17% a one-to-one conversation.;
- 81% of our core target group – "hard to reach" 11-16 year olds - said they would use the service should they need to;
- Propensity to use the service for all group types considering gender, age and ethnicity was high. Approximately the same percentage for each group said yes they would use the service. There4m advisors felt that they did not need extra training to operate this texting service; and
- Learning from other organisations which have experience of using SMS Text suggests that this is an important means of accessing their service. The Samaritans launched their text service after research found that 61 per cent of users would prefer contact with Samaritans through the use of text messaging, compared to 44 per cent preferring email, 31 per cent favouring the phone and eight per cent choosing face to face contact. Other text helplines have been set

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[32] Bober, M., Livingstone, S. (2005) *UK Children go online*. Final report of key project findings. ESCR. Available online at : http://personal.lse.ac.uk/BOBER/UKCGOfinalReport.pdf

[33] Haste, H., (2005) *Joined up Texting: The role of mobile phones in young people's lives.*. Nestle Social Research Programme, fieldwork conducted by MORI. Available online at:

up by Barnardo's and Newport Police to tackle bullying among young people. Both organisations recognise that text is best possible channel of communication to interact with young people.

Please provide any contact details or references to reports or published information that would help us. If you have electronic documents you would like to send then please email beejalparmar@cesi.org.uk. If you would like to directly send documents by post then please address them to Beejal Parmar at Inclusion, 89 Albert Embankment, 3rd Floor, London, SE1 7TP.

References to research quoted in footnotes; research report *Living with hardship 24/7: The diverse experiences of families living in poverty in England* will be available from the Frank Buttle Trust in July 2007.

Section D: Your contact details

To conclude, we would appreciate it if you would provide us with your contact details. To allow us to analyse our findings it is mandatory for you to provide your job title, the level of operation and sector of your organisation and whether your submission comprises a personal or a corporate response

Full name

David Coulter

Job title

Policy Adviser, social exclusion, youth justice and asylum

Email address

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Name [and address] of organisation

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42 Curtain Road
London EC2A 3NH

Level of operation

- ***National***
- *Regional*
- *Local*

Sector

- *Public*
- ***Voluntary***
- *Private*

Type of response

- *Personal response*
- ***Corporate response***