Families experiencing multiple adversities: a review of the international literature


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Families experiencing multiple adversities: A review of the international literature

Believe in children

Barnardo’s Northern Ireland

This report was commissioned by Barnardo’s NI, NSPCC and NCB

September 2012

By Dr Gavin Davidson, Dr Lisa Bunting and Mary Anne Webb
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Introduction

This literature review was commissioned by Barnardo’s NI, NSPCC and NCB as the first stage of a wider project examining how to most effectively address the needs of families experiencing multiple adversities in Northern Ireland (NI). Informed by the literature review, the commissioning organisations will then examine policy, service and practice developments across NI. This will involve interviews with service users, service providers and other key stakeholders exploring the support needs of different groups at different times and how they are being dealt with by the current system. A discussion/position paper will then be developed to inform the development of policy, services and practice in this area.

Rationale for the literature review

There is a well established association between multiple adversities and an increased likelihood of harm and/or other negative outcomes throughout the life course. The Adverse Childhood Experiences (ACE) study (Felitti et al, 1998; Dube et al, 2003), which will be discussed in more depth in Chapter 4, has been extremely important in this area because it established a strong, graded relationship between the number of childhood adversities experienced and a wide range of negative outcomes in adulthood. Effective intervention with families experiencing multiple adversities therefore has the potential to prevent or decrease the likelihood of harm with all the related health, welfare and economic benefits for the children and families involved, the communities they live in and for society in general. Previous reviews of the literature (Davidson et al, 2010) have suggested that our knowledge of the precise prevalence of multiple adversities, how they may interact and impact on families and how they may be effectively responded to, is still developing.

The particular significance of multiple adversities is also highlighted by the work of Sameroff et al (1998) and Gutman et al (2002) who found that while there were significant effects of single risk factors, most children with only one risk factor were less likely to develop major problems. It is the accumulated number of risks that has been found to be most damaging and also predictive of higher probabilities of negative outcomes (Sabates and Dex, 2012). Spratt (2011a, p. 4) argues the central idea is that ‘multiples matter’, namely that the more adversities a child encounters, the more likely it will be that they will go on to experience poor outcomes as an adult:

“In all cases the pattern has been the same - the greater the number of adverse experiences in childhood, the greater the likelihood of health problems in later life” (Center on the Developing Child at Harvard University, 2010, p 6).

This review of the literature therefore aims to bring together an overview of the existing international research on:

- the definition and prevalence of multiple adversities
the theoretical explanations of why and how adversities impact on outcomes
- the main areas of impact
- the policy context
- the services developed to respond.

Structure of the report
Chapter 1 provides the methodology of the literature review, while Chapter 2 considers the range of definitions of families experiencing multiple adversities and estimates of prevalence. In Chapter 3 the range of theoretical models that have been developed to explain how adversity impacts on people are identified and discussed, while Chapter 4 considers the main areas of impact across a range of health, welfare and economic domains. In Chapter 5 the relevant UK and NI policy context is examined and in Chapter 6 selected models for service provision to respond to this issue are reviewed. The conclusion then highlights the main findings and some implications for research, policy and service development.
Chapter 1: Review methodology

Aims
This review aimed to provide an overview of the existing international/UK research on:

- the definition and prevalence of multiple adversities
- theoretical models explaining how and why adversities impact on outcomes
- the key areas of impact
- the UK policy context
- UK services developed to address multiple adversities.

Sources of information
Four main sources of information were utilised:

1. The Multiple Adverse Childhood Experiences research team at the School of Sociology, Social Policy and Social Work, Queen’s University Belfast. The lead author of this literature review is part of that team, which is led by Dr Trevor Spratt and Dr John Devaney. They have produced a number of publications on this area including:


2. Previous related literature reviews including:

   - Rosengard, A; Laing, I; Ridley, J; Hunter, S (2007) *A literature review on multiple and complex*
needs. Scottish Executive Social Research, Edinburgh.

3. Electronic database searches - a focused search strategy was developed as the potentially relevant literature on this subject covers a wide range of research. Therefore the search strategy involved using only the search terms “famil* AND multiple AND adversit*” and was limited to titles, abstracts or keywords and by date to 2000-2012. The databases searched were: the Campbell Library; ChildData; the Cochrane Library; Embase; Medline; PsycINFO; Social Care Online; SocINDEX; Web of Science; and Zetoc.

The results of the database searches are presented in Table 1. Of the 470 results 253 were identified as duplicates, leaving 217. These abstracts were then screened to determine whether the article was potentially relevant. The key inclusion criterion was if the article addressed the issue of multiple adversity and a further 79 were excluded as they were focused on a specific form of adversity. The remaining 138 were then reviewed.

4. The final component of the methodology was to search the grey literature. A number of websites were searched for additional reports or documents, including the relevant government and voluntary sector sites, and international research centres and networks. These additional reports from the grey literature website searches were also screened and those determined to be relevant were reviewed in detail. The overall flow of the literature is presented in Figure 1.

Table 1: Results of the database searches

<table>
<thead>
<tr>
<th>Database</th>
<th>Number of results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campbell Library</td>
<td>0</td>
</tr>
<tr>
<td>ChildData</td>
<td>8</td>
</tr>
<tr>
<td>Cochrane Library</td>
<td>0</td>
</tr>
<tr>
<td>Embase</td>
<td>74</td>
</tr>
<tr>
<td>Medline</td>
<td>70</td>
</tr>
<tr>
<td>PsycINFO</td>
<td>131</td>
</tr>
<tr>
<td>Social Care Online</td>
<td>10</td>
</tr>
<tr>
<td>SocINDEX</td>
<td>43</td>
</tr>
<tr>
<td>Web of Science</td>
<td>100</td>
</tr>
<tr>
<td>Zetoc</td>
<td>34</td>
</tr>
<tr>
<td>Total</td>
<td>470</td>
</tr>
</tbody>
</table>
Figure 1: The flow of the literature

References located through database searches
\( n = 470 \)

Duplicates
\( n = 253 \)

Unique studies and reports
\( n = 217 \)

Excluded on abstract
\( n = 79 \)

Included from databases
\( n = 138 \)

Included from grey literature, other reviews and sources
\( n = 160 \)

Included in review
\( n = 298 \)
Chapter 2: Defining and counting families experiencing multiple adversities

Definitions
An important initial step in considering families experiencing multiple adversities is to consider what is meant by both ‘family’ and ‘multiple adversities’. Morris et al (2008, p11) have highlighted the family as ‘a changing and evolving social institution, which is also the subject of changing perceptions and changing expectations’. In this literature review a broad definition of family is used. This acknowledges that:

‘An inclusive twenty-first century definition of family must go beyond traditional thinking to include people who choose to spend their lives together in a kinship relationship despite the lack of legal sanctions or blood lines’ (Goldenberg and Goldenberg, 2008, p2).

This broad definition of family has also been reflected in recent policy documents. For example, the Department of Health, Social Services and Public Safety (DHSSPS, 2009) Families Matter: Supporting Families in Northern Ireland Regional Family and Parenting Strategy defines family as:

‘A family consists of any child or young person under the age of 18 (21 for young people leaving care and disabled young people) and their primary caretakers. A primary caretaker can be a parent, an expectant mother or other biological relative or any person involved in bringing up the child or young person’ (p. 7).

An inclusive definition of adversity is also important. In their review of the research evidence on the association between childhood adversity and adult outcomes, Davidson et al (2010) highlight the lack of a single common term or definition used by all researchers. The complexity of forms of abuse, the processes by which it may impact on people and the wide range of possible outcomes means that research has tended to focus on:

- relatively specific forms of abuse, for example child sexual abuse (Browne and Finkelhor 1986);
- a narrow range of forms of abuse (Mullen et al, 1996); or
- relatively broad measures of adversity such as the ACE questionnaire which only asks 18 questions to determine the presence or absence of adversity in eight categories (Dube et al 2003).

This means that the adversity being investigated tends to be either very specific or not defined in depth.

Similarly Rosengard et al’s (2007, p ii) review of multiple and complex needs also acknowledged the multiple terminology and complexities involved. They note the plethora of terms linked with the concepts of ‘complex’ and ‘multiple’ needs, used by various disciplines, sometimes specifically, and often interchangeably. These include: ‘multiple disadvantage’, ‘multiple disabilities’, ‘multiple impairment’,
‘dual diagnosis’, ‘high support needs’, ‘complex health needs’, and ‘multiple and complex needs’. Rankin and Regan (2004) usefully identify the essence of complex needs as implying both breadth of need (more than one need, with multiple needs interconnected) and depth of need (profound, severe, serious or intense needs). Additionally, they use the term ‘complex needs’ as a framework for understanding multiple, interlocking needs that span health and social issues.

The breadth and complexity of multiple adversities is highlighted in Table 2, which provides an overview of the definitions and types of multiple adversities identified in key studies and UK policy documents. Lea’s (2011) analysis of definitions of complex needs suggests that most include reference to education, crime and health disadvantage, alongside poverty and risky behaviour. Similarly, the range of different adversities used can be grouped under eight broad headings:

- poverty, debt, financial pressures
- child abuse/child protection concerns
- family violence/domestic violence
- parental violence/disability
- parental substance abuse
- parental mental illness
- family separation/bereavement/imprisonment
- parental offending, anti-social behaviour.

While this provides a useful framework for identifying the prevalence of individual adversities and their co-existence within the parent population, it is important to consider the limitations. Lea (2011) cautions that: ‘rigid definitions, whilst useful and lending a scientific method to work, will only act as artificial constructs and may risk defining out key characteristics of a family’s make-up. Whatever definition of families and complex needs that we decide upon, there will be the possibility that we miss a key factor because it is outside the scope for identification’ (p32).
### Table 2: Definitions of families experiencing multiple adversities

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Adversities – definitions and type</td>
<td>People with multiple and complex needs</td>
<td>Families with multiple problems defined as having five or more of the following</td>
<td>Adverse childhood experiences</td>
<td>Multiple and complex needs of families</td>
<td>Multiple risks for families with very young children in the UK</td>
</tr>
<tr>
<td>Parental mental health/mental illness</td>
<td>✓ (people who have a ‘dual diagnosis’ of mental ill health and substance misuse, or of other combinations of medically defined conditions)</td>
<td>✓ (maternal)</td>
<td>✓</td>
<td>✓</td>
<td>✓ (depression)</td>
</tr>
<tr>
<td>Parental unemployment</td>
<td>✓ (no parent in work)</td>
<td>✓ (worklessness)</td>
<td>✓</td>
<td>✓</td>
<td>(worklessness)</td>
</tr>
<tr>
<td>Parental low/no educational qualifications</td>
<td>✓ (No parent has any qualifications)</td>
<td></td>
<td></td>
<td>✓</td>
<td>(Basic skills)</td>
</tr>
<tr>
<td>Family lives in poor quality or overcrowded housing</td>
<td>✓ (people who are multiply disadvantaged by poverty, poor housing, poor environments)</td>
<td></td>
<td></td>
<td></td>
<td>✓ (overcrowding)</td>
</tr>
<tr>
<td>Parent has longstanding limiting illness or disability</td>
<td>✓ (at least one parent)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Adversities – definitions and type</td>
<td>People with multiple and complex needs</td>
<td>Families with multiple problems defined as having five or more of the following</td>
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<td>Multiple and complex needs of families</td>
<td>Multiple risks for families with very young children in the UK</td>
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</tr>
<tr>
<td>Family poverty/low income ✔</td>
<td>(people who are multiply disadvantaged by poverty, poor housing, poor environments) ✔</td>
<td>(income below 60% of the median) ✔</td>
<td>(poverty and debt) ✔</td>
<td>(financial stress) ✔</td>
<td></td>
</tr>
<tr>
<td>Family cannot afford a number of food and clothing items ✔</td>
<td>✔</td>
<td>✔</td>
<td>(financial stress) ✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teenage parenthood</td>
<td></td>
<td>★</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental separation through relationship breakup/divorce/imprisonment or bereavement</td>
<td>✔</td>
<td>(parental separation/divorce/imprisonment) ✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic violence ★</td>
<td></td>
<td>★</td>
<td></td>
<td></td>
<td>(One or either parent flies into violent rage) ✔</td>
</tr>
<tr>
<td>Parental substance/alcohol abuse ✔</td>
<td>(people who have a ‘dual diagnosis’ of mental ill health and substance misuse, or of other combinations of medically defined conditions) ✔</td>
<td>(substance) ✔</td>
<td>(drugs and alcohol) ✔</td>
<td></td>
<td>(drugs and alcohol) ✔</td>
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</table>
Table 2: Definitions of families experiencing multiple adversities cont’d

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<tbody>
<tr>
<td>Adversities – definitions and type</td>
<td>People with multiple and complex needs</td>
<td>Families with multiple problems defined as having five or more of the following</td>
<td>Adverse childhood experiences</td>
<td>Multiple and complex needs of families</td>
<td>Multiple risks for families with very young children in the UK</td>
</tr>
<tr>
<td>Parental vulnerability</td>
<td>✔️</td>
<td></td>
<td></td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Persistent offending behaviour</td>
<td>✔️ (people who present challenging behaviours to services, for example in schools, within residential services/ hostels or in their own neighbourhoods)</td>
<td></td>
<td></td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Persistent anti-social behaviour</td>
<td>✔️ (those who may be involved in substance misuse, offending and at risk of exclusion)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prejudiced behaviour</td>
<td>✔️ (people who present challenging behaviours to services, for example in schools, within residential services/ hostels or in their own neighbourhoods)</td>
<td></td>
<td></td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Adversities – definitions and type</td>
<td>People with multiple and complex needs</td>
<td>Families with multiple problems defined as having five or more of the following</td>
<td>Adverse childhood experiences</td>
<td>Multiple and complex needs of families</td>
<td>Multiple risks for families with very young children in the UK</td>
</tr>
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<td>----------------------------------------</td>
<td>-----------------------------------------------------------------</td>
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<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>Child protection concerns</td>
<td></td>
<td></td>
<td>✔️</td>
<td>(safeguarding concerns)</td>
<td></td>
</tr>
<tr>
<td>Childhood history of abuse and/or neglect</td>
<td></td>
<td></td>
<td>✔️</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Those disadvantaged by age and transitions</td>
<td>✔️ (young and older people; those fleeing abuse and violence – mainly women and refugees)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Those culturally and circumstantially disadvantaged or excluded</td>
<td>✔️ (minority ethnic groups; travelling people; people with a disability, including profound, severe or long term impairment or disability and those with sensory disabilities with ‘additional needs’)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People who are ‘marginal, high risk and hard to reach’</td>
<td>✔️</td>
<td></td>
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</tr>
</tbody>
</table>
Prevalence of families experiencing multiple adversities
The discussion about the range of potential definitions highlights some of the complexity involved in estimating how many families are experiencing, or at risk of experiencing, multiple adversities. On the other hand, some indication of prevalence is essential for the planning and development of services.

In Illinois, Goerge et al (2010) identified families who were using multiple services across five possible areas of need: foster care, mental illness in adults and emotional disorders in children, substance abuse, adult incarceration, and juvenile incarceration. They found that of the 502,165 families included, 43 per cent received none of these services, 34 per cent used one, and 23 per cent used two or more services. They also found the proportion of families using multiple services varied considerably across the state ranging from 14-32 per cent across areas. Likewise, an English study mapping the use of health and social care services over a three year period found that 22 per cent of service users were in touch with at least two service clusters (a cluster was defined as different delivery agencies that comprise one branch of social services, such as learning disability cluster or mental health cluster). It also found that 41 per cent of social services clients with substance misuse problems also attended mental health services, indicating that these were clients with ‘dual diagnosis’ (Keene, 2001; Keene and Li, 2005).

Anda and Brown (2010) reported in an area population study in Washington State that 62 per cent of adults had at least one adverse childhood experience\(^1\), with just over a quarter reporting three or more. In their study based on the Millennium Cohort Study (MCS), which included 18,818 babies in 18,552 families across the four UK nations, Sabates and Dex (2012) reported that in 30 to 31 per cent of families the child was exposed to only one risk factor\(^2\), a level of risk that previous studies have found to be mostly unproblematic for child development. However, between 27 and 28 per cent of children under one were subject to multiple risk factors, a finding that was linked to poorer cognitive and behavioural development at ages three and five. Overall, 15-16 per cent faced two risk factors; 6.9-7.5 per cent three risk factors; and in less than 2 per cent of families children were exposed to five or more risk factors. The analysis also pointed to variation in levels of adversity across the four UK nations with a lower proportion of children in NI exposed to at least one (54 per cent) or two risks (24 per cent) than in other countries. This was followed by Scotland and then England, with Wales having the highest proportion of children exposed to at least one (60 per cent) or two risks (30 per cent).

\(^1\) From the ten ACE areas: emotional abuse; physical abuse; sexual abuse; emotional neglect; physical neglect; parental separation/divorce; domestic violence; substance misuse; mental health problems and imprisonment.

\(^2\) From ten risk factors: depression; worklessness; financial stress; teenage parenthood; basic skills; overcrowding; substance abuse; alcohol abuse; domestic violence; physical disability.
Depression was the most common risk factor affecting 19 per cent of the MCS parent population, followed by physical disability, alcohol or substance abuse and teenage parenthood. However, the multiple adversities examined did not necessarily group together in predictable patterns, with no one combination of factors accounting for more than 9 per cent of families in each of the three, four, five, six or seven plus risk factor groupings. Nonetheless, depression was common to a majority of risk combinations. Parents with alcohol problems, violence within the home and parental longstanding illness rarely appeared among the most common combinations, until the seven risk combinations were reached. However, basic skills, worklessness, teenage motherhood and parental depression appeared pervasively among the most common combinations from four risks upwards. The researchers also note that worklessness and basic skills, although relatively low in terms of prevalence, tended to be associated with many of the more common combinations.

Analysis of the Family and Children Survey, as part of the Cabinet Office’s Social Exclusion Taskforce’s (2007b) report Families at Risk: Background on families with multiple disadvantages, also showed a small minority of families with children in England, Wales and Scotland (2 per cent) experience five or more disadvantages. This included seven measures of adversity, a number of which were similar to the MCS, and formed the basis of the now commonly cited figure of 140,000 ‘troubled families’. However, caution has been urged in relation to this estimate on the grounds of the age of the data (2004) and the small numbers involved:

‘Because it is an estimate from survey data in which the actual number of families with five or more of these disadvantages was very small, anyone with any statistical sophistication will recognise it as spuriously accurate. It ignores both sampling error (the probable discrepancy between even a randomly generated sample and the population from which it is drawn) and sample bias (the departure from randomness of the effective sample, principally caused by differential response rates across the population). The poorest (and the richest) sections of the population tend generally to have somewhat lower response rate. It is likely that sample bias would suggest that the figure for those suffering such severe disadvantage was somewhat higher at the time. The figure is now eight years out of date, and almost certainly now rising as a result of Coalition policies. The normal caution about sampling error, as opposed to bias, suggests ‘plus or minus 3 per cent’. On the face of it, this could take the actual figure down to minus 60,000 (which is of course nonsense: we know the figure is greater than zero, because some actual families were identified in FACS), or up as high as 300,000’ (Levitas, 2012, p 5).

3 No parent in the family is in work; family lives in poor quality or overcrowded housing; no parent has any qualifications; mother has mental health problems; at least one parent has longstanding limiting illness or disability; family has low income (below 60% of the median), and family cannot afford a number of food and clothing items.
### Table 3: Summary of estimates of prevalence

<table>
<thead>
<tr>
<th>Authors</th>
<th>Research study</th>
<th>Estimate of prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anda and Brown (2010)</td>
<td>Area population study in Washington State of adverse childhood experiences</td>
<td>62% of adults had experienced at least one adverse childhood experience with just over a quarter reporting three or more</td>
</tr>
<tr>
<td>Keene (2001) and Keene and Li (2005)</td>
<td>Study of a total social services care population and its inter-agency shared care populations</td>
<td>22% of service users were in touch with at least 2 service clusters</td>
</tr>
<tr>
<td>Goerge et al (2010)</td>
<td>Illinois families and their use of multiple service systems</td>
<td>23% of families had one or more individuals who used two or more services</td>
</tr>
<tr>
<td>Sabates and Dex (2012)</td>
<td>Study based on Millennium Cohort Study</td>
<td>Between 27 and 28% of these very young children were subject to multiple risk factors</td>
</tr>
<tr>
<td>Social Exclusion Taskforce (2007b)</td>
<td>Families at risk: Background on families with multiple disadvantages</td>
<td>Estimates that around 2% of families with children in Britain experience five or more disadvantages</td>
</tr>
</tbody>
</table>
Summary: Defining and counting families experiencing multiple adversities

The definition of multiple adversity is important as it will have a direct impact on the estimate of prevalence. However, multiple adversity is not well defined and multiple concepts and terminology are common throughout the research and policy literature. From the range of studies considered, eight areas of adversity emerge as key factors: poverty, debt and financial pressures; child abuse/child protection concerns; family violence/domestic violence; parental illness/disability; parental substance abuse; parental mental health problems; family separation/bereavement/imprisonment; and parental offending/anti-social behaviour.

Both US and UK research findings suggest that 20-25 per cent of service users are in contact with multiple service systems or clusters. Although definitions and adversities considered differ across studies, US and British research also highlights the presence of childhood adversity to be common; with 62 per cent of US adults and 57-59 per cent of UK families with a child under one having experience of, or exposure to, at least one risk factor. While previous studies suggest the presence of one adversity to be mostly unproblematic for child development, nearly three in ten children in the Millennium Cohort Study were subject to multiple risk factors. This was linked to poorer outcomes for children, suggesting the importance of not only addressing the needs of the minority who experience a large quantity of co-occurring difficulties, but those who experience smaller numbers of multiple adversities.

While caution is urged when extrapolating these data to the UK population, together the Millennium Cohort Study and Family and Children Survey provide valuable insight into the scale of adversities parents face. Although a clear pattern of co-occurrence is lacking, depression emerges as a key factor common to the majority of adversity combinations with issues such as family violence and alcohol/substance misuse tending to appear only at the very high numbers of adversity.

Useful as this data is, it is worth noting that there is no one UK data source which measures the eight areas identified in the literature. Abuse experiences and child protection concerns are most noticeably absent, as is parental criminality and antisocial behaviour and parental abuse history. Current data is also limited by the measures used within individual surveys, many of which can only act as proxy measures of risk (for example, either mother or partner often gets in violent rage as a measure of domestic violence). This, together with variation in the levels of adversity across England, Scotland, Wales and Northern Ireland, suggests the need to develop nation specific surveys which address these deficiencies.
Chapter 3: Theoretical models of how adversity impacts on outcomes

In this chapter the range of theoretical models that contribute to explaining how and why multiple adversities may impact on families and outcomes is explored. Research on families experiencing multiple adversities has established that trauma and adverse experiences in childhood are associated with negative outcomes across a range of domains including mental health, social functioning, physical health, offending, education, employment and service use (Felitti et al, 1998; Read et al, 2005) and will be reviewed in more depth in Chapter 4. Based on this research, current UK Government policy across the nations is concerned with the possible connections between childhood adversities and negative outcomes across the life course (HM Government, 2004; Scottish Executive, 2007; Department of Health, Social Services and Public Safety, 2009).

Given the research and policy context, understanding how trauma impacts on outcomes is central to informing the development of effective interventions across all levels and sectors. A previous review of the literature (Davidson et al, 2010) has identified an incomplete understanding of the inputs (the range of adverse experiences in childhood), the processes (how these may affect people) and the outcomes (across all domains). This chapter therefore focuses on exploring the mechanisms or processes involved.

An important point to highlight about these theoretical models is that they usually acknowledge that these processes tend not to involve straightforward linear causality, such as adversity A causes outcome C. Rather they identify more circular processes in which multiple adversities A may influence a range of mediating processes B, which may lead to outcomes C, which may in turn impact on the likelihood of adversities A and reinforce processes B and so on over time. For example, a linear causality view would be that parental mental health problems may impact on the development and welfare of children in a range of ways. Circular causality brings in the complexity of the affected child then having emotional and behavioural needs that may increase the stress of parenting and impact on parental mental health. The interactions and complexity involved in these processes lead to the need for theoretical models to help understand what is happening but the complexities involved should also be acknowledged.

In their work on social factors and education, Ackerman and Brown (2006) have suggested that debates around the processes involved have become more sophisticated:

*Historically, developmental perspectives have embodied social address and main effects models, snapshot views of poverty effects at single points in time, and a rather narrow focus on income as the...*
symbolic marker of the ecology of disadvantage. More recent views, in contrast, emphasize the diverse circumstances of disadvantaged families and diverse outcomes of disadvantaged children, the multiple sources of risk and the multiple determinants of poor outcomes for these children, dynamic aspects of that ecology, and change as well as continuity in outcome trajectories’ (p 91).

Schoon et al’s (2003) research on the 1958 and 1970 birth cohort studies in Great Britain also supports the need to consider a wide range of potential factors and processes. Their results reject a simple selection, or social causation, argument suggesting that both dynamics operate in life course development: ‘The effects of social risk cumulate throughout the life course, influencing both behaviour adjustment during childhood and adult psychosocial functioning ... the explanation of health differences in adult life must account for the reciprocal interaction between individual behaviour and social circumstances’ (p 1001).

At present there are a range of different, uni-disciplinary theoretical models proposed for how childhood adversities impact on outcomes, including biomedical, psychological and social models. These will be explored first, before more integrated theoretical models are considered. While most theoretical models still tend to focus more on the negative processes involved in adversities leading to negative outcomes, there are also theoretical approaches and models, such as resilience and social capital, which concentrate more on possible protective processes. These are also discussed as they offer some explanation of why, in response to what appear to be similar levels of adversities, outcomes for individual and families may vary widely. Overall the range of theoretical ideas may provide extremely useful frameworks for accessing, understanding and responding to the complexities involved in discussing families experiencing multiple adversities. However, it is important to assert that no one theoretical model offers a complete understanding of all the issues involved, although all of them contribute important perspectives, ideas and insights to the complexities involved.

**Biomedical models**

Biomedical explanations for why adversities impact on outcomes tend to focus on the genetic, biochemical and physiological factors that may be involved in these processes. Three main theories will be considered here: the role of genes, a neuro-developmental model, and the role of stress.

**Role of genes:** One perspective on the role of genes in adversity concentrates on the role of genetic factors as a fixed input, regardless of what processes or experiences then follow, and suggests that specific genes make negative outcomes at least more likely. This is most clearly demonstrated in the role of genes in relatively rare inherited
physical health problems (such as cystic fibrosis and Huntington's disease) where individuals inheriting a specific gene will nearly always develop the associated disease. In the health service there are currently tests available for around 300 rare single gene disorders. The proposed possibility of identifying genetic causes across the range of outcomes (such as mental health, educational achievement, and offending) has remained elusive. For example, Sander et al's (2008) work on schizophrenia found that the evidence for all the most likely genes identified remains modest and/or inconclusive. In looking at mental health in general, Wermter et al (2010) concluded that: ‘despite initial optimism, few susceptibility genes (i.e., predisposing sequence variations) have been replicated with some consistency. Even for replicated findings the effects are very small: taking all risk genotypes into account explains only a small fraction of the variation in the expression of a disorder’ (p 200).

The general emphasis of research on this area has therefore shifted from straightforward causal processes more to examining the interaction of certain genes and environmental factors. While the idea that our genetic make-up may have an influence in how we respond and cope with adversities makes intuitive sense, the concept of a simple causal relationship has, perhaps, been over-stated. For example, a recent research finding on the role of genes in ADHD, published in the Lancet (Williams et al, 2010), found that only 16 per cent of children with a diagnosis of ADHD in the study had the proposed genetic variation. Nevertheless, it was reported as the first study to find direct evidence that ADHD is a genetic disorder.

As well as the seduction of genes offering a relatively simple, scientific explanation of outcomes, another concern about inflating the role of genes in outcomes is that it can be misinterpreted as deterministic. In other words, given your genetic make-up, there is little that intervention can achieve in influencing trajectories and/or outcomes. This may be the case in the rare inherited physical health disorders that are now tested for but to use this to extrapolate across all outcomes is unwarranted and unhelpful.

Neurodevelopment: Advances in neuroscience have produced a more sophisticated understanding of the interaction between biology and the environment which is explained through the neurodevelopment model (Perry, 1996). In this model infant brain development is continuously shaping, and being shaped by, the external world, primarily through interactions with caregivers. The majority of this development takes place over the first four years of life through a hierarchical process where the brain develops from the brainstem up to the neo-cortex. Exposure to trauma and adversity during this time period is thought to impact on later outcomes through processes of hyper-arousal and dissociation.
Figure 2: Model of structure and development of the brain

Hyper-arousal is where: ‘the child will very easily be moved from being mildly anxious to feeling threatened to being terrorised. In the long run, what is observed in these children is a set of maladaptive emotional, behavioral, and cognitive problems, which are rooted in the original adaptive response to a traumatic event’ (Perry et al, 1995, p 277).

The other response is dissociation, which similar to hyper-arousal, may be adaptive or protective as an immediate response to extremely stressful events but again may be harmful over the longer term (Read et al, 2001). It is argued that these processes impact on the hypothalamic–pituitary–adrenal axis and can lead to abnormalities in neurotransmitter systems, structural brain changes, including hippocampal damage, and so increased vulnerability to negative outcomes (Read et al, 2001). It is also suggested that these processes offer some explanation of how and why adversities may continue to impact on outcomes long after the adversity itself may have ended.

Stress: Related to the neurodevelopmental approach to understanding the impact of adversities is the suggestion that stress generated by adversity can be harmful in a range of ways. In the US, the National Center for Injury Prevention and Control of the Centers for Disease Control and Prevention (2008) reported that prolonged exposure to stress hormones can impact the brain and impair functioning in a variety of ways:
toxic stress can impair the connection of brain circuits and, in the extreme, result in the development of a smaller brain.

brain circuits are especially vulnerable as they are developing during early childhood. Toxic stress can disrupt the development of these circuits. This can cause an individual to develop a low threshold for stress, thereby becoming overly reactive to adverse experiences throughout life.

high levels of stress hormones, including cortisol, can suppress the body’s immune response. This can leave an individual vulnerable to a variety of infections and chronic health problems.

sustained high levels of cortisol can damage the hippocampus, an area of the brain responsible for learning and memory. These cognitive deficits can continue into adulthood’ (p 4).

The ACE study (Felitti and Anda, 2010) has also suggested that adverse experiences in childhood may be related to adult physical health problems by two mechanisms. The first is that people’s self-help attempts to address the difficulties associated with childhood adversity, such as smoking and substance misuse, may increase their risks of physical health problems. The second is that childhood adversity may create sufficiently high and long-lasting levels of stress to have a direct impact on people’s physical health and well-being.

Psychological models
There are also a range of psychological models that mainly focus on the mediating, subjective, relational, cognitive and behavioural processes, which may arise as a result of adversities which then contribute to outcomes. Two main possibilities that will be considered here are attachment and cognitive or attributional beliefs.

Attachment: Attachment theory (Bowlby, 1951; 1979; 1988) suggests that our early experiences of relationships, especially the responses of our main carer/s, may have a far reaching influence on our subsequent relationships and how we view ourselves, the world and other people. A central idea of this theory is that when a child experiences some form of threat, fear and/or distress, this will trigger their need to seek their carer/s (in other words activate their attachment system) to ensure they are safe. How the carer responds to this need over time will create one of four main types of attachment (Ainsworth et al, 1978; Main and Soloman, 1986; Howe, 2009):

if the response is consistently available, affectionate and reassuring this enables the child to feel secure and to develop a positive view or internal working model of themselves and others which enables them to form and maintain other positive relationships.

if the response is inconsistent, sometimes appropriate but at other times neglectful and/or over intrusive the attachment may be
insecure and anxious where the child may have a positive view of others but not of themselves.

- if the response is consistently indifferent or even hostile then the attachment may be insecure and avoidant. The child may be able to retain some positive sense of themselves but a negative view of others.

- the final attachment style is disorganised that may develop if the care giver is experienced as unpredictable, frightened, dissociated, frightening and/or abusive, and the child may develop a negative view of themselves and others.

The child’s attachment style will therefore influence how they interpret themselves, others and the world, the nature and level of supportive relationships available to them, and so how stressful life is. The associated cumulative stress may then be associated with difficulties across the range of outcomes including physical health, mental health, social functioning, education, employment and offending.

**Attributional:** Morrison et al (2003) reviewed a range of cognitive models for how people respond to trauma and how this may impact on their mental health. One of the processes considered is people’s attributional style. This model was developed in relation to depression (Abramson et al, 1978) to suggest that people who are depressed tend to attribute uncontrollable negative events to internal (rather than external), stable (rather than unstable or changing), and global (rather than specific) causes, for example, the belief that ‘my parents have separated because I’m a bad and worthless child’ (Peterson et al, 1982, p 288). This would therefore offer another perspective on explaining how people may respond to adversity and how it may impact on them, as well as suggesting processes that may illuminate why people may respond very differently to what appear to be similar adversities.

An applied example of a psychological approach is Plumb’s (in Tew, 2005) social trauma model for understanding the, despite the name, mainly psychological processes that may impact on people following abuse. It suggests that fear may be the main theme characterising the processes involved.

**Social models**

There are a range of social models that may contribute to explaining how and why multiple adversities may impact on families and outcomes. Three that will be considered here are social construction, societal response and social causation.

**Social construction:** A social constructionist understanding emphasises the role of the social forces and power relations involved in developing people’s understanding of the concepts of trauma and adversity. In other words how people construct the meaning of trauma and adversity, and how these constructions then influence the impact of these experiences and
Figure 3: The Social/trauma model

(OCD = obsessive compulsive disorder; PTSD = post traumatic stress disorder)

Abuse

Guilt/Shame

Self-Hate

Inability to Define Personal Boundaries
(e.g. trusting everyone or no-one)

Fear of Weakness

Need to Control

Fear of anger

Anger

Self-directed

Depression
Unassertiveness
Vulnerability

Anxiety
Panic
Attacks Phobias

about
• more abuse
• protection of own children
• people finding out

Low Self-Esteem
Lack of Self-Confidence
Negative Self-Image

Abusive Relationships

Dependency

Poor Relationships
Isolation

Inability to Grieve
(grief issues)

Fear of Grief

Dissociation and PTSD
Lack of emotion
Flashbacks
‘Fugue’
Voices/visual hallucinations
Multiple personalities
Regression

Avoidance of pain

Self-Harm:
Cutting
Bulimia/anorexia
Alcohol/drug misuse

Unexplained and explained outbreaks of anger

Overdoses
Suicide
Suicide Attempts

Source: Tew (2005)
associated outcomes. Witkin (2012, p 17-18) offers several definitions of social construction which may help clarify this:

‘The leading idea always has been that the world we live in and our place in it are not simply and evidently ‘there’ for participants. Rather, participants actively construct the world of everyday life and its constituent elements’ (Holstein and Gubrium, 2008: 3). Social constructionists do not assume a pre-existing world waiting to be discovered. Rather, it is through social interchange that what we take as the realities of the world come into being... In a wider sense of ‘social construction’, everything, including giraffes and molecules, is socially constructed, for no vocabulary (e.g. that of zoology or physics) cuts reality at the joints. Reality has no joints. It just has descriptions – some more socially useful than others’.

It could be argued that social constructionist ideas overlap with the psychological models but place more emphasis on how language, power and groups influence how reality is constructed and therefore experienced. Social constructionist ideas may also provide a helpful framework for understanding the developing research on why some countries that have managed to move out of high levels of absolute poverty may still have relatively poor outcomes. The research suggests that it may be how unequal and acquisitive the society is that can then predict outcomes and that may be because inequality is experienced or constructed as anxiety-provoking and stressful for all involved (Wilkinson and Pickett, 2009; Marmot Review, 2010; James, 2007).

Societal response: Another related and overlapping way of understanding the impact of adversities is to consider the role of societal response. This should not be misunderstood as minimising the direct impact of adversity but, as with the psychological models and social construction, it acknowledges the importance of how these experiences are framed by the people involved and wider society. A societal response perspective on adversities would therefore focus on the role of stigma and self-stigma, media portrayals of adversities and their outcomes, discrimination and anticipated discrimination, and societal expectations of impact. Finkelhor and Browne (1985) in their conceptualisation of the impact of sexual abuse suggested that four traumagenic dynamics may be involved: traumatic sexualisation, betrayal, powerlessness and stigmatization. There is a concern that the current policy framing of families experiencing multiple adversities as ‘troubled families’ may have the impact of reinforcing rather than addressing stigma and discrimination (Levitas, 2012).

Social causation: This social model suggests that adversities such as poverty, unemployment, abuse, social deprivation and exclusion have a direct impact on outcomes. In relation to mental health outcomes,
the Department of Health (1999, p 14) identified a number of findings that may support this more direct relationship:

- ‘unemployed people are twice as likely to have depression as people in work
- children in the poorest households are three times more likely to have mental health problems than children in well off households
- half of all women and a quarter of all men will be affected by depression at some period during their lives
- people who have been abused or been victims of domestic violence have higher rates of mental health problems
- people with drug and alcohol problems have higher rates of mental health problems
- between a quarter and a half of people using night shelters or sleeping rough may have a serious mental disorder, and up to half may be alcohol dependent
- some black and minority ethnic communities are diagnosed as having higher rates of mental health problems than the general population; refugees are especially vulnerable
- there is a high rate of mental health problems in the prison population
- people with physical illnesses have twice the rate of mental health problem compared to the general population’.

Social causation suggests that the stress caused by negative social factors such as poverty, racism and unemployment has a direct impact on outcomes. This does not mean that mediating factors do not protect or exacerbate this impact but the central process is the negative social factor causing the negative outcome.

**Positive models**

The biomedical, psychological and social models discussed above tend to focus on the processes involved in adversities leading to negative outcomes. These models could also be applied to consider why some families experiencing multiple adversities do not have the associated negative outcomes. For example, it could be that for some individuals their genetic vulnerability is less, that the cognitive processes they have developed to interpret their experiences are protective and/or that the social factors involve other processes, such as social approval, cohesion and identity, which help counter the impact of adversities. There are a range of other models which focus more on these positive views of the possible processes. These include: general strengths approaches (Saleeby, 2006); salutogenesis (Antonovsky, 1996) which looks at how people manage stress and stay well; and the recovery approach (Care Services Improvement Partnership et al, 2007) in mental health. Two further positive approaches explored here are resilience and social capital.

**Resilience:** Although the research on the associations between multiple adversities and negative outcomes is very strong, it is still the case that not
all families who experience multiple adversities have negative outcomes: ‘A universal finding in all studies of both physical and psychosocial adversity is that there is huge heterogeneity in outcome. . . . The awareness that this is so has led to the concept of ‘resilience’, meaning the phenomenon that some individuals have a relatively good outcome despite suffering risk experiences that would be expected to bring about serious sequelae’ (Rutter, 2007, p 205).

Benard (2006) estimated that approximately half of children who experience multiple adversities will overcome these and achieve relatively good outcomes. She suggests that the key protective factors or systems involved are caring relationships, high expectation messages and opportunities for participation and contribution. Rutter (2007) highlights three important considerations in the complexities involved in thinking about resilience that overlap with some of the theoretical models. He suggests that overcoming adversity may depend on experiences before and after it; people may have different genetic and physical responses to adversity which may account for some of the differences in outcome; and the mediating mechanisms that enable some people to be resilient to adversity may involve what they do in response. As such, these processes should be examined along with the more traditional risk and protective variables.

Ungar (2008), reinforcing some of the social perspectives, highlights that there may also be important cultural and contextual factors. A recurring finding in the research that has tried to identify what the protective factors and processes may be is the association of relatively good outcomes with positive relationships (Banyard and Williams, 2007; Collishaw et al, 2007; DuMont et al, 2007; Heller et al, 1999) which provide security, support, positive reinforcement and modelling (Benard, 2006).

Jaffee et al (2007) have suggested that, as well as the individual and relationships context, the wider context may also be important. They found that children whose parents had substance use problems and who lived in relatively high crime neighbourhoods that were low on social cohesion and informal social control were less likely to be resilient to maltreatment. Individual strengths distinguished resilient from non-resilient children under conditions of low, but not high, family and neighbourhood stress. These findings are consistent with a cumulative stressors model of children’s adaptation and suggest that for children residing in multi-problem families, personal resources may not be enough to promote their adaptive functioning.

Social Capital: It could be argued that social capital is another way of framing the idea of resilience that, perhaps, focuses more on the social relationships, context and resources that may be protective, rather than the individual’s ability to be resilient to
the impact of adversities (Morris et al, 2008). Social capital has been used to refer to the resources and cohesion of whole communities (Puttnam, 2000) and how individuals and families may develop social connections and resources that are protective (Coleman, 1994) and may exclude others from these resources (Bourdieu, 1997). Edwards (2003) breaks social capital down into an objective or structural aspect such as physical infrastructure; an intersubjective aspect such as shared community values; and an internalized or cognitive aspect of people’s own attitudes and beliefs. Morris et al (2008) have explored how this idea may apply to families experiencing multiple adversities and suggested how it may inform intervention:

‘Families experiencing multiple disadvantage may typically face deficits in relation to structural, intersubjective and cognitive aspects of social capital – so effective strategies to address their situation may need to be pitched so as to engage simultaneously with all of these. This suggests a ‘twin-track’ approach combining interventions to develop social capital and open up access within the wider community with strategies to engage directly with families around the attitudes and skills – and the underlying belief systems – that they may need in order to engage effectively with whatever resources and opportunities may be out there for them. This may involve acknowledging any negative (and self-excluding) messages that they may have internalised on the basis of their previous relationships with the wider community and professional services’ (p 22).

Again there are clear overlaps between these models as this application of social capital is explicitly drawing on psychological and social processes to help explain how a family may be experiencing adversity.

**Integrated models**
The distinction between the bio-medical, psychological and social models is helpful to clarify each approach, and in practice all are important. There have been a number of integrated models developed to try and convey the complexity and range of factors and processes involved. One simple model for understanding complex processes is Donabedian's (1966; 2005) inputs/structures, processes, outcomes model. It was devised to consider the inputs and processes that may be important in health outcomes but it can also be applied across other outcomes.
Engel’s (1977) biopsychosocial model was an early expression of the need to move beyond the traditional biomedical approach and, drawing on systems theory, he argued that the social psychological and behavioural aspects of what is happening also need to be considered. Zubin and Spring (1977) also provided a very clear model for understanding that a range of factors may be important and this may vary between people and across time and contexts. Their stress vulnerability model suggests that for people who have a relatively low vulnerability to stress (and this could be for any combination of bio-medical, psychological and social factors), a relatively low level of multiple adversities may lead to negative outcomes (Read et al, 2005).

Another model which concisely communicates the range of factors that may impact on families’ trajectories through life is McDermott’s (2004) developmental model. Again it enables the possible influence of the full range of factors to be considered and, importantly, highlights the possible impact of adversities in the ante-natal period.

Source: Donabedian (1966, 2005)
Figure 5: Stress vulnerability model

Source: Zubin and Spring (1977)

Figure 6: McDermott’s developmental model

Feinstein et al’s (2004) intergenerational model was developed to understand how educational success may be transmitted across generations and it focuses on the interactions between parents and children but it also brings in the wider social and family factors that may be important.

Sabates and Dex (2012) have also drawn on systems theory to help understand the complexities of the processes involved. They use Bronfenbrenner’s (1979; 1986) ecological model of human development to distinguish between proximal factors which are the primary and immediate processes for influencing development in the day-to-day life of a child such as parent-child relationships, and distal factors in the immediate and wider context such as the school, community and wider socio-economic environment. They conclude that ‘the child is therefore at the centre of a set of proximal and then ever extending concentric circles of distal interacting relationships’ (p 5).

Finally, Shonkoff et al (2012) have developed an ecobiodevelopmental framework to inform the development of early childhood policies and services. This builds on Bronfenbrenner’s ecological model, combining it with a biodevelopmental framework developed by Shonkoff (2010) to offer an integrated, science-based approach to coordinated, early childhood policy making and practice across sectors. Again it demonstrates how factors across all the models discussed may be important in how multiple adversities impact on families.

Figure 7: Feinstein et al’s intergenerational model

A final consideration is about the theoretical ideas specifically about the impact of multiple adversities. Spratt (2011a) in discussing why multiples matter considers two theories. One is that there is a multiplication or exponential impact of adversities as supported by Rutter’s (1979) finding that having two risk factors was associated with a four-fold increase in mental health problems and having four risk factors was associated with a tenfold increase. Other studies, including the ACE studies (Felitti et al, 1998) suggest a more linear or graded, dose-effect impact of adversity but these tend not to measure the severity of the outcome just the presence or absence of it.

It would make intuitive sense that there may be a key point, depending on all the factors we have considered, that a family’s resources may no longer protect them against adversities and a negative cycle develops of impact across the inter-related domains. This process may vary widely across families, contexts and time.

Figure 8: Shonkoff et al’s ecobiodevelopmental framework

Source: Shonkoff et al (2012)
Summary: Theoretical models of how adversity impacts on outcomes

Understanding how adversity impacts on families and outcomes is central to informing the development of effective interventions. As such an array of theoretical models have been developed to address this, both uni-disciplinary and integrated. The uni-disciplinary models discussed in this chapter focus on biomedical, psychological and social processes to explain the impact of adversity on outcomes. From the biomedical perspective, establishing a causal link between genes and negative outcomes has remained elusive. However, neurodevelopmental models offer a more sophisticated explanation of the impact of adversity, highlighting a symbiotic interaction between biology and the environment in the early years of life. Neurodevelopmental models overlap with psychological models through developing our understanding of how psychological responses such as hyper-arousal and dissociation emanate from the biological changes in the brain which may occur as a result of exposure to trauma. Related to this is the concept of ‘toxic stress’, the idea that prolonged exposure to stress hormones can impact and impair brain functioning in a variety of ways, in extreme cases resulting in the development of a smaller brain.

A key concept considered important to psychological models is attributional style, the way in which people explain to themselves why they experience a particular event, either positive or negative. Developed in relation to depression, the central concept of attribution theory is that attributing uncontrollable bad events to internal, stable, and global factors leads to poor mental health. Attachment theory, another key psychological model, considers a child’s early relationships, especially those with carers, to be central to child development and outcomes, having a far reaching influence on subsequent relationships and how children view themselves, the world and other people. Again there is a strong overlap with neurodevelopmental theories, indeed, neurodevelopmental models can be viewed as providing an integrated biological and psychological model through which the role of attachment is further explained and developed.

In contrast with psychological models, social models, as the name suggests, rely on the relationship between the individual and the wider society to explain the impact of adversity of outcomes, although, as with biomedical and psychological models, some overlap is apparent. Social constructionist approaches emphasise the role of the social forces and power relations in developing people’s understanding of the concepts of trauma and adversity. Similarly, a societal response perspective stresses the importance of how experiences of adversity are framed by both the people involved and the wider society, while social causation suggests that the stress caused by negative social factors such as poverty, racism and unemployment has a direct impact on outcomes.
While biomedical, psychological and social models tend to focus on the processes leading to negative outcomes, there are a range of other models that take a more positive view of the possible processes. The concept of resilience is a core element of the adversity literature that, while still acknowledging the strong association between multiple adversities and negative outcomes, focuses on the reasons why all families do not experience the same negative outcomes. The literature identifies a range of protective factors including: positive relationships, which provide security, support, positive reinforcement and modelling; high expectation messages; opportunities for participation and contribution; experiences before and after the experience of adversity; differing genetic and physical responses to adversity as well as the wider environmental context in which adversity occurs. Arguably the concept of social capital is another way of framing the idea of resilience, although this tends to focus more on contextual and environmental factors than individual factors.

While there are obvious overlaps between the biomedical, psychological, social and resilience based models, no one theoretical model offers a complete understanding of all the issues involved. As such, the emergence of integrated models to take account of the complexity of processes and range of factors is an important development. While there are a wide variety of models, some developed to look specifically at the role of stress (Zubin’s stress vulnerability model), the impact on educational outcomes (Feinstein’s intergenerational model) or certain developmental periods (McDermott’s developmental model), they all share the aim of uniting diverse fields of inquiry to better understand the broad spectrum of factors which may impact on human development. Bronfenbrenner’s ecological model, based on systems theory, is the most well known and widely adapted of these models and forms the foundation for a number of the integrated models described. The ecological model provides a whole system approach to understanding the complex and inter-related relationships between the individual and their family, the community and the broader society of which they are part.

A particularly interesting development has been the combination of the ecological model with a biodevelopmental model to provide an ecobiodevelopmental framework for considering the development of early childhood policies and practice. This takes account of national policies and programmes, caregiver and community resources, the physical and relational context in which families live together with the individual biological and environmental influences which can impact on health and well being.
Chapter 4: Impact of adversity across outcomes

Chapter 1 explored the definition and prevalence of families experiencing multiple adversities, highlighting the connection made by both the Millennium Cohort Study and the Family and Children Survey between multiple adversity and poorer outcomes for children. This chapter examines in greater depth the literature associating adversity with negative outcomes across a range of domains, looking at what is known about the cumulative effect of multiple adversity as well as the specific areas of:

- mental health and social functioning
- physical health
- offending.

The economic impact of childhood adversities is also considered.

Cumulative effect of adversity

It is important to note that, as with prevalence data, the majority of studies cited in this chapter do not address the full range of multiple adversities that a family may experience. Similarly they do not consider all the different types of processes that may mediate between adversity and outcome or consider the range of possible outcomes. Davidson et al (2010) have previously identified this deficit in our current understanding: ‘studies have tended to focus on specific forms of adversity, predominantly abuse and neglect, and either: specific populations and specific outcomes; specific populations and general outcomes; or general populations and specific outcomes. This means there may be incomplete understanding of the inputs (the range of adverse experiences in childhood), the processes (how these may affect people) and the outcomes...across domains’ (p 369).

Nonetheless, research focused on specific aspects of inputs, processes and outcomes for families experiencing multiple adversities does contribute to providing an overview of the factors and possible relationships involved.

Building on this work, there are also a number of large scale studies that have attempted to investigate a range of adversities and outcomes. As discussed in the introduction, the US ACE study (Felitti et al, 1998; Dube et al, 2003), has made a huge contribution to our understanding of the impact of multiple adversities. The ACE study established a strong; graded relationship between the number of categories of childhood exposure and adult health risk behaviors and diseases. Adverse childhood experiences tended to be interrelated rather than occurring independently (Dong et al, 2004), with 87 per cent of respondents who had one adverse childhood experience reporting at least one other.

Likewise in the UK, the 1958 and 1970 Birth Cohort Studies have been used to investigate the consequences of exposure to multiple risks; with various studies showing that early
exposure to multiple risks in childhood has cumulative effects throughout the life course influencing both behavioural adjustment during childhood, psychosocial functioning and educational achievement (Schoon et al, 2003; Schoon, 2006). Analysis of the Family and Children Survey, used to inform the Social Exclusion Taskforce’s (2007a) Think Family review, also reported a clear relationship between the number of parent-based disadvantages that families experience and outcomes for children. Families experiencing multiple disadvantages were more likely to:

■ be rated by their parents as well below average in English and mathematics
■ have been suspended or excluded from school
■ to have poor social networks
■ to have been in trouble with the police than children from families with fewer or no family disadvantages.

More recently, MCS data has been used to explore association between exposure to risk for children under one year old and outcomes at the age of 3 and 5 (Sabates and Dex, 2012). The results indicate that being exposed to two or more risks in the first year of life is likely to disadvantage children’s cognitive and behavioural development as they grow up. Although both low income and the experience of other risks in the family were found to be important for child development, the problems associated with compounding risks were more important. Sabates and Dex (2012) conclude that ‘the greater the number of risks experienced by the child, the greater the problems that the child will face during the life course’ (p 22).

A recent systematic review (Jacobs et al, 2012) of research into patterns of clustering of adversities suggested that although most studies (11/12) did identify that adversities clustered in predictable ways, there was inconsistency across the studies which perhaps reflects the complexity of the factors involved.

Impact on mental health and social functioning

Focusing on more specific outcomes areas, an array of studies have explored the associations between various adversities and mental health and social functioning. Social functioning is defined broadly to include relationships and parenting:

Sabates and Dex (2012) have highlighted the central issue, that ‘children living in families with multiple risks are more likely to have long-term disadvantageous cognitive and behavioural consequences’ (p 22). In an early literature review in this area Browne and Finkelhor (1986) examined 28 studies on the effects of childhood sexual abuse. Although they identified methodological issues with many of the studies, they also found that the most common reported impacts included depression, self-harm, anxiety, social isolation, stigma, low self-esteem, relationship difficulties and substance misuse. In response to the early focus on
sexual abuse in the literature, Mullen et al (1996) conducted a community survey of women to identify histories of physical, emotional and/or sexual abuse. They concluded that a history of any form of abuse was associated with increased rates of psychopathology, sexual difficulties, decreased self-esteem, and interpersonal problems (Mullen et al, 1996).

In the US, ACE study adults who had been exposed to four or more categories of childhood adversity had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression and suicide attempt, compared to those who had experienced none (Felitti et al, 1998, p 245). Min et al (2007, p 833) reported that 'as many as 62%–81% of adult women in drug treatment have been victimized by childhood abuse and neglect compared to general population rates of 26%-30%'. Cumulative adverse experiences, including negative life events and early childhood adversity, together with parental depression and/or non-supportive school or familial environments, have also been shown to place young people at risk of developing depression (Burns et al, 2002) and it is reported that anxiety disorders in adolescents are also related to early stress (Phillips et al, 2005).

Estimates suggest that depression may affect as many as one in five people at some point in their lives (Royal College of Psychiatrists, 2011a) and anxiety around one in ten (Royal College of Psychiatrists, 2011b). Psychosis is less common with schizophrenia and bipolar affective disorder, both affecting approximately one in a hundred people at some point in their lives (Royal College of Psychiatrists, 2011c and d). In a review of the literature on childhood trauma and psychosis, Read et al (2005, p 330) reported that symptoms usually associated with psychosis, especially hallucinations, 'are at least as strongly related to childhood abuse and neglect as many other mental health problems'. They reviewed 46 studies of women (n = 2604) who were using mental health services and found that 69 per cent had been subjected to sexual abuse, physical abuse or both in childhood. They also considered 31 studies of male service users (n = 1536) and found that 59 per cent had been abused. The review also highlighted that recent large scale general population studies indicate the relationship is a causal one, with a dose-effect. While it makes intuitive sense that adverse experiences in childhood would have a negative impact on [people’s] mental health, the strength of these findings is striking.

Another key issue in relation to mental health is the association between multiple adversity and suicide which is an especially important issue in the NI context where rates have risen alarmingly over recent years, especially among young people (Northern Ireland Statistics and Research Agency, 2012). As Van Heeringen (2001) has stated, there is evidence that for a significant proportion of young people who die by suicide, it follows a long process of negative life events that increase their vulnerability and decrease their ability to cope. Factors such as social and
educational disadvantage, childhood and family adversity; psychopathology; individual and personal vulnerabilities, exposure to stressful life events and circumstances, and social, cultural and contextual factors have been identified as contributing to increased risk (Beautrais, 2000):

‘Frequently, suicidal behaviours in young people appear to be a consequence of adverse life sequences in which multiple risk factors from these domains combine to increase risk of suicidal behaviour’ (p 420).

Within the family, some of the specific adversities associated with suicide include: low levels of family support; living in a house where there is domestic abuse and/or drug and alcohol misuse; family conflict; difficult transitions; breakdown of intimate relationships; exam failure; severe punishment; sexual abuse; traumatic loss; and exposure to suicidal behaviour (Roy and Janal, 2005). In the wider context, social isolation (Van Heeringen, 2001) and a lack of positive experiences in school (Schoon, 2006) are also important; although, as Beautrais (2000) acknowledges, positive family factors may provide important protection both against mental health problems and suicide.

The research literature also establishes that the impact of early adversity may continue throughout a person’s life. McLaughlin et al (2010), in their analysis of a US national co-morbidity study, highlighted the ongoing significance of childhood adversities at every stage of the life course. Wethington and Ganzel (2004) analysed data from three national studies of people aged 40-93 to explore the relationship between a history of adversity across the life course, life events and depression. They suggest that childhood adversity undermines the ability to adapt to stressors and the accumulated ‘load’ decreases the ability to use social and personal resources to cope.

As considered in the discussion about theoretical models of how multiple adversities impact, it may be that there are important mediating processes between adversity and mental health outcomes. In considering the association between childhood sexual abuse and adult depression, Whiffen et al (2000) suggested that the main mediating factor may be interpersonal problems. In other words, it could be the interpersonal or relationship difficulties that people who experienced childhood sexual abuse may develop that often increase the risk of depression. Angst et al (2011) reported that childhood adversities are risk factors for the chronicity or persistence of both uni and bi-polar depression but also suggests that this risk may be mediated partly by anxious personality traits, poor coping skills and low self-esteem.

Frederick and Goddard (2008) in their qualitative study of people who had experienced childhood adversity reinforce the importance of the impact of these experiences on attachment and so future personal and social relationships which are central to mental health. Doucet (2002) also reported that:
‘childhood adversities do have persistent, long-term effects on relationship experiences, partly because of compromised adolescent relationships and functioning’ (p 5995).

A key aspect of the potential impact of adversity is on parenting. Kerr et al (2009) refer to the evidence that patterns of parenting and discipline that parents use with their children can be at least partly predicted by their own experience of being parented. In relation to people who were sexually abused in childhood, Barrett (2009) found they reported significantly lower rates of parental warmth, higher rates of psychological aggression, and more frequent use of corporal punishment than mothers who had not experienced childhood sexual abuse. These effects, however, were non-significant when sociodemographic factors and other forms of childhood adversity were considered. Rikhye et al (2008) also found that the impact of childhood adversity on quality of life in adulthood appears to be associated with the quality of paternal care and whether the person has experienced depression.

**Impact on physical health**

Marmot and Wilkinson (2006) argue that there is evidence for the role of social factors or determinants in most causes of physical health problems. The ACE study provides an excellent example of this evidence and a summary of its findings was included in the World Health Organisation’s (WHO) (2006) *Preventing child maltreatment: a guide to taking action and generating evidence* (see Text Box 1). Bonomi et al (2008a) focused specifically on the impact of adversities on women’s health and reported that:

‘those with a history of physical and/or sexual child abuse experience a range of adverse health outcomes in adulthood, including cardiovascular symptoms, impaired physical function, pain, gastrointestinal symptoms, gynaecological disorders, depressive disorders, and psychosomatic symptoms of anxiety, panic, or post-traumatic stress disorder’ (p 693).

**Text Box 1: The Adverse Childhood Experiences (ACE) Study**

‘The Adverse Childhood Experiences (ACE) study, in which some 17,300 middle-aged, middle-class and mostly employed residents of the state of California participated, suggests that childhood maltreatment and household dysfunction contribute to the development – decades later – of the chronic diseases that are the most common causes of death and disability in the United States. The study examined the long-term effects of maltreatment and household dysfunction during childhood, including: psychological, physical and sexual abuse; violence against the mother; and living with household members who were either substance abusers, mentally ill or suicidal, or else had been in prison. A strong relationship was seen between the number of adverse experiences (including physical and sexual abuse
in childhood) and self-reports of cigarette smoking, obesity, physical inactivity, alcoholism, drug abuse, depression, attempted suicide, sexual promiscuity and sexually transmitted diseases in later life. Furthermore, people who reported higher numbers of negative experiences in childhood were much more likely to exhibit multiple health-risk behaviours, which the study suggested were adopted as coping devices. Similarly, the more adverse childhood experiences reported, the more likely the person was to have heart disease, cancer, stroke, diabetes, skeletal fractures, liver disease and poor health as an adult. Maltreatment and other adverse childhood experiences may thus be among the basic factors that underlie health risks, illness and death, and could be identified by routine screening of all patients’ (WHO, p 12).

As discussed in Chapter 3, there may be a number of processes by which adversity leads to physical health problems. The ACE study has suggested two possible mechanisms (Felitti and Anda, 2010). The first is that people’s responses to adversity, such as smoking and substance misuse, may increase their risks of physical health problems. The second is that childhood adversity may create sufficiently high and long-lasting levels of stress to have a direct impact on people’s physical health and well-being.

Brunner and Marmot (2006) reinforce the importance of stress by arguing that living in stressful situations, such as with parental substance misuse or domestic violence, results in high levels of stress hormones over prolonged periods which affects people’s cardiovascular and immune systems. Perry (2002) has argued that the stress caused by early trauma and adversity can lead to disruption in the processes of neurodevelopment in childhood, which may require a range of therapeutic interventions to address. People’s physical health may also be affected indirectly, for example if adversity has made relationships, education and employment more difficult, then a person may be more socially isolated, unemployed and less active (Bartley, 1994). There may also be specific impacts which could have a general negative impact on health, for example, Koskenvuo et al (2010) have found a strong association between childhood adversities and people’s quality of sleep in adulthood. Kiecolt-Glaser et al (2011) reinforce that the impact of growing up in a family experiencing multiple adversities persists into later life:

‘adverse childhood events are related to continued vulnerability among older adults, enhancing the impact of chronic stressors. Childhood adversities cast a very long shadow’ (p 16).

Impact on offending
Currie and Tekin (2006) report that childhood abuse and/or neglect approximately doubles the probability of committing many types of crime. Similarly Farrington (2007), in his review of the literature on childhood
risk factors for offending, also reported that children who have been physically abused or neglected are more likely to become offenders later in life. McCord (1983) found that approximately half of the boys identified as having been abused and/or neglected had been convicted of a serious offence, developed alcohol and/or mental health problems, or had died before age 35. Johnson et al (2006) found that, in their stratified probability sample of one hundred men in jail in Texas, 59 per cent reported experiencing some form of contact sexual abuse during childhood. Lee et al (2002) also reported that childhood emotional abuse and family dysfunction, childhood behaviour problems, and childhood sexual abuse were found to be risk factors for sex offending.

Stewart et al (2008, pp 60-1) have focused more on the impact of the timing, severity and type of abuse and/or neglect on offending outcomes. Their research found that school transitions, when children either commence school or move from primary to secondary school, are times when children are likely to experience maltreatment. They also found that ‘maltreatment trajectories were significant predictors of juvenile offending’, specifically children who experienced chronic maltreatment and/or maltreatment that started or extended into adolescence were more likely to offend. Equally a survey of a student population (Duke et al, 2010) found that each type of adverse childhood experience was significantly associated with adolescent interpersonal violence, self harm and suicide attempt, while a parent being imprisoned has been highlighted as a strong risk factor for mental health problems (Murray and Murray, 2010).

Murray and Murray (2010) suggest that this increased risk of offending may be because of the impact on attachment, economic difficulties, stigma, reduced supervision and support. Similarly, in their review of the main theories that have been developed to explain the relationship between childhood adversity and subsequent offending, Brezina (1998) identified three main theoretical frameworks. The first focuses on the impact on attachment and bonding and the subsequent difficulties establishing positive relationships which may have prevented offending. The second emphasises social learning and suggests that children may also learn and repeat the abusive and offending behaviour of parents. A third possible process is that childhood adversities generate negative emotions, such as anger and resentment, which make offending, such as domestic and sexual violence more likely (Anda et al, 2006).

**Economic impact**
The need to consider the economic impact of families experiencing multiple adversities has been argued recently by Barclays Wealth (2011) who stated that: ‘not only are these families costly to support in the short term, they also carry a high future cost, because growing up in a family with these problems compromises children’s futures. It places them at risk of going into care, youth offending, poor mental health, substance abuse,
low qualifications and unemployment – problems that are themselves very costly. The relationship between parental disadvantages and children’s difficulties is clear: Children from families experiencing five or more disadvantages are eight times as likely to be suspended or excluded from school and ten times as likely to be in trouble with the police’ (p 16).

A key issue for the prioritisation of this area in social policy is the estimated economic impact of childhood adversity. While the economic evaluation literature is extremely scarce (Corso and Lutzker, 2006; Currie and Tekin, 2006), there have been some attempts to estimate the costs of families experiencing multiple adversities. However, before considering those estimates it is important to consider the processes which may lead to economic impacts. An initial factor is that childhood adversities are associated with lower cognitive ability in childhood and adolescence (Richards and Wadsworth, 2004; Frederick and Goddard, 2007), and, presumably related to this, with poor outcomes in education (Vargas, 2010), both of which would have implications for employability and longer term engagement with the labour market.

The range of negative outcomes discussed in this chapter, across mental health, social functioning, physical health and offending, will also have direct and indirect costs associated with them, most notably from the cost of increased health and social services use and the indirect loss of productivity and need for support. Walker et al (1999) found significantly higher primary care and outpatient costs and more frequent emergency department visits among women with sexual abuse histories than those without. Likewise, a study of 3333 women members of a health care provider (Bonomi et al, 2008b) found significantly higher annual health care use and costs for women with a child abuse history, while the ACE Study (Anda et al, 2008) found that the presence of child adversities substantially increased the number of prescriptions and classes of drugs used for as long as 7 or 8 decades after occurrence. The ACE study also showed that the increase in prescription drugs was largely mediated by documented ACE-related health and social problems (Anda et al, 2008).

Canadian research (Tang et al, 2006) has also suggested four main pathways for higher health and social care use, through:

- higher levels of mental health problems
- increased risk behaviours such as smoking, substance abuse and risky sexual behaviour
- increased physical health problems
- increased risk of traumatic experiences in adulthood directly and indirectly requiring health service use.

Estimates of the economic costs of childhood adversity in Canada in 1998 (Bowlus et al, 2003) across the criminal justice system, social services, education, health, employment and
personal costs produced a figure of $16,000,000,000 (the current equivalent of £9,000,000,000). The authors argued that investment in social services did not reflect the level of costs to the individuals involved and to society, especially in terms of lost productivity, concluding that: ‘well-planned and thoughtful investment of significant public funds in early detection, prevention and treatment of all forms of child abuse is not only a moral necessity for Canadian society, it is also sound fiscal policy that would directly benefit us all’ (p iv-v).

In the USA, Wang and Holton (2007) also estimated the costs of childhood abuse, using the costs of hospitalization, mental health care, child welfare services, law enforcement, special education and lost productivity. They suggested that in 2007 the direct costs were $33,000,000,000 and the indirect costs were $71,000,000,000, giving an annual total of $104,000,000,000 (the current equivalent of £75,000,000,000).

In the UK, Barclays Wealth (2011) have also estimated the costs of the 2 per cent of families experiencing multiple adversities identified in the Social Exclusion Taskforce’s (2007b) report Families At Risk: Background on families with multiple disadvantages. They estimated that the 140,000 families with multiple problems, such as substance abuse, worklessness and poor health, cost society around £12bn a year in health and social services, and benefits. Children growing up in such families are severely disadvantaged in terms of educational attainment, life skills and future prospects, and are also likely to carry significant costs to society in the future. On this basis, the report presents strong economic evidence for the importance of early intervention.

Summary: Impact of adversity across outcomes

As with prevalence data, there are still significant gaps in the literature with the majority of research studies either focusing on specific rather than multiple adversities, and/or specific rather than multiple outcomes. Nonetheless, a number of large scale US and UK studies investigating a range of adversities and outcomes show a strong relationship between the number of adversities experienced in childhood and health, educational, behavioural, psychological and emotional outcomes. This cumulative effect occurs throughout the life course influencing both childhood and adult outcomes. For example, the US ACE study found that those who experienced four or more adversities in childhood had 4-to 12-fold increases in risks of alcoholism, drug abuse, depression, and suicide attempts in adulthood.

Negative impact on mental health and social functioning was also a common finding from studies examining the impact of specific adversities, in particular...
sexual abuse. This was linked to increased risk of depression, self-harm, anxiety, social isolation, stigma, low self-esteem, relationship difficulties and substance misuse. Family factors such as stress in childhood, parental depression, non-supportive familial environments, family conflict and exposure to abuse or trauma were associated with suicide and depression. Poor physical outcomes were also highlighted as a common outcome of multiple childhood adversity with the ACE study demonstrating a link with a range of chronic diseases that are the most common causes of death and disability in the United States, including heart disease, cancer, stroke, diabetes, skeletal fractures and liver disease. Abuse or neglect in childhood was also strongly associated with increased risk of offending behaviour and interpersonal violence.

Building on our understanding of the theoretical models discussed previously, a number of studies seek to clarify the processes that mediate the impact of adversity on outcomes. Some consider that a person’s exposure to multiple adversities undermines their ability to adapt to stressors and decreases their ability to use social and personal resources to cope, resulting in increased risk of poor mental health. Others suggest that, for sexual abuse victims, the main mediating factor may be resulting attachment and interpersonal problems which increase the risk of depression, yet others suggest that this risk may be mediated partly by anxious personality traits, poor coping skills and low self-esteem.

Two possible mechanisms for physical health problems resulting from multiple childhood adversity include the adoption of coping mechanisms such as smoking and substance misuse; and multiple adversities causing sufficiently high and long-lasting levels of stress to have a direct impact on a person’s physical health and well-being. In relation to the risk of offending, three main theoretical frameworks have been identified as: those which focus on the impact on attachment and bonding; those which emphasise social learning; and those which argue that childhood adversities generate negative emotions which make offending and violent behaviour more likely.
Chapter 5: UK policy context

The introduction of the Children Act 1989 in England and Wales, the Children (Scotland) Act 1995 in Scotland and the Children (NI) Order 1995 in NI broadened the remit of statutory social services, placing a clearer duty on local authorities to provide support to children in need. This legislation sought to strike a balance between family support and statutory child protection by reducing the likelihood of family crisis, breakdown and abuse, whilst at the same time ensuring that children requiring safeguarding from harm were protected. In reality, however, child protection concerns often remained to the fore (Devaney and Spratt, 2009).

Following the introduction of this legislation across the UK, successive legislative and policy developments have focused on bridging the divide between preventative and reactive services, aiming to integrate services to families and promote more holistic approaches to service delivery. The key policy trends and developments in each of the four UK nations are considered in this chapter.

**England**

As identified, a key impetus behind the Children Act 1989 was to develop services for children in need as well as those at risk of abuse. While the introduction of this legislation initially appeared to result in declining numbers of children coming into care or being placed on the child protection register, concerns emerged over the development of family support services (Aldgate and Tunstill, 1995). It was suggested that continued prioritisation of child protection work was stifling the Children Act’s emphasis on family support and partnership, a situation reinforced by scarce resources. The report, *Child Protection: Messages from Research* (Department of Health (DH), 1995) suggested that a narrow focus on investigating abuse allegations often resulted in the child’s wider development and well-being being overlooked. Where abuse was not substantiated, access to families support services was limited, even when the children’s needs appeared to warrant them. To address these concerns, the DH strategy ‘Supporting Families’ was launched in 1998. This policy introduced an expanded role for health visitors and launched the now familiar UK wide initiative, Sure Start, aimed at giving a better start to children aged 0-4 years, living in areas of deprivation. It also formed the basis for establishing a new national parent helpline (Parent Line) and setting up the National Family and Parenting Institute that, between 2004-2011, managed £40 million through the Parent Fund to grassroots organisations across the country who, in turn, supported the most vulnerable families in their communities.

The tragic death of Victoria Climbié and the resulting inquiry report (Laming, 2003) saw further development in broadening the focus of intervention from child protection to safeguarding.

‘child protection cannot be separated from policies to improve children’s lives as a whole. We need to focus both on the universal services which every child uses, and on more targeted services for those with additional needs’ (p 5).

The policies set out in the Green Paper outlined a framework for services covering children and young people from birth to 19 living in England. Key aims were to reduce the numbers of children experiencing educational failure, engaging in offending or anti-social behaviour, suffering from ill health, or becoming teenage parents. Early intervention at the onset of problems, improved information sharing through the development of a common assessment framework and the introduction of a lead professional to co-ordinate service delivery were central concepts to achieving this. Professionals were encouraged to work in multi-disciplinary teams based in and around schools and Children’s Centres in order to provide a rapid response to the concerns of frontline teachers, childcare workers and others in universal services.

The introduction of the Children Act 2004 saw the creation of Local Safeguarding Children’s Boards and Children’s Trusts to facilitate the integration of services, acknowledging both difficulties with co-ordination and communication, but also that families experiencing multiple adversities were often in contact with a wide range of service providers. The National Service Framework for Children and Young People and Maternity Services (Department of Health, 2004), reinforced the key priorities of the Every Child Matters agenda, emphasising the ‘importance of assessing the needs of children and young people and intervening early’ (p 13).

The idea of working with families who are experiencing multiple adversities and who are therefore involved with multiple services and systems took on greater policy significance with publication of the Families at Risk Review, Reaching Out: Think Family (Cabinet Office Social Exclusion Task Force, 2007a). The report sought to build on the reforms introduced under Every Child Matters and focused on the small, but significant, minority of around 2 per cent of families who experience multiple problems:

‘Growing up in a family with multiple problems puts children at a higher risk of adverse outcomes. Families with multiple problems can also exert a heavy cost upon public services as well as the wider community. If we are to reach out to families at risk we need to identify and exploit opportunities to build the capacity of systems and services to ‘think family’’ (p 4).

Service providers and practitioners were exhorted to ‘think family’, to focus
on the strengths and difficulties of the whole family rather than those of the parent or child in isolation. Whole family approaches such as the Family Group Conferencing, the Marlborough Family Service for personal/behavioural problems, intensive therapeutic interventions, Multi-Systemic Therapy (MST) and Family Intervention Projects (FIPs) were highlighted as innovative practice to be developed. Of particular interest, Family Intervention Projects emerged from a separate but related policy initiative, the Government’s Respect agenda launched in September 2005. This aimed to reduce anti-social behaviour (ASB) perpetrated by the most anti-social and challenging families, prevent cycles of homelessness due to ASB and achieve the five Every Child Matters outcomes for children and young people. As part of the Respect Action Plan a national network of FIPs was set up to take an ‘assertive’ and ‘persistent’ style of working to challenge and support families to address the root causes of their ASB.

The second report of the Families at Risk Review, Think Family: Improving the life chances of families at risk (Cabinet Office Social Exclusion Task Force, 2008) provided more direction about how the ‘Think Family’ agenda could be achieved. Service developments to enable this included closer working between children’s and adult services, Sure Start Children’s Centres, Family Intervention Projects, the Family Nurse Partnership Programme, and the Family Pathfinder Scheme which supports Local Authorities to implement new family focused models of working. An early evaluation of the Pathfinder family initiative suggested that:

‘There is a growing body of evidence...which shows that family focused support can be effective in improving outcomes for families with multiple problems, particularly for those who have experienced difficulties in engaging with services previously. Findings...show a range of positive outcomes, including a reduction in family violence, antisocial behaviour, housing enforcement actions, and early signs that this way of working can be successful in getting people back into work. For children a reduction in school truancy, exclusion and a decline in child protection concerns were evident. Early indications also suggest these positive outcomes are sustained for families, post-intervention’ (Kendall et al, 2010, p 1).

Following the death of baby Peter Connolly in 2008, Lord Laming was instructed to conduct a review of child protection procedures. The Government accepted all his recommendations and followed up with an action plan in 2009 (HM Government, 2009) and a progress report a year later (HM Government, 2010). In the progress report they highlighted the work of the new National Safeguarding Delivery Unit to improve co-ordination, stating that ‘it is particularly important that we learn together and across the whole system about new solutions, emerging practice and innovation including:'
the role of universal services in developing comprehensive, inclusive and early support for families, given that this is where people see children and young people day to day, know them well and may be best placed to identify risk factors and provide the support they need

what makes for effective work with families whose children are on the edge of the care system - making best use of the advice from the national task group on the roll-out of family intervention

the potential of developing ‘Total Place’ policies and the impact that local arrangements might have for children, young people and families, including the performance of services, reductions in duplication and inefficiencies

a range of effective interventions and services where there is known vulnerability for children and their families’ (p 3-4).

Following the election in May 2010, the incoming Conservative/Liberal Democrat coalition government asked Professor Eileen Munro, of the London School of Economics, to review all child protection procedures in England on the basis that previous changes had now made the system too bureaucratic and restricted professional initiative and judgement in making difficult decisions. Consequently the three reports of the Munro Review of Child Protection (Department for Education (DfE), 2010, 2011a, 2011b) provided important recommendations for future policy developments. The first report in October 2010 described the child protection system in recent times as one that has been shaped by four key driving forces:

the importance of the safety and welfare of children and young people and the understandable strong reaction when a child is killed or seriously harmed

a commonly held belief that the complexity and associated uncertainty of child protection work can be eradicated

a readiness, in high profile public inquiries into the death of a child, to focus on professional error without looking deeply enough into its causes

the undue importance given to performance indicators and targets which provide only part of the picture of practice, and which have skewed attention to process over the quality and effectiveness of help given.

Munro observes that: ‘these forces have come together to create a defensive system that puts so much emphasis on procedures and recording that insufficient attention is given to developing and supporting the expertise to work effectively with children, young people and families’ (DfE, 2011b, p 6).

The final Munro report highlighted the growing body of evidence on the effectiveness of early intervention with children and families. The ability of preventative services to reduce abuse
and neglect over and above the response of reactive services is emphasised, as is the importance of co-ordinating services and professionals to reduce inefficiencies and omissions. The review recommended that Government:

*place a duty on local authorities and their statutory partners to secure the sufficient provision of local early help services for children, young people and families. This should lead to the identification of the early help that is needed by a particular child and their family and to the provision of an offer of help where their needs do not match the criteria for receiving children’s social care services*’ (DfE, 2011b, p 7).

A related development, and one cited and supported by Professor Munro, is the work of the Early Intervention Review Team who, lead by Graham Allen, have made the social and economic case for early intervention (Allen, 2011a; 2011b). These reports reinforce the overwhelming body of evidence now pointing to the benefits of intervening early in children’s lives, before problems develop, in particular emphasising the first three years of children’s lives as a key opportunity for intervention.

Concern has been raised however about the impact of the current economic climate on provision of early intervention services. A recent study by CIPFA (2011) for the NSPCC in England shows that cuts to children’s social services in 2011/12 are expected to be reduced by an average of 24 per cent, with the services most likely to be cut being those that focus on prevention. The report highlights concerns that deep cuts to discretionary early intervention services may lead to a further increase in the numbers of children in need and looked after children.

The Coalition Government has indicated its intention to fund programmes aimed at tackling families’ complex social, health and economic problems. Amongst the key objectives outlined for children and families in the Coalition’s Programme for Government (May, 2010) was the introduction of new approaches to ‘high need’ families with multiple problems. Partly in response to the riots in England in 2011, it launched the ‘Troubled Families’ initiative aimed at transforming the lives of 120,000 troubled families by 2015 through co-ordinated and intensive support (HM Government, 2012).

Service delivery to families with multiple problems/troubled families will fit within the Coalition’s vision of decentralization towards locally driven approaches, with emphasis on outcomes rather than outputs. Local authorities will receive new funding through Early Intervention Grants and also be given the freedom to pool budgets to provide joined-up, innovative, and responsive solutions to vulnerable families. Building on the approach developed in the FIPs under the last Labour government, the intention is that spending will be better targeted to provide tailored one-to-one support to the whole family, offering personalised and holistic support to
help them overcome the full range of their problems.

**Wales**

A focus on integrated working, early intervention and service development to address multiple and complex needs is a common theme of legislation and policy across all UK nations. However, variation in approach taken is also apparent. To date Wales is the only UK nation to take a legislative approach to the provision of Integrated Family Support Services (IFSS), which are specifically designed to work with families experiencing multiple adversities. The Children and Families (Wales) Measure 2010 established IFSS and they are intended:

> ‘to provide targeted support through multi-agency teams of highly skilled professionals, using evidence based interventions and techniques with children and families where there is some level of risk or welfare concern for the child. The main aim of IFSS is to provide intense support to families to stay together by empowering them to take positive steps to improve their lives. Initially, IFSS is receiving referrals for alcohol or drug dependent parents (or prospective parents) of children at risk or in need. The aim is to extend this service to other families with complex needs resulting from parental mental health problems or mental illness, learning disabilities and domestic violence’ (Welsh Government, 2011, p 6).

The *Families First* programme (Welsh Government, 2011) promotes the development by local authority areas of effective multi-agency systems and support, with a clear emphasis on early intervention and prevention for families, particularly those living in poverty. It reinforces the need to look outside typical organizational boundaries towards integrated working across health, education and social services, in order to meet the needs of families and demonstrate ‘a joined-up, whole system, approach’ (p 5). The policy direction of *Families First* is intended to support the other main relevant policy and service initiatives in Wales, including *Flying Start* (Welsh Government, 2012) which provides support to families with children aged 0-3 in the most socially deprived areas; and the *Communities First* (Welsh Assembly Government, 2007) programme which again targets the most deprived areas and supports people to engage with their community and be involved in service development.

A literature review (GHK and Arad Research, 2011) conducted as part of an early evaluation of the Family First Pioneers (similar to the Pathfinders in England) highlighted some relevant issues of consideration for Families First, including:

- it takes time to develop the detail of change program
- partnerships take time to develop and to embed
- innovation and new ways of working create challenges and workforce development is required to build capacity.

There has been a positive recent evaluation of Integrated Children’s
Centres (ICCs) in Wales (National Foundation for Educational Research, 2010). It concluded that ICCs have a positive impact on children and parents, have been able to develop close links with other services, including local schools, and encourage multi-agency working:

‘Centres encourage dialogues and sharing of good practice between practitioners and different service providers based. This contributes to the quality and effectiveness of the services they deliver’ (p 7).

Scotland

The Scottish Executive’s 2001 report For Scotland’s children: Better integrated children’s services highlighted that every child in Scotland does not have the same starting point, with poverty concentrated in ‘pockets of deprivation’ (p 13). Suggesting that one third of Scottish children begin life in poverty, and that 1 in 10 households is ‘multiply deprived’ and 1 in 100 ‘seriously deprived’, the report (p 73) identified six key action points:

- consider children’s services as a single service system
- establish a joint children’s service plan
- ensure inclusive access to universal services
- co-ordinate needs assessment
- co-ordinate intervention
- target services.

A literature review exploring the evidence base for integrating children’s services in Scotland (Brown and White, 2006) found that most of the literature on integrated working is process rather than outcome focused, with emphasis on the barriers, challenges and key factors for success. Common themes emerging from the literature included concern about funding integrated services; cultural differences between professionals; clarity about roles and responsibilities and the purpose of partnership working; leadership; and organisational climate. The authors recommended that the substantial evidence on the process of integrated working should contribute to further developments in integrating children’s services.

The current Getting it right for every child approach (Scottish Executive, 2008) promotes collaborative, co-ordinated, working based on ten core components:

- a focus on improving outcomes for children, young people and their families based on a shared understanding of well-being
- a common approach to gaining consent and to sharing information where appropriate
- an integral role for children, young people and families in assessment, planning and intervention
- a co-ordinated and unified approach to identifying concerns, assessing needs, agreeing actions and outcomes, based on the Well-being Indicators
- streamlined planning, assessment and decision-making processes that lead to the right help at the right time
consistent high standards of cooperation, joint working and communication where more than one agency needs to be involved, locally and across Scotland

- a lead professional to co-ordinate and monitor multi-agency activity where necessary

- maximising the skilled workforce within universal services to address needs and risks at the earliest possible time

- a confident and competent workforce across all services for children, young people and their families

- the capacity to share demographic, assessment, and planning information electronically within and across agency boundaries through the national eCare programme where appropriate

In a recent guide to implementing *Getting it right for every child* (Scottish Government, 2010), it was asserted that: ‘Getting it right for every child is important because it improves outcomes for all children. It does this by creating a single system of service planning and delivery across children’s services. It helps to create a positive culture of collaborative working, streamlines systems, achieving valuable savings, in time and resources and develops consistently high standards of practice. It builds on research and practice to help practitioners focus on what makes a positive difference to the lives of children and young people’ (p 8).

The Scottish Government’s legislative programme for 2012-2013 includes a Children and Young People’s Bill. While the intention behind this is to achieve a decisive shift towards preventative spending and early intervention, particularly in the early years, the measures proposed are modest. The proposals include a new duty on public bodies to work together to design, plan and jointly deliver their policies and services with a focus on improving child wellbeing. Public bodies will be required to report on the wellbeing of children and young people in their area, through a common set of high level outcomes based on the SHANARRI Wellbeing Indicators (Safe, Healthy, Active, Nurtured, Achieving, Respected, Responsible and Included) which are part of GIRFEC. Arrangements are also proposed to support a single planning process/a child’s plan for those who need it, and the creation of a ‘Named Person’ for every child, from birth to the age of 18. This person will be the single point of contact for young people and/or their parents or carers if they are seeking advice or information, as well as being the first point of contact for other agencies if they have a concern about the wellbeing of an individual young person.

**Northern Ireland**

There has been a range of significant policy developments relating to children and families in NI in recent years. New structures have been developed, such as the Public Health Agency, the creation of a single Health and Social Services Care Board for NI as well as the creation of the Safeguarding Board for
NI. There has been a complete review of the child protection system resulting in new systems to protect the most vulnerable, including the introduction of a universal assessment to be used by all professionals (Understanding the Needs of Children in Northern Ireland (UNOCINI)), as well as the introduction of a strategy for looked after children; Care Matters (DHSSPS, 2007).

Currently in NI, as in other parts of the UK, there is a growing awareness of the importance of early intervention to promote the health and wellbeing of young children. The creation of integrated Children's Services Planning within the context of the 10 year Children and Young People's Strategy, Our Children and Young People (Office of the First Minister and Deputy First Minister, 2006), family support hubs, and proposals to designate NI as an early intervention zone are increasingly driving forward an agenda that is focused on integrated service provision and early intervention. Some concerns have been raised, however, about the impact of the economic climate on provision of early intervention and prevention services in NI. A recent paper by Barnardo's NI suggests that in order to protect vulnerable children in the new public spending austerity, the NI Executive should conduct a strategic, evidence-based review of what is efficient and effective in the delivery of child and family services (Talbot, 2010).

In NI, health and social care structures have been integrated since 1972 and so some of the more recent developments towards providing a fully integrated service have focused on further developing integration with education. The potential of schools as a centre for services and intervention across levels has also been promoted through Extended Schools: schools, families, communities – working together (Department of Education (DE), 2006) and reinforced in Extended Schools – Building on Good Practice (DE, 2010) which focuses on ‘improving educational outcomes, reducing barriers to learning, and providing additional support to help improve the life chances of disadvantaged children and young people’ (p 1).

Integrated health and social care structures, however, do not themselves ensure well co-ordinated, seamless services and the DHSSPS, for example, has funded a three year mental health and children's services project in order to establish a ‘Think Child, Think Parent, Think Family’ approach (Social Care Institute of Excellence, 2009) to planning and delivery of services. This project is aimed at enhancing collaborative working and better understanding of multi-disciplinary roles and responsibilities of all staff working across the adult mental health and child protection interface.

In addition, the Families Matter Strategy (DHSSPS, 2009) is being rolled out and there is a renewed focus on health and social care prevention along with the development of the role of the health visitor, and early intervention work and preventative strategies much more to the fore. The Child Health Promotion Programme
within NI, introduced in 2006, is based on *Health for All Children* (Hall and Elliman, 2006). It has been reinforced more recently by *Healthy Child, Healthy Future*, (DHSSPS, 2010) which is designed to be *A framework for the Universal Child Promotion Programme in NI from pregnancy to 19*, and recognises securing improvements in child health across a range of issues as core to improving outcomes for all children and families. It is predicated on the idea that strong parent/child attachments and positive parenting results in better social and emotional wellbeing. The programme details the universal services to be delivered to all children and their families, including health led parenting programmes and preventative initiatives in pregnancy. Comprehensive assessment of need will identify where additional support and interventions are to be offered. Where this is the case these must be done within clear care pathways, which continue to be developed within the UNOCINI framework. The programme is a universal service that requires a number of set contacts to be made with each family to identify health need, through a holistic assessment that includes screening and surveillance, and where necessary provide early intervention to ameliorate the potential early negative impact of any physical, social or emotional factor. Where early intervention is unable to address need, children/families are escalated to a more progressive level of intervention.

The programme is guided by the following seven principles:

- a focus on the whole child model with an emphasis on improving outcomes for children and young people through integrated planning of services
- major emphasis on parenting support and positive parenting
- the application of new information about neurological development and child development
- changing public health priorities
- an increased focus on vulnerable families, underpinned by a model of progressive universalism
- an emphasis on integrated services
- the use of new technologies and scientific developments.
The framework sets out a clear core programme of child health contacts that every family can expect, wherever they live in NI, recognising that individual families are different and that there is a need to be flexible and innovative to ensure that all families are able to access and benefit from available advice, support and services.

Summary: UK policy context

Family policy has developed rapidly in recent years, with a particular focus on balancing service provision and resources between preventative or early intervention and reactive child protection. Since the election of the Labour Government in 1997 the UK has witnessed an unprecedented level of interest and development in family policy and intervention services. Sure Start was introduced nationally to give a better start to very young children living in areas of deprivation, and ideas about working with families experiencing multiple adversities increasingly emerged. Family Intervention Projects (FIPs), for example, were set up in England to combat ‘antisocial behaviour’ through a multi-agency approach to working with all family members.

Across each of the UK nations, the three key themes of early intervention, integrated children’s services and whole family approaches appear to be consistently identified across the range of policy developments, particularly in relation to families with multiple, complex needs. Rather than the traditional way of working with a parent or child individually, service providers and practitioners are urged to ‘think family’ and address the needs of the family as a whole. Most recently, and building on the FIPs approach, the Coalition government has launched its ‘Troubled Families’ initiative providing targeted and tailored one-to-one support to the whole family.

Some variation in approach across the UK is also evident, for example, to date Wales is the only nation to take a legislative approach to the provision of integrated family support and statutory services which are specifically designed to work with families experiencing multiple adversities. In Scotland the ambition is to embed an early intervention approach, with a focus on the early years by legislative means, through the proposed Children and Young People’s Bill. The increasing drive towards integrated service provision and early intervention in Northern Ireland is evident through Children’s Services Planning and the development of family support hubs. One commonly acknowledged factor in each of the nations is concern around cuts to early intervention and prevention services as a result of the current economic climate, and the potentially detrimental impact this could have on children and families.
Chapter 6: Practice and service provision

As highlighted in Chapter 5, the overlapping and inter-related themes of early intervention, integrated services and whole family approaches have been key drivers in relation to policy development across the UK. Consequently there is a wide ranging body of literature which examines these concepts, identifying elements of practice and service delivery and models of intervention which exemplify each of these approaches. While it is outside the scope of this review to examine each of the relevant studies and reports in detail, there are a number of recent reviews which provide valuable oversight of the central issues. Key findings and discussion points from these are summarised throughout this chapter, together with selected examples of interventions identified in the literature.

**Early intervention**

Although prevention and early intervention have always been central tenets of family and child welfare policy, the publication of Graham Allen and Iain Duncan-Smith’s report on early intervention in 2008 brought these to the fore. Allen and Duncan-Smith argue that:

> ‘it is cheaper and more sensible to tackle problems before they begin, rather than spend ever greater sums on ineffective remedial policies, whether they take the form of more prisons, police, drug rehabilitation or supporting longer and more costly lifetimes on benefits. The philosophy of Early Intervention goes much further than prevention. It is about breaking the intergenerational cycle of underachievement in many of our communities and enabling our communities over time to heal themselves’ (p 4).

They advocate that two crucial aspects of an early intervention approach are to ensure that 0-3 year olds receive the care and support they need and that all young people 0-18 receive the knowledge and support they need to be positive parents; and so create a virtuous cycle of pro-social parents and children who will become parents.

Allen (2011a) has reinforced the rationale for early intervention as the opportunity:

> ‘to make lasting improvements in the lives of our children, to forestall many persistent social problems and end their transmission from one generation to the next, and to make long-term savings in public spending’ (p vii).

Allen (2011a) also provides a range of 72 examples of universal and targeted evidence based on early intervention approaches and highlights 19 that are argued to have the strongest evidence base (see Table 4). In addition, Allen (2011b) recommends the involvement of
providers across sectors to implement early intervention and, controversially, suggests using outcome-based funding as a way of facilitating the process of change:

‘Central government needs to trust the accumulation of evidence that we do have, on many programmes and from many countries, and so model outcomes and likely cashable savings from what we know now. It needs to agree a price that we will attach to children not being in care, to young people not being in the criminal justice system, and to young people having the social and emotional capabilities to hold down good jobs, so that we can reward those companies and investors who deliver this for us. Central government can also hedge its bets by transferring the risk onto providers and investors who, if they want to be paid, then need to make sure that the programme works’ (p 80).

Drawing on recent research reviews and policy documents, the Centre for Social Justice (2011, p 2) has suggested that an effective framework for early intervention would comprise the following six components:

- a commitment to prevention
- priority focus on the early years
- continuing early intervention in later years
- multi-agency systems approach
- high quality of workforce
- investment in programmes that work.

It also argues that an effective framework:

‘requires a focus beyond specific programmes to an overall approach that favours preventing harm before it is done to children, and intervening as early as possible when it is clear they are being failed – or are at risk of it’ (p 12).

Likewise, Statham and Smith (2010) make the important point that it is not simply a case of either or and that families require a continuum of services, from universal to specialist, depending on their needs at different stages throughout the life course. Their review of ‘earlier intervention’ identifies three approaches:

- early years interventions
- earlier intervention as the early identification of problems and additional needs, as well as earlier delivery of services and interventions
- earlier intervention as interventions aimed at reducing exposure to known risk factors or promoting resilience, protective factors and coping among groups at risk of poor outcomes.

As such, earlier intervention can be conceptualised as preventive, protective or therapeutic. Statham and Smith (2010) do caution against the perception of early intervention as a magic bullet to resolve adversity and prevent the ongoing need for services across levels. They point to the work of researchers and academics which has been critical of the concept of earlier intervention...
on the basis that it: involves increased surveillance of families (Parton, 2006); takes little account of the 'significant conceptual and practical hurdles involved' (Pithouse, 2008, p 1537); places too much emphasis upon individual problems and gives insufficient attention to the social and economic conditions that impact on children’s lives (Morris et al, 2008). Likewise Lea (2011) argues that alongside early intervention: ‘there will need to be a focus on remedial measures for adults already down a path of complex need and disadvantage. Work cannot focus purely on the intergenerational cycle of disadvantage - it will also need to address current issues.’

Although Statham and Smith (2010) found limited evidence of earlier intervention specifically producing better outcomes than later intervention, they highlight increasing evidence of the effectiveness of a range of different early interventions currently in use in the UK (see Table 4).

Central to achieving early, or earlier intervention, is accurate identification of those families requiring support. Statham and Smith (2008) highlight the distinction between person-based or family-based targeting and place-based targeting. Sure Start provides a good example of place-based targeting. Developed as an initiative for supporting families within the areas of highest deprivation, it provides universal services across the neighbourhood in which it is located. In relation to person based identification, universal services play a key role in the identification of families or individuals in need or at risk of adverse outcomes. However, this necessarily relies on appropriate assessment of need or risk in the first instance. However, as we have seen in previous chapters, the inter-connectedness of multiple adversities and the interactions between the different factors that can influence behaviour make risk assessment difficult, particularly in relation to early intervention where adverse outcomes have yet to manifest, if indeed, they ever do. The difficulty in identifying accurate risk factors and the high likelihood of false positive hampers both person and place-based targeting.

Text Box 2: Sure Start / Family Nurse Partnership

Sure Start Children’s Centres:
The National Roll out of Sure Start occurred between 2006 and 2010, bringing the total number of centres from 800 to around 3,500. Early assessments of Sure Start programmes showed mixed results, but the more recent evaluations of fully established programmes show more positive effects, with similar positive effects for all children from a range of backgrounds, for example, workless households and teenage mothers (Field, 2010, p 57).

Nurse Family Partnership/Family Nurse Partnership: Developed by Dr David Olds, the Nurse Family Partnership provides intensive visitation by nurses during a woman’s pregnancy and the first two years
Table 4: Examples of early/earlier interventions; interventions for families with complex needs; and whole family approaches

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<td>• Curiosity Corner (as part of Success for All) Early Literacy and Learning Model</td>
<td>• Early Intervention Model</td>
<td>• Friends</td>
<td>• Family Group Conferencing</td>
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<td>• Functional Family Therapy</td>
<td>• Incredible Years</td>
<td>• Social and Emotional Aspects of Learning</td>
<td>• Family Care Planning</td>
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<td>• Incredible Years</td>
<td>• Co-production</td>
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<td>• Let’s Begin with the Letter People</td>
<td>• Multi-Systemic Therapy</td>
<td>• Dinosaur School</td>
<td>• Family Intervention Projects</td>
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<td>• Life Skills Training</td>
<td>• Functional Family Therapy</td>
<td>• Family Nurse Partnership</td>
<td>• SAFE Children</td>
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<td>• Multidimensional Treatment Foster Care</td>
<td>• Family Working</td>
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<td>• Multisystemic Therapy (MST)</td>
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<td>• Nurse Family Partnership (NFP)</td>
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<td>• Project Towards No Drug Abuse (Project TND)</td>
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<td>• Promoting Alternative Thinking Strategies (PATHS)</td>
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<td>• Reading Recovery</td>
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<td>• Ready, Set, Leap! Safe Dates</td>
<td>• Co-located and Coordinated Approaches</td>
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<td>• Systemic and Narrative Family Therapy</td>
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<td>• Safer Choices</td>
<td>• Westminster Family Recovery Project</td>
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<td>• Start Taking Alcohol Risks Seriously (STARS) for Families</td>
<td>• Building Bridges</td>
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and Smith (2010) also note that most interventions target one or a limited number of aspects of risk, ‘and cannot realistically be expected to effectively change the life chances of children or their families experiencing multiple problems.’ Improved integration and co-ordination of services, a central focus of UK policy for more than a decade, has been the primary means by which successive Governments have sought to better address complex and multiple needs and develop early intervention. Whilst highlighting that inter-agency and/or integrated working can mean different things to different people, Brown and White (2006) summarise the concept as all the key agencies providing services to children, including health, social services and education, being co-ordinated across strategic policy, operational guidance and practice.

Integrated services and practice, in particular, has been the subject of an array of research studies and various in-depth reviews. For example, Robinson et al (2008) draws on the findings from studies of integrated working in order to build an overview of the theories and models of integration; and Oliver et al’s (2010) comprehensive review focused on the effectiveness of integrated working, specifically its impact on outcomes.

A report commissioned by the CfBT Education Trust (2010) also examined international perspectives on integrated children’s services in terms of national policy; while the series of evaluation reports produced on behalf of the Local Authority Research Consortium (Lord et al, 2008; Easton et al, 2010) evaluated

Nonetheless, area based interventions such as Sure Start or group based interventions such as Nurse Family Partnership, which targets single mothers, have been shown to be effective. Similarly, Lea’s (2011) review notes that the most effective interventions for addressing multiple needs tend to be those that are targeted at specific populations. Additionally they tend to be intensive, voluntary, maintain fidelity to the original model and work with both parents and children. Lea also specifically highlights Sure Start and Family Nurse Partnership as frequently highlighted within the literature as models of best practice which are key to the delivery of effective interventions (see Text Box 2). Discussed later in this chapter, Nottingham City’s Early Intervention Model is also commonly cited as a model of best practice (Allen 2011a; 2011b; Lea 2011) (see Figure 9).

Integrated children’s services
In addition to difficulties in accurate identification and targeting families at risk of adverse outcomes, Statham and Smith (2010) also note that most interventions target one or a limited number of aspects of risk, ‘and cannot realistically be expected to effectively change the life chances of children or their families experiencing multiple problems.’ Improved integration and co-ordination of services, a central focus of UK policy for more than a decade, has been the primary means by which successive Governments have sought to better address complex and multiple needs and develop early intervention. Whilst highlighting that inter-agency and/or integrated working can mean different things to different people, Brown and White (2006) summarise the concept as all the key agencies providing services to children, including health, social services and education, being co-ordinated across strategic policy, operational guidance and practice.

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the impact of integrated children’s services, the utility of the common assessment framework in supporting integration and the economic case for early intervention supported by the common assessment framework and team around the child model of working.

It is clear from the literature that integration can take many forms and there is no one definition, with terms such as partnership working, joint-working, joined-up working, inter-agency working, multi-agency working, inter-organisational collaboration and collaborative working often used interchangeably (Oliver et al, 2010, Percy-Smith 2006, Sloper 2004). Much of the literature within the field suggests the use of a continuum, with organisations working autonomously within their own boundaries at one end and full structural integration at the other end (Brown and White, 2006). Robinson et al (2008) indicate that integration is multi-layered and that more than one level of integration is needed. Their examination of models of integration focuses on key dimensions such as the extent of integration, the integration of structures, integration of processes, and the reach of integration. Likewise Lord et al (2008) observe that ‘three dimensions of integration recur and can be presented as the following questions for considering progress in integrated children’s services:

- to what extent are we integrated: for example, is it sharing information, coordination, joint management, formal merger?
- at which structural level are we integrated: for example, is it at delivery to service user, at local management or at a whole system level?
- how far is the reach of our integration: for example, what other agencies and sectors are we integrated with?’

Specific outcomes such as the development of joint strategic planning, pooled budgets, co-location of services, the development of co-ordinated multi-disciplinary, multi-agency teams with common goals and a shared understanding of the importance of collaboration, shared IT systems and common assessment tools and guidance have all been cited as indications of movement toward integration (CfBT Education Trust, 2010).

Similarly, Lea (2011) stresses the importance of co-ordinated and integrated practice approaches to meeting the needs of families with complex needs. In relation to frontline services this can involve one of two approaches:

- a co-ordinated approach incorporating a key worker or professional that coordinates work between the family and agencies, acting as a single point of contact (for example, the lead professional)
- a co-located approach bringing together all the practitioners working with a family in one place, alongside a key worker, which facilitates cross-working and joining up understanding (for
example, Team Around the Family/Team Around the Child).

The ‘Team Around the Family’ (TAF) approach used by Westminster Family Recovery Project is highlighted as a particular example of good integrated practice (see Text Box 3).

**Text Box 3: Westminster Family Recovery Project (Lea, 2011, p 68-9)**

Westminster City Council’s Family Recovery Programme (FRP) focuses on treating the root causes of social breakdown rather than dealing only with its symptoms. This ‘whole family’ approach to intervention recognises the interrelationship of the causes and effects of social breakdown. For instance, it recognises that poor housing and parental drug misuse are likely to lead to poor health and a lack of educational achievement for children. The programme has developed an innovative ‘cost-avoidance’ methodology. With the council as the lead partner, the FRP brings together a number of public services, as well as national and local voluntary groups, to share resources, intelligence and expertise and provide a single focus for dealing with the deep-rooted problems suffered by the individual families concerned.

The ‘Team Around the Family’ (TAF) approach consists of a range of different expertise, including adult mental health, substance misuse, housing advice and intensive outreach work to engage hard-to-reach families.

The TAF receives referrals from a wide range of statutory and non-statutory organisations. It acts as a single unit, based in one location, and reports directly to a single operational head. TAF members share information from their respective services in a unique way, overcoming agency barriers to provide coherent and consistent action. Integrated support is provided early to young siblings. The TAF seeks a family’s consent prior to intervention in a clear and commonsense way – except in cases where crime and children’s safeguarding are of critical importance and thus override data protection legislation. It sets clear and achievable goals and is honest about the consequences for those individuals who fail radically to improve their behaviour.

The scheme has been shown to reduce child poverty, antisocial behaviour, truancy, and youth crime, keeping children and young people out of the care system, and getting them back into school and college.

In her recent review of the international evidence on interagency working Statham (2011) concluded that: ‘interagency working is becoming increasingly common in children’s services internationally and is widely regarded as improving the quality of services and support offered to children, young people and their families. There is, as yet, limited evidence on improved outcomes for
children and families from this way of working, but there is promising evidence from many countries on the benefits of a more joined-up approach in improving professional practice and providing better support at an earlier stage for children and families who need it' (p 4).

Oliver et al (2010) also note that direct evidence of effectiveness between service integration and child and family outcomes is limited for a variety of reasons, including fidelity of programmes and initiatives and the evaluation being undertaken before outcomes can be evidenced. Nevertheless, they conclude that interventions that address family problems ‘in the round’, such as marital conflict and parental depression result in improved child outcomes. There is also strong evidence that high quality pre-school provision that integrates childcare and education is associated with improved cognitive and behavioural outcomes for children and that school-based integrated working can bring about measurable improvements in school attendance and reduce school exclusion. Although initiatives taking a multi-agency approach to reduce youth offending and anti-social behaviour have shown mixed results, parents and children tend to report positive impacts in terms of changing attitudes and behaviours that might signal youth crime and anti-social behaviour, and improvements in family relationships and risky behaviour. Promising evidence is also reported for the positive impact on school attendance, alcohol consumption and anti-social behaviour. Studies considering the impacts of integrated working on children with disabilities or mental health difficulties as perceived by professionals and families have overall reported positive results with improved outcomes for children and parents. However findings were mixed regarding parents’ perceptions of the emotional support they receive from professionals working in an integrated way.

While Oliver et al (2010) found limited evidence on the outcomes of key processes associated with integrated working, such as the Common Assessment Framework (CAF), the Lead Professional and Team Around the Child, ‘findings suggest that the trajectory of evidence is moving in a positive direction’. Professionals report that the CAF significantly improved multi-agency working, brought a greater awareness of services for children and families and improvement in the quantity and quality of data collected. Although there is little evidence as yet in relation to Team Around the Child and its outcomes, studies tend to report positive outcomes for children and families as a result of key-working.

Whole family approach
An early example of this approach was the development of ‘wraparound’ services in the US in the early 1980s. These services were designed by all the stakeholders involved, including the family, to develop and implement a
plan to deal with their needs (Walker et al, 2010). The general theme is that families experiencing multiple adversities need a service response that is not fragmented and is able to address all the family’s needs. This has been developed and implemented through initiatives such as SCIE’s (2009) ‘Think child, think parent, think family’ guidance which was aimed at improving the interface between child protection and mental health services.

Morris et al (2008) have reviewed the literature on this theme, identifying three categories of whole family approaches and analysing the associated evidence base:

1. Working with the family to support the service user

- ‘the family is seen as a basis for support for an individual within that family. The focus on other family members is determined by their ability to offer support and assistance.
- service provision seeks to strengthen the ability of family members to offer support to the service user; in some instances through the responsibilisation of family members, or through addressing barriers to the support of the service user within the family setting.
- evidence was also found of attempts to develop further networks of support for the service user within the family and immediate community.

2. Identifying and addressing the needs of family members

- services are developed that address the specific and independent needs of family members so as to maintain or enhance support to the service user, and develop family strengths.
- such services highlight and address previously unidentified needs, often resulting in family members being perceived to be service users in their own right.
- research evidence has highlighted the importance of addressing the individual needs of family members in isolation from the service user.

3. Whole family support

- whole family approaches are seen to offer opportunities to focus on shared needs, develop strengths and address risk factors that could not be dealt with through a focus on family members as individuals.
- this review has illustrated a momentum towards whole family approaches within policy and provision in relation to a number of service user groups, however it has also illustrated that many such interventions are still in their infancy and require further evaluation.
- professional and agency competency in delivering whole family approaches merits review’ (p 5-6).
Lea’s (2011) review of interventions with families with complex needs (see Table 4) highlights key aspects of effective family working. In addition to the importance of taking a whole family approach, she highlights the value of co-produced or co-designed approaches which take on board the views and opinions of families themselves, working with them rather than doing unto them. The importance of taking a strengths-based approach is also emphasised, as is the empowerment of families through developing interpersonal skills and building family resilience to ensure positive change is maintained over time. The role of the wider community and third sector as an important source of information and, potentially, more neutral provider of services is also highlighted, as is the importance of high quality services and staff, intensive one-to-one support and intensive services that ‘stick with’ a family.

An intensive and co-ordinated approach to family support has underpinned the development of Family Intervention Projects (FIPs) and services across England over the past decade. Emerging from Labour’s Respect agenda and now a central plank of the Coalition government’s Troubled Families Unit, FIPs were highlighted throughout the ‘Think Family’ initiative as promising interventions for working with families with complex needs. The £16m Family Pathfinder Programme, announced in the Children’s Plan in 2007, also set out to test and develop the ‘Think family’ approaches through the establishment of fifteen Pathfinders across local authorities in England.

Collectively the Pathfinders focused on conducting family-based and/or joint assessments; delivering intensive, one-to-one support; and minimising the numbers of professionals involved with the family. Integral to this was a TAF approach providing a coordinated and integrated response to families’ needs. The Pathfinders also made use of evidence based and solution-focused approaches related to family functioning and parenting support, including Triple P; Family Group Conferencing; and solution focused therapy. An independent evaluation report (DfE, 2011c) showed significant improvement in outcomes for nearly half (46 per cent) of families supported by the Family Pathfinders and nearly a third (31 per cent) of the families supported by the Young Carer Pathfinders. Savings to local partners were also demonstrated, so that for every £1 spent, the Family Pathfinders generated a financial return of £1.90.

The most recent statistical release for Family Intervention Projects and services (DfE, 2011d) showed between 1 April 2010 and 31 March 2011 local authorities worked with just over 3,000 families, 85 per cent of whom are reported to have left the intervention following a successful outcome (for example, formal sanctions had been lifted). Reductions in truancy, exclusion or poor behaviour in school; anti-social behaviour; child protection issues; domestic violence; mental health problems; drug and alcohol problems and crime were also reported.
However, the picture is not a totally positive one and Gregg (2010) has called into question the reported effectiveness of FIPs and the validity of the annual statistics produced by DfE. He argues that FIPs have targeted ‘the wrong people for the wrong reasons’ and that the measure of success used in FIP evaluations is purely qualitative, largely subjective and even arbitrary. Likewise, Morris et al’s (2008) review of whole family approaches draws attention to difficulties in engaging both professionals and families in the ‘think family’ approaches. They conclude that:

‘International evidence reflects the UK experience of large scale preventative programmes struggling to respond effectively to the needs of families experiencing chronic difficulties – however there is as yet limited documented evidence about successful next steps in preventative family provision… Despite intentions many programmes actually fail to engage with multiple difficulties and multiple ‘players’. There is a need to review the actual take up rates amongst various target populations, and the messages within this for provision’ (p 7).

Based on a small-scale study examining the experiences of highly vulnerable families with complex and enduring needs, and which revealed evident gaps in existing practice, Morris (2012) further suggests there are some difficult practice questions to be addressed. Pointing out that ‘family’ is not always typified by who lives together in the same household, with extended family members often having a significant role in family life, Morris argues that social work must therefore ‘think family’ in new ways through:

‘the development of nuanced practice capable of recognising and working with the ways highly vulnerable families “do family”, and the processes that support and inhibit professional interventions’ (p 1).

Text Box 4: Family Intervention Projects (Lea, 2011)

Family Intervention projects (FIPs) were set up in 2006 as part of the Respect Action Plan to combat antisocial behaviour and aimed to work with families for between six and twelve months. Features critical to successful outcomes have been identified as:

■ recruitment and retention of high quality staff
■ small caseloads
■ having a dedicated key worker who manages a family and works intensively with them
■ a whole-family approach
■ staying involved with a family for as long as necessary
■ scope to use resources creatively
■ using sanctions with support
■ effective multi-agency relationships.

Evaluation of FIPs (DCSF, 2010) shows improved outcomes for families including:

■ 72 % reduction in housing enforcement actions
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- a drop in anti-social behaviour by almost two-thirds
- 58% reduction in truancy, exclusion and bad behaviour at school
- 59% decline in domestic violence
- 47% decline in drug and alcohol problems
- 42% decline in child protection concerns.

Integrated, family focused intervention across the life-course: Nottingham City’s early intervention model

As discussed in this chapter, the literature makes it clear that a co-ordinated and integrated range of services needs to be made available to families throughout the life-course, and at different levels of need and intervention. Nottingham City’s Early Intervention Model is cited by a number of sources (Allen 2011a; 2011b; Lea, 2011) as an exemplar model of evidence based early intervention which delivers a proven suite of interventions that can be applied through childhood and young adulthood.

Nottingham Council and its partner agencies and organisations have committed themselves to a 22-year strategy to help break the cycle of intergenerational poverty and social exclusion. Through an agreed partnership with all relevant agencies working with families and children across Nottingham, the aim is to improve outcomes for children, young people, adults and families who are very likely to experience difficulties and to break the intergenerational cycle of problems in the long-term. The model has been implemented through changing systems and structures to embed the principle of early intervention across the children’s workforce. This has involved the creation of a Core Standard for the children’s workforce to improve consistency of approach, underpinned by the CAF as the central early intervention assessment and planning tool. Based at Sure Start Children’s Centres, Family Community Teams have also been created and offer a range of services, including family support, for those 0 to 19 years.

Sixteen programmes, including Family Nurse Partnership (FNP), have been selected and are being trialed currently. In some cases, as with FNP, interventions came with a strong evidence base of effectiveness, while others, such as the Raising Aspirations project4, were adapted or created to meet the needs identified through a process of consultation with young people, families and service providers. The programmes range from providing help for teenage mums, to supporting survivors of domestic violence. A number are school-based and focus on improving the aspirations and skills of all schools children as well as addressing the needs of children who are in the care of the local authority. Partnership arrangements with the University of Nottingham are helping to facilitate evaluation of the programme and its various strands.

4 The Raising Aspirations project has involved developing an innovative package to raise children’s aspirations in schools, trialing interventions, and producing an aspirations raising toolkit with a unique aspiration assessment tool, all co-produced with deliverers, the University of Nottingham, school staff and pupils.
The Hardiker Model

Hardiker et al’s (1991) four level model of prevention uses the public health approach of primary (universal), secondary (vulnerable/at risk of social exclusion) and tertiary (in need) prevention and adds a fourth level of rehabilitation (after a child is in state care and/or has complex and enduring needs). The model is used in the current regional family and parenting strategy for Northern Ireland, Families Matter (DHSSPS, 2009, p 19) and is also a useful framework to highlight some examples of practice at the different levels which may address the needs of families experiencing, or at risk of experiencing, multiple adversities.

Level 1 – All children and young people

Families experiencing multiple adversities will require a higher level of intervention than universal services, however the provision of services at this level may prevent some of those complex needs arising. Advocates of the Triple P-Positive Parenting Programme (Sanders et al, 2003) have suggested that...
there should be a universal approach to supporting parenting but with a tiered continuum which could respond to even the most complex families. O’Donnell et al (2008) have also advocated for a public health approach to addressing abuse and neglect, reinforcing many of the early intervention arguments.

**Level 2 – Children who are vulnerable**

At level 2, the target population is children who may be vulnerable to becoming in need. There could be a strong economic case for intervention using programmes with vulnerable young mothers such as Family Nurse Partnership (Barclays Wealth, 2011). Vulnerability might also be targeted in areas where there are very high levels of deprivation, perhaps using approaches like the successful Harlem Children’s Zone Project in New York.

**Level 3 - Children in need in the community**

At level 3, the children are already in some form of need. Schools may provide an excellent opportunity to intervene with families across the different levels and address children’s mental health issues; for example, a recent major US meta-analysis (Durlack et al, 2011) suggested that effective social and emotional interventions in schools can have a significant impact.
**Level 4 – Children in need of rehabilitation**

At this level, families will have identified complex needs and children may be in state care. As highlighted above, Lea (2011) has identified some of the recurring themes in the most effective service models for families experiencing multiple adversities. These programmes tend to be targeted at specific populations; intensive; voluntary; maintain fidelity to the original model; and work with both parents and children. Examples of key interventions include the Westminster Family Recovery Project and Family Intervention Projects.

**Summary: Practice and service provision**

There are a number of recent research reviews which provide valuable oversight of the central issues relevant to the key policy drivers and inter-related themes of early intervention, integrated services and whole family approaches across the UK. Reinforcing the rationale for early intervention as the opportunity to break intergenerational disadvantage and underachievement, and make long-term savings in public spending, Graham Allen has identified a number of universal and targeted early intervention programmes in the UK with the strongest evidence base. However, some have argued that an effective framework requires a focus beyond specific programmes to an overall preventative approach that advocates intervention with vulnerable children as soon as risk is identified. Others further caution against the perception of early intervention as a magic bullet to resolve adversity and prevent the ongoing need for a continuum of services to families across different levels.

Improved integration and co-ordination of services has been the primary means by which successive Governments have sought to better address complex and multiple needs and develop early intervention. While recent reviews of integrated children’s services and interagency working have found limited evidence on improved outcomes, there is some promising evidence emerging such as benefits to professional practice and also earlier support to children and families who are in need of it. There is strong evidence that high quality pre-school provision that integrates childcare and education is associated with improved cognitive and behavioural outcomes for children and that school-based integrated working can bring about measurable improvements in school attendance and reduce school exclusion.
It is evident from the research, however, that integration can take many forms and there is no one definition, with terms such as partnership working, joint-working, joined-up working, inter-agency working, multi-agency working, inter-organisational collaboration and collaborative working often used interchangeably. In considering progress in integrated children’s services, it has been suggested that key questions about the extent and structural level of integration, and how far integration reaches, need to be addressed. The importance of co-ordinated and integrated practice in meeting the needs of families with complex and multiple needs has also been stressed, with some suggestion of the need for either a co-ordinated approach incorporating a key worker that coordinates work between the family and agencies; or a co-located approach bringing together all the practitioners working with a family in one place, alongside a key worker.

An intensive and co-ordinated approach to family support has underpinned the development of Family Intervention Projects (FIPs) and services across England in recent years. Illustrating a momentum towards whole family approaches, the general theme of these various interventions is that families experiencing multiple adversities receive a service response that is not fragmented and is able to address all their needs. While some successful outcomes have been reported, other evidence suggests they are struggling to respond effectively to the needs of families experiencing chronic difficulties and require further evaluation.

Achieving early intervention and integrated coordinated services which effectively respond to the needs of families experiencing multiple adversities is a complex and difficult issue. Most interventions target one or a limited number of aspects of risk, and therefore cannot realistically change the life chances of children or their families experiencing multiple problems. Accurate identification of families in need or at risk of adverse outcomes is central to achieving early, or earlier, intervention, but the inter-connectedness of multiple adversities and the interactions between the different factors that can influence behaviour make risk assessment difficult. It has been noted, however, that the most effective interventions for addressing multiple needs tend to be those which are targeted at specific populations. Additionally they tend to be intensive, voluntary, maintain fidelity to the original model and work with both parents and children.
Conclusion

This literature review was commissioned by Barnardo’s NI, NSPCC and NCB, as the first stage of a wider project examining how to most effectively address the needs of families experiencing multiple adversities in NI. The review provides an overview of the literature relating to definitions and prevalence of multiple adversities, the theoretical explanations of why and how adversities impact on outcomes, the main areas of impact, the policy context and examples of UK practice and services developed to respond to these adversities. Given the broad scope, this review is, by necessity, focused rather than systematic, building on the work of the Multiple Adverse Childhood Experiences research team at Queen’s University Belfast and the commissioning organisations.

The research on multiple adversities shows clear and consistent evidence that those exposed to adversities in childhood are at increased risk of negative psychological, emotional and health related outcomes in later life. This risk is cumulative, with the US ACE study (Felitti et al, 1998; Dube et al, 2003) reporting a strong, graded relationship between the number of childhood adversities experienced and a wide range of negative outcomes in adulthood. While there can be significant effects of single risk factors (Sameroff et al, 1998; Gutman et al, 2002), it is the accumulated number of risks that has been found to be most damaging and also predictive of higher probabilities of negative outcomes (Sabates and Dex, 2012). Put simply, ‘multiples matter’ (Spratt, 2011a).

However, what constitutes ‘multiple adversities’ is not well defined and multiple concepts and terminology are common through the research and policy literature. Nonetheless, from the range of studies considered, eight areas of adversity emerge as key factors related to multiple adversities and negative outcomes:

- poverty, debt, financial pressures
- child abuse/child protection concerns
- family violence/domestic violence
- parental illness/disability
- parental substance abuse
- parental mental health problems
- family separation/bereavement/imprisonment
- parental offending, anti-social behaviour.

Unfortunately, there is no one UK data source which encompasses all these areas. There are, however, various studies which look at the prevalence of a number of these factors, with the most frequently used estimate in the UK emanating from the Cabinet Office’s Social Exclusion Taskforce’s (2007b) report Families At Risk: Background on families with multiple disadvantages.
Based on seven measures of adversity, the report estimated that around 2 per cent, or 140,000, of families with children in Britain experience five or more of these disadvantages. While extreme caution is always needed when considering such figures, it is interesting to note that Sabates and Dex (2012), using different survey data and different adversity indicators, also found that in the region of 2 per cent of families experienced five or more adversities.

Significantly, while these studies cover adversities such as poverty, substance misuse, and mental health, the absence of child abuse and neglect data means that our understanding of the prevalence of the wider range of adversities children experience is considerably limited. Sabates and Dex (2012) also argue that multiple adversities do not necessarily group together in predictable patterns and this raises further challenges for identifying and targeting families who may be at most risk and/or experiencing the highest levels of multiple adversities.

Understanding how adversity impacts on families and outcomes is central to informing the development of effective interventions and there are a range of theoretical models which have been developed to do this. The different, uni-disciplinary models for how childhood adversities impact on outcomes include biomedical, psychological and social models which tend to focus more on the negative processes involved in adversities leading to negative outcomes. There are also positive theoretical approaches and models, such as resilience and social capital, which concentrate more on possible protective processes and offer some explanation of why, in response to what appear to be similar levels of adversities, outcomes for individuals and families may vary widely. While no one theoretical model offers a complete understanding of all the issues involved, the emergence of integrated models to take account of the complexity of processes and range of factors and involved is significant. Models utilizing a systemic approach, such as the ecological model, offer a more coherent, whole system approach to considering multiple adversities at individual, family, community and societal levels.

Growing understanding of the need for a more holistic approach has seen the emergence of whole family or family focused policies and interventions across the UK. This has been accompanied by a growing consensus that more fully integrated and targeted children and family services are needed to meet the complex needs of families experiencing multiple adversities. In pooling funding and reducing lines of accountability, this approach is also viewed as a more cost effective way of supporting families with multiple needs. While it has been a policy focus for many decades, early intervention is at the heart of the Coalition government’s policy agenda and is a central tenet of policy across the UK.

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5 No parent in the family is in work; family lives in poor quality or overcrowded housing; no parent has any qualifications; mother has mental health problems; at least one parent has longstanding limiting illness or disability; family has low income (below 60 per cent of the median), and family cannot afford a number of food and clothing items
These three policy themes are supported, to varying degrees, by the current literature with the evidence for early intervention being clearest, and perhaps most intuitively and politically appealing. Although the emerging evidence on neurodevelopment is important and persuasive it is necessary to consider the full range of processes across the life-course and the range of services needed at all levels. As the Centre for Social Justice (2011) and Statham and Smith (2010) have warned, it is important not to disproportionately focus on specific programmes and/or on any one age range as the full continuum of services are, and will continue to be, needed to meet the needs of children and families, especially those experiencing multiple adversities.

Given the complexity of the issues involved, there are considerable challenges for establishing conclusive research evidence on the most effective configuration of integrated services. Nonetheless, as Statham argues:

“There is considerable agreement in the literature on what hinders and what helps interagency working. Barriers include lack of senior management commitment and buy-in; a climate of constant organisational change; differences between agencies in priorities, systems, culture and professional beliefs; and difficulties with information sharing. Factors that facilitate interagency working include a coherent long-term vision; clarity of roles and responsibilities; commitment to joint working at all levels; strong leadership; dedicated posts for developing capacity; and time for strong personal relationships and trust to develop between partners’ (2011, p 2).

The complexity of the families, the adversities they experience and service structure all provide challenges for effective policy and service development. To date however, there has been limited consideration of how these challenges have been addressed within each of the four UK nations. The next stage of this research project will examine developments in England, Scotland, Wales and NI at different system levels to identify what can be learnt from other UK nations. This phase of the work will also include interviews with families and key stakeholders in Northern Ireland to chart the onset and development of multiple adversities, the support needs of different groups at different times and how the current system and services respond.
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