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Tom Jeffery, Director General,
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Ray Shostak, Director,
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Call for evidence: DfES/HM Treasury Joint Policy Review on Children and Young People

Dear Tom Jeffery and Ray Shostak,

We have pleasure in submitting evidence to inform the Joint Policy Review on Children and Young People, on behalf of the Association for Family Therapy and Systemic Practice in the UK (AFT)

We recognise the importance of decisions informed by this review to the lives of children, young people and their families, and we look forward to making informed and constructive contributions to future policy and practice discussions.

Annex A – Covering Template for Responses

Please complete the attached cover sheet when sending evidence, indicating the set of questions to which a response is being provided and contact details of the person for any follow-up queries.

Contact details for respondent

Name	
Job title	Chair
Do you represent an organisation? (if so, name of organisation and type: e.g. voluntary, public body, private company).	Association for Family Therapy and Systemic Practice in the UK (AFT)
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	Which area of the review are you responding to? (please mark X)
Prevention strand	X
Review of disabled children	X
Strategy for youth services	
Review of high cost, high harm families	X

THE ASSOCIATION FOR FAMILY THERAPY AND SYSTEMIC PRACTICE IN THE UK (AFT)

**OPENING STATEMENT TO EVIDENCE SUBMITTED TO THE JOINT POLICY REVIEW ON
CHILDREN AND YOUNG PEOPLE**

The dependence of children on their emotional and social contexts for survival, development and well-being is clear. Significant relationships within and beyond the family are key to a child or young person's experiences of the world, what they hope and expect from others and what they feel they have to offer.

Protective and preventative support services and risk assessment and referral processes that acknowledge and work with these important relationships as well as with the individual child or young person are essential to the development of services that

- o Tailor support to the child and young person's particular needs, capacities and circumstances
- o Recognise the importance of parental well-being to children and young people's development and life experiences
- o Recognise the importance of other significant relational and social networks – friends, peer groups, relatives, teachers, neighbours, social workers and other involved professionals – to children and young people's healthy development
- o Uses the strengths and understandings of parents and others as a valuable resource, supporting well-being and recovery from problems before they become acute and building on the capacities of families and communities to shape the design and delivery of services and interventions

AFT is the leading professional body representing those working with families in the public and independent sector in the UK. The broad group of therapies under the banner of "systemic family therapy" work not only with families, but with individuals, couples, and the wider communities of clients. They work in ways that not only support change with individuals but also in their relationships in the family and beyond, so

children, young people and/or those important to them are supported in continued recovery.

As well as qualified Family Therapists and Systemic Psychotherapists, AFT members include clinical psychologists, child and adult psychiatrists, occupational therapists, community psychiatric nurses, social workers, mediation and CAFCASS (Children and Family Court Advisory and Support Service) staff, general practitioners, health visitors and other psychotherapists working with family groups

As an organisation, AFT promotes understanding of the relationship between individual well-being and family functioning and family dynamics. We support the training of social and health care practitioners in systemic practice and systemic psychotherapy through procedures of registration and accreditation. We aim to promote and support strength and resilience in family groups and their communities of support. Our members have a great deal of expertise and experience to offer the current policy debate and future planning of services.

We would welcome the opportunity to meet with you to discuss and elaborate the points raised in our submissions to the Children and Young People's Review, and look forward to making a constructive contribution.

THE ASSOCIATION FOR FAMILY THERAPY AND SYSTEMIC PRACTICE IN THE UK (AFT)

EVIDENCE TO ANNEX B1: PREVENTION STRAND**Supporting relationships to support children and young people**

Close relationships are the keystone of children's and young people's resilience and happiness, and to social well-being. Yet these relationships have long been ignored in many aspects of health and social policy and services.

For every child or young person who experiences social, health or psychological difficulty - from schizophrenia to criminality, anti-social behaviour to addiction, illness to the challenges of changing family structure - there are close others who are affecting and affected by the situation. If unsupported, those relational connections may fuel difficulties and/or break down under the strain.

At present, a limited amount of professional help with family relationships is currently available to families in great difficulties, through health, social and education services. The effectiveness of such work is clear (see Stratton, P. 2005 for a meta-analysis of the evidence base for Systemic Family Therapy), yet too many families are having to wait until they reach crisis point before it becomes available.

Family therapists and others trained in systemic family therapy are already helping families and other groups mobilise their resources to support children and tackle difficulties, respecting families' particular needs and insights and encouraging family members to find constructive ways to help each other. The challenge now is to spread this work and training throughout health, education and social care services.

The evidence for the effectiveness of interventions that acknowledge and work with children's relationships is compelling and growing fast (Stratton, P. 2005; NICE, 2002, 2004a, 2005). Working with families encountering serious difficulties, rather than solely with the child or young person deemed to have 'the problem', is proving effective across an extraordinarily wide range of problems, including

- Childhood physical abuse and neglect
- Conduct problems in childhood and adolescence
- Problems with attention and over-activity
- Substance misuse, especially in adolescence
- Eating disorders
- Emotional disorders including anxiety, depression and grief following bereavement
- Psychosomatic problems
- Management of chronic illness.

Throughout the life span, Family Therapy is shown to be effective in treatment and management of depression and chronic physical illness, and the problems that can arise as families change through parental separation and divorce, formation of step-families and other circumstances that affect their constitution or way of life.

There is consistent support for the effectiveness of Family Therapy for adults (Stratton, 2005) experiencing difficulties that have potentially serious consequences for children and young people close to them if they are not treated and/or managed effectively. These include

- Couple, family and other relationship difficulties
- Mood disorders, including depression
- Drug and alcohol misuse
- Chronic pain
- Psychosexual difficulties
- Agoraphobia with panic disorder
- Psychotic disorders
- Chronic physical illness.

Family Therapy is also being used to effectively address a range of problems and situations without a clear (DSM-type) 'diagnostic definition'. The areas within which it can be confidently expected to be effective is therefore much wider than even these lists suggest.

Research points to benefits of Family Therapy beyond its effectiveness with referred problems (Cottrell and Boston, 2002). These benefits include:

- Greater acceptability to clients and families
- Continued improvements after therapy has ended in many cases
- Greater compliance with medication programmes when medical and therapy treatments are combined.

A child in a family often symptomatises a difficulty within the family that has yet to emerge clearly or which has emerged but remains untreated. It is often the distress of the child that the referring frontline professionals recognise, but this often masks a deeper problem within the family unit or other significant relationships, for example, parental mental health difficulties or problems in the adult couple relationship.

Yet too often the 'bigger' family picture remains unexplored. In our experience, for example, too few practitioners explore whether children live in a context of violence, fear, intimidation and coercion, where parents are frightened and/or frightening, as part of routine assessment. Neglect of this question can leave children vulnerable to the inappropriate application of psychiatric labels and all family members without appropriate and effective support, as the symptom of one individual is treated, and its cause(s) left unexplored.

Expanding training

Family relationships are increasingly self-defining, including gay relationships and adoptive and fostering families and step-families. The 'family' takes many shapes in our culturally diverse society. This underlines the importance of appropriate training for those who support and work with families and relationships in all their many forms and contexts.

Appropriately trained professionals can participate effectively in *risk conversations* with family members, assessing serious mental illness, substance abuse, domestic violence and other known risk factors for children and young people. Suitable interventions can then be offered to those whose difficulties or behaviours may impact on children's well-being, thus increasing the life chances of children and young people and the value for money of public spending on children, young people and families.

Family Therapists are well placed to offer services, train others in safe and suitable intervention approaches and to supervise the practice of other professionals. Community-based family therapists can liaise with schools, providing consultation, advice and support.

Family therapists specialise in inter-agency practice and are experienced in working with and convening local networks of professional workers for the benefit of families they see.

Our profession's commitment to working with cultural differences supports Family Therapists in raising the profile of different cultural groups within our communities, helping professional networks establish how best they might serve diverse groups' needs.

While other disciplines have studied the family, Family Therapists have the most extensive experience of working in detail with family difficulties. This experience should be made available to a wider group of professionals. Evidence-based practice (EBP) approaches can be used to specify effective approaches to working with families and other relationship groups within the full range of physical and psychosocial difficulties in children and young people seen within the NHS and Social Services.

Much effective work with children and young people in their families and/or supportive relationships can be provided by those not formally accredited as fully trained systemic family therapists (registered with UKCP as Systemic Psychotherapists). But this work is only likely to achieve the necessary standards if other professionals have access to current best practice of family work through working with, and where appropriate, being guided and supervised by, fully trained Family Therapists.

A cornerstone of Systemic Family Therapy is working in ways that work as far as possible in partnership with adults and children and which mobilise family resources. Many healthcare workers would welcome access to expertise in building the capacities of parents, families and communities to shape the design and delivery of services and particular interventions.

Through training, supervision, support and consultation, Family Therapists in designated posts will be able to 'cascade their expertise', making these approaches available to all who offer family interventions at different levels.

Value for money, valuing people

'A review of the evidence base finds substantial evidence for the efficacy and the effectiveness of family interventions... In economic analyses, family therapy is found to be no more costly, and sometimes substantially cheaper, than alternative treatments without loss of efficacy.'

Prof Peter Stratton, 2005

'Marriage and family therapy is now an empirically supported therapy in the plain English sense of the phrase - it clearly works, both in general and for a variety of specific problems.'

Shadish & Baldwin, 2003

Those trained in family and systemic therapy bring an understanding of family dynamics within relationships and across the generations, and offer genuinely supportive intervention, working with the families they see, not on them.

Far from fuelling 'therapy dependency', family therapists work to build on family members' understandings and to develop their particular strengths and resources to help each other.

Recent developments in Family Therapy, such as mobilising support for families in their local communities, working with families outside clinic settings and bringing different

families together for therapy are being shown to have sustained clinical effectiveness and cost-savings.

Preventative services with time-limited funding have experienced recruitment problems and have been unable to provide the long-term continuity needed for the development of such important work. Many projects in the voluntary and independent sector have not attracted adequately trained staff because of low salaries and short-term funding. Preventative services need to be properly resourced and developed in the mainstream of public services if they are to be expected to provide skilled, effective interventions, responsive to families' and communities' changing needs.

From birth on...

There is emerging evidence that babies of depressed mothers are at greater risk for later psychopathology. There is also growing understanding of the emotional and economic costs such later disorders will incur.

These parents, parents who have a very sick infant, and parents of extremely premature infants who are at an increased risk of attachment insecurity, need psychological interventions provided by a practitioner with specialist knowledge about infancy and the abilities to work with parental mood disorders (especially depression and anxiety).

Ideally, this should be provided by a practitioner trained to support the *relationship* between parent and child rather than solely focusing intervention on the parent. Emerging evidence from the States offers a different perspective to the view that the infant's and siblings' emotional needs will 'often be best served by prompt and effective treatment of the women's illness ...' (see Nysten, Moran, Franklin & O'Hara, 2006, for a review). The value of interventions that support and help develop parent-infant relationships, rather than focusing on treating an individual mother's cognitions and beliefs, is being increasingly recognised (See Goodman & Gotlib, 2002; Radke-Yarrow & Klimes-Dougan, 2002 for examples.)

The importance of involving fathers and partners in care of the mother and infant has been widely recognised over the last 30 years, as has the potential benefits to most

families of fathers' greater involvement in family life. Approaches that acknowledge fathers as a relational resource, and which support and nurture healthy family relationships, rather than solely mother-infant bonds, are an important element of preventative services in the early years.

Given that this a vulnerable time for both mother and child and fathers and other important people in family's life, an important role for Family Therapists would be in providing team management / supervision / training to promote respect for families' ways of coping and sensitive ways of engaging with them.

Multi-family work

Work with groups of families is being developed in schools and in some clinical settings. Asen (2002) concludes that there is strong evidence for using Family Therapy with conduct problems of children and eating problems in adolescence. Further detail is provided by Eisler, leGrange, & Asen (2002) who conclude that Family Therapy is an effective treatment for anorexia nervosa in adolescence. The majority of adolescents suffering from anorexia nervosa, even when severely ill, can be managed on an outpatient basis providing the family has an active role in treatment. They felt that family interventions are best viewed as treatments that mobilise family resources rather than treat family dysfunction. They also argue that brief, intensive multiple family interventions provide an important alternative to engaging families in treatment and are viewed very positively by families.

Challenges and opportunities

Research already shows the long-term benefits of respecting the needs and insights of families and other supportive groups, acknowledging and developing their understandings. The political challenge now is to spread family and relationship work throughout health and social care.

Future services for children and young people would benefit from a greater acknowledgement of family resources, including the role of the extended family and of community and wider professional networks.

Family therapists and others trained in family systemic therapy are already helping families and other groups mobilise their resources to tackle difficulties, in ways that respect families' needs and insights and encourage family members to find constructive ways to help each other. Were training and provision to be developed, work with family relationships at risk of or already experiencing breakdown would become more flexible, responsive, respectful and effective, for the benefit of those children, young people and families experiencing difficulties and for the community at large.

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THE ASSOCIATION FOR FAMILY THERAPY AND SYSTEMIC PRACTICE IN THE UK (AFT)

EVIDENCE TO ANNEX B2: REVIEW OF DISABLED CHILDREN

Children and young people with disability and their parents and carers tell us that having one trusted point of contact to professional services would improve their experiences of those services considerably.

The transition from child to adult services is a stressful one for many individuals and families, particularly those with young people with disabilities. It is to be hoped that this review will include explorations of ways to bridge this 'gap', including creative multi-disciplinary team working that prioritises families' needs above traditional organisational and service boundaries.

As well as the child or young person with the disability, it is important to note the impact of the disability on family life and all family members, including siblings (Altschuler, 1997). Children's experiences of having a seriously ill or disabled sibling vary widely, and many develop self-worth, competence, compassion and understanding (Altschuler, 1997; Seligman, 1998). Yet recent studies into the experiences of siblings of children with physical illness also reveal serious implications to the 'well' child's emotional well-being if their own needs are overlooked or minimised by parents and professionals (Sloper, 2000; Sloper & While, 1996). Some studies have found evidence of more anxiety and low self-esteem among "well" siblings than among their brothers or sisters "with the problem" (Sloper, 2000; Altschuler, 1997).

Research into the experiences of siblings of children with disability indicates that those who report most internalised and externalised behaviour difficulties themselves are not those whose siblings' disability is most severe, but those whose brothers or sisters display aggressive, challenging behaviour (Connors & Stalker, 2003). Some children with ill or disabled brothers or sisters have been found to shield parents from further

worry by keeping concerns to themselves or otherwise minimising or disguising their own distress (Altschuler, 1997, Connors & Stalker, 2003; Sloper, 2000; Tozer, 1996).

Clearly, developments in effective service provision for disabled children and their families require that they acknowledge the experiences of all family members. AFT believes that services should help mobilise the family's own resources as well as those of professional support systems.

In this Annex we will focus on two particular areas of expertise among family therapists. The issues they raise are very relevant to many other forms of disability among children and young people.

ADHD

ADHD Primary, community and secondary (primary and tier two levels as described by HAS model) services are limited in their ability to resource and provide a multi-modal assessment to ADHD referrals.

Increasingly we are aware that primary and secondary level services experience difficulty with atypical presentations and neuro-developmental complex co-morbid features. Frequently when there are over-lapping difficulties and atypical presentations, a fine-grained, multi-disciplinary diagnostic assessment is required. The advantage of tier three assessments is that neuro-developmental features, cognitive issues and environmental factors can be addressed as part of a comprehensive multi-disciplinary intervention model. Moreover treatment can be long term and multi-modal.

The weakness of tier one/two intervention, whilst it may address issues of early identification, is that the assessment and treatment outcomes may only partially meet the needs of the child or young person and their family. As a result, there may need to be subsequent onward referral to tier three service for 'specialist' neuro-developmental assessment. The result for the patient and the patient's family is an increase in waiting times as they are referred between tiered services and frequently a duplication of assessment.

It is to be hoped that this review will address the streamlining of service provision and comprehensive service delivery so that comprehensive multi-disciplinary input can be provided at one point of contact for the child or young person and their family.

Unless primary care services are able to offer comprehensive, multi-disciplinary assessment and treatment interventions that can be sustained over the long-term (ADHD being a condition that affects individuals across their lifespan) then the likelihood of onward referral increases. Early intervention is crucial but in our view it must be sustained with well-resourced provision. The ability to undertake complex assessments with atypical neuro-developmental presentations, which includes the ability to provide psychometric assessment, family assessment, school observation, and individual clinical assessment of the child at a single point of contact is as important for these patients as the ability to identify the condition early.

A frequent concern of AFT members is that too often children are diagnosed within primary tier services on the basis of a brief, 'parent-only' report/interview, supported by completed questionnaires. In our view this might be described as a 'screen' rather than a comprehensive assessment of ADHD. This carries with it a risk of misdiagnosis.

If children receive a diagnosis and psycho-pharmacological treatment but difficulties persist or escalate and there is a need for onward referral for a more comprehensive assessment, this is potentially detrimental to patient care. The child or young person may experience a wait before engaging with a new service, there may be duplication of assessment, there are new professionals for the patient to engage with, and the needs of the child or young person and other family members often remain unmet.

The multi-faceted, long term and complex nature of ADHD presentations need to be addressed. Early intervention is but one aspect of effective provision.

The experiences and needs of the siblings of children with ADHD should also be respected. Kendall's (1999) US study into sibling accounts of ADHD alerts readers to the 'potentially quite deleterious' effects on sibling health and well-being (p117).

Siblings described feeling fearful (p128), 'worried and sad' (p130) and 'invisible' in the family, purposefully 'not requiring too much help or attention' (p. 131). Children who felt victimised by their brother or sister and whose parents were either 'too exhausted or too overwhelmed to intervene' (p129) were found to be particularly vulnerable.

Evidence and clinical experience point to the importance of approaches that work with the family, acknowledging all family members' experiences and needs, not solely those of the 'index patient', for the benefit of the IP child, their parents and siblings.

Children and young people with medically unexplained physical symptoms

Medically Unexplained Physical Symptoms (MUPS) affect 10 per cent of all children (Garralda, 2004). In areas of the UK, it accounts for between 35% and 40% of all paediatric admissions (Slaveska-Hollis and Fletcher, 2006).

These children and young people have very often endured profound symptoms yet have no discernable clinical diagnosis. Many define MUPS as disabling. Family dynamics and experiences form an important part of the complex picture of MUPS. Yet work with families is not yet a core and consistent element of care for these children in medical inpatient and outpatient settings. Family psychotherapeutic provision is woefully patchy.

Where it does exist, welcome, constructive and effective support is being offered to these children, young people and families, and the medical teams who work with them.

Dr Karmen Slaveska-Hollis, Consultant Child Psychiatrist and Paul Fletcher, Systemic and Family Psychotherapist, and colleagues form the Paediatric Liaison team at Queens Medical Centre and Nottingham Healthcare Trust. This multi-disciplinary team has a dual primary task. Firstly, to offer direct psychotherapeutic work and assessment to children, young people and their families who are inpatients on paediatric wards and paediatric intensive care. Secondly, to provide supervision, consultation, and

teaching to medical staff on psycho/social issues relating to children, adolescents and their families with chronic and acute illness. The team facilitates good interdisciplinary collaboration between professionals from disparate backgrounds, which seems so crucial to the understanding and treatment of MUPS. A key element of the team's bio-psycho-social approach to MUPS in children and young people is to engage and empower parents and extended family members as co-therapists, to support the child's progress.

The team's experiences echo those of other clinicians and researchers who have highlighted the importance of harnessing the resources of a sick child's parents and siblings, seeing them as crucial members of the medical team (Gustafsson, 2005). Hotopf's (2002) study highlights the mutual influence in relationships in the parental child relationship. He found that childhood experience of illness in parents is a risk factor for the later appearance of MUPS in later life.

The Nottingham Paediatric Liaison team has noted predisposing family factors in their work with MUPS, including

- o limited verbal communication
- o suspicion of medical expertise
- o parental history of somatoform illness, anxiety or depression
- o problems with boundary setting for children

Predisposing factors for the child or young person with MUPS include

- o emotional lability, vulnerability, or sense of worthlessness
- o earlier emotional abuse
- o low IQ
- o social-relating difficulties

Precipitating factors in the child include

- o Anxiety
- o life stresses
- o physical illness
- o peer group problems
- o academic problems

- o low self esteem.

In parents, life events and crises are precipitating factors. Maintaining factors for MUPS in children and young people include:

- o current family relationship difficulties
- o a family model of serious illness,
- o current parental mental ill health
- o school problems
- o the benefits of a sick 'role' in the family (ie the ill child may have a special role in family dynamics and/or communicate through their symptom).

Stressors for family when a child has MUPS include:

- o Strained family relationships
- o Limitations on family activities, goals, time
- o Increased financial burdens
- o Housing adaptation
- o Social isolation
- o Difficult school experiences
- o Grieving

The team is aware of the cultural and social stories associated with management and understanding of pain, and support other health care practitioners in the need to attend to a child, young person's and parental developmental stages, abilities, race and culture in considering how they communicate and explain sometimes complex or sensitive information to children and families.

Children and families who live with MUPS claim large amount of resources in primary and tertiary care services. This large group of children present challenges and opportunities for a collaborative and integrated approach between physical and mental health services. Multi-disciplinary paediatric liaison teams are one way this collaboration is working creatively and effectively, for the benefits of children, young people and their families. However, such collaboration continues to be patchy.

The importance of working with children and young people's families is clear, yet it is to be regretted that relational orientations to MUPS appear to still be secondary to an individual approach to treatment in most of the UK.

Conclusion

As these two explorations of child, family and professional experiences of disability so clearly illustrate, services for children with disability need to expand their focus to include children's close relationships. Only then can we meet children and young people's needs for services that acknowledge the complexity of their conditions and circumstances, and that support those relationships that support them.

These brief explorations also highlight the importance of multi-disciplinary team work to best support children and young people with disabilities and their families. Systemic Family Therapists, trained in facilitating, supervising and training such teams, have a key role to play in the future development of such services.

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THE ASSOCIATION FOR FAMILY THERAPY AND SYSTEMIC PRACTICE IN THE UK (AFT)

EVIDENCE TO ANNEX B4: REVIEW OF HIGH COST, HIGH HARM FAMILIES

As the title to this strand of the review acknowledges, families and not only individuals can become caught in cycles of low attainment, high cost and high harm. Approaches that acknowledge transgenerational patterns and relational dynamics, and that work with families and their support networks to better support all family members, are essential if these families' needs are to be met and the life chances of those within them improved.

Family Therapy in its various forms is already an important resource within the NHS and social and education services, not just as a resource for families and for referral of children, young people and families with complex and entrenched difficulties, but also as specialist support for other professionals who need to extend their work to take account of the resources that families and the wider communities can provide. Unfortunately, however, provision remains patchy and in some areas poor.

Therapies that acknowledge the importance of people's relationships and contexts and work directly with them have been found to increase the chances of long-term recovery in a wide range of child, adolescent and adult problems very relevant to the scope of this review, including depression and other mood disorders, psychotic disorders, couple and family relationship problems, children's conduct difficulties, eating disorders and drug and alcohol misuse. (Stratton, P. 2005. Please see AFT's submission to the 'prevention' strand of this review for a fuller list of child, adolescent and family difficulties effectively treated by Family Therapy).

Many of the children and young people we see come from families with multiple and serious problems. They benefit from an approach that acknowledges complexity and context, and from clinicians skilled in 'networking' with other professional disciplines to address each child and family's particular and multiple needs.

It is to be hoped that this policy review includes a recognition and examination of effective services for children and adolescents that both acknowledge and work with

parents, family and/or other close relationships. This is particularly important in children and adolescents of 'high cost, high harm' families. If these approaches are marginalized in the discussions, the review will risk decontextualising children and replicating the known problems of some children's services, where treatment and services are only offered to children, not families. These children are often returned to the same relational environments that fuelled their problems. Their parents often feel unsupported and desperate in their felt inability to improve their children's lives and life chances. Or they may feel too emotionally dislocated or overwhelmed by their own problems to care. Systemic Family Therapists are skilled in working with children and adolescents' supportive relationships wherever they may be, inside or outside the home.

Supporting families with complex needs

Exemplary and effective practice: REFRAME, A Conduct Disorder Outreach Team [Tier 3 CFCS/CAMHS] in Newham, works with 5-11 year old children and their families at risk of social & educational exclusion. The team is staffed mainly by systemic family therapists with the additional input of clinical & educational psychology.

The team won a NIMHE (National Institute for Mental Health in England) Positive Practice Award in 2005 for its partnership work and outreach approach to service provision for families with children with severe anti-social behaviour, who do not engage with the NHS Child and Adolescent Mental Health Service (CAMHS). These families have either not attended appointments or might find it (at least initially) very hard to engage. Reframe also actively seek out families who have not responded to standard opt-in letters at the clinic where the child is aged between 5 and 11 with severe challenging behaviour.

The team's 'assertive outreach' approach reflects a change in service provision. It is accessible, responsive and flexible, offering home visits, network liaison and a range of specialist services.

The children it sees show persistent patterns of behaviour involving defiance, aggressiveness and anti-social behaviour, which is significantly different to that of the majority of their peers. There is a serious negative impact on the overall development of the child.

The children may be excluded from school, accommodated by the Local Authority or known to the police or youth offending team. They will probably be at risk of school exclusion or accommodation. They are often socially isolated as they are excluded from leisure activities such as after-school provision or holiday schemes.

Previous attempts by statutory or voluntary agencies to engage the family may have not effected change, or services offered have not been taken up.

The team has found that parenting programmes alone will not impact children from families where there are severe/persistent/complex problems and that these children/families need a multi-disciplinary input with intensive work involving the complex networks in which they are embedded. For these families, combination therapies (ie parenting and systemic family work and educational inputs) will adequately address the complexity but none will work in isolation. Systemic therapists have a valuable role in this successful work with families, not only for their skills in engaging and working with adults, children and adolescents but also their skills in multi-disciplinary team management and supervision.

The NICE "quick reference guide" on "parent training/education programmes in the management of children with conduct disorders" (July 2006) acknowledges that group programmes are not suitable for families with complex difficulties. Yet the alternative envisaged is individual parent-training /education programmes. The experiences of the Reframe team suggests that this may not be enough for many 'high cost, high harm' families.

Drugs misuse

Family work can simultaneously address the impacts on children and adolescents of personal and parental drug misuse, and possible trans-generational patterns and effects of substance misuse.

Avoidance of relapse usually depends on developing positive roles and expectations in supportive close relationships in the family and/or beyond. While family and friends may sometimes contribute to the development and/or maintenance of the problem, they are potentially a major resource in the treatment and prognosis of people with substance dependence.

Systemic family therapy reduced relapse rates and ameliorates co-morbid problems. Treatments that fail to tackle associated problems will leave young people and those important to them much more vulnerable to relapse as these problems work to reinstate their felt need for drugs.

Children who experience or witness family violence

It is to be hoped that this review acknowledges the impact of hidden and masked trauma, in all family members, across the generations, and the need to support the family more widely if we are to protect and serve children's best interests (Cooper and Vetere, 2005; Vetere and Cooper, 2005).

There needs to be a safe, thoughtful and systemic response to the problems of violence in our communities. Clearly, proper training is necessary in to assessment for both front-line workers and tertiary service colleagues. Family therapists are trained in understanding family dynamics, the impact of trauma, and thorough assessment of both individual and family well-being and resilience. Early identification and assessment of children's needs can be promoted through family therapy practice. They are also a resource that can be called on in assessment training for other professionals.

Family violence is complex and often requires integration of psychological and social theories to explain and intervene helpfully. A range of service responses is known to be helpful and family therapists are well placed to both offer such services and to train others in safe and suitable intervention approaches. In supporting children, we need to support their carers, and to provide services to perpetrators, not only to protect women and children, but to recognise their right to appropriate services.

Early relationship support

It is hoped that this review will draw from infancy research to foreground how an infant's forming mental health (and brain development) can suffer when a mother (or father) is emotionally and/or mentally ill in the perinatal period.

An infant's own mental health can become 'disordered'. DC:0-3R (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early

Childhood: Revised Edition, 2005), following the format of DSM 1V, has a list of diagnosable Axis 1 Clinical Disorders that manifest in infancy. The Axis 11 Relationship Classification also notes a range of disordered relationships that parents and infants can suffer from. A mother suffering from, for example, clinical depression and anxiety, is likely to have a symptomatic baby whose symptoms are signalling relational disturbance (such as non-organic failure to thrive). These symptoms are likely to further reinforce the mother's suffering. There is emerging evidence that treating the mother/father-infant relationship can bring relief: both in terms of adult symptoms and infant development (see Nysten, Moran, Franklin & O'Hara, 2006, for a review).

There is evidence that suggests, for example, that reduction of maternal depressive symptoms (achieved through individual treatment) may itself not be sufficient to prevent negative effects for the infant (Forman *et al.*, 2005) [See O'Hara, Stuart, Gorman, & Wenzel, 2000, for a detailed description of study methodology]. The results of Forman's study suggested that despite significant improvements in maternal mood, at 18 months' post-treatment children of the depressed (but improved) mothers continued to show lower attachment security, higher negative affect, and more internalizing and externalizing problems.

Mothers suffering from clinical levels of anxiety have difficulty responding to their infants' cues and this has a deleterious impact on the formation of the infants' mental health (see Fonagy, Gergely, Jurist, & Target, 2002 for a thorough review). Studies suggest that mothers can benefit from a therapeutic focus on enhancing reflective capacities about the infant and facilitating maternal responsiveness, sensitivity and engagement (Cohen *et al.*, 1999; Cooper *et al.*, 2002; Field *et al.*, 2000; Gelfand *et al.*, 1996; Lyons-Ruth *et al.*, 1990). Such an intervention necessarily involves the infant in his or her own right in the treatment process.

This policy review might find it helpful to consult those providing specialist parent-infant interventions:

- o The Parent-Infant Project at the Anna Freud Centre
- o The Tavistock Under 5s Service
- o The Parent-Infant Mental Health Service, North East London Mental Health Trust

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