

High-cost, High-harm families and Prevention

I. Introduction

This paper gives Barnardo's response to the two CSR strands on high-cost, high-harm*¹ families and on prevention.

We deliver over 360 child care services throughout the UK. We have a strong investment in preventive services, including family centres, parenting programmes and pre-school services for children with conduct and attention disorders. We are also the lead agency in a large number of Sure Start programmes. As well as a strong practice base, we have been promoting effective, evidence-based programmes through our research and publication programme since 1993. Our first edition of "What works in parenting education?", published in 1999, contributed to the popularising of Carolyn Webster-Stratton's programmes in the UK and we have published a number of other evidence based research reports relevant to this review¹.

We welcome the Government's commissioning of research, announced in the Social Exclusion Action Plan, from the Institute of Education at the University of London on the potential for different types of indicator to predict later adolescent and adult adverse consequences. We would welcome any opportunity to contribute.

Barnardo's recommendations

- As acknowledged in the Social Exclusion Action Plan, our ability to predict behaviour prospectively is and will remain limited². So **we need to focus more on learning from resilient survivors**. As one of Barnardo's *What Works?* Series, we reviewed evidence-based strategies for promoting resilience in the ante-natal, infancy and pre-school periods³
- **Informed choice is as important for the poorest families as for the richest** – families offered choice will be more likely to co-operate, access and remain in services and move out of dependency⁴.
- Programmes for parents should **either deliver, or signpost parents to relevant complementary services**.⁵ Families need home-based, problem-solving support to ensure that children **are able to enter and settle both pre-school and infant school settings satisfactorily**.⁶
- **The voluntary sector is well placed to meet the needs of highly vulnerable families**. However, it is essential that as well as using

*We use this term throughout the paper, since it is the one used in the CSR document. But for public communications we would urge the government to adopt a less pejorative term, such as 'families with complex needs'. This would avoid stigmatisation and reduce the risk that public policy focuses solely on the costs to the Exchequer and not the costs borne by these families themselves.

effective programmes, services are sufficiently resourced to offer a holistic service and programmes are offered to a general population of parents⁷.

- While it is important that intervention programmes use robust and validated methods⁸, **the growing experience of those who deliver parenting programmes in the UK – of which Barnardo’s is a major provider – must be exploited to refine and improve services⁹. Better learning needs to be transmitted between the four UK countries.** Avenues to diffuse practice innovation are needed between the devolved administrations and London¹⁰.
- Families with complex problems will not usually be helped by short term interventions. Programme providers must be willing **to commit to a medium to long term multi-dimensional involvement¹¹.**
- Programmes designed to help parents serious control conduct disorders must recognise that **the genesis and course of male and female conduct disorders are different** and not take a ‘gender-blind’ approach.¹²
- We urge the government **not to further stigmatise single mothers.** The overwhelming amount of care for children in the UK is provided by females; the overwhelming amount of anti-social and delinquent behaviour is the responsibility of males. Males need to play a much more prominent role both as recipients of, and deliverers of, parenting programmes^{13 14}.
- As the number of adults in UK prisons increases, so does the number of children whose parents are imprisoned. Many of these adults are from families in the ‘high-cost, high-harm’ category. **Family breakdown resulting from inadequate support and contact to imprisoned parents and their children is a major contributing factor in adult recidivism and in increasing the likelihood of child and adolescent criminality.** Despite acknowledgement by government of the social and economic consequences of a lack of support^{15 16 17}, services for prisoners and their children remain seriously under-funded and of inappropriately low priority.

2. Response to key questions in the high-cost, high-harm review

Who are these families? How can we define them and how many of them are there?

In responding to this question, we first need to be clear whether we are identifying high-cost, high-harm *families* or high-cost, high harm *children*.

Features of *families* that render them more likely to attract a 'high-cost, high-harm' label include low parental attainment in education, insecure housing, overcrowding, paternal criminality, alcohol and/or drug dependency, presence of male children, exposure to violence and abuse, maternal depression, absent father, absence of extended family support, workless household and a hostile external environment. High-cost, high-harm families will be affected by most or all of these factors. However, many families with these characteristics will not necessarily contain children with severe or enduring antisocial behaviours, though we can expect a significantly higher prevalence than in more privileged populations.

Features of *children* that will be associated with a high-cost, high harm label are primarily associated with conduct disorders. These are children with repetitive and persistent patterns of anti-social, aggressive or defiant conduct significantly more severe than routine boisterousness or teenage rebellion whose vulnerability is compounded by a chaotic and unstructured family context. They will primarily be male. These children will meet DSM-IV (Diagnostic and Statistical Manual of Mental Disorders (4th edition), published by the American Psychological Association) or ICD-10 (10th edition of the International Classification of Diseases, maintained by the World Health Organisation) criteria for conduct disorder and oppositional defiant disorder (ODD), which requires at least three of the behavioural inclusion criteria to have been present in the previous 12 months and at least one in the previous six months, as evidenced through the use of a standardised assessment schedule, such as the Child Behaviour Checklist (CBCL). UK prevalence figures are 6% and 3% for boys and girls aged 5 – 10 years respectively, and 9% and 4% for boys and girls aged 11- 15 years (rounded up).

While the utmost sensitivity needs to be shown when identifying specific sub-populations where problems of particular magnitude exist, some additional factors must be considered in seeking to identify high-cost, high-harm families. While some very small sub-sections of the population exhibit a higher prevalence of conduct disorders, notably looked after children and Black Caribbean children, the most significant factor by far is the sex of the child. Conduct disorders, delinquency and anti-social behaviour are overwhelmingly male phenomena. High-risk, high-cost families are significantly more likely to contain one or more male children. The onset, pattern and persistence of severe conduct disorders are radically different in males and females. While the exact neurological, cognitive and genetic pathways driving gender differences in conduct disorders are still not clear, it is essential that this factor is taken into consideration in the process of identification and definition.

The families of most concern will have pre-school male children already exhibiting persistent conduct disorders, compounded by a combination of the predisposing factors listed above, which make it unlikely that the family will possess the necessary capital to rectify the situation without external help. Area based methods of identification have proved unsatisfactory as large number of families who fall outside this category may live in highly deprived districts; similarly, families who need help may live in more affluent areas. The most effective method of identification appears to be school or pre-school based screening using a standardised instrument such as the Robert Goodman's Strengths and Difficulties Questionnaire or the CBCL, enhanced by the professional knowledge of health, education and social care staff familiar with the community. We can expect the Common Assessment Framework to be a major route for identification when it is fully operational.

Early screening of children for behavioural traits which may later lead to criminality is a strategy which requires careful management and oversight. The potential to do harm through labelling and stigma is self evident. However, it is unlikely that any significant progress can be made in helping families without a significant investment in a process of early identification and intervention, which should preferably take place in the pre-school period. The principle of pro-active intervention does not conflict, we believe, with the notion of families at risk being families at risk of receiving insufficient help, guidance and support. While Barnardo's, like every other child care organisation encounters some families who are resistant to help, we encounter far more frequently families who are desperate for help to resist or move out of a 'high-cost, high-harm' environment but lack the support and resources to do so.

What progress has already been made in addressing the needs of high cost, high harm families?

The major accomplishment of the current administration has been to embed into public policy the notion that poor parenting is a major public health issue – some would argue the most significant issue – and that government has a legitimate role in promoting positive parenting. The Sure Start programme, the growing network of Children's Centres, the Parenting Fund, Parenting Orders, the increasingly widespread availability of parenting programmes through the NGO sector and the Respect agenda, together with the establishment of the National Family and Parenting Institute have all been routes through which this consensus has been established. While these initiatives have enjoyed a large measure of success, many services still struggle to engage families in the high-cost high-harm category. Indications of lifetime persistent anti-social behaviour, especially in males, usually emerge at ages 2-3 years. Around 60% of untreated 3 year olds still exhibit problems at age 8 and half of children diagnosed with conduct disorders receive a diagnosis of anti-social personality disorder or other serious psychological illness as adults. At the pre-school stage, there are several promising treatment options; by the teenage years, untreated conduct disorders have a much more pessimistic prognosis. Too little investment and expertise is still evident in the early identification of children whose behaviour is likely to cause serious harm to those around them,

resulting in the corresponding inflation of investment in remedial services during and after the teenage years.

As the CSR acknowledges, the identification and treatment of children and families can will only be partially successful unless other key targets are met, especially the elimination of child poverty and the structural and social revival of highly deprived neighbourhood in which high-cost high-harm families disproportionately live. However, poverty is not just a precipitating factor for child conduct disorders, it also *arises* from untreated disorders; the earning capacity of families is restricted, partnership prospects of lone parents damaged, direct cost to families are incurred by fines and material damage, housing options are restricted and social and community networks harmed. While the social costs of lifespan anti-social behaviour can and has been measured at a community level, the biggest costs are incurred within families themselves.

Can we better align local services to improve identification of these families earlier on and before they become high cost high harm?

As noted above, the most important chronological period for both identification and treatment is during the pre-school years, preferably before the child reaches the age of three years. This requires close collaboration between health visitors, GPs, social care staff, nurseries and playgroups. In many cases, identification may not be a problem; where difficulties arise it is more likely that referral routes are unclear, responsibility for action is diffused and that even where these are not factors, the relevant expertise is not available locally. The role of CAMHS also needs to be considered in relation to these families. Conduct disorders are more likely to be considered social problems and are thus less likely to attract specialist CAMHS input than other mental disorders.

Are current incentives and levers adequate to deliver co-ordinated responses for families across relevant services such as health, education, housing, social services and the police at local level?

Despite substantial investment in co-ordinated working, especially through the medium of Sure Start programmes, our experience is that results remain patchy, with wide variation being reported by all parties in the effectiveness of collaboration at a local level. The effectiveness of key worker systems where a single agent takes responsibility for the overall co-ordination of services to a person or family has achieved significant success with disabled children over the past two decades. However, such systems are typically undermined when lead professionals wield insufficient authority or control over resources. Professional and organisational boundaries will always be a potential challenge to inter-agency working. The government has appeared to have recognised this problem with the proposal to pilot single budget account pathfinders. While this is not necessarily the only approach that can improve service co-ordination, we would, in general, favour a much clearer investment of authority and responsibility for specific families in named professionals at a local level.

What interventions here and abroad have been shown to work in reducing the harm caused by these families and supporting them to exit the cycle of low achievement?

It is generally accepted that 30-40% of variation in child anti-social behaviours are associated with parent interaction, which is the single largest non-genetic variable. The improvement of parent-child interaction, especially in the child's very early years, provides the greatest potential source of leverage for change. Overall, the biggest positive impact appears to arise from a) intensive home based support (both lay and professional) in the ante-natal and peri-natal period and by b) effective parenting programmes.

A range of effective interventions in both these areas are described in: Buchanan, A. and Ritchie, C. (2002) *What works for troubled children?* and in : McInnes, K. et al. (2005) *Parenting Education: messages from research*; both Barking: Barnardo's.

We would also commend the comprehensive review of parenting programmes published by NFPI: Barrett, H. (2003) *Parenting programmes for families at risk: a source book*. London, NFPI. A positive evaluation of parenting programmes in disadvantaged areas using the Webster-Stratton *Incredible Years* model, published by the Joseph Rowntree Foundation (July 2006) provided encouraging news on the high demand for services and the apparent applicability of the model used to families from different ethnic communities. Definitive guidance on effective parent training/guidance in the management of child conduct problems has been issued jointly by SCIE and NICE; available at: <http://www.scie.org.uk/publications/misc/parenttraining.pdf> .

What is the appropriate balance between support and sanctions for these families?

Mandatory parent education programmes, where applied fairly and sensitively, appear to be accepted by parents and have produced positive results, though the results for parents of teenagers are, as with elective programmes, less impressive. As the single biggest cost burden arising from conduct disorders when children are of primary school age falls on the parent(s), we believe that such programmes have a role to play the overall framework of parent support. Where programmes are mandatory, it is even more essential than in elective programmes that the models used are evidence-based and delivered with the highest level of reliability and expertise. In addition, mandatory programmes should also provide access, where applicable, to other support services which may be disproportionately needed by attenders. We should stress however, that we would regard mandatory programmes based on a *prediction* of future probability of criminal behaviour as both scientifically flawed, due to our inability to predict individual pathways with any degree of accuracy and a contravention of the rights of both children and parents. We would strongly oppose any suggestion that parents should be compelled to enter programmes based on a prediction of future child criminality.

The number of parents needing help and not receiving it is far larger than the number of parents needing help and refusing it. A preoccupation with compulsion misses the point – there are more effective ways of gaining parents' cooperation. As a first step, services must be better at going out to hard to reach families, for example through more intensive health visiting. However, compulsion of parents may sometimes be justified in the interests of the child. This would be where families have consistently failed to engage with services and where there is an actual, not just statistically predicted, problem with a child.

Supporting Evidence*

¹ Lloyd, E. (Ed.) (1999) *What works in parenting education?*
Buchanan, A. and Ritchie, C. (2004) *What works for troubled children?*
Cooper, P. (2001) *What works in educating children with social, emotional and behavioural difficulties outside mainstream classrooms?*
MacDonald, G. and Roberts, H. (1995) *What works in the early years?*
Utting, D. and Vennard, J. (2000) *What works with young offenders in the community?*
Newman, T. (2004) *What works in promoting resilience?*
(All published by Barnardo's: Barkingside.)

Also see: McNeish, D., Newman, T. and Roberts, H. (2002) *What works for children: effective services for children and families*. Buckinghamshire: Open University Press.

² Farrington, D. (in press) Childhood risk factors and risk focused prevention. In M. McGuire, R. Morgan and R. Reiner (Eds) *The Oxford Handbook of Criminality*, 4th Ed. Oxford: Oxford University Press.
Farrington states: "Typically, prospective prediction (e.g. the percentage of high risk children who become persistent offenders) is poor but retrospective prediction (e.g. the percentage of persistent offenders who were high risk children) is good."

Feinstein, L. and Sabates, R. (2006) *Predicting adult life outcomes from earlier signals: identifying those at risk*. Report to the PMSU (version 2.2). University of London: Centre for Research on the Wider Benefits of Learning.
Feinstein and Sabates state: "... the relationship between childhood risk and high cost or high harm outcomes in adolescence or adulthood is not deterministic, mechanistic or inevitable... There are children at risk who do not experience harmful outcomes and there are children with low apparent or observable risk who do."

This means that while we have powerful evidence of the factors that will be likely to promote delinquency, we cannot achieve accurate predictions of individual pathways. There is no single 'biggest' risk factor, risk of delinquent careers substantially increase where multiple risk factors are present. This increases the justification for addressing a range of risk factors simultaneously, rather than just focusing on, for example, individual pathology through the delivery of behavioural programmes. It is neither a realistic scientific or policy goal to rely on screening instruments to identify children who will join the 5% of offenders responsible for 60% of crime. Longitudinal studies confirm that

early anti-social behaviour is the best single predictor of later criminality, but many children who exhibit such behaviour early in life will not progress to a delinquent career.

³ Our ability to predict behaviour prospectively is still, and will remain limited. We need to focus more on learning from resilient survivors, rather than being pre-occupied by the experience of those who succumb to serious disadvantages. These factors are reviewed in:

Newman, T. (2004) *What works in building resilience?* Barking: Barnardo's.

Chapter 4 of this book reviews effective, evidence-based strategies for promoting resilience in the ante-natal, infancy and pre-school periods. These are summarised on p. 42. They include:

In the ante-natal period:

- adequate maternal nutrition in pregnancy
- avoidance of maternal and passive smoking
- moderate maternal alcohol consumption
- social support to mothers from partners, family and external networks
- good access to ante-natal care
- interventions to prevent domestic violence

During infancy:

- adequate parental income
- social support to mothers vulnerable to perinatal stress
- good quality housing
- parent education
- safe play areas and provision of learning materials
- breastfeeding to six months
- support from male partners
- continuous home based input from health and social care professionals

During the pre-school period:

- high quality pre-school day care
- preparatory work with parents on home-school links
- pairing with resilient peers
- availability of alternative caregivers
- food supplements
- links with other parents, community networks and faith groups
community regeneration initiatives

⁴ Barnardo's Tuar Ceatha service in Northern Ireland has been successful in developing parenting programmes with both Chinese and Bangladeshi communities. This has involved considerable dialogue with parents to design programme content, as simply using a standardised model would not respond adequately to the parents' cultures,

concerns, living contexts and gender relationships. Building of trust, choice and ownership were all crucial factors in securing and maintaining engagement.

⁵ Benefit advice, welfare-to-work, literacy, health checks and child care are all likely to be relevant. 'High-cost, high harm' families will typically be affected by a range of problems and a single focus on child conduct disorders is unlikely to be a sufficient moderating factor. The importance of being able to offer or signpost vulnerable families to other services was highlighted in:

Ghate, D. and Ramella, M. (2002) *Positive parenting: the national evaluation of the Youth Justice Board's parenting programme*. Policy Research Bureau: London.

This evaluation also suggested that parents made the subject of Parenting Orders accepted the justification for the element of compulsion and the compulsory nature of the programme did not detract from its effectiveness. We should stress, however, that this response would not be expected if compulsion is based on a prediction of, rather than a consequence of, criminal behaviour.

⁶ Barnardo's has an excellent example of such a programme in Wiltshire. The School Start Service provides a short term intervention with children who have been identified as likely to present difficulties settling in school. Referral takes place when the child is in nursery and the associated intervention during the six month period before the child enters the reception class of primary school. A recent evaluation of the service reported a significant decline in problematic SDQ scores at six month follow up, from baseline measurements at the pre-intervention period. The full report is available from Barnardo's:

Dowling, R. (2005) *An evaluation of the Wiltshire School Start Service*. Barkingside: Barnardo's.

⁷ The voluntary sector can offer flexible, non-stigmatising provision and has the ability to secure and retain the trust of families. Universality is preferred over specialist provision. This reduces the possibility of stigmatising families, facilitates a model of open access, empowers parents and enable services to enlist and exploit the expertise of parents themselves. This is one of many accounts provided in the annual reports of Barnardo's services; in this case, from a service in South Wales:

Anna's Story

Anna, aged 20, came along to the Intensive Family Support Service as a young inexperienced mother, whose two year old daughter Sian, was already placed in foster care and destined for adoption.

Anna's morale and confidence were low, she was isolated from her family, often unable to trust anyone. Her life had reached an all time low when Sian had failed to recognise her during a rare contact visit.

However, through the individual and parenting sessions provided at the service, six months later, Anna's care of her daughter, was good enough for Sian to return home. Twelve months later, Anna and Sian continue to thrive together at home. Anna says that she would like to "thank Barnardo's for all the work" and she looks forward to "a bright future with Sian, something I wouldn't have dreamt possible a year ago".

⁸ McInnes, K, Downie, A. and Newman, T. (2005) *Parent Education: messages from research*. Barkingside: Barnardo's.

Produced in co-operation with Wiltshire Children and Young People's Partnership, this reviews the effectiveness of parent education programmes across from birth to adolescence. Pre-school programmes are reviewed in Chapter 3. In recognition of the high drop out rate in many programmes, the crucial importance of engagement and maintenance of contact is stressed, and strategies for accomplishing this discussed.

⁹ Barrett, H. (2003) *Parenting programmes for families at risk: a source book*. London: NFPI.

Practitioners build on and improve the content of standardised programmes, yet this work is rarely recorded systematically and fed into programme improvement. This is described by Barrett (p.200) as a "huge, untapped reservoir of knowledge". As well as identifying 'untapped' practitioner knowledge as the major omission in our knowledge base on the effectiveness of parenting programmes, this book summarises effective parent education strategies, with a particular focus on studies which have been evaluated by randomised controlled trials.

¹⁰ Barnardo's provides services to all four UK countries. We have learnt that devolution has provided substantial opportunities for the development of innovative approaches in the devolved nations. As well as Wales, Scotland and Northern Ireland learning from developments in England, we need to ensure that adaptation of effective strategies pioneered in the devolved nations also takes place in England.

¹¹ Parents must have the opportunity to contribute to or become involved in the shaping and delivery of services, families should be able to re-enter programmes if they need to 'top up' or improve their parenting abilities and the availability of open access rather than referral only parenting programmes should be increased.

Barnardo's Parenting Matters service in Neath-Port Talbot allows parents to re-enter programmes, runs programmes in the evenings as well as during the day and has thus been successful in enrolling males, encourages friends and relatives to become involved and offers a home visiting programme for families in the greatest need. The service maintains pre- and post- intervention SDQ scores and has achieved a constant reduction from the 4th percentile danger zone to scores within the normal range. Retention rate in programmes is 80%. Staff are unable to offer open access but have estimated that an open access parenting service can be delivered to the local population

of 138,000 (0-18 years old) c. £450K p.a. An especially important part of the programme is the involvement of parents as co-educators. Empowerment arises from having an element of control over one's life - many parents, especially single mothers, have experienced nothing in their lives other than negative criticism from their own parents, schools and health and social care workers.

¹² Delinquency and anti-social behaviour is largely a male, not a female issue. High-cost, high-harm families will usually contain male children:

Moffitt, T.E., Caspi, A., Rutter, M. and Silva, P.A. (2006) *Sex differences in antisocial behaviour*. Cambridge: Cambridge University Press.

Using data from the influential Dunedin Longitudinal Study, Moffitt et al. argue that while both males and females may develop a pattern of anti-social behaviour as a result of being exposed to dysfunctional social relationships in early life, a small proportion of males, unlike females will also be affected by a developmental disorder of bio-genetic origin which may lead to some of the most persistent and intractable delinquent and criminal behaviour in later life.

The majority of Parenting Orders are imposed on females; the majority of Anti-Social Behaviour Orders are imposed on males. The children of the vast majority of lone teenage mothers have been fathered by teenage males. Yet it is still the case that the large majority of parents attending programmes, either voluntarily or through compulsion, are female.

¹³ For example, the single biggest factor influencing a woman's decision to breastfeed is the attitude of the male partner:

Giugliani, E., Bronner, Y., Vogelhut, J., Witter, R. And Perman, J. (1994) Effect of breastfeeding support from different sources on mothers' decision to breastfeed. *Journal of Human Lactation*. 10 (3): 157-161.

Male on female domestic violence is one of the biggest threats to the welfare of mothers and children during pregnancy. Withholding of financial support by absent fathers maintains mothers and children in poverty.

¹⁴ The social costs of anti-social behaviour should not be attributed primarily to mothers. Up to junior school age, the largest proportion of both costs and harm accrue not to society as a whole but to the families themselves:

Romeo, R., Knapp, M. and Scott, S. (2006) Economic cost of severe anti-social behaviour in children- and who pays for it. *British Journal of Psychiatry*, 188: 547-553.

Over three-quarters of the cost of anti-social behaviour of children aged between three and eight was borne by the family – families estimated they spent an average eight additional hours per week dealing with the consequences of destructive child behaviour.

¹⁵ Prison Reform Trust (April 2006) Bromley Briefings: Prison Factfile. At: <http://www.prisonreformtrust.org.uk/uploads/documents/factfile180710.pdf> pp. 17-18.

The UK's prison population is at a record high. Two thirds of women in prison, and almost 60% of men, have dependent children under 18 years. A third of women have children under five years. Over 17,000 children are separated from their mother by imprisonment each year – one third of this total is lone mothers. Only 84 places are available in prisons for mothers with children under 18 months. Only 5% of children whose mothers are imprisoned remain in their own homes. Some 150,000 children have a parent in prison at any one time. It is estimated that a third of prisoners' children experience mental health problems; three times higher than the general population. The government has acknowledged the importance of maintaining family ties and its contribution to successful rehabilitation. Nonetheless, numbers of family visits have fallen in recent years, prisoners continue to be held at considerable distances from their homes and arranging visits to prisons continues to cause difficulties for families.

¹⁶ A failure to support and sustain family ties is an important contributor to the maintenance of criminality. In terms of desistance from criminality, the key factor appears to be a capacity and a reason to make and sustain important social relationships in adult life. Empirical support for this thesis is reported in:
Laub, J.H. and Sampson, R.J. (2003) *Shared beginnings, divergent lives: delinquent boys to age 70*. Cambridge, Ma.: Harvard University Press.

This study is the longest follow up study of delinquent boys ever undertaken. The most significant finding was the key success criterion that caused males to desist from criminality – social ties to family and community, and the accompanying responsibilities. The tipping point occurred when men built up more social capital than they wished to risk losing through acts of criminality. This tipping point is less likely to be reached when incarceration significantly enhances the probability of relationship breakdown yet, at present, some 45% of people lose contact with their families during their sentence.

¹⁷ Barnardo's provides a developing range of services throughout the UK for parents in prison and their children, The most long standing is the Parenting Matters service, which has been working in prisons in Northern Ireland since 1996. It has developed a continuum of services in each of the three prisons in Northern Ireland. Most of the programmes are co-facilitated with members of the prison service who have been trained in Parent Facilitator Training which the service project offers. These programmes include:

Staying in Touch - a half day programme which is part of induction at Maghaberry Prison but is also delivered periodically at the other 2 prisons where appropriate.

Being a Parent in Prison – an 8-12 session programme incorporating prison initiatives such as the Book and Tape Club and Child centred visits.

Preparing for Release – a 4 session programme for prisoners at the end of their sentences dealing with preparing for home and the associated issues

Making the most of myself – an 8 session programme for women in prison about self esteem and choices.

Parenting in Prison - an 8 session programme specifically for women in prison.

Infant massage - for mothers with a baby with them in prison

Parenting the 0-5s - a programme for young offenders in prison

Parenting in the community - a programme for Partners of prisoners

Talking to children about tough issues - a 3 session programme about talking to children about drugs and alcohol. This has been delivered both in the community and in prison

The service has also produced a range of publications including *Staying in Touch*, *Support for Partners of Prisoners* and *It's a Tough Time for Everyone* (a booklet for children).

Building on this experience, Barnardo's has developed a service for women affected by domestic and sexual violence at HMP Low Newton in NE England and similar associated initiatives are currently being pursued in several sites in England, and also Scotland and Wales.

***All Barnardo's publications can be found on our website:**
<http://www.barnardos.org.uk/> or telephone 020 8498 7750