

Combining State and Voluntary Provision: Using Volunteers in Home-Based Child Protection - Preliminary Indications for the Mental Wellbeing of Family Members

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ABSTRACT

Background: In the UK there is a policy initiative to encourage volunteering to promote community participation and engagement in society. 'Volunteers in Child Protection' is a scheme promoting volunteers to work alongside statutory child care workers in complex child protection cases. Trained volunteers offer practical and emotional support to families. This project evaluated the experience of the scheme from the perspective of the families, the statutory workers and the mental health outcomes for the family.

Methods: This is a small scale mixed methods study of families subject to child protection procedures, who are very hard to engage in research. The study examines the impact of volunteers using standardized, repeat measures of mental wellbeing, plus semi-structured interviews with parents, volunteers and stakeholders.

Results: Family experience – families value their volunteers involvement and report increased confidence in their parenting capacity. Volunteer experience – volunteers feel they are performing a worthwhile service and report improvement in the families. Mental wellbeing outcomes - on referral two thirds of the families are dysfunctional, children have emotional and behavioral disturbance and some mothers have clinical levels of depression. Repeat measures indicate improvements during the volunteer intervention.

Conclusions: Volunteers can work effectively with complex families, working alongside statutory professional involvement. The volunteers are highly valued by the service users who report improved confidence in their parenting skills and improvements in their own mental wellbeing. Repeat measures support the service user's reports of improvement in children's emotional and behavioral wellbeing, family functioning and mother's mental wellbeing.

Keywords: volunteers, home-based child protection, mental wellbeing.

1. Background

Is there a 'role' for volunteers to work with families who are subject to child protection proceedings? Can they fulfil a role that is not met through statutory services or is this simply a cheaper option than using employed family support workers? It must be said, at the outset, that volunteers come at a cost (including recruitment, screening, training, matching and supervising) so they are definitely not a

'free' service. To examine the impact of volunteers we need to identify the outcomes that would be indicative of success.

Children's physical and mental wellbeing is a major priority for governments with Munro placing protecting children and supporting parents and carers as a priority (Munro, 2011). Care in the family for all except the most vulnerable, is emphasised, by government, as the preferred option for bringing up children, with service planners required to focus not just on children in extreme circumstances but on the wider community of families and children 'in need' (Children Act, 1989). Research indicates that there are many families in the community who could benefit from parenting support in one form or another, although attracting parents to attend and engaging them with parenting programmes remains a challenge (Moran, Ghate, and van der Merwe, 2004). To engage parents in support services, attention needs to be paid to relational, environmental, cultural and contextual factors and diversity issues. Trusted local professionals, trained staff and ensuring that user feedback is incorporated into changes to the service, all help to persuade parents to stay involved long enough to benefit from the service (Ghate, 2007). Ghate reports a parent view, that support means that you are still in charge: the parent is still in charge and they are asking for help, advice or whatever but they are still the one in charge and are not handing over their kids to someone else to take over. The importance of being 'still in charge' may be critical to the parent's willingness to engage with a service offered.

Parental and child mental health, family functioning and changes in the level of concern in the child protection system are key outcome indicators for improving the wellbeing of children and their families (Davidson, Duffy, Barry, Curry, Darragh, and Lees, 2010; Darlington, Feeney, and Rixon, 2005). We would expect families who are the subject of child protection concerns, would be having significant difficulty in one or more of these domains, and successful interventions would need to evidence improvement in one or more of these outcomes. At the present time the mental wellbeing of families with children 'in need' or under child protection is not routinely assessed, leaving evaluation of interventions designed to support families reliant on non-standardised measures.

1.1 Parental and Child Mental Health

Government data in the UK and research findings have consistently demonstrated that children in the care system are overrepresented in the mental health statistics (Akister, Owens, and Goodyer, 2010; Meltzer, Gatward, Corbin, Goodman, Ford, 2003). Evidence suggests that mental health problems have a serious impact on life chances (Fergusson, Horwood, and Ridder, 2005), for example, long term outcomes from national birth cohorts indicate that mental health could be a key predictor for subsequent psychosocial adjustment. Using three national birth cohorts, Richards and Abbott (2009) examined the long-term consequences of childhood and adolescent mental health problems and found that conduct problems in childhood are strongly associated with a wide range of adverse outcomes in adult life including economic inactivity, no educational qualifications, teenage pregnancy and court convictions. Additionally research shows that the children of adults with mental health problems have an increased likelihood of mental health difficulties themselves. The increased psychiatric risk for children of mentally ill parents is due partly to genetic influences and partly due to the altered natures of the parent-child interaction because of the parents' mental illness (Mattejat, and Remschmidt, 2008). For this reason, preventive strategies must involve effective treatment of the parental mental illness.

With regards to the risk of abuse for children of parents with mental illness, the research findings are conflicting and depending on the nature and degree of the illness the risk will vary. Parents with mental health problems may be reluctant to seek help for fear of initiating child protection procedures, although research by Aldridge (2006) found no evidence of physical harm or neglect.

1.2 Family Functioning

How well a family is functioning is crucial to their capacity to parent their children and to promoting the wellbeing of all family members. The capacity of the family to problem solve, communicate and to manage behaviour will influence their ability to protect their children from harm and neglect and to promote their wellbeing (Miller, Epstein, Bishop, and Keitner, 1985). In addition to a systemic approach to understanding the functioning within a family, a systems approach to the delivery of services to protect children has been proposed, which would lead to more targeted referrals and monitoring interagency involvement (Munro, 2011).

1.3 The Volunteers in Child Protection Scheme (ViCP)

The ViCP project was established by CSV (Community Service Volunteers) as a response to the Victoria Climbié enquiry, to support families in their own homes. The ViCP scheme aims to support families who are already within the 'child protection system' by virtue of having at least one child on a Child Protection Plan. They work with families with children from the full age range 0 – 16, and the volunteers work alongside local authority professional staff, offering practical and emotional support.

This study measured parent and child mental wellbeing and family functioning during the ViCP intervention to explore their mental wellbeing and mental capital (Goodyer I., 2008). Mental capital encompasses a person's cognitive and emotional resources and influences both the contribution that they are able to make to society and their experience of wellbeing. The study also looked at whether the level of concern about the safety of the children decreased through the period of involvement with ViCP. In some cases, we found that ViCP uncovered unmet need, raising previously unidentified concerns (Akister, O'Brien, and Cleary, 2011).

It is unusual to engage volunteers to work with families who have such high levels of difficulty (Eisner, Grimm, Maynard, and Washburn, 2009). Although the interventions are carried out by non-paid volunteers there is a cost in the recruitment, training and supervision of the volunteers. Informal feedback suggests that families find the ViCP scheme helpful. Other family support services using volunteers, such as Home-Start, have also been experienced as positive by the recipients (Akister, Johnson, McKeigue, & Ambler, 2003). but research has not always confirmed any identifiable or measurable benefit (McCauley, McCurry, Knapp, Beecham, and Sleed, 2006).

Is this just a cut-price solution to the problem of social worker recruitment and should this work be undertaken by qualified social workers? In 1991, the U.S. advisory board on child abuse and neglect recommended that the federal government began phasing in a national, universal home visiting programme for children during the neo-natal period (Krugman, 1993). The notion of volunteers gaining a families trust early on has been researched by the Family Welfare Association who investigated the effectiveness of Family Support Workers who were able to support families, to gain trust and to identify early indications of child protection cases (Gray, 2002). Additionally, child protection has tended to be considered simply within the family and Jack (2004) proposes a community-level aspect to protecting children, including the involvement of volunteers offering support to families.

An evaluation of the service users' experiences of ViCP concluded that although there had been initial apprehension, volunteers were acceptable to service users and were regarded by service users and social workers as making an important contribution to the wellbeing of the children and families (Tunstall, 2004).

This study examined the family functioning, parental and child mental health using standardized measures which begin to look underneath the families own experiences of satisfaction, and give us an understanding of the mental wellbeing of families at the outset as well as outcome indicators of

whether the ViCP scheme alters the trajectory that the family was on in a way that might propose long term gain from the intervention.

2. Methodology and Sample

Evaluating the ViCP project must take account of the comparative safety, effectiveness, cost effectiveness and acceptability of the intervention which is intended to improve outcomes or experience for service users. The cost effectiveness findings are presented in the report to CSV (Akister, O'Brien, and Cleary, 2011). Ethical approval for the project was given by the university ethics committee.

Families referred to the ViCP scheme are usually on Stages 3 or 4 child protection plans, with thresholds of concern measured by the Common Assessment Framework (CAF) (Essex County Council, 2011). Any movement down from Stage 4 to Stage 3, Stage 2 or Stage 1 represents an improvement in the family's parenting capacity and a reduced level of concern by professionals about the protection of the children.

This is a small scale mixed methods study. It comprises a group of families subject to child protection procedures who are very hard to engage in research. The study used standardized measures of mental wellbeing for the whole family and for individual family members and was combined with semi-structured interviews with parents, volunteers and stakeholders. The interviews explored families and volunteers expectations and experiences from the ViCP scheme and were conducted by telephone giving participants an opportunity to share their experiences of ViCP (Akister et al., 2011).

The General Health Questionnaire (GHQ), Family Assessment Device (FAD) and Strengths and Difficulties Questionnaire (SDQ) have been extensively used are well validated, enabling comparisons of the ViCP sample with normative community populations. Questionnaires were sent out when a volunteer was assigned to a family and the measures were repeated after 3 months and again at the 6 month point.

The GHQ is an established instrument for identifying mental health difficulties in adults. There are a number of versions of the GHQ, and the 12 item GHQ has proved remarkably robust for use as a screening instrument and case detector, and works as well as the longer version of the instrument. It is recommended as a screening tool to detect mood or anxiety disorders (Goldberg, Gater, Sartorius, Ustun, Piccinelli, Gureje and Rutter, 1997; Cano, Sprafkin, Scaturo, Lantinga, Fiese and Brand, 2001).

The FAD was developed by the McMaster research group in Canada and has been tested for reliability and validity in over 50 countries, including the UK. It is a screening device used to detect difficulties in Family functioning and has established cut-offs for Family wellbeing (Miller, Epstein, Bishop, and Keitner, 1985). There is a 60-item version and a 12-item version. The 12-item version used here identifies difficulties in general functioning as contrasted with the 60-item version which identifies areas of specific difficulty. The 12-item version is generally used as a screening tool.

"Before" and "after" SDQs can be used to audit everyday practice (e.g. in clinics or special schools) and to evaluate effectiveness of specific interventions (e.g. parenting groups) (SDQ, 2012). Studies using the SDQ along with research interviews and clinical ratings have shown that the SDQ is sensitive to treatment effects. The SDQ's emphasis on strengths as well as difficulties makes it particularly acceptable to community samples where it can predict the presence of a psychiatric disorder with good specificity and moderate sensitivity.

The GHQ and the SDQ were completed in relation to one member of the family, mother and focal child. If these reveal problems at the outset then this can indicate that these individuals may need specialist help in addition to any intervention offered to the whole family.

2.1 Case studies

Three case studies were compiled using qualitative and quantitative information from the questionnaires, interviews and from the CSV case records for individual families. They give a window into the experiences of the families and also demonstrate how while one measure e.g. maternal mental health may improve another measure may not. As a result of this complexity it is important to examine some of the individual experiences through the use of case studies (Akister et al., 2011). One case study is included in this paper.

2.2 Sample

The study took place in the ViCP project in Southend-on-Sea. At the outset of the study all families (n=37) who were currently engaged with the Volunteers in Child Protection Project (ViCP) were invited to participate, and of these 13 families agreed to participate. Questionnaires were to be completed at the initial contact phase, and repeated at 3 months and then at 6 months. It is extremely difficult to engage these families in research as they are under surveillance with regards to child protection issues and tend to be both distressed and disorganized. For these reasons it was agreed to use the volunteers as researchers rather than introduce yet another person into the family. Volunteers were trained to administer the questionnaires. Families were asked if they would be willing to participate in a telephone interview to further discuss their experiences and expectations of ViCP. The telephone interviews were conducted by one of the researchers (NO'B).

Due to the small numbers who completed second and third questionnaires we cannot draw any firm conclusions about change during the intervention in the whole sample. We are able to characterize the sample at Time 1 and we have included a case study of one family who completed all the questionnaires. Research carried out by Tunstill experienced the same problems with recruitment and retention of the sample (Tunstill, and Malin, 2011).

3. Southend-on-Sea Demographics

Southend has areas of both extreme deprivation and high affluence, with approximately 45% of the borough's population living within the 20% most deprived areas in the East of England (Southend Children's Partnership, 2009). Southend is deprived in terms of income, employment, health, education, barriers to education and crime, with the figures for living environment deprivation being very high (Office for National Statistics, 2010). Children living in deprived areas do less well than their peers, raised in more favourable areas, in relation to attainment and general quality of life (Scott, O'Connor, and Fauth, 2010), with research by the Office for National Statistics of over 10,000 children aged 5-15 reporting that children in low income families (16% of sample) were three times more likely to have a 'mental disorder' than those in high income families. However if those children growing up in poorer areas receive warmth and encouragement from their parents they may succeed just as well as their peers (Scott et al., 2010).

A review of US studies shows a link between families receiving welfare and child maltreatment (Fauth and Ellis, 2010). Children of families in receipt of welfare were 3.3 times more likely to be repeatedly maltreated than children whose family did not rely on benefits.

Environmental factors such as poverty, and unsafe neighbourhoods combined with maltreatment and poor childcare creates a very dangerous situation for children (Office for National Statistics, 2010).

Such disadvantage may hugely disrupt a parent's ability to cope, with families under stress need extra support. Barnardo's (2010) provide revealing data about parenting:

- 61 per cent of British parents describe parenting as 'fairly' or 'very difficult'.
- 94 per cent of parents say it is helpful to talk to another person about parenting problems (Akister, & Johnson, 2004).

4. Results

4.1 Family Functioning and Mental Wellbeing for all the Families

a. Children's Behaviour and Wellbeing

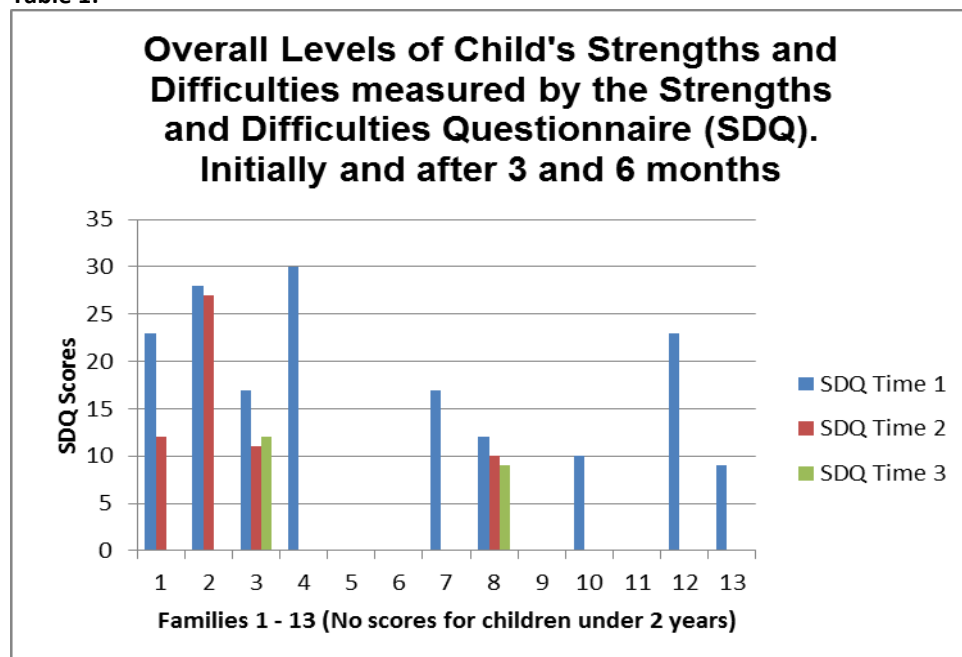
The SDQ scores for the children on referral to ViCP are a cause for great concern (see Table 1; where there are gaps in Table 1 this is where the child is under 2 years of age and too young for an SDQ to be completed).

The SDQ questionnaire is completed by the parent in respect of the focal child and is an effective screen for children's emotional and behavioural difficulties. The average British scores for an SDQ completed by parents are 8.4 (s.d. 5.8) (SDQ, 2012). This would mean that we would be concerned about scores greater than 14.2 and scores above 20 would be exceptional. From Table 1 we can see that in 6 of the 9 families where the child was old enough for the SDQ to be completed, the child's SDQ scores are above 14.2 and for four families the child's SDQ scores are above 20. These scores indicate high levels of emotional and behavioural difficulty being experienced by the child and emphasize the need to assess the child's wellbeing as well as that of the whole family.

For all the families who completed the SDQ at Time 1 and Time 2 there was an improvement in their scores, which was also reflected in the parental interviews.

Families 3 and 8 completed the SDQ at Time 3 and both report sustained improvement (see Table 1 below).

Table 1:



b. Parental Mental Health

With the GHQ scoring method (Goldberg et al., 1997, any scores higher than 2 are indicative of mental health concerns; the higher the score the greater the level concern. The maximum score is 12.

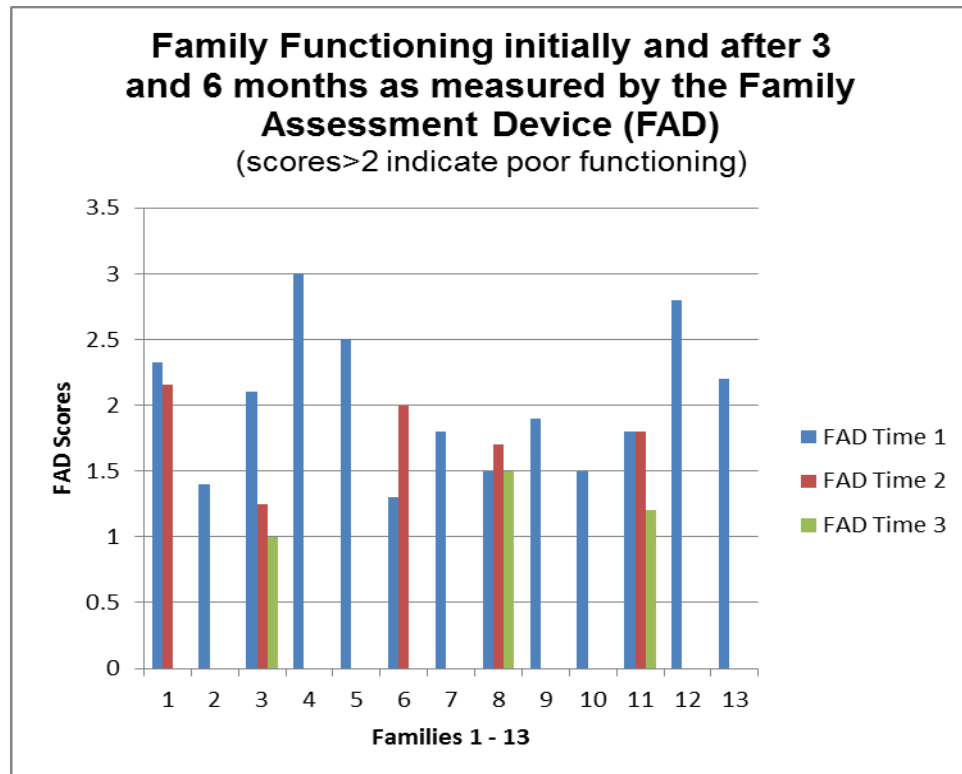
All the mothers described being depressed although in only 2 cases did their GHQ scores reach clinical levels. For the majority of the sample, they are overwhelmed by their circumstances and lack confidence to deal with the parenting task and to engage with helping services. Although not clinically depressed their wellbeing is clearly of concern.

The 2 mothers who scored in the clinical range at Time 1 had high scores (Family 3, GHQ=9 and Family 12, GHQ=8) suggesting that they are highly likely to have clinical mental health problems. At Time 2 there was considerable improvement for both mothers (Family 3, GHQ=4 and Family 12, GHQ=0) and this improvement continued for Family 3 at Time 3 (GHQ=0). During their time with the ViCP scheme, both mothers GHQ scores moved from the clinical (>2) to non-clinical range. None of the other mothers reported significant mental health concerns (GHQ>2) at Times 1, 2 or 3.

c. Family Functioning

The 12-item version of the FAD has a cut-off established for family dysfunction of scores >2 (Miller et al., 1985). Half of the families (6 out of 13; see Table 2) have scores of 2 or above. This is interesting as we might have expected all the families coming under the remit of Stages 3 and 4 of child protection concern to report difficulties with their family functioning. The explanation may lie in the fact that families in this situation have most difficulty in the interface of the demands of society such as getting the children to school and may not be entirely unhappy with their family circumstances per se. The difficulty of coping with external demands, such as getting the children to school or going to the doctor, can reflect an inability to deal with their child's needs as well as their own needs.

Table 2:



For the 5 families who completed the FAD at Time 2, Families 1 and 3 reported improvement in their family functioning and Families 6 and 8 reported having more difficulty. For Family 8 this related to the children returning from out-of-home care to the family home, and the score still falls in the functional range. For Family 6 the FAD score is worse but overall improvements in the professional assessment of the family led to decrease in the CAF level from 4 to 2.

All 3 families who completed the FAD at Time 3 report improvement in their family function, with their scores at Time 3 indicating good family function.

4.2 Case Study: An individual Family Experience with ViCP, including Family Functioning and Mental Wellbeing

A case study is presented to illustrate the family experience and their responses to their volunteer. This case study draws on information collected from the questionnaires, from the case files and from telephone interviews with the mother and with the families volunteer. Family 3 completed questionnaires at Times 1, 2 and 3.

Family 3

Family 3 were subject to Stage 4 safeguarding procedures and were referred to ViCP by their social worker as it was felt a volunteer could help address parenting, finance, family dysfunction and unpleasant living arrangements. Family 3 are a one parent, White British family including mother and 4 children. The eldest child is a 16 year old girl who, due to mother's depression, has taken on the caring role within the family. Social services referred the family to ViCP as they were concerned that Family 3 were not engaging with provided services, and the children were subject to a Child Protection Plan under the category of 'neglect'.

The ViCP volunteer visited for one hour twice a week and provided practical help and support relating to budgeting, helping to maintain the family home, ensuring appointments are kept, helping with healthy cooking and eating and supporting engagement with other agencies such as mental health services for mum who suffers with depression. Other agencies that the family had been referred to included Family Mosaic and the Dove project. The Dove project is a support service for women and children experiencing domestic violence and Family Mosaic provides support relating to housing issues, money matters and health issues.

a. Family expectations and experiences

The mother of Family 3 expected that having a volunteer would help her to change. She believed that the break up of her marriage had affected her mental health and as a result she was spending most of her time in bed. She also said that she wanted practical help from the ViCP volunteer to help her tidy her house and encourage the children to help in this process and maintain the home together.

Below is the mother's description of the ViCP volunteer:

'She is brilliant, she is like an extra mum – teaching my little one how to play the guitar and she bakes cakes with them. She encourages the boys to tidy their room – they wouldn't do it for me (laughs). She fits in perfectly with my Family.

She's got me out of bed and got me doing things with the kids. She has let me be me again and helping with family functioning.'

b. Volunteer expectations and experiences

The ViCP volunteer said it was the children who took on the role of tidying the house and keeping things in order and described how she has worked with Family 3 to tidy up certain rooms or set them the task of having it done by her next visit:

‘Mum doesn’t use her role as a mum to encourage everyone to do it and to stop dropping their clothes etc in the house. Sometimes I don’t even feel its one step forward two back, its more like one forward, three or four back. Sometimes mum takes the initiative but most of the time her philosophy is to get the kids to do it. It’s a lot more involved than tidying up. There has now been a role reversal, mum has been ill although there are suspicions that she has become quite manipulative with it, she was lying in bed all day and the children were looking after themselves. This has changed somewhat where the children are now refusing to do things unless mum helps. I think we’ve reached a stale mate.’

The children in Family 3 have been helped to take pride in their home but also to encourage mum to do the same. This case is still ongoing. The biggest change reported has been in the children’s school attendance. The ViCP volunteer also commented on this:

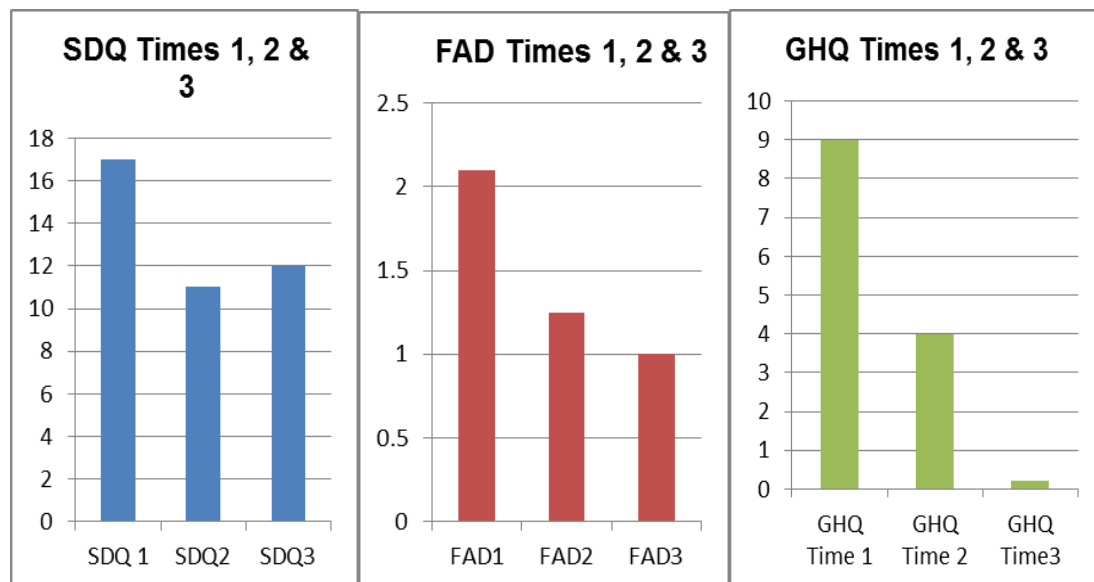
‘For one of the children his attendance was 48.6% but since September-December it went to 100% he even got an award for it. He is hoping to do his GCSE’s and the school is very supportive.’

The family is now working together to maintain the family home and have been moved from Stage 4 to Stage 3 child protection concerns. Improvements reported in the interview are supported by the questionnaire data (see Table 3).

c. Findings from the questionnaires for Family 3

All the questionnaire results suggest improvement in wellbeing for this family during the period of the ViCP intervention. From Table 3 we can see that the mothers GHQ score at the outset indicates clinical mental health problems (GHQ=9 (GHQ>2 indicates clinical concern)). The GHQ score improves over the three time periods, remaining at clinical levels at Time 2 (GHQ=4) and continuing to improve to a non-clinical score by Time 3 (6 month period). This supports the mothers’ view that the presence of the ViCP volunteer has led to significant improvement in her mental health.

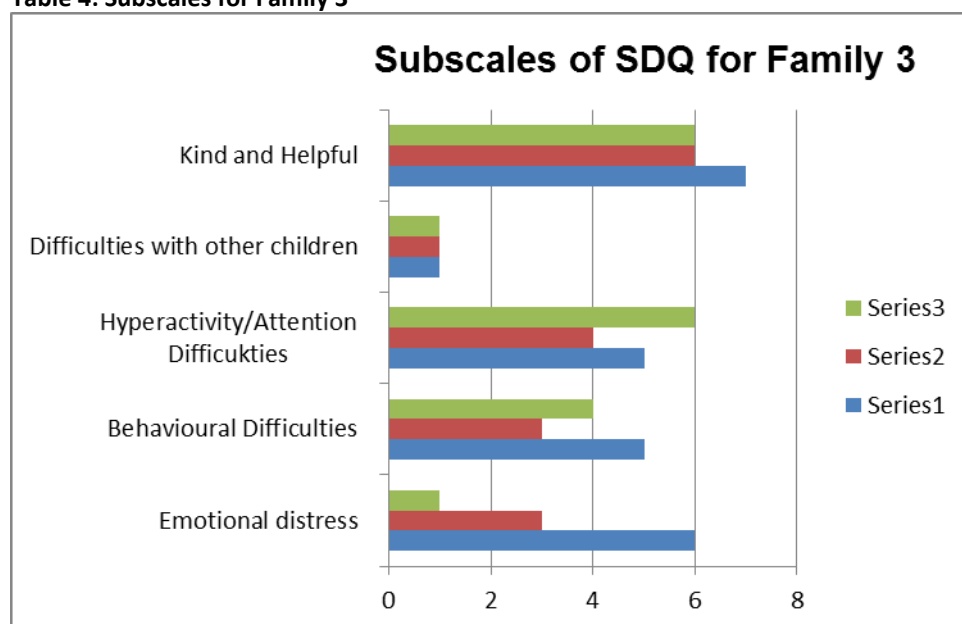
Table 3: Family 3 - Changes in the Parent Mental Health Measure (GHQ), the Child Mental Health Measure (SDQ) and Family Functioning between Times 1, 2 and 3



Family functioning (see FAD scores in Table 3), also improves during the period and moves from 2.1 at Time 1, to 1.3 at Time 2 and to 1.0 at Time 3 (cut off FAD>2.0). This indicates that family functioning has significantly improved, moving into the healthy range and the improvement has been sustained between Times 2 and 3 (see Table 3).

Finally, the child's overall stress (as measured by the SDQ, Table 3) improves. At the outset the child's overall SDQ score is high (SDQ=17) but after 3 months with ViCP this has lowered and the improvement is sustained at 6 months (GHQ=12 at Time 3). The subscales of the SDQ score are shown in Table 4. At Times 2 and 3, the mother reports the child to have fewer behavioural difficulties than at the outset and to show much less emotional distress. There is no change in getting along with other children and the low score here suggests that the child gets on well with other children. Hyperactive behavior decreases at Time 2 and increases a little again at Time 3, and the child is reported to be less kind and helpful at Times 2 and 3. The decrease in 'kind and helpful' behaviour is to be welcomed as the child was described by the volunteer as taking too much responsibility at the outset.

Table 4: Subscales for Family 3



Overall all the measures, qualitative and quantitative indicate improvement for Family 3. Importantly, the CAF level, a measure external to the ViCP project has been lowered from level 4 (children with complex needs, usually in need of specialist services and statutory intervention) to level 3 (children with additional needs, requiring a lead professional and targeted multi-agency response).

5. Implications/impact of ViCP Scheme and Limitations of the Study

The findings from the questionnaires indicate that the ViCP families have high levels of dysfunction, particularly in relation to the children's emotional and behavioural disturbance at the beginning of their contact with ViCP. Some of the mothers also have clinical levels of depression. Where there are repeat measures, there are improvements during the period of the ViCP intervention.

As with any study there are limitations. It is very difficult to engage these families in research and so the numbers of questionnaires returned is lower than we had hoped for and there are less returned at times 2 and times 3 than we would wish. We plan to repeat the study to increase the return of the questionnaires using research staff rather than volunteers, as this would lend greater weight to the findings and to the question of generalisability. We will also use a more structured interview tool to explore early experience (Cambridge Early Experiences Interview (CAMEEI)) (Dunn, Abbott, Croudace, Wilkinson, Jones, Herbert, and Goodyer, 2011).

There is also the issue that there are other agencies who continue to be involved with these families at the same time as ViCP and it is not possible to be precise about the contribution of each, although both the families and the stakeholders indicate their view that ViCP is pivotal to the changes observed

6. Discussion

At the outset of the ViCP intervention the reports on children's' wellbeing (SDQ scores) are of great concern. Parents report their children' as having emotional and behavioural difficulties in two thirds of the sample. When working with families under child protection much of the initial focus of the work is on the capacity of the parents to improve their parenting to an acceptable level of care (Budd, 2001; Woodcock, 2003). The focus on the child relates to levels of neglect and safety, and would not, necessarily, in the first instance consider their mental wellbeing. Difficult behaviour can be interpreted as related to inconsistent parenting, when it may be reflecting problems with mental wellbeing. The question of the knowledge base and interpreting what we see remains complex (Akister, 2011). If we focus on the parenting skills, rather than the wellbeing of the child and family this may increase the risk to the child (Horwath, 2011).

Half the ViCP families report dysfunctional family functioning. At first glance this is surprisingly low, but families subject to professional concern can be relatively happy with their home circumstance but have difficulty with meeting external demands such as school or workplace. Part of the problem may be that they do not see their parenting as neglectful or abusive. Part of it is also that they lack confidence in engaging with the community and with services outside their own four walls.

Similarly, while many of the mothers' describe being depressed, their GHQ scores only place 2 (out of 13) in the clinical range of mental health concerns. These mothers both reported marked improvement in their mental state which they attributed to the involvement of their ViCP volunteer. It is important not to ignore the expression of depression, even though it does not reach levels requiring clinical intervention. The sense of isolation and difficulty in meeting their children's needs, combined with their lack of confidence to engage with services they are referred to, makes these parents feel 'hopeless'.

ViCP are working with extremely complex families who are very hard to engage, and for the small number of families in this study there is evidence of marked improvement after the ViCP intervention, either in their questionnaire data or in the changes of levels of concern from social workers. It has to be noted that the ViCP intervention takes place in the context of continued, active social work and in the context of other provision being on offer for these families. Thus it would not be accurate to claim that all the change relates to the ViCP scheme. Nonetheless the nature of the relationship between the volunteer and the family may be the catalyst promoting positive outcomes. Munro (2011) proposes that relationships need to be forged with these families and a systemic approach to service delivery is required to foster effective engagement between the family and the agencies they are involved with. The fact that the volunteer, who does not have to spend time with them is prepared to do so is commented on by the families as giving them a sense of worth. Also the presence of someone

who will actually accompany them to places they have been referred to facilitates engagement with the world outside the home.

Overall families reported a very positive experience with their volunteer: *"My volunteer was second to none."* Families were also able to recognize that they needed the support of a volunteer in order to help them improve their home life for their children, including practical help and advice, support with mental health problems and help to move away from child protection. Families reported that volunteers were supporting them emotionally and found that the practical help, for example attending an appointment with them, developed their confidence to do these things independently. The lack of confidence to engage in arenas outside their home, including doctors' appointments and school, is a major barrier to improving parenting competence and this aspect is clearly improved by being accompanied by a trusted volunteer.

The experiences of the volunteers are interesting in themselves, as the engagement and management of the volunteers in work of this complexity is challenging. Volunteers spoke about the wonderful experiences they had with their families despite being apprehensive to begin with. Many spoke about the wonderful relationships they had developed with their families and how they felt a sense of empowering the families to make positive changes in their lives. The volunteers themselves described how challenging the work can be, but also praised their families for the good work they are trying to do, and indicating their belief that the project is a very worthwhile resource for families experiencing the types of difficulties these families have had to deal with.

Not everything will go well, or be positive and there were 2 cases (Families 4 and 7) where the volunteers identified 'unmet need' and were able to alert professionals to this. This is not an easy experience for the volunteer, who is hoping to 'make a difference' and needs careful management and supervision (Eisner, Grimm, Maynard, and Washburn, 2009). This outcome is just as important as a successful outcome for the family, since it facilitates raising levels of concern and intervention and therefore potentially improved outcomes for the child.

7. Conclusions

This is a small scale study of an innovative approach to child protection, using volunteers to work with complex families with high levels of need. This approach articulates with the findings of the Munro report (2011), proposing a relationship based model to assist these families in practical ways, and operating within a systemic approach to service delivery. The ViCP scheme works alongside statutory professional involvement adding a voluntary dimension and is highly valued by the service users who report improved confidence in their parenting skills and improvements in their own mental wellbeing. Questionnaire responses support the service user's reports of improvement in the three dimensions of children's emotional and behavioural wellbeing, family functioning and mother's mental wellbeing.

All the improvement cannot be attributed to the ViCP scheme, as other agencies and professionals are involved with all the families. The ViCP scheme does appear to be pivotal in facilitating the engagement of these families in the range of services and activities required for effective parenting. The parents experience the volunteer as 'being on their side' and as a resource that they are able to use for both practical support and for guidance.

List of Abbreviations

CAF – Common Assessment Framework
CSV – Community Service Volunteers
FAD – Family Assessment Device
GHQ – General Health Questionnaire
SDQ – Strengths and Difficulties Questionnaire
ViCP – Volunteers in Child Protection

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